Oregon inventory of services for co-occurring substance use and mental health disorders, 2022

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Acknoweldgements

Authors:

Sara Rainer, MPH[a]
Elizabeth Needham Waddell, PhD[a,b]

[a]Oregon Health & Science University-Portland State University School of Public Health
[b]Section of Addiction Medicine, Division of General Internal Medicine OHSU School of Medicine

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Oversight provided by:

Samantha DuPont, MPH
Health Systems Division, Oregon Health Authority

Samantha Byers, MPA
Health Systems Division, Oregon Health Authority

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Executive Summary

Background

In Oregon and nationally, a substantial proportion of clients in treatment for substance use disorders also have a mental health disorder. According to the 2022 National Substance Use and Mental Health Services Survey (N-SUMHSS), 59% of substance use (SU) treatment clients in the United States (US) have a co-occurring mental health disorder (COD), compared to 69% of SU treatment clients in Oregon. Among mental health (MH) clients in the US, 27% have a diagnosed SU disorder, compared to 37% of MH treatment clients in Oregon.[1]

A detailed inventory of services offered by both SU and MH treatment programs improves understanding of the state's capacity to provide (COD) treatment. This report describes the current availability of programs that provide both SU and MH treatment. Data sources include self-reported service information from Oregon programs that responded to the 2022 N-SUMHSS and the 2022 OHSU-PSU School of Public Health Substance Use Disorder Services Survey (SUDSS). Topics include: 1) overview of MH and SU treatment services, 2) detoxification, 3) medications, 4) smoking, 5) gambling, 6) emergency mental health services, 7) physical health screening, ancillary services and recovery support, 8) harm reduction, and 9) health equity.

Key findings

Overall, Oregon's behavioral health system has limited capacity to treat patients with both SU and MH disorders concurrently.

- 42% of outpatient SU programs indicated they treat COD, compared to 33% of residential SU programs.
- 81% of MH programs indicated they treat COD, with no difference between residential and outpatient programs.
- While 81% of SU programs offered screening for mental disorders, 49% provided comprehensive mental health assessments.
- MH programs frequently reported providing individual and group counseling (63% and 52%, respectively) and case management (47%) for clients with COD, but most did not offer medications for alcohol use disorder (21%) or opioid use disorder (28%).

Key findings

Among programs reporting that they treat COD:

- 51% of SU COD programs offered treatment for gambling disorder.
- SU COD programs offered a wide range of ancillary services and recovery support, but only 59% reported offering naloxone and overdose education.
- 39% of SU COD programs administered/prescribed medications for alcohol use disorder (67% of residential and 36% of outpatient,).
- 35% of SU COD programs prescribed buprenorphine for opioid use disorder (42% of residential and 36% of outpatient).
- Programming for specific populations including LGBTQ and youth clients was rarely offered. Just over one third of COD programs offer services in Spanish, and half offered services in sign language.
- Among residential SU COD programs, 58% accepted Medicaid, and 25% accepted Medicare. Among residential MH programs that treat COD, 97% accepted Medicaid, and 55% accepted Medicare.

Recommendations

The recommendations below respond directly to self-reported survey data from Oregon behavioral health programs. They are intended to inform ongoing state efforts to improve access to and quality of services delivered to clients with COD.

- SU programs reported lower rates of COD treatment (33% in residential and 42% in outpatient programs), compared to MH programs (81%). This disparity suggests a need to **prioritize support for SU treatment programs** that serve clients with COD.
- 83% of SU programs conducted mental health screenings, but only 49% provided comprehensive mental health assessments. Efforts to **increase the dually-credentialed workforce in SU settings are essential to enable timely assessment and referral to specialty mental health care** as needed.

Recommendations

- Within MH service settings, just 21% of programs reported offering medications for AUD, and 28% offered medications for OUD to their clients with COD. In support of a no wrong door approach to treatment, **evidence-based medications for both AUD and OUD should be available to all clients with COD through on-site prescribing or partnerships with prescribers, including OTPs**.
- While SU COD programs offered comprehensive transitional and ancillary services to support long term recovery of clients, only 59% reported offering naloxone and overdose education. **Continued efforts to expand access to overdose reversal drugs along with workforce education regarding the importance of harm reduction** are needed. Current OHA initiatives include statewide efforts to expand harm reduction and syringe service interventions. Save Lives Oregon launched in 2020 as a resource hub to distribute harm reduction supplies and educational materials.[2]
- More qualitative research is need to understand barriers to and facilitators of access to SU and MH treatment experienced by Oregonians at highest risk for untreated SU and MH conditions. This **research needs to include voices of both current behavioral health clients, as well as those who are not in treatment**. These include individuals experiencing homelessness, individuals involved in the criminal legal system, and those cycling through Oregon's emergency departments and the State Hospital.
- New analysis of insurance claims data could identify more specific gaps in concurrent services for those diagnosed with COD and document length of time between billed encounters for MH and SU treatment. Subgroup analyses could **identify disparities in concurrent treatment for COD by race, ethnicity, gender, and geography**.

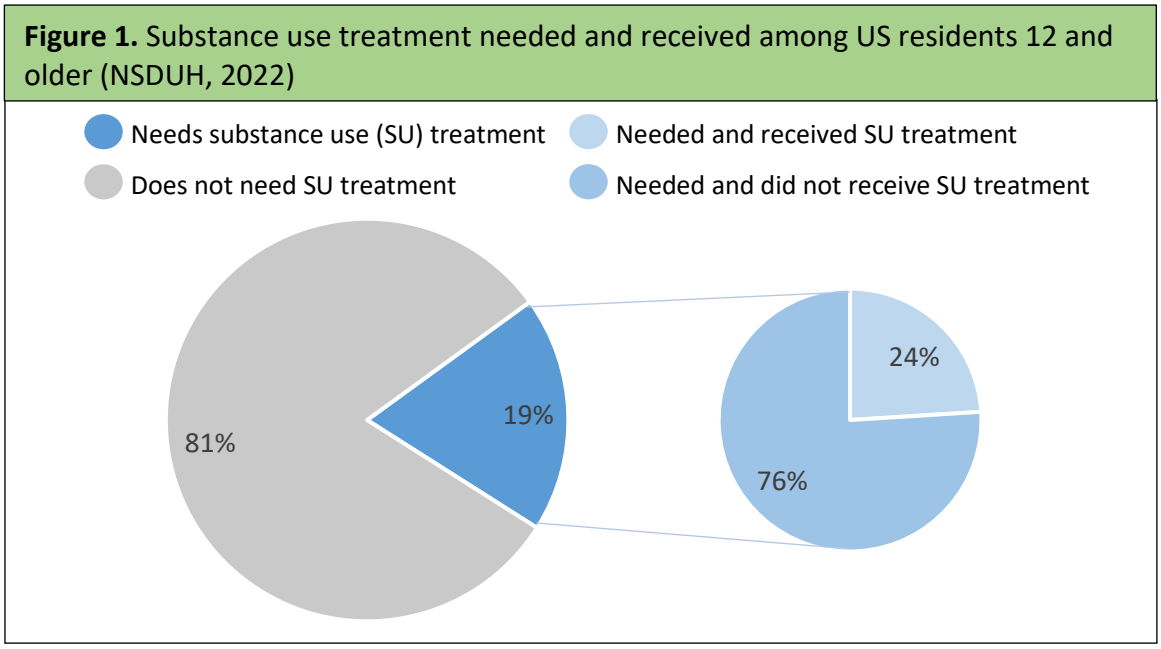
Background

In Oregon and nationally, a substantial proportion of clients in treatment for substance use disorders also have a mental health disorder. According to the 2022 *National Substance Use and Mental Health Services Survey* (N-SUMHSS),[3] 59% of substance use (SU) treatment clients in the United States (US) have a co-occurring mental health disorder, compared to 69% of SU treatment clients in Oregon.[1] Among mental health (MH) clients in the US, 27% have a diagnosed SU disorder, compared to 37% of MH treatment clients in Oregon.[1] This report describes Oregon's treatment landscape for co-occurring SU and MH disorders based primarily on 2022 N-SUMHSS survey data collected from 173 SU and 108 MH treatment programs across the state.

1) Prevalence and treatment of mental health and substance use disorders

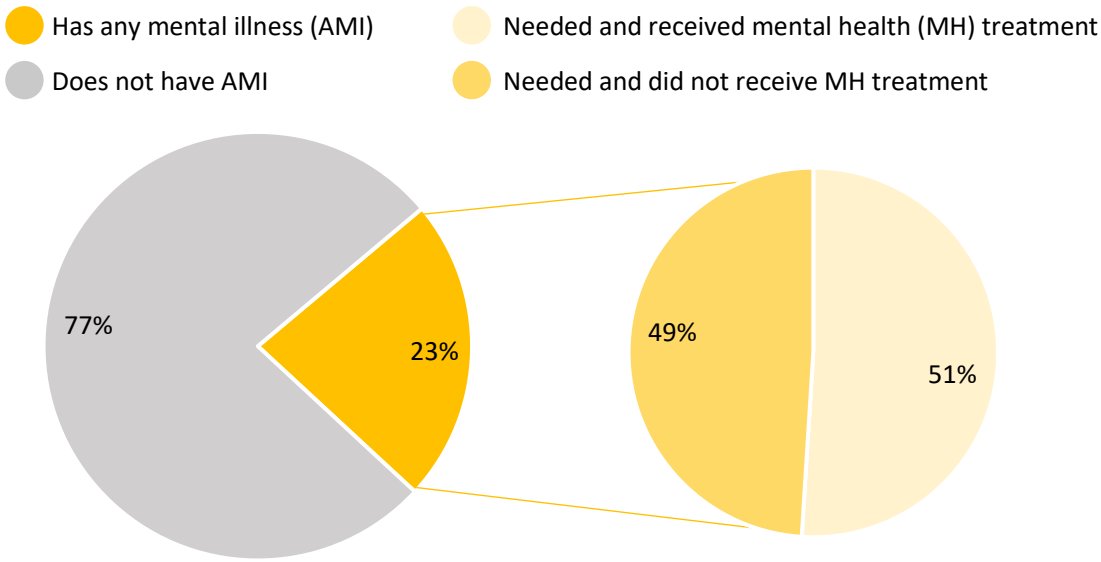
Those in treatment for MH or SU disorders represent only a fraction of individuals who have a MH or SU disorder. Data from the 2022 *National Survey on Drug Use and Health* (NSDUH)[4] suggest a treatment gap between those who have a MH or SU disorder and those who receive treatment for their MH or SU disorder. Among those with SU disorders; almost 1 in 5 (19%) of people 12 and older in the US were classified as needing SU treatment, but only 24% of those needing treatment received SU treatment or other services in 2022 (Figure 1).[5] Most (95%) of those who did not receive treatment did not seek it because they did not think they should get it. Top barriers to SU treatment among the remaining 5% who sought treatment or thought they needed it included: thought they should be able to handle alcohol or drug use on their own (75%), not ready to start treatment (52%), thought it would cost too much (46%), did not know how or where to go (48%), and were worried what people would say (42%).[5]

Figure 1. Substance use treatment needed and received among US residents 12 and older (NSDUH, 2022)



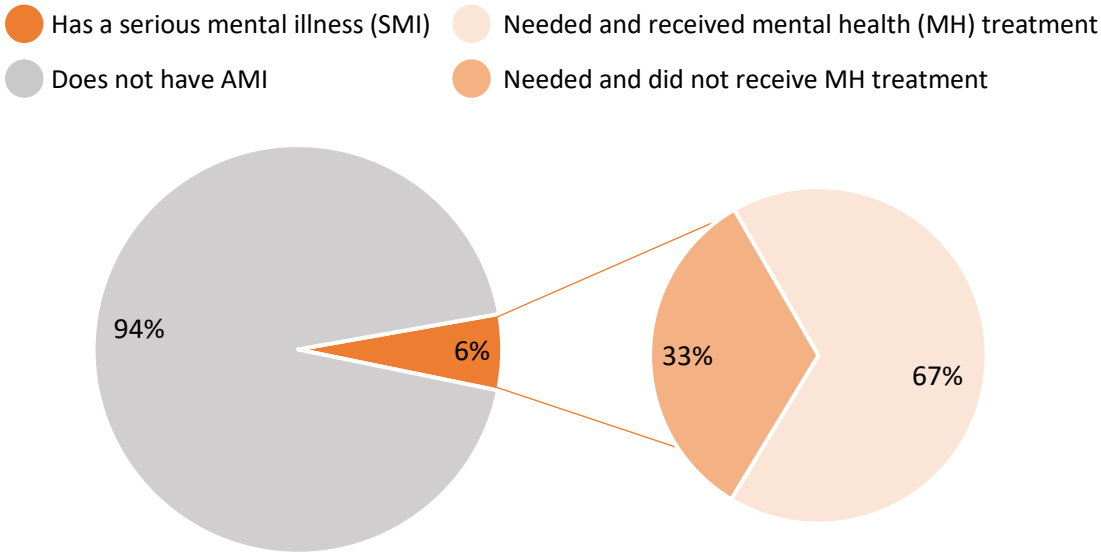
MH prevalence and treatment rates for US adults in 2022 are somewhat higher. In total, 23% of adults were classified as having any mental illness (AMI); 51% got treatment (Figure 2).[5]

Figure 2. Mental health treatment needed and received among US residents 18 and older with any mental illness (NSDUH, 2022)



6% of adults were classified as having a serious mental illness (SMI) that substantially limits one or more major life activities. 67% got treatment (Figure 3).[5]

Figure 3. Mental health treatment needed and received among US residents 18 and older with a serious mental illness (NSDUH, 2022)



94% of all adults 18 and older (including but limited to SMI) who did not receive MH treatment did not seek treatment and did not think they should get it. Top barriers to MH treatment among the remaining 6% who sought treatment or thought they should get treatment included: thought they should be able to handle their mental health, emotions, or behavior on their own (70%), not ready to start treatment (49%), thought it would cost too much (52%), did not know where to go (51%), and did not have enough time (44%).[5]

2) Prevalence and treatment of co-occurring serious mental illness and substance use disorders

Treatment of clients with severe SU and MH diagnoses includes intensive case management and ancillary services, as well as long term recovery support. Nearly 3% of US adults have a co-occurring SUD and serious mental illness (SMI), defined as people with AMI that resulted in serious functional impairment. Adults with co-occurring substance use and **any** mental health disorder (AMI) represent a small population[5] but their service needs are urgent and client outreach is crucial to increase engagement in care.

People with co-occurring SU and MH disorders (COD) are at a higher risk for morbidity and mortality than those with SU or MH disorders alone, and experience a higher risk of homelessness, incarceration, self-harm, and suicide.[6] Further, the presence of an untreated substance use disorder (SUD) may contribute to or worsen a mental condition, and vice versa.[7,8] People with COD have a higher level of involvement with the criminal justice system. A recent Pew Research Center report analyzing NSDUH data show that nearly 10% of adults with COD were arrested annually, which is twelve times more than adults with neither a MH or SUD, and six times more likely than those with a mental illness alone.[9]

Current SAMHSA guidelines for COD recommend concurrent treatment for SU and MH disorders,[6,10-12] but 2022 national data suggest a treatment gap for this population – particularly for needed SU treatment. 71% of US adults who had a co-occurring SUD and SMI in the past year received any SU or MH treatment; 23% received both SU and MH treatment. 45% of adults with co-occurring SUD and SMI received MH treatment only, and 2% received SU treatment only.[5] Note that adults with COD are a subset of those with any SUD or MH treatment need. While reasons for not seeking treatment were not published for this subpopulation, we can assume that they are similar to those described above.

3) Oregon inventory of services for co-occurring substance use and mental health disorders

In Oregon, the overall service gap (the number of services needed in Oregon compared to the actual number of services available) is at least 49% for SUD prevention, treatment, harm reduction, and recovery services, and likely higher for those with complex mental health and substance use treatment needs.[13] In an effort to better understand the extent to which services for COD clients have capacity to meet their complex medical and social needs, the OHSU-PSU School of Public Health conducted and inventory of current services offered to adults with SU, MH and COD. The US Department of Health and Human Services (HHS) recommends that conducting an inventory of existing services is necessary as a foundation for estimating specific

gaps in services in any locality, but this process is highly complex in practice. Treatment system boundaries are difficult to define, and multiple data sources are required to establish an accurate baseline (e.g., analysis of SAMHSA's annual N-SUMHSS; local surveys). A direct inquiry of all service locations, the majority of which are reporting service information to SAMHSA and other entities, allows localities to leverage existing sources of service information and increases local knowledge to inform assessment of capacity.[14] Data for this descriptive report are from the 2022 N-SUMHSS[15-17] and the 2022 *Oregon Substance Use Disorder Services Survey* (SUDSS).[13,18]

Findings are reported for outpatient programs, residential treatment facilities, and medical detoxification programs. Topics include:

1) Overview of co-occurring substance use and mental health treatment programs;
2) Detoxification (medical withdrawal);
3) Medications used in treatment;
4) Smoking policies and treatment;
5) Gambling disorder treatment;
6) Emergency mental health services;
7) Health screening, ancillary services, and recovery support;
8) Harm reduction; and
9) Health equity.

4) Treatment strategies for co-occurring substance use and mental health disorders

SAMHSA identifies six guiding principles for treating clients with COD:[6]

1) Use a recovery perspective, recognizing that changes proceed through various stages.

2) Adopt a multi-problem viewpoint that includes both immediate and long-term needs for housing, work, health care, and a supportive network.

3) Develop a phased approach to treatment, including engagement, stabilization/persuasion, active treatment, and continuing care.

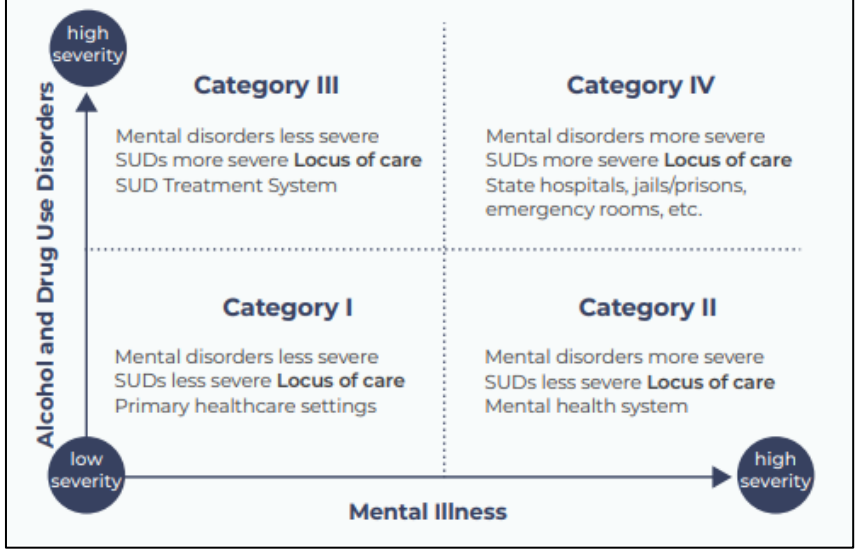
4) Address specific real-life problems early in treatment. Approaches might include case management, vocational services, legal support, and housing services.

5) Plan for the client's cognitive and functional impairments, with services tailored to clients' individual needs and functioning.

6) Use support systems to maintain and extend treatment effectiveness. These might include family, peer providers, faith community, and other community resources.

The National Institute on Drug Abuse, the National Institute of Mental Health, and the National Alliance on Mental Illness, have common recommendations and best practices for treating clients with COD, which are consistent with these six principles.[6,19,20] Service models for treatment of COD range from basic screening and brief intervention for SU or MH disorders and referrals to external services, to warm hand-offs to co-located providers, to fully integrated care teams where SU, MH, and primary care sit under one roof.

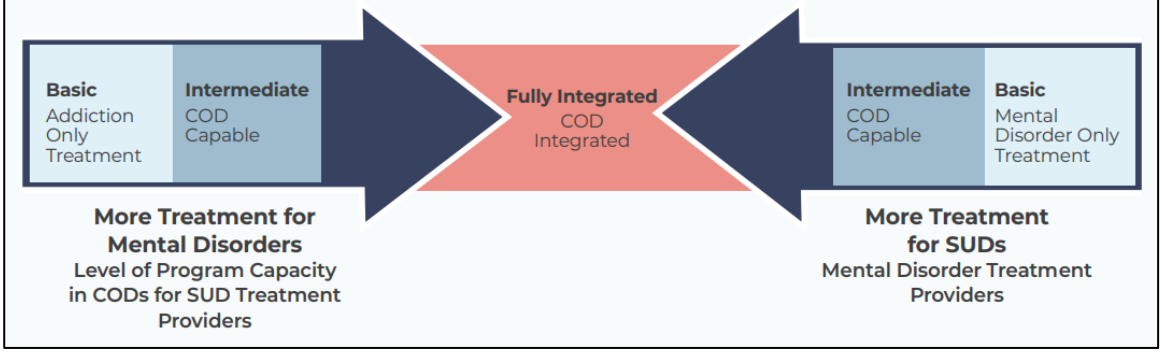
Figure 4. Four Quadrants Model



Treatment and referral strategies implemented by providers are directly related to both the clients served and the level of program capacity. The **Four Quadrants Model** is a conceptual framework that helps providers group clients based on severity of symptoms to inform appropriate levels of care (Figure 4).[6] Based on this model, clients with lower severity of MH and SU illness may be adequately served in a primary care setting. Clients with less severe SU illness but higher severity MH illness are more likely to be served in mental health settings, while clients with more acute or severe SU illness are more likely to be seen in the SUD treatment system. When severity of SU and MH illness are both high, clients' needs are least likely met in primary care, MH, or SU treatment settings. These clients, who may benefit most from fully integrated treatment settings, are at highest risk for untreated illness resulting in emergency room, state hospital, or carceral stays.[6]

The **Levels of Program Capacity in CODs** provides a classification system for COD programs and their capacity to provide treatment for one or both disorders (Figure 5).[6] Basic programs have the capacity to treat MH **or** SUDs and may screen or assess for other disorders, but do not have on-site capacity to treat. Intermediate programs focus primarily on one disorder and have the capacity to address specific needs related to the other disorder. Advanced programs provide services for both MH and SUDs, often collaborating closely with other agencies to offer comprehensive services. Fully integrated programs "actively combine SUD and mental illness interventions to treat disorders, related problems, and the whole person more effectively."[6]

Figure 5. Levels of Program Capacity in CODs



Regardless of the treatment setting, SAMHSA endorses a "no wrong door" policy ensuring that those who need treatment are identified and assessed, whether this is done directly in a fully integrated setting or via referral in basic settings. The "no wrong door" approach has implications for service planning within the health care delivery system. Briefly, these include: 1) assessment, referral and treatment planning, 2) outreach, 3) flexibility in expectations and program requirements to improve engagement, 4) individualized treatment plans, and 5) interagency cooperation.[6]

5) Oregon efforts to expand capacity for integrated COD care

Prior research used the validated Dual Diagnosis Capability Index (DDCAT) and the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index to assess capacity to address co-occurring disorders in MH and SU treatment settings in the US, and found that health care settings remain at a low level of capability to provide comprehensive COD care.[21,22] These tools are used to score health care settings using a mixed methods approach to assess the dual diagnosis capability in community addiction treatment programs. Domains include program structure, program setting, assessment, treatment, continuity of care, staffing and training. In 2020, the Northwest Addiction Technology Transfer Center Network and the Oregon Council of Behavioral Health implemented the DDCAT in collaboration with 10 Oregon SU treatment facilities as part of a larger process improvement project. At baseline, only 3/10 participating facilities were scored as capable to treat COD clients, but after implementation of the process improvement intervention, 7/10 facilities met criteria for the capable level.[23] While this level of intensive technical assistance requires substantial investment, findings from the Oregon pilot suggest that intensive training and technical assistance at the site level are likely to increase service capacity for clients with COD.[23]

In collaboration with Medicaid payers and community partners, Oregon continues to prioritize expansion of integrated SU and MH services, with emphasis on building system-wide capacity to provide integrated services for clients with complex health and social needs. Each of the programs described below is an example of efforts to develop innovative models, standards of care, and technical assistance that supports health care providers striving to achieve integrated care.

Oregon Health Authority Integrated Co-occurring Disorders Program[24]

The Oregon Integrated Co-occurring Disorders Program (ICD) program incentivizes health care programs and facilities to provide an integrated approach to COD treatment for Oregon Health Plan (Medicaid) members.[24] ICD supports providers through use of a single payment model for integrated treatment services, a specialty clinical endorsement/credential for Integrated COD treatment and support providers, and advances higher quality care to meet the needs of all Oregonians dealing with COD. As of October 16, 2023, the Oregon Health Authority (OHA) approved 55 programs to provide ICD services.[24]

The ICD initiative has developed clinical training and supports for service providers, focused on knowledge and skill enhancement for integrated psychotherapy and peer services, including clinical adaptations for clients with intellectual and developmental disabilities, eating disorders, and problem gambling. ICD training also provides knowledge and skill enhancement for social determinants of health-driven case management and harm reduction strategies. Structured technical assistance is provided to start up grant awardees (and other interested organizations) through use of the internationally recognized DDCAT and DDCMHT, which are central tools used in the implementation of the SAMHSA endorsed Integrated Dual Disorder Treatment (IDDT) model.[25] IDDT underpins the Oregon Administrative Rules for Integrated COD (309-019-0145 and 309-018-0160).[26,27]

Certified Community Behavioral Health Clinics[28]

Certified Community Behavioral Health Clinics (CCBHCs) offer whole person care to those living with behavioral health conditions. CCBHC is regarded as one of the best models for delivering high quality, community-based behavioral health care. Oregon is one of eight original CCBHC demonstration states and currently operates 12 clinics across 14 counties. Clinics must provide 9 core services, either directly or through formal relationships with other providers: targeted case management, crisis services; outpatient primary care screening and monitoring; peer support, counseling and family support; psychiatric rehabilitation services; screening, assessment and diagnosis; intensive mental health care for veterans; patient-centered treatment planning; and outpatient mental health and SUD services. CCBHCs operating in Oregon must also provide 20 hours of primary care services per week on-site and are required to make connections with other providers and systems, such as criminal justice, foster care, child welfare, education, primary care, and hospitals. A key feature of the CCBHC model is the use of a Prospective Payment System, which takes the full cost of providing care into account, including services that may not be typically reimbursed under other payment models, such as costs associated with care coordination and providing services in non-clinic settings.[28]

CCBHCs are improving access to care and outcomes in Oregon. A recent state evaluation showed that CCBHCs increased access to behavioral health treatment by 4.3% between 2017-2019, with even greater gains in rural and remote areas (23.4% and 18.3%). The evaluation also showed that emergency department use and inpatient utilization for mental health conditions decreased for CCBHC service users.[29]

Assertive Community Treatment[30]

The Oregon Center of Excellence for Assertive Community Treatment was created to promote and implement Assertive Community Treatment (ACT) as an evidence-based practice throughout Oregon. ACT programs are designed to provide comprehensive treatment and support services to individuals who are diagnosed with SMI. ACT teams are comprised of multidisciplinary staff, including but not limited to MH and SU treatment providers, case management, and counseling providers. The model aims to integrate people with SMI into their communities. ACT team members share their case load, meaning all team members can work with all individuals served by the team. The staffing structure of ACT makes the program particularly unique, as it includes a team lead, therapist, case management, nurse, and employment specialists. If the staff/client ratio allows for it, programs may also have a peer on staff.[30]

These three programs are large, well-funded initiatives supported by state legislature and codified in Oregon Administrative Rules. They have each shown potential to improve statewide access to COD treatment services. Survey findings presented below identify opportunities for future state policy development and structural support for programs and facilities with a broad range of capacity to provide COD services. To explore potential disparities in access to care, we include information about programs that provide population specific programs/groups, language services, access to transportation and telemedicine, and client payment options. Note that assessments of payment structures in place for Oregon COD providers and shortages in the behavioral health workforce were previously published.[31,32] This report focuses on current services provided to screen, diagnose and treat COD in Oregon.

Methods

Data Sources

A detailed methodology is provided in Appendix B. Methodology tables are included in Appendix C. This report draws on the following data sources:

1. **The National Substance Use and Mental Health Services Survey (N-SUMHSS), 2022**, is an annual program survey administered by SAMHSA and includes in-depth information on location, characteristics, and utilization of SU and MH services in all states and US territories. The field period for the 2022 N-SUMHSS, ran from March 31, 2022, through December 4, 2022.[33]

2. **Oregon Substance Use Disorder Services Survey (SUDSS), 2022**, conducted as part of the Oregon Substance Use Disorder Services Inventory and Gap Analysis, by the Oregon Health & Science University (OHSU)-Portland State University (PSU) School of Public Health, collected detailed information on services provided across SU prevention, treatment, and recovery providers in all 36 Oregon counties.[13] Data collection began on February 16, 2022, and concluded on June 30, 2022; 756 service locations were identified, including 254 parent organizations who provide SU prevention, harm reduction, treatment, or recovery services. Of those 254 parent organizations, 164 (65%) participated in the survey. Detailed findings were published previously.[13] This report presents data for treatment facilities (N=134) reporting provision of services for COD.[18]

Definitions of COD diagnosis and services

Precise definitions of COD vary across agencies, localities, and professions, and occasionally other terminology is used, such as dual diagnosis. OHA defines COD broadly as having more than one behavioral health disorder, which could be substance use, gambling, mental health disorders, and intellectual and developmental disabilities.[24] SAMHSA's NSDUH includes separate COD measures of: 1) AMI or SUD in the past year, and 2) and SMI or SUD in the past year.[34] SAMHSA's N-SUMHSS, the primary data source for this report, specifies COD as SUD and SMI in adults and/or serious emotional disturbance in children.[35]

Key definitions from the N-SUMHSS questionnaire are provided in Table 1. The primary definition of COD treatment used in this report is noted as "Treats COD" in, which includes treatment for co-occurring SU and SMI in adults, or SU and serious emotional disturbance in children.

Table 1. Definitions of services representing treatment for co-occurring disorders, 2022 N-SUMHSS

Service provided	Questionnaire definitions[36,37]
Substance use programs (SU)	
Treats COD	Treatment for co-occurring substance use plus either serious mental health illness in adults/serious emotional disturbance in children. Refers to treatment services intended to help their clients' ability to function as a result of either or both disorders. By definition, serious mental illness is someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. For people under the age of 18, the term "Serious Emotional Disturbance" refers to a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.
Special groups for COD	Facility has a program or group specifically tailored for persons with co-occurring mental and substance abuse disorders.
Screening for mental disorders	Test to determine whether a person is experiencing symptoms of mental health conditions and needs treatment.
Comprehensive mental health assessments	An examination used to determine if a patient is functioning on a healthy psychological, social, or developmental level. It can also be used to aid diagnosis of some neurological disorders, specific diseases, or possible drug abuse.
Mental health services	Assessment, diagnosis, treatment or counseling in a professional relationship to assist an individual or group in alleviating mental or emotional illness, symptoms, conditions or disorders.
Integrated primary care	These services address the general health care needs of persons with mental and substance use disorders. These general health care needs include the prevention and treatment of chronic illnesses (e.g., hypertension, diabetes, obesity, and cardiovascular disease) that can be aggravated by poor health habits such as inadequate physical activity, poor nutrition, and smoking. The services include screening, care coordination with staff, and providing linkages to ensure that all patient needs are met in order to promote wellness and produce the best outcomes.
Mental health programs (MH)	
Treats COD	Treatment for co-occurring substance use plus either serious mental health illness in adults/serious emotional disturbance in children. Refers to treatment services intended to help their clients' ability to function as a result of substance use and/or mental disorders. By definition, serious mental illness is someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. For people under the age of 18, the term "Serious Emotional Disturbance" refers to a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.
Special groups for COD	Facility has a program or group specifically tailored for persons with co-occurring mental and substance abuse disorders.

Service provided	Questionnaire definitions[36,37]
Integrated MH/SU	Provides combined treatment for mental illness and substance abuse from the same clinician or treatment team. Effective integrated treatment programs view recovery as a long-term, community-based process. The approach employs counseling designed especially for those with co-occurring disorders.
Integrated primary care	These services address the general health care needs of persons with mental and substance use disorders. These general health care needs include the prevention and treatment of chronic illnesses (e.g., hypertension, diabetes, obesity, and cardiovascular disease) that can be aggravated by poor health habits such as inadequate physical activity, poor nutrition, and smoking. The services include screening, care coordination with staff, and providing linkages to ensure that all patient needs are met in order to promote wellness and produce the best outcomes.
Substance use treatment	Refers to a broad range of activities or services including behavioral counseling; medication; medical devices and applications used to treat withdrawal symptoms or deliver skills training; evaluation and treatment for co-occurring mental health issues such as depression and anxiety; and long-term follow-up to prevent relapse. Treatment should include both medical and mental health services as needed. Follow-up care may include community- or family-based recovery support systems.

Findings

1) Overview of co-occurring substance use and mental health disorder services treatment services

A total of 173 surveys were completed by SU programs, and 108 surveys were completed by MH programs in Oregon. 40% of SU programs offered treatment for COD, compared to 81% of MH programs (Figure 6).

Figure 6. Substance use and mental health programs, by treatment of co-occurring disorders (Oregon, N-SUMHSS, 2022)

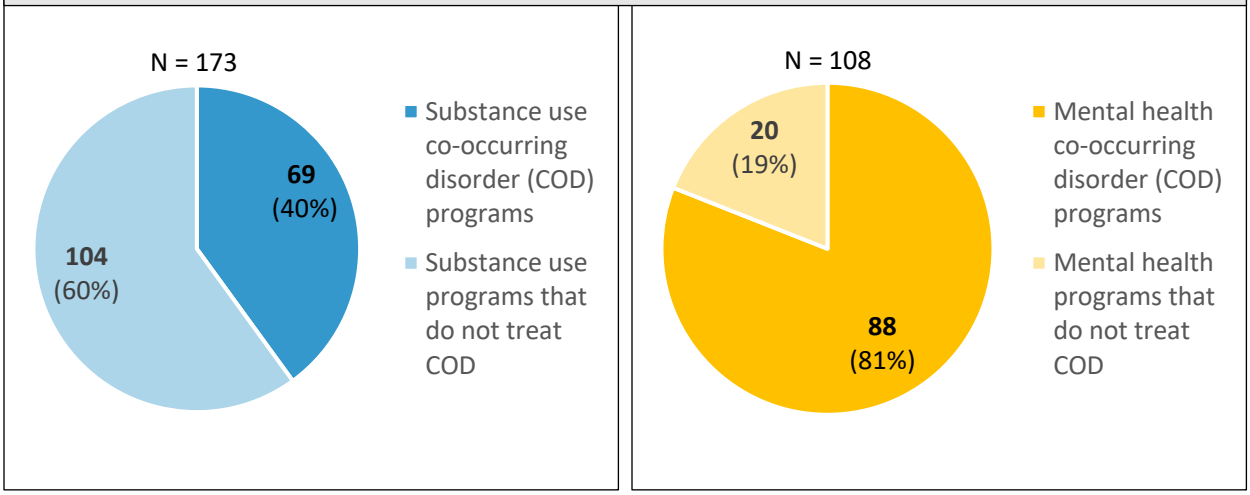


Table 2 summarizes COD services reported by Oregon MH and SU programs. Provision of integrated services varied by setting.

Table 2. Co-occurring disorder services reported by substance use and mental health programs, by service setting (Oregon N-SUMHSS, 2022)

	Outpatient programs		Residential/24-hour residential programs		All programs*	
Service provided	**n**	**%**	**n**	**%**	**n**	**%**
Substance use programs (SU)	**145**	**100%**	**36**	**100%**	**173**	**100**
Treats COD	61	42%	12	33%	69	40%
Special groups for COD	91	63%	25	69%	110	64%
Screening for mental disorders	122	84%	29	81%	143	83%
Comprehensive mental health assessments	72	50%	19	53%	84	49%
Mental health services	85	59%	28	78%	105	61%
Medications for mental disorders	52	36%	21	58%	67	39%
Integrated primary care	40	28%	16	44%	50	29%
Complete medical history/physical exam	43	30%	15	42%	53	31%

	Outpatient programs		Residential/24-hour residential programs		All programs*	
Service provided	**n**	**%**	**n**	**%**	**n**	**%**
Mental health programs (MH)	**74**	**100%**	**36**	**100%**	**108**	**100%**
Treats COD	60	81%	29	81%	88	82%
Special groups for COD	45	61%	15	42%	57	53%
Integrated MH/SU	49	66%	11	31%	57	53%
Integrated primary care	25	34%	14	39%	35	32%
Mental health programs (MH)*	**77**	**100%**	**26**	**100%**	**114**	**100%**
Detox (medical withdrawal) for co-occurring clients	3	4%	1	4%	3	3%
Medications for alcohol use disorder for co-occurring clients	20	26%	5	19%	24	21%
Medications for opioid use disorder for co-occurring clients	24	31%	7	27%	32	28%
Individual counseling for co-occurring serious mental illness/serious emotional disturbance and substance use disorder	63	82%	12	46%	72	63%
Group counseling for co-occurring clients	50	65%	12	46%	59	52%
12-step groups for co-occurring clients	6	8%	9	35%	15	13%
Case management for co-occurring serious mental illness/serious emotional disturbance and substance use disorder	44	57%	12	46%	53	46%

*Includes all treatment settings.
**Responses to this question block were not included in the identified dataset. Data are from the 2022 Oregon N-SUMHSS de-identified pubic use data, for the subset of programs that gave permission to be included in the National Directory.

Mental health services in substance use programs

Among the 173 SU programs:

- 83% offered screening for mental disorders; 49% offered comprehensive mental health assessments.
- 64% offered special groups for clients with COD.
- 61% offered mental health services (59% of outpatient and 78% of residential).
- 39% offered medications for mental disorders (36% of outpatient and 58% of residential).

Substance use services in mental health programs

Among the 108 MH programs:

- 53% offered integrated MH and SU treatment for COD clients (66% of outpatient and 31% of residential).
- 53% offered special groups for clients with COD.
- Availability of treatment with medications for SUD among MH COD programs was uncommon, including detoxification (medical withdrawal) (3%), medications for alcohol use disorder (AUD) (21%), and medications for opioid use disorder (OUD) (28%).

Integrated primary care

Integrated primary care promotes better health outcomes and more accessible, equitable service provision, by combining social and health services into treatment/care models.[38,39]

- Among 173 SU programs, 29% offered integrated primary care (28% of outpatient and 44% of residential).
- Among 108 MH programs, 32% offered integrated primary care (34% of outpatient and 39% of residential).

COD service models

Integration of behavioral health and primary care services is known to lower health systems' costs and improve quality of life. Findings from a recent evaluation report of the Oregon CCBHC programs, which require a minimum of 20 hours of onsite primary care provider services per week, suggest integrated health services (e.g., primary care and dentistry) play an important role in getting Oregonians into behavioral health settings. Further, integrated services support client engagement across the broader health system, likely due to the convenience of having various services available under one roof.[29]

MH and SU programs offer different levels of care and have different levels of capacity to treat MH, SU, or CODs. Some programs offer more MH treatment whereas others offer more SU treatment; some may screen or assess for other disorders, but do not have on-site capacity to treat; some programs may primarily focus on one disorder and have the capacity to address specific needs related to the other disorder. Fully integrated programs "actively combine SUD and mental illness interventions to treat disorders, related problems, and the whole person more effectively."[6] While fully integrated programs provide an ultimate goal to provide whole-person care for complex patients, not all programs need to strive for the highest level of integration.

Table 3 shows the distribution of COD service models reported by SU and MH treatment programs.

Table 3. Distribution of co-occurring disorder service models reported by substance use and mental health treatment programs (Oregon, N-SUMHSS, 2022)

Substance use programs (SU)	**n**	**%**
SU programs offered only stand-alone SU services	81	48%
SU programs offered COD treatment, without integrated primary care	38	22%
SU programs offered both COD treatment and integrated primary care	31	18%
SU programs offered integrated primary care, but not COD treatment	19	11%
Mental health programs (MH)	**n**	**%**
MH programs offered only stand-alone MH services	13	12%
MH programs offered treatment for COD, without additional integrated services	27	25%
MH programs offered COD treatment and integrated MH and SU services	32	30%
MH programs offered COD treatment, integrated MH and SU services, and integrated primary care	23	21%
MH programs offered COD treatment and integrated primary care	6	6%
MH programs offered stand-alone MH services with integrated primary care	5	5%
MH program indicated integrated MH and SU services, but not treatment for COD	1	--
MH program indicated integrated treatment MH and SU substance use services and integrated primary care, but not treatment for COD	1	--

As shown in Table 3, most SU programs (48%) offered only stand-alone SU treatment services, and the largest proportion of MH programs (30%) offered both COD treatment and integrated MH and SU services.

Type of facility and service setting

MH and SU treatment are provided in a variety of service settings. The setting and type or level of care depend on many factors, including the nature and severity of a person's MH, SU, or COD condition, their physical health status, and the type of treatment needed or prescribed. Some services can be provided remotely via telehealth services, which is discussed in a later section on accessible services.

The majority of SU and MH programs that treat COD were operated by private, non-profit organizations. 57% of the SU COD programs were operated by private, non-profit organizations, and 65% of the MH COD programs were operated by private, non-profit organizations.

Provision of COD treatment varied by SU vs MH program, as well as service setting. Table 4 summarizes the proportion of SU and MH programs that treat COD, by service setting.

Table 4. Substance use and mental health service settings, by treatment of co-occurring disorders (Oregon, N-SUMHSS, 2022)

	All programs	Programs that treat COD	
Service setting	**n**	**n**	**% of all programs**
Substance use programs (SU)	**173**	**69**	**40%**
Outpatient	145	61	42%
Outpatient detoxification	9	3	33%
Residential/24-hour residential*	36	12	33%
Residential detoxification	14	7	50%
Hospital inpatient/24-hour hospital inpatient	10	3	30%
Hospital inpatient detoxification	7	2	29%
Mental health programs (MH)	**108**	**88**	**81%**
Outpatient	74	60	81%
Residential/24-hour residential	36	29	81%
Hospital inpatient/24-hour hospital inpatient	9	3	33%
Partial hospitalization/day treatment	11	8	73%

*As of August 16, 2023, Oregon Health Authority licensed 21 substance use disorder withdrawal management sites and 46 substance use disorder residential treatment facilities.

2) Detoxification (medical withdrawal)

Provision of medical withdrawal treatment for clients with COD is especially complex, as clients may need to stay on essential MH medications that are not specifically managed by the detox facility. A total of 24 SU programs reported offering medical detoxification services, and 10 of those programs offered treatment for COD.

Table 5 shows the number and percent of SU programs that offered detoxification from specific substances, by hospital inpatient, outpatient, and residential detoxification setting, as well as provision of COD treatment. Among programs reporting medical detox services (N=24), hospital inpatient detoxification programs offered more comprehensive services, with 100% reporting providing detoxification from each substance type as well as routine use of medications in detoxifications. However, the total number of hospital inpatient programs was small (N=7), and even smaller among those who offered treatment for COD (N=2).

The majority of residential detox programs overall offered treatment for alcohol (93%), benzodiazepines (79%), cocaine (86%), methamphetamines (79%), and opioids (93%). The pattern is similar across residential detox facilities that treat COD.

Table 5. Detoxification (medical withdrawal) services by substance type, service setting, and provision of COD treatment (Oregon, N-SUMHSS, 2022)

	Hospital inpatient detoxification		Outpatient detoxification		Residential detoxification		Total	
Substances treated	**n**	**%**	**n**	**%**	**n**	**%**	**N**	**%**
All detox programs	**7**	**100%**	**9**	**100%**	**14**	**100%**	**24**	**100%**
Alcohol	7	100%	2	22%	13	93%	16	67%
Benzodiazepines	7	100%	1	11%	11	79%	13	54%
Cocaine	7	100%	2	22%	12	86%	15	63%
Methamphetamines	7	100%	3	33%	11	79%	16	67%
Opioids	7	100%	7	78%	13	93%	20	83%
Medication routinely used in detoxification	7	100%	8	89%	13	93%	22	92%
COD detox programs	**2**	**100%**	**3**	**100%**	**7**	**100%**	**10**	**100%**
Alcohol	2	100%	1	33%	6	86%	7	70%
Benzodiazepines	2	100%	0	--	5	71%	5	50%
Cocaine	2	100%	1	33%	5	71%	6	60%
Methamphetamines	2	100%	2	67%	5	71%	8	80%
Opioids	2	100%	2	67%	6	86%	7	70%
Medication routinely used in detoxification	2	100%	3	100%	6	86%	9	90%

As reported in Table 2, only 3% of MH programs reported offering detoxification (medical withdrawal) for COD clients.

3) Medications used in treatment

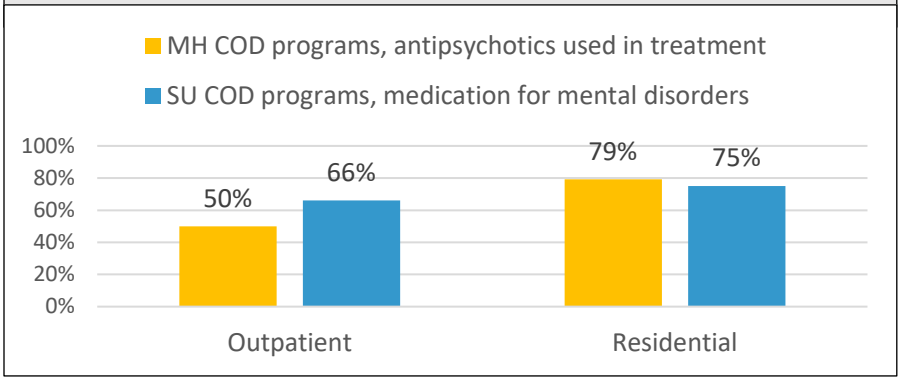
Medications for mental health disorders

Although medications are not prescribed to or wanted by for all individuals with COD, medications for mental health disorders can improve overall functioning when indicated. MH and SU program staff should be aware of pharmacotherapies used in treatment, including their benefits and side effects, to best monitor clients for safety and to offer appropriate medication evaluations or referrals.[6] Figure 7 displays the percent of MH COD and SU COD programs offering medications for mental disorders.

In outpatient settings, 50% of the 60 MH COD programs offered antipsychotics used in treatment. 66% of the 61 SU COD programs offered medication for mental disorders in outpatient settings.

Medications or antipsychotics for mental health disorders were offered more often in residential treatment settings. 79% of the 29 residential MH COD programs in residential settings, and 75% of the 12 residential SU COD programs offer medication for mental disorders.

Figure 7. Medications for mental health disorders at outpatient and residential mental health and substance use treatment programs that treat co-occurring disorders (Oregon, N-SUMHSS, 2022)



Medications for alcohol and opioid use disorders

There are multiple medications approved by the Food and Drug Administration (FDA) to treat AUD and OUD. For AUD, these include acamprosate, disulfiram, and naltrexone. For OUD, these include buprenorphine (a partial opioid agonist), naltrexone (an opioid antagonist), and methadone (an opioid agonist).[40] In the US, methadone can only be dispensed at authorized Opioid Treatment Programs (OTPs). The other medications can be prescribed and dispensed in primary care or other health care settings. Table 6 summarizes the availability of FDA approved medications for AUD and OUD at SU COD programs, by setting.

- 39% of SU COD programs administered/prescribed medication for AUD (36% of outpatient and 67% of residential). SU COD programs They were more likely to administer/prescribe oral naltrexone (42%) than acamprosate (23%) or disulfiram (22%). Residential SU COD programs used all medications to treat AUD more often than outpatient programs.
- For OUD, 48% of SU COD programs used buprenorphine, and 51% used naltrexone in treatment. A higher proportion of residential SU COD programs (75%) used buprenorphine in treatment than outpatient SU COD programs (44%). 86% of residential SU COD programs treated OUD with buprenorphine, compared to 46% of outpatient SU COD programs.
- 65% of SU COD programs reported accepting clients using medications for OUD but prescribed elsewhere, and 48% accepted clients using medication assisted treatment for AUD but prescribed elsewhere.

Table 6. Medications for opioid and alcohol use disorder treatment in SU COD programs, by treatment setting (Oregon, N-SUMHSS, 2022)

	All SU COD Programs (n=69)		Outpatient SU COD programs (n=61)		Residential SU COD programs (n=12)	
	n	%	n	%	n	%
Opioid use disorder treatment						
Does **not** treat opioid use disorders	9	13%	9	15%	1	8%
Accepts clients using medication assisted treatment for opioid use disorder but prescribed elsewhere	45	65%	39	64%	7	58%
Buprenorphine used in treatment	33	48%	27	44%	9	75%
Prescribes buprenorphine	24	35%	22	36%	5	42%
Naltrexone used in treatment	35	51%	28	46%	10	83%
Prescribes naltrexone	25	36%	21	34%	7	58%
Alcohol use disorder treatment						
Does **not** use medication assisted treatment for alcohol use disorder	16	23%	16	26%	1	8%
Accepts clients using medication assisted treatment for alcohol use disorder but prescribed elsewhere	33	48%	28	46%	6	50%
Administers/prescribes medication for alcohol use disorder	27	39%	22	36%	8	67%
Administers/prescribes acamprosate	16	23%	13	21%	6	50%
Administers/prescribes disulfiram	15	22%	13	21%	5	42%
Administers/prescribes oral naltrexone	29	42%	24	39%	8	67%

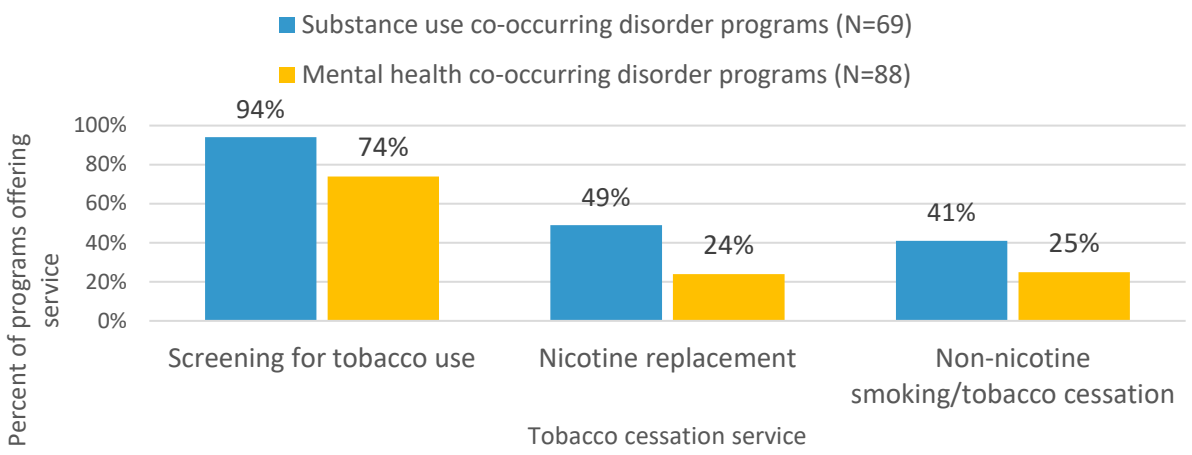
The Oregon Health Authority oversees regulation of OTPs in Oregon.[26] OTPs are the only locations permitted to dispense and administer methadone to treat OUD.[41] As of November 27, 2023, there were 27 OTPs in Oregon. 24 OTPs responded to the *2022 N-SUMHSS*. Of those, only 6 programs indicated that they treat COD.

4) Smoking policies and treatment

People with behavioral health disorders are more likely to smoke and have higher rates of nicotine dependence compared to the general population.[42,43] In 2019, smoking prevalence was nearly twice as high for adults with AMI in the past year compared to those without (28% vs 15.8%). Among people with SMI, rates of smoking are much higher. As many as 70% to 85% of adults with schizophrenia, and up to 50% to 70% of people with bipolar disorder smoke.[44]

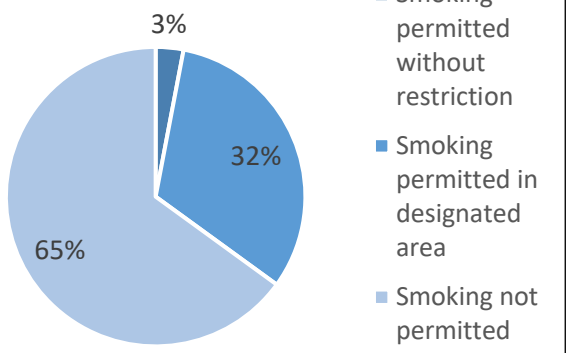
As shown in Figure 8, most SU COD programs (94%) and MH COD programs (74%) screen clients for tobacco use, but do not offer tobacco cessation services such as nicotine replacement or non-nicotine smoking/tobacco cessation.

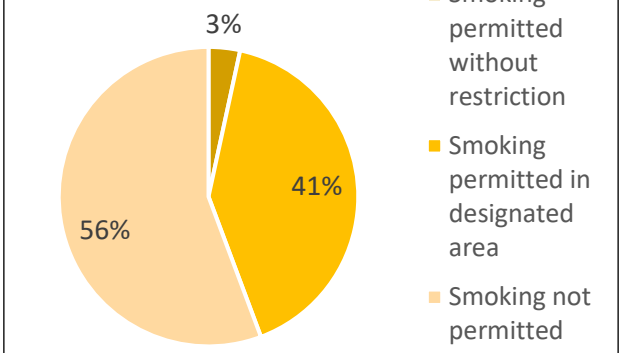
Figure 8. Smoking cessation services among substance use and mental health co-occurring treatment programs (Oregon, N-SUMHSS, 2022)



About half of MH COD programs reported smoking was not permitted, and two thirds of the SU COD programs did not permit smoking (Figure 9).

Figure 9. Smoking policy at substance use and mental health co-occurring disorder treatment programs (Oregon, N-SUMHSS, 2022)



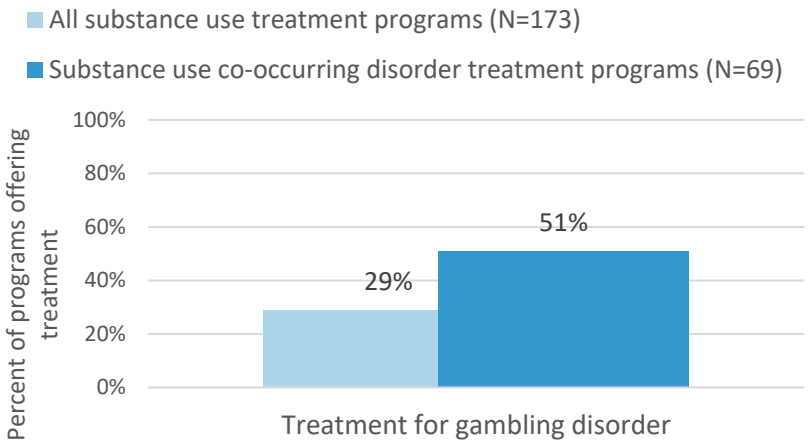


5) Gambling disorder treatment

There is overlap between SU and gambling disorders, as approximately half of people with gambling disorders have an SUD, typically AUD.[45] Those experiencing co-occurring SUD and gambling disorder face greater risk of physical health problems, financial losses, legal issues, and suicidality.[45] Gambling disorder is the first non-substance behavioral health addiction officially recognized and included in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders.[46]

SU treatment programs were asked whether they provide treatment for gambling disorder. Figure 10 shows that a higher proportion of SU COD programs offered treatment for gambling disorder than among SU programs overall. 51% of SU COD programs offered treatment for gambling disorder, and 29% of all SU programs offered treatment for gambling disorder.

Figure 10. Treatment for gambling disorder among all substance use treatment programs and substance use co-occurring treatment programs (Oregon, N-SUMHSS, 2022)

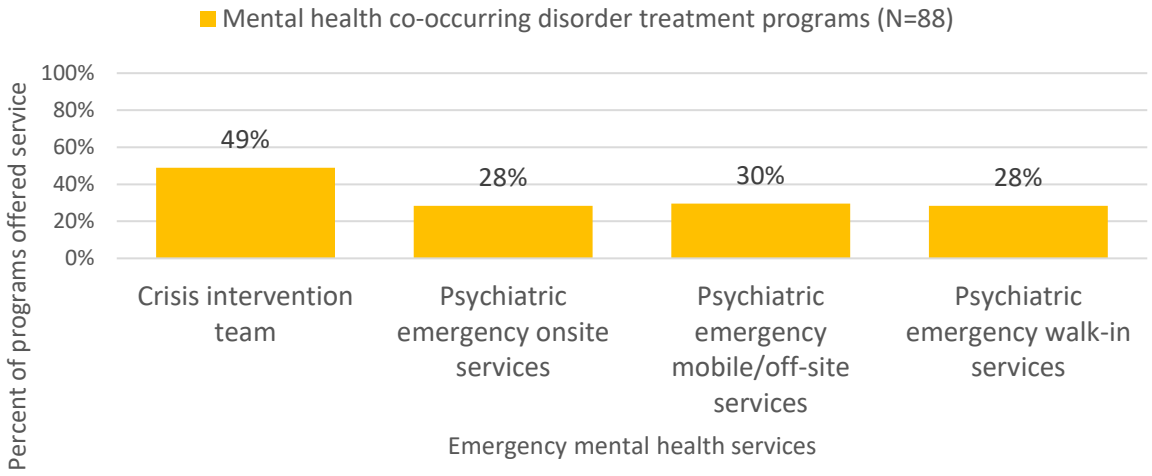


6) Emergency mental health services

Emergency mental health services, such as crisis intervention teams, are often deployed in response to acute mental health crises, offering mental health supports in place or alongside law enforcement or other emergency response teams. Crisis intervention teams are known to reduce the time law enforcement spend responding to mental health calls, and increase the likelihood that individuals will receive mental health services.[47]

Among MH COD programs, 49% had crisis intervention teams. Less common were onsite psychiatric emergency services (28%), mobile/off-site psychiatric emergency services (30%), and psychiatric emergency walk-in services (28%) (Figure 11).

Figure 11. Emergency mental health services among mental health co-occurring treatment programs (Oregon, N-SUMHSS, 2022)

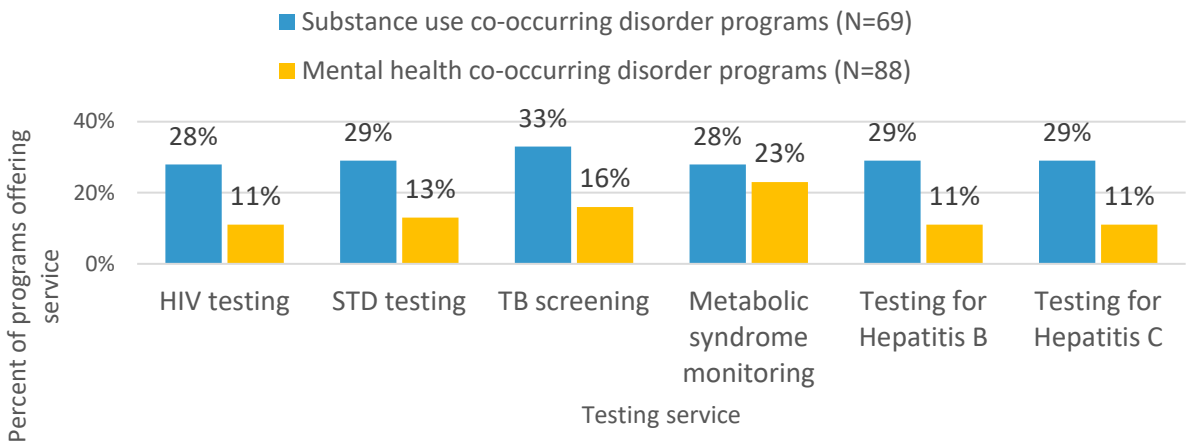


7) Physical health screening, ancillary services, and recovery support

The presence of physical health conditions, such as human immunodeficiency virus (HIV) or hepatitis C virus (HCV), can exacerbate other disorders such as MH or SUDs, and vice-versa. Screening and testing for physical health issues are indicated as a best practice for COD providers in both SU and MH settings.[6]

As shown in Figure 12, testing services for physical health conditions are still uncommon at both SU COD and MH COD programs. Among SU COD programs, one third or less offered health testing/screening services for HIV, sexually transmitted diseases (STDs), tuberculosis (TB), hepatitis B virus (HBV), HCV, and metabolic syndrome monitoring. A smaller proportion of MH COD programs provided these services.

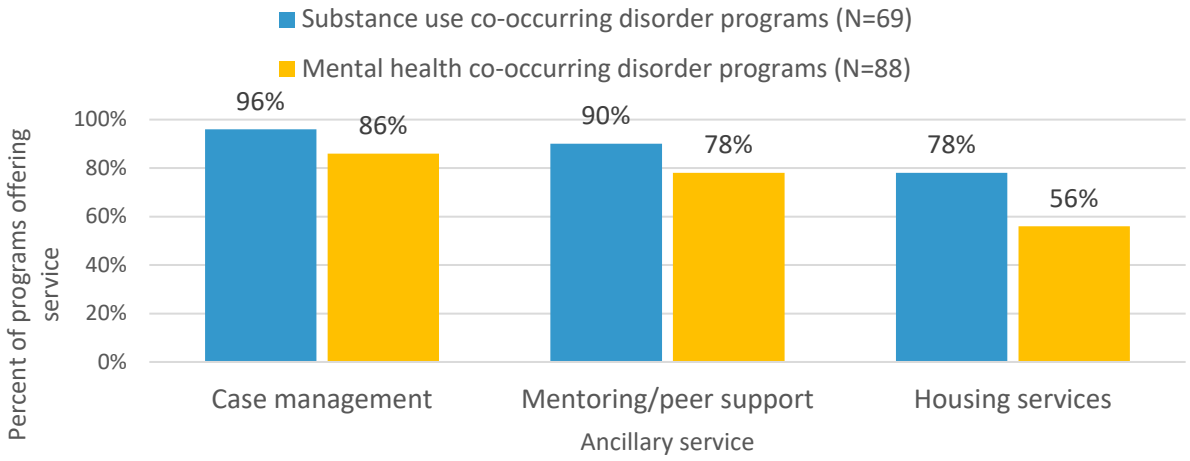
Figure 12. Health testing services among substance use and mental health co-occurring treatment programs (Oregon, N-SUMHSS, 2022)



Case managers monitor the needs of clients and their families and coordinate medical and social services, such as mental health, health, educational, vocational, recreational, transportation, advocacy, and respite care. Peer support services are provided by certified staff with lived experience who provide navigation and support services across the continuum of SU and MH services.[48]

As shown in Figure 13, SU COD programs often had case management (96%) and mentoring peer/support (90%) available. MH COD programs also had case management (86%) and slightly less availability of mentoring/peer support (78%). Housing services, broadly defined as services "designed to assist individuals with finding and maintaining appropriate housing arrangements,"[36] were provided by 78% of SU COD and 56% of MH COD programs.

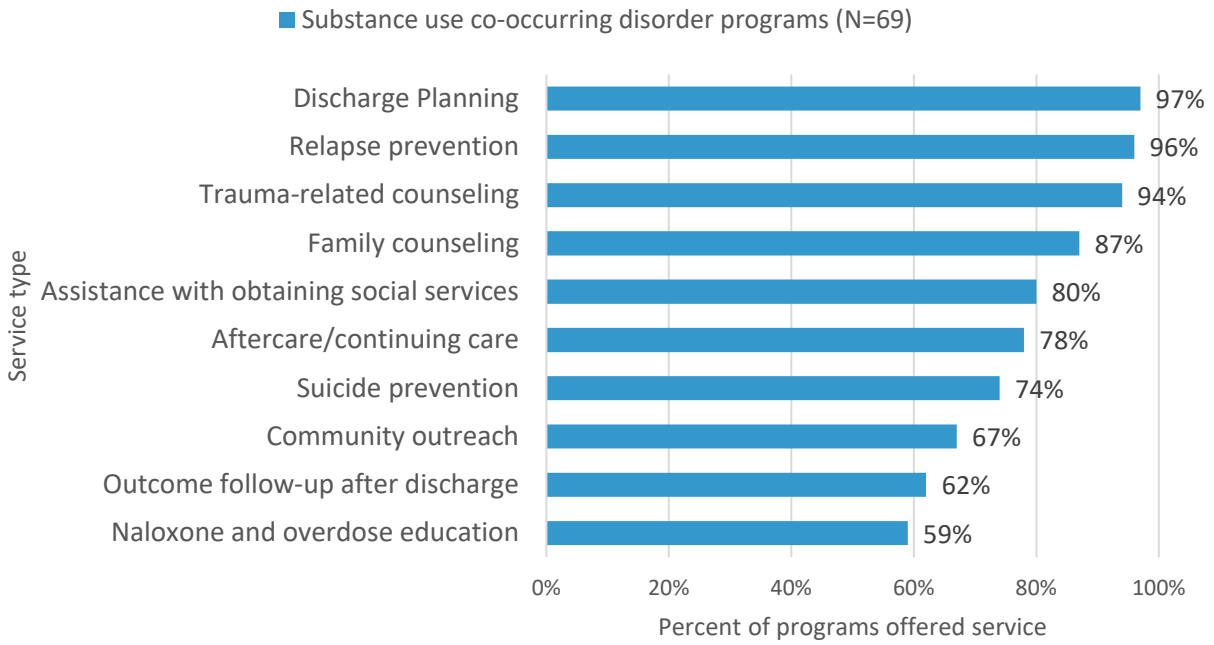
Figure 13. Recovery support at substance use and mental health co-occurring treatment programs (Oregon, N-SUMHSS, 2022)



As described above, wrap-around services that support long-term engagement in treatment are critical components of care for COD clients. Wrap-around services support long-term recovery and the development of stable social support networks, as well as housing, employment, transportation.[6]

Figure 14 summarizes transitional and other ancillary services offered by SU COD programs. Among the 69 SU COD programs, over 90% offer discharge planning, relapse prevention, and trauma-related counseling. 74% to 80% of SU COD programs provide family counseling, help with obtaining social services, aftercare/continuing care, and suicide prevention services. More than half of SU COD programs offer community outreach, outcome follow-up after discharge, and naloxone and overdose education.

Figure 14. Transitional and other ancillary services at substance use co-occurring treatment programs (Oregon, N-SUMHSS, 2022)



8) Harm reduction

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with substance use. Harm reduction meets people where they are, supporting their agency in preventing overdose and adopting safer practices, on their own terms and with the respect and dignity they deserve.[2] Harm reduction strategies to support clients with COD include but are not limited to syringe service programs, drug checking (e.g., testing for presence of fentanyl), non-abstinence-based services, overdose prevention and reversal (e.g., nasal naloxone), and information on safer drug use.[13]

As shown in Figure 14 above, naloxone and overdose education were offered at 59% of SU COD programs. With limited information about harm reduction available in N-SUMHSS, selected findings from the 2022 Oregon SUDSS[13,18] are provided in Table 7.

Among the 134 respondents to the 2022 Oregon SUDSS who self-reported providing treatment for COD, 109 (81%) offered at least one harm reduction service. Of those, the majority provided information on safer drug use (86%). More than half of those who provided non-abstinence-based services (67%) and overdose prevention and reversal (64%). Less than one-third of participants offering harm reduction reported providing syringe service programs (15%) or drug checking (28%) (Table 7).

Table 7. Types of harm reduction services provided by treatment facilities who reported services for co-occurring disorders (Oregon, Substance Use Disorder Services Survey, 2022)

		Syringe service program	Drug checking[a]	Non-abstinence-based services	Overdose prevention and reversal	Info on safer drug use
	Total county surveys[b]	% Yes	% Yes	% Yes	% Yes	% Yes
Percent providing service	109	14.7%	27.5%	67.0%	64.2%	86.2%

[a]Drug checking refers to distribution of fentanyl test strips.
[b]Total includes only facilities who reported offering at least one harm reduction service.

9) Health equity

The Health Equity Committee,[49] a subcommittee of the Oregon Health Policy Board (OHPB), believes that a common definition of health equity helps foster dialogue and bridge divides. In October 2019, OHPB and OHA adopted the following language to describe a state of health equity within Oregon's health system:[50]

> *Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*
>
> *Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*
> - *The equitable distribution or redistribution of resources and power; and*
> - *Recognizing, reconciling, and rectifying historical and contemporary injustices.*

It is not possible to adequately assess health equity across Oregon's SU and MH services system using health services survey data alone. An understanding of how individuals are disadvantaged by socially determined circumstances requires direct input from health services clients, as well as those who are systematically excluded from SU and MH services.

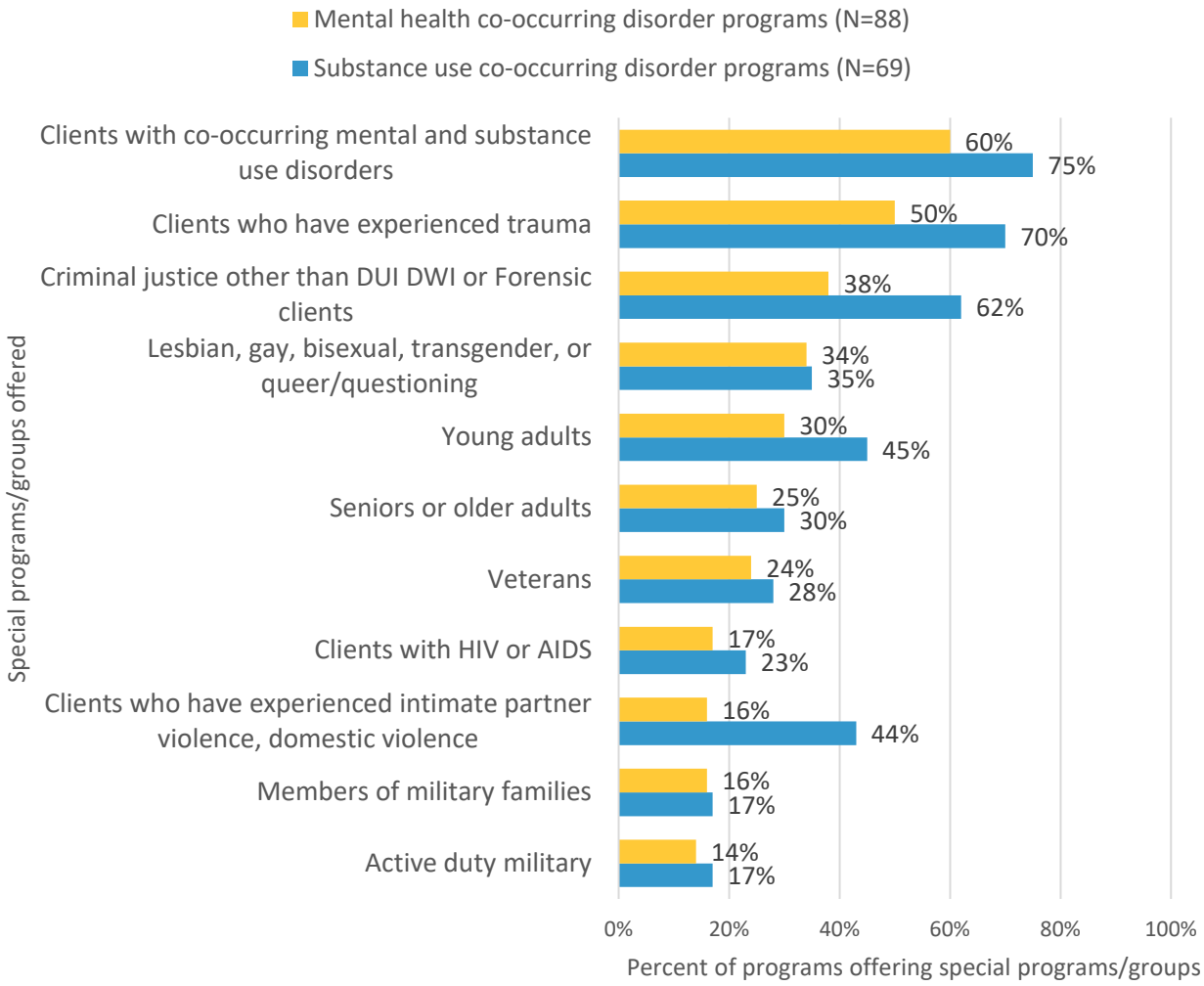
This section of the report addresses selected barriers to treatment reported by service providers on the N-SUMHSS and SUDSS. These include provision of population specific services for protected classes, language services, access to transportation and telemedicine, and client payment.

Population-specific services

Population-specific services offer targeted, tailored treatment for specific groups, such as groups specifically for women, young adults, individuals or families experiencing homelessness, or those involved in the criminal-legal system. Prior research shows that offering individual treatment alongside group intervention may increase acceptability of and engagement in treatment.[51] SAMHSA encourages treatment programs to develop special services for populations that are represented in significant numbers in their programs. Treatment needs and approaches will likely vary depending on the subpopulation targeted.[6]

Figure 15 summarizes the breadth of special programs/groups offered for specific populations at substance use and mental health co-occurring treatment programs. As shown in Figure 15, the most common type of special programming/groups offered at MH COD (60%) and SU COD programs (75%) were specific to clients with co-occurring mental and substance use disorders. More than half of SU COD (70%) and half of MH COD programs offered special programs/groups for clients how have experienced trauma, and more than half of SU COD (62%) programs offered special programs/groups for criminal justice-involved clients. Programs specifically for young adults were offered at 45% of SU COD programs and 30% of MH COD programs. Programs specifically for lesbian, gay, bisexual, transgender, or queer/ questioning (LGBTQ+) clients were offered at just 35% of SU COD programs and 34% of MH COD programs.

Figure 15. Special programs/groups offered for specific populations at substance use and mental health co-occurring treatment programs (Oregon, N-SUMHSS, 2022)

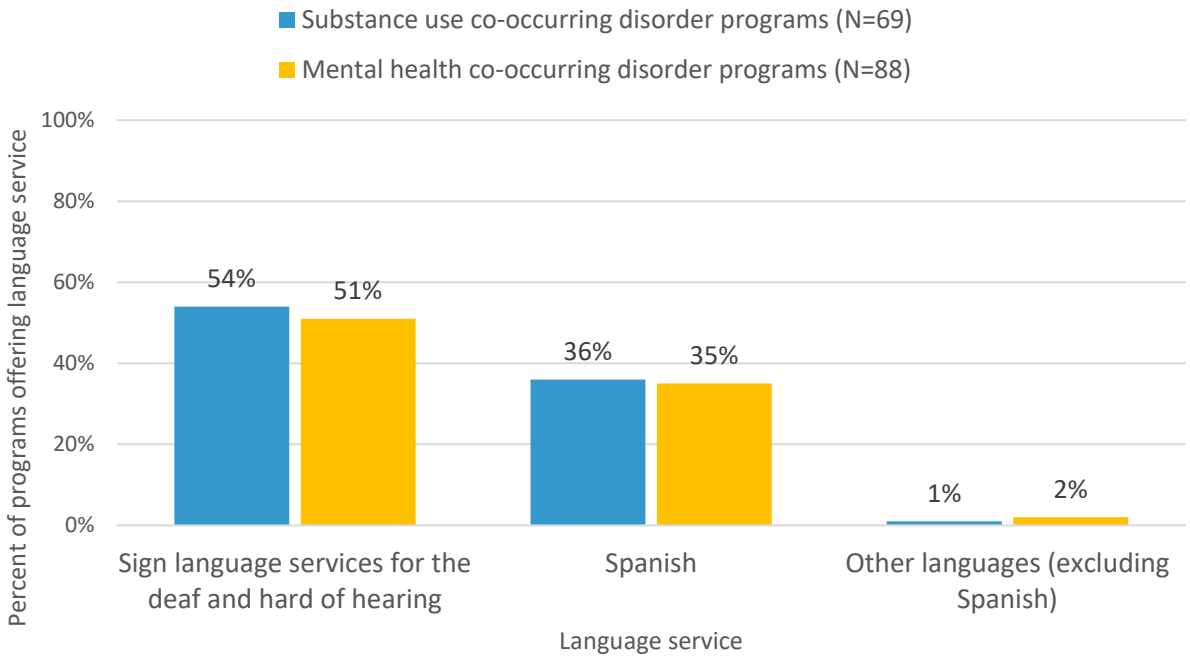


Of the 2022 SUDSS respondents who provided SU treatment and COD services, 125 offered services for people of protected classes. Around one-third (31%) provided no specific services for people of a protected class. Nearly half (46%) reported services specific to a racial or ethnic group (culturally responsive services). Few provided services specific for people with a mental or physical disability (18%), or to certain religious groups (3%).[13,18]

Language services

Figure 16 summarizes availability of services in languages other than English among SU COD an MH COD programs. There was little variation between SU and MH programs, with only about half offering language services in sign language (e.g., American Sign Language [ASL]). Just over one third of programs offered language services in Spanish, and under 2% of programs offered language services in other languages.

Figure 16. Language services offered at substance use and mental health co-occurring treatment programs (Oregon, N-SUMHSS, 2022)



Among SU COD treatment programs responding to the 2022 SUDSS (N=130), services in languages other than English were similarly scarce. 22% of SU COD programs had certified interpreters on staff. About half of programs employed multi-lingual staff certified to interpret (55%), and 53% contracted with a service like Language Line for interpretation services. When interpretation services were available (N=75), they were most often in Spanish only (92%). ASL (29%), Chinese (10%), Russian (12%), and Vietnamese (11%) were rare.[13,18]

A total of 67 SUDSS SU COD programs offered printed or web-based information available in languages other than English. As shown in Table 8, translated materials were offered in Spanish (100%), but rarely in other languages. Materials in accessible formats (e.g., large print, Braille) were rarely made available (9%).[13,18] This is important for ICD programs who are trying to adapt their services to reach people with intellectual and developmental disabilities.

Table 8. Translated materials available for clients by substance use treatment facilities who reported services for co-occurring disorders (Oregon, Substance Use Disorder Services Survey, 2022)

	Percent with materials in each language[a] (N=67)					
	Accessible formats	Chinese	Russian	Spanish	Vietnamese	Other
N=67	9.0	14.9	17.9	100.0	17.9	14.9

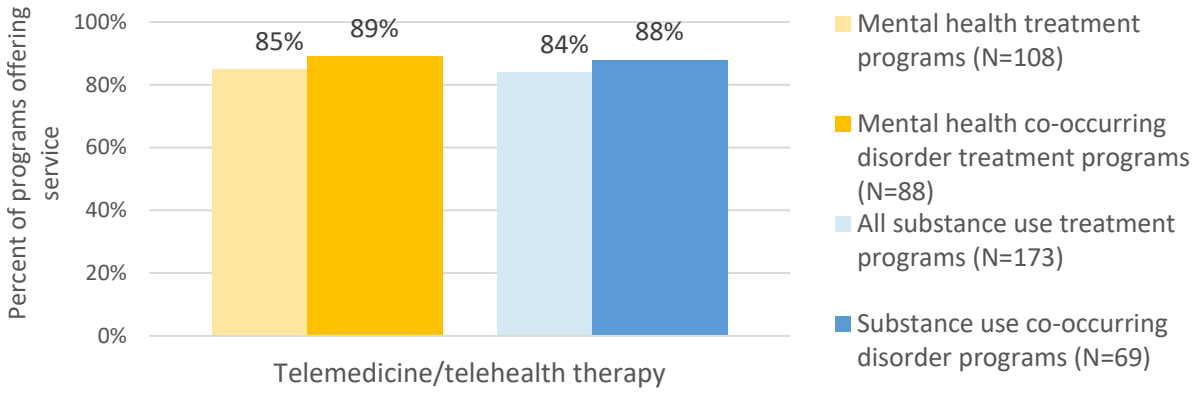
[a]Among programs who reported offering any printed or web-based information available in languages other than English (n=68).

Telemedicine/telehealth and travel to services

Telemedicine/telehealth therapy allows health care providers working from a distance to communicate with patients, diagnose conditions, provide treatment, and discuss healthcare issues with other providers to ensure quality services are provided. Telemedicine has been effective at bridging the gap between patients, providers, and health systems when in-person visits are not feasible or needed. When access to care is otherwise limited due to travel barriers, telemedicine can improve access to treatment and support recovery.[52] While telemedicine is a powerful tool for expanding access to care, there are limitations. Clients need access to appropriate technology (e.g., laptop, smartphone), the ability to navigate required software, and a stable internet or mobile network connection. Clients with limited financial resources, unstable housing, or cognitive challenges are less likely to access telemedicine than others.

As shown in Figure 17, telemedicine/telehealth therapy was available at the majority of MH and SU programs, regardless of whether they offered treatment for COD.

Figure 17. Telemedicine/telehealth therapy at substance use and mental health programs, by treatment of co-occurring disorders (Oregon, N-SUMHSS, 2022)



Of the 134 SU treatment programs that reported provision COD treatment, the majority offered telemedicine for SU treatment (79%) or counseling (84%). However, both technology and travel

time/transportation access were still noted as barriers to treatment among about 70% of programs responding to the 2022 SUDSS.[18]

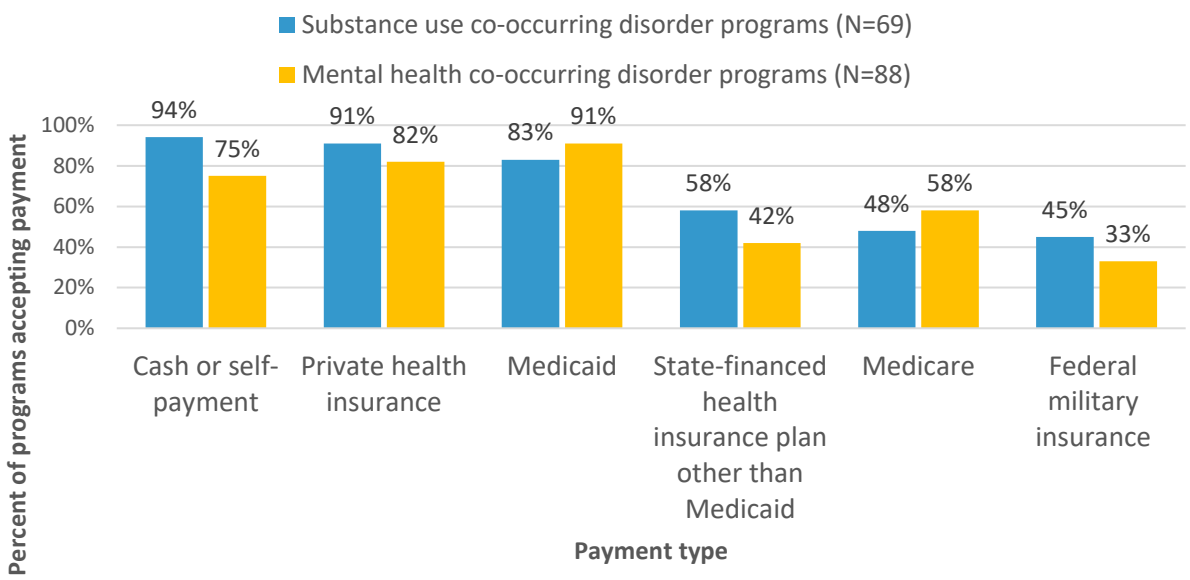
Payment

As of 2019, the Oregon Health Insurance Survey found that most Oregonians (94%) were covered by health insurance. About half of Oregonians (53.3%) had private health insurance, 25.4% were covered by Medicaid through the Oregon Health Plan (OHP) 15.2% had Medicare. 6% of Oregonians were not insured.[53]

Availability of treatment services that accept Medicaid and Medicare is essential to meet the needs of Oregon's high need population with COD. Nationally, rates of mental health and substance use disorders are at least 50% higher among Medicaid members compared to those with other insurance.[32,54] Yet, as shown in Figure 18 and Figure 19, a large proportion of SU COD and MH COD programs do not accept public insurance.

Figure 18 shows types of payment accepted among SU COD and MH COD programs. Medicaid was accepted by 83% of SU COD programs and 91% of MH COD programs, but Medicare was accepted by 48% of SU COD programs and 58% of MH COD programs.

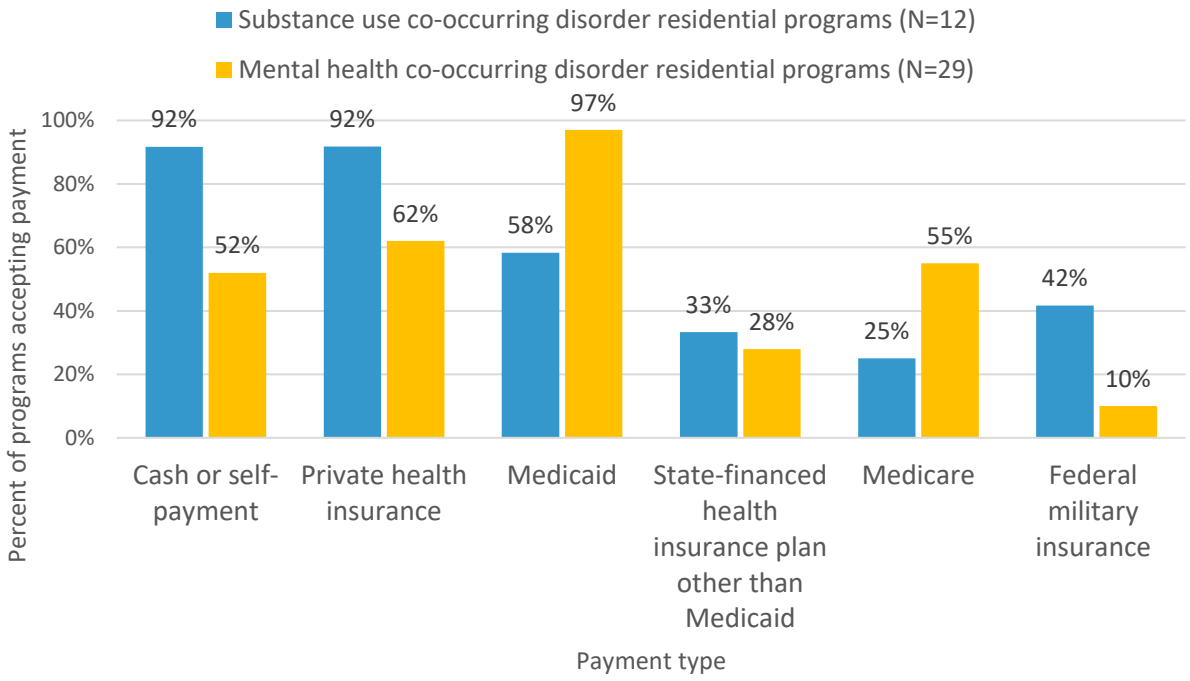
Figure 18. Payment accepted at substance use and mental health co-occurring treatment programs (Oregon, N-SUMHSS, 2022)



Among outpatient COD programs, there was little variation in type of payment accepted, but there were notable differences in payment accepted by SU and MH COD programs in residential settings (Figure 19). SU COD programs in residential settings were much less likely to accept Medicaid or Medicare compared to MH COD programs.

Among the 12 SU COD residential programs, Medicaid was accepted by 58%, while Medicare was accepted by only 25%. Among the 29 MH COD residential programs, 97% accepted Medicaid, while on 55% accepted Medicare (Figure 19).

Figure 19. Payment accepted at residential substance use and mental health co-occurring treatment programs (Oregon, N-SUMHSS, 2022)



Summary of findings

Using data collected from services providers in 2022, this report describes the state's current availability of programs that provide both SU and MH treatment, and those who report providing SU and MH treatment services concurrently for clients with COD. Key findings are discussed below.

1) Overall

- 40% of SU programs indicated that they treat COD (i.e., treatment for co-occurring substance use plus either serious mental health illness in adults/serious emotional disturbance in children)[35]. However, 64% of SU programs reported offering special groups for COD clients, 83% offered screening for mental disorders, and 61% provided mental health services.
- 81% of MH programs indicated that they treat COD, but just half offered integrated MH and SU treatment (i.e., *combined* treatment for mental illness and substance abuse from the same clinician or treatment team)[35] and special groups for clients with COD.
- Integrated primary care was available at less than one third of SU and MH programs.
- MH programs reported providing individual and group counseling (63% and 52%, respectively), and case management (47%) specifically for clients with COD.
- Less than one third of MH programs reported offering medications for AUD (21%) and medications for OUD (28%) specially for clients with COD.
- 29% of SU programs and 51% of SU programs that treat COD reported offering treatment for gambling disorder.
- 24 of 27 OTPs authorized to dispense methadone in Oregon responded to the 2022 N-SUMHSS. Of those, 6 OTPs indicated that they treat COD.

2) Less than half of COD programs offer testing for infectious disease or monitor chronic conditions.

- Among SU COD programs, less than 30% of programs offered testing for HIV, STDs, HBV, or HCV. About a third of SU COD programs offered TB screening, and 28% offered metabolic monitoring.
- Among MH COD programs, 11% of offered HIV, HBV and HCV testing; 13% offered STD testing, 16% offered TB screening, and 23% offered metabolic monitoring.
- The majority of SU COD programs (94%) and MH COD programs (74%) screen for tobacco use, but less than half offer nicotine replacement treatment (49% of SU COD programs; 24% of MH COD programs).

3) **In settings that treated COD, medications for mental health conditions, AUD, and OUD (other than methadone) were most often provided in residential treatment settings.**

- Antipsychotics were offered in 79% of residential MH COD programs, compared to 50% of outpatient MH COD programs. 75% of residential SU COD programs offer medication for mental disorders, compared to 66% of outpatient SU COD programs.
- 39% of SU COD programs administered/prescribed medication for AUD, including 36% of outpatient and 67% of residential SU COD programs.
- 35% of SU COD programs prescribed buprenorphine for OUD, including 42% of residential and 36% of outpatient.
- 36% of SU COD programs prescribed naltrexone for OUD, including 58% of residential and 34% of outpatient programs.
- 65% of SU COD accepted clients using medications for OUD but prescribed elsewhere, and 48% accepted clients using medication for AUD but prescribed elsewhere.

4) **Oregon's COD programs offer a wide range of ancillary services and recovery support.**

- Most SU COD programs had case management (96%) and mentoring peer/support (90%) available. Most MH COD programs also had case management (86%), but less availability of mentoring/peer support (78%).
- Housing services were offered by 78% of SU COD and 56% of MH COD programs.
- Over 90% of SU COD programs offer discharge planning (97%), relapse prevention (96%), and trauma-related counseling (94%). 74% to 87% of SU COD programs provide family counseling services (87%), offered help with obtaining social services (80%), provided aftercare/continuing care (78%), and suicide prevention services (74%).
- More than half of SU COD programs offered community outreach (67%), outcome follow-up after discharge (62%), and naloxone and overdose education (59%).

5) **Most COD treatment programs do not offer services or groups tailored to specific populations.**

- 60% of MH COD programs offered programs/groups specifically tailored to clients with co-occurring mental and substance use disorders. Programs/groups specifically for young adults were offered at 30% of MH COD programs. Programs/groups specifically for LGBTQ+ clients were offered at 34% of MH COD programs.
- 75% of SU COD programs offered programs/groups specifically tailored to clients with co-occurring mental and substance use disorders. Programs/groups specifically for young adults were offered at 45% of SU COD programs. Programs/groups specifically for LGBTQ+ clients were offered at 35% of SU COD programs.

- 38% MH COD and 62% of SU COD programs had special programs/groups for clients with involvement in the criminal-legal system.

6) COD programs need more language support services, especially in languages other than Spanish.

- Among SU COD treatment programs responding to the 2022 SUDSS, services in 22% of SU COD programs had certified interpreters on staff. About half of programs employed multi-lingual staff certified to interpret (55%), and 53% contracted with a service like Language Line for interpretation services. When interpretation services were available (N=75), it was most often in Spanish (92%).[18]

- 52% SU COD programs responding to the 2022 SUDSS offered printed or web-based information available in languages other than English.[18] Translated materials were offered in Spanish (100%), but rarely in other languages. Materials in accessible formats (e.g., large print, Braille) were rarely made available (9%).[18]

7) Residential SU programs are less likely than residential MH programs to accept public insurance.

- Among the 12 SU COD residential programs responding to the 2022 N-SUMHSS, Medicaid was accepted by 58%, while Medicare was accepted by 25%.

- Among the 29 MH COD residential programs responding to the 2022 N-SUMHSS, 97% accepted Medicaid, and 55% accepted Medicare.

Discussion

Integrated systems of care are known to reduce health disparities and support better health outcomes through care coordination.[55,56] Coordinated, concurrent treatment for substance use and mental health diagnoses lead to better outcomes compared to MH or SU treatment alone.[6] Half (49%) of Oregon SUD programs who offered treatment for COD in 2022 reported capacity did not meet current demand for services.[18]

1) Client-level barriers to and facilitators of COD treatment

Prior negative experiences in health care systems (e.g., stigma, racism, lack of culturally and linguistically appropriate services), lack of information about available services (e.g., lack of information about options, not knowing where to go), as well as cost and transportation can pose substantial barriers to individual use of available COD services.

Socioeconomic factors

Socio-economic factors are leading barriers to SU and MH treatment. These include but are not limited to poverty, unreliable transportation, and unstable housing.[56,57] Housing services were offered by 78% of SU COD and 56% of MH COD programs in Oregon. While telemedicine may alleviate disparities in accessing COD treatment services for those experiencing time or travel barriers, 70% of Oregon SU treatment programs noted technology, travel time, and transportation challenges posed barriers to accessing treatment.[18]

Case management and other wrap-around services

Wrap-around services to support long-term engagement in treatment are critical components for care for COD clients. Ancillary supports can improve both access to and long-term engagement in services.[6] Most SU COD (96%) and MH COD (86%) programs offered case management. Among SU COD programs in Oregon, over 90% offer discharge planning, relapse prevention, and trauma-related counseling. Most SU COD programs (90%) had mentoring peer/support available, as did MH COD programs (78%).

Population-specific programming

To meet the needs of specific populations with COD, SAMHSA recommends developing special services for specific populations. Population-specific services offer targeted, tailored treatment for specific groups that are represented in high numbers in SU or MH programs, such as groups specifically for women, for young adults, for individuals or families experiencing homelessness, or for clients involved in the criminal-legal system.[6] For example, people with COD have a higher level of involvement with the criminal justice system. A recent analysis of NSDUH data found that adults with COD were 12 times more likely to be arrested annually than adults with neither a MH or SUD, and 6 times more likely to be arrested annually than those with a mental illness alone. Offering individual treatment alongside group intervention for specific populations may increase acceptability of and engagement in treatment.[9]

In Oregon, just 38% of MH COD and 62% of SU COD programs had special programs/groups for criminal justice clients (other than DUI, DWI, or Forensic clients). The most common type of special programming/groups offered at MH COD (60%) and SU COD programs (75%) were specific to clients with co-occurring mental and substance use disorders. Disparities in COD are further noted among LGBTQ+ youth and adults.[51] Programs specifically for young adults were offered at 45% of SU COD programs and 30% of MH COD programs. Programs specifically for LGBTQ+ clients were offered at just 35% of SU COD programs and 34% of MH COD programs. Services and interpretation are rarely offered in languages other than English or Spanish.

2) Provider and health system barriers to and facilitators of COD treatment

Workforce

Previous research has described Oregon's behavioral health workforce challenges:[13,31,32]

- Because of the underrepresentation of people of color in the behavioral health workforce, it is difficult for service users of color to find culturally specific care.
- Workforce turnover causes burden on care coordination efforts in Oregon, especially around billing and transferring health records, causing delays in care.
- While Oregon has many outpatient programs, BH professionals have described "log jams" in trying to refer from inpatient to outpatient services due to capacity issues, and capacity is even worse for youth.
- Low wages and work environment stressors are contributors to recruitment/retention issues.

Screening and referral

Nationally, the majority of individuals that needed but did not receive SU or MH treatment did not think they needed it.[5] Not all programs need fully integrated MH and SU services, but to achieve a "no wrong door" approach to care, mechanisms for screening and assessment must be routinely implemented and lead to successful referrals. Failure to routinely screen clients receiving behavioral health services for mental disorders and SUDs leads to lack of comprehensive assessment, diagnosis, and treatment. Even when fully integrated treatment services are not in place, health care providers in all settings can be taught to screen, assess for, and recognize diagnostic symptoms of mental disorders and SUDs presented by their clients.[6]

In the absence of fully integrated services, establishing collaborative relationships across agency types helps to ensure more comprehensive service availability for clients with CODs. Staff training is needed to ensure interventions are implemented effectively, and in a way that meets the needs of clients with CODs. Access to needed medical records across care teams improves referral processes and continuity of care. Gaps in the referral process may lead to delays in care. Successful referrals are hard to come by; when providers feel systems of care do not have the capacity to support patients, provider burnout is increasingly documented.[56,58,59]

Opportunities for screening and referral are not limited to traditional treatment settings. Implementing a "no wrong door" approach to SU and MH service delivery includes outreach conducted in settings where emergency and other acute services are required. Less than half of Oregon's detoxification programs (42%) treat COD. Among MH COD programs, nearly half (49%) had crisis intervention teams. Less common were onsite psychiatric emergency services (28%), mobile/off-site psychiatric emergency services (30%), and psychiatric emergency walk-in services (28%).

Prescribing

Medication management and prescribing in SU and MH settings improves recovery rates and recovery time.[6] SU treatment for COD clients, including medical detoxification (3%), medications for AUD (21%), and medications for OUD (28%), were rarely reported by Oregon MH programs. At SU COD programs, medications for AUD were not widely available, including administration/prescribing of naltrexone (36%), acamprosate (23%) and disulfiram (22%). Medications for OUD varied in availability by treatment setting, with 75% of residential SU COD programs reporting use of buprenorphine in treatment compared to 44% of outpatient SU COD programs, and 86% of residential SU COD programs reporting use of naltrexone in treatment compared to 46% of outpatient SU COD programs.

Medications for mental disorders were offered at 36% of SU COD outpatient programs and 58% of SU COD residential programs; antipsychotics were offered at 50% of MH COD outpatient program and 79% of MH COD residential programs.

Known barriers to prescribing and dispensing medications for people with CODs include a lack of training for providers specific to CODs, and workforce shortages limiting access to prescribing clinicians.[59] Moreover, clinicians have expressed concerns around complicated prescribing regulations and laws.[56]

Billing for COD

The 2022 Integrated COD Co-Occurring Disorders Reimbursement Study noted that a key issue is "the division of Oregon's service system."[31] Structural divides add complication around payment methods for different disorders, with added challenges when cross-referencing reimbursement codes.[31] MH and SU services are typically provided in different settings, by different providers, using different billing codes, without options for billing for both MH and SU treatment at the same encounter. For example, an individual with a MH and SUD may see a provider who is dually-credentialed and able to provide support for both conditions. However, any service the provider renders and bills for can only be coded using one billing code, forcing the provider to choose whether the supports provided should be billed as SU or MH.[31] Another systems issue noted in the 2022 study was a lack of payer support for certain services, including care coordination, peer support, and case managers – all of which negatively impacting provider wages reimbursement rates.[31]

Medicaid and Medicare coverage

Availability of treatment services that accept Medicaid and Medicare is essential to meet the needs of Oregonians with COD. Adults with COD are far more likely to be publicly insured than the general population,[32,54] yet a large proportion of SU COD and MH COD programs do not accept Medicare or Medicaid. Medicaid was accepted by 83% of SU COD programs and 91% of MH COD programs, but Medicare was accepted by 48% of SU COD programs and 58% of MH COD programs. This leaves a concerning treatment gap for older adults in Oregon. The public insurance gap is most pronounced in residential SU programs that treat COD – only 58% accepted Medicaid and 25% accepted Medicare.

Recommendations

Oregon's behavioral health policy landscape has evolved over the past decade, as the state has prioritized increased access to quality care and effective behavioral health services and supports.[60] In 2023, the Oregon Legislature made $153 million in investments to build the capacity and increase access to behavioral health services with a focus on increasing the number of treatment beds and addressing gaps in the system.[61] Specific strategies include more funding for mobiles crisis centers, Medicaid rate increases for community behavioral health providers, more case management for those exiting the State Hospital, funds to expand and diversify the behavioral health workforce, investment in mental health and substance use disorder treatment facilities, and allocation of opioid settlement proceeds for harm reduction services.[61]

Oregon continues to prioritize expansion of integrated SU and MH services, in collaboration with Medicaid payers and community partners, with emphasis on building system-wide capacity to provide person-centered integrated services for clients with complex health and social needs. Current efforts supported by the state's Integrated Co-Occurring Disorders (ICD),[24] Certified Community Behavioral Health Clinics (CCBHC)[28] and Assertive Community Treatment (ACT)[30] programs, are in place to address barriers to appropriate COD treatment that include innovative payment mechanisms, grant funding, and technical assistance. These include strategies to ensure reimbursement for appropriate services, support training and credentialing across disciplines, and expand services for clients with problem gambling and intellectual and developmental disabilities.[31] Further, the ICD program incentivizes community outreach plans to better address health related social needs and social determinants of health.

The following recommendations respond directly to self-reported survey data from Oregon behavioral health programs in 2022. They are intended to inform ongoing state efforts to improve access to and quality of services delivered to clients with COD.

1) SU programs reported lower rates of COD treatment (33% in residential and 42% in outpatient programs), compared to MH programs (81%). This disparity suggests a need to **prioritize support for SU treatment programs** that serve clients with COD.

2) 83% of SU programs conducted mental health screenings, but only 49% provided comprehensive mental health assessments. Efforts to **increase the dually-credentialed workforce in SU settings are essential to enable timely assessment and referral to specialty mental health care** when needed.

3) Within MH service settings, just 21% of programs reported offering medications for AUD, and 28% offered medications for OUD to their clients with COD. In support of a no wrong door approach to treatment, **evidence-based medications for both AUD and OUD should be available to all clients with COD through on-site prescribing or partnerships with prescribers, including OTPs**.

4) While SU COD programs offered comprehensive transitional and ancillary services to support long term recovery of clients, only 59% reported offering naloxone and overdose education. **Continued efforts to expand access to overdose reversal drugs along with workforce education regarding the importance of harm reduction** are needed. Current OHA initiatives include statewide efforts to expand harm reduction and syringe service interventions. Save Lives Oregon launched in 2020 as a resource hub to distribute harm reduction supplies and educational materials.[2]

5) More qualitative research is need to understand barriers to and facilitators of access to SU and MH treatment experienced by Oregonians at highest risk for untreated SU and MH conditions. This **research needs to include voices of both current behavioral health clients, as well as those who are not in treatment**. These include individuals experiencing homelessness, individuals involved in the criminal legal system, and those cycling through Oregon's emergency departments and the State Hospital.

6) New analysis of insurance claims data could identify more specific gaps in concurrent services for those diagnosed with COD, documenting length of time between billed encounters for MH and SU treatment. Subgroup analyses could **identify disparities in concurrent treatment for COD by race, ethnicity, gender, and geography**.

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Appendices

Appendix A. Acronym list

ACT	Assertive Community Treatment
AMI	Any mental illness
ASL	American Sign Language
AUD	Alcohol use disorder
CCBHCs	Certified Community Behavioral Health Clinics
CCO	Coordinated Care Organization
COD	Co-occurring disorder
DDCAT	Dual Diagnosis Capability Index
DDCMHT	Dual Diagnosis Capability in Mental Health Treatment
DUI/DWI	Driving under the influence/driving while intoxicated
FDA	Food and Drug Administration
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HHS	US Department of Health and Human Services
HIV	Human immunodeficiency virus
ICD	Integrated Co-Occurring Disorders program
IDDT	Integrated Dual Disorder Treatment
LGBTQ+	Lesbian, gay, bisexual, transgender, or queer/ questioning
MDE	Major depressive episode
MH	Mental health
MH COD	Mental health co-occurring disorder program
NSDUH	National Survey on Drug Use and Health
N-SUMHSS	National Substance Use and Mental Health Services Survey (administered by SAMHSA)
OAR	Oregon Administrative Rule
OHA	Oregon Health Authority
OHPB	Oregon Health Policy Board
OHSU	Oregon Health & Science University
OTPs	Opioid Treatment Programs
OUD	Opioid Use Disorder
PSU	Portland State University

SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	Serious mental illness
STDs	Sexually transmitted diseases
SU	Substance use
SU COD	Substance use co-occurring disorder program
SUD	Substance use disorder
SUDSS	Substance Use Disorder Services Survey
TB	Tuberculosis
US	United States

Appendix B. Methodology

National Substance Use and Mental Health Services Survey[3]

This report draws on the following N-SUMHSS data sources:

1. **N-SUMHSS, 2022** data include in-depth de-identified information on location, characteristics, and utilization of SU and MH services in all states and US territories. The field period for the 2022 N-SUMHSS, ran from March 31, 2022, through December 4, 2022. The reference date was March 31, 2022. The response rate in Oregon was 88%, as was the national response rate. Detailed data tables and reports published by SAMSHA are intended to provide behavioral health services providers, researchers, and federal, state, and local governments with information about the number and characteristics of public and private SU and MH treatment facilities. Complete public use research data sets are de-identified, so are used minimally in this report to provide supplementary information regarding topics that are excluded from the identified National Directories (i.e., client level information and service capacity).[33]

2. **The National Directory of Mental Health Treatment Facilities** – **July 2023** is a public resource for locating treatment facilities for MH disorders in the United States and its territories. It includes treatment facilities that responded to the 2022 N-SUMHSS MH questionnaire and is available online as a reference tool for providers and clients seeking MH services. Data are identified at the facility level, and exclude survey items regarding facility capacity and client populations. The July 2023 National Directory includes 108 Oregon MH treatment facilities. Public use data used for analyses presented in this report are posted by SAMSHA.[15]

3. **The National Directory of Drug and Alcohol Use Treatment Facilities – July 2023** is a listing of facilities that provide SU treatment. It includes treatment facilities that responded to the 2022 N-SUMHSS. Data are identified at the facility level, and exclude survey items regarding facility capacity and client populations. The July 2023 National Directory includes 174 Oregon SU treatment facilities, but one facility was excluded from our analysis due to missing data on type of care provided. Public use data for the analyses presented in this report are posted by SAMSHA.[16]

Unless otherwise indicated, this report presents 2022 Oregon N-SUMHSS data for facilities identified in the July 2023 N-SUMHSS National Directories of Drug and Alcohol Treatment and Mental Health Treatment Facilities. As facilities responding to the N-SUMHSS are not required to be listed in the National Directories, the number of Oregon facilities included in the National Directories (174 SU, 108 MH) is lower overall than the number included in the public use, de-identified data set (220 SU, 143 MH).[17] Use of data from the National Directories data allows us to focus on facilities with contact and service information available to clients and service providers.

Oregon Substance Use Disorder Services Survey, 2022[13]

As part of the Oregon Substance Use Disorder Services Inventory and Gap Analysis,[13] conducted by the Oregon Health & Science University (OHSU)-Portland State University (PSU) School of Public Health, the Oregon Substance Use Disorder Services Survey (SUDSS) collected detailed information on services provided across SU prevention, treatment, and recovery providers in all 36 Oregon counties. Data collection began on February 16, 2022, and concluded on June 30, 2022. Organizations identified through the statewide inventory of SU services had two options to complete the survey: 1) the organization's identified representative could schedule a phone interview with a research staff member; or 2) organizations could complete an online, self-directed version of the survey on their own time. Most interviews were conducted by phone, with research staff completing the web-based survey tool.

Research staff identified and verified 756 service locations across the state. These sites included 254 service organizations in the state of Oregon offering: SUD prevention, harm reduction, treatment, or recovery services. Of those 254 parent organizations, 164 (65%) participated in the survey.

This report draws on the Oregon SUDSS to provide context for findings from the 2022 N-SUMHSS. Detailed service findings were published previously. This report presents data for treatment facilities (N=134) reporting provision of services for COD by responding **yes** to the following question:[13,18]

> *"This question is about services for co-occurring disorders, also known as dual diagnosis. For the purposes of this survey, co-occurring disorders refers to an individual having one or more substance use disorders and one or more mental health disorders. Does your organization offer services for co-occurring disorders?"*

Definitions

Precise definitions of COD vary across agencies, localities, and professions, and occasionally other terminology is used, such as dual diagnosis. OHA defines COD broadly as having more than one behavioral health disorder, which could be substance use, gambling, mental health disorders, and intellectual and developmental disabilities. SAMHSA's NSDUH includes separate COD measures of: 1) AMI or SUD in the past year, and 2) and SMI or SUD in the past year.[5] SAMHSA's N-SUMHSS, the primary data source for this report, specifies COD as SUD and SMI in adults and/or serious emotional disturbance in children.[36]

Note that N-SUMHSS uses the term "facility" to indicate a specific treatment facility or program. This report uses the term "program" as responses are at the program level, meaning organizations may have more than one program, and each program provided site-specific program information. "SU COD programs" is used to refer to the substance use co-occurring disorder programs (n=69), and "MH COD programs" to refer to mental health co-occurring disorder programs (n=88).

Key definitions from the N-SUMHSS questionnaire are provided in Table A1. The primary definition of COD treatment used in this report is noted as "Treats COD" in Table A1, which includes treatment for co-occurring SU and SMI in adults, or SU and serious emotional disturbance in children.

Table A1. Definitions of services representing treatment for co-occurring disorders, 2022 N-SUMHSS

Service provided	Questionnaire definitions[36,37]
Substance use programs (SU)	
Treats COD	Treatment for co-occurring substance use plus either serious mental health illness in adults/serious emotional disturbance in children. Refers to treatment services intended to help their clients' ability to function as a result of either or both disorders. By definition, serious mental illness is someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. For people under the age of 18, the term "Serious Emotional Disturbance" refers to a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.
Special groups for COD	Facility has a program or group specifically tailored for persons with co-occurring mental and substance abuse disorders.
Screening for mental disorders	Test to determine whether a person is experiencing symptoms of mental health conditions and needs treatment.
Comprehensive mental health assessments	An examination used to determine if a patient is functioning on a healthy psychological, social, or developmental level. It can also be used to aid diagnosis of some neurological disorders, specific diseases, or possible drug abuse.
Mental health services	Assessment, diagnosis, treatment or counseling in a professional relationship to assist an individual or group in alleviating mental or emotional illness, symptoms, conditions or disorders.
Integrated primary care	These services address the general health care needs of persons with mental and substance use disorders. These general health care needs include the prevention and treatment of chronic illnesses (e.g., hypertension, diabetes, obesity, and cardiovascular disease) that can be aggravated by poor health habits such as inadequate physical activity, poor nutrition, and smoking. The services include screening, care coordination with staff, and providing linkages to ensure that all patient needs are met in order to promote wellness and produce the best outcomes.

Mental health programs (MH)	
Treats COD	Treatment for co-occurring substance use plus either serious mental health illness in adults/serious emotional disturbance in children. Refers to treatment services intended to help their clients' ability to function as a result of substance use and/or mental disorders. By definition, serious mental illness is someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. For people under the age of 18, the term "Serious Emotional Disturbance" refers to a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.
Special groups for COD	Facility has a program or group specifically tailored for persons with co-occurring mental and substance abuse disorders.
Integrated MH/SU	Provides combined treatment for mental illness and substance abuse from the same clinician or treatment team. Effective integrated treatment programs view recovery as a long-term, community-based process. The approach employs counseling designed especially for those with co-occurring disorders.
Integrated primary care	These services address the general health care needs of persons with mental and substance use disorders. These general health care needs include the prevention and treatment of chronic illnesses (e.g., hypertension, diabetes, obesity, and cardiovascular disease) that can be aggravated by poor health habits such as inadequate physical activity, poor nutrition, and smoking. The services include screening, care coordination with staff, and providing linkages to ensure that all patient needs are met in order to promote wellness and produce the best outcomes.
Substance use treatment	Refers to a broad range of activities or services including behavioral counseling; medication; medical devices and applications used to treat withdrawal symptoms or deliver skills training; evaluation and treatment for co-occurring mental health issues such as depression and anxiety; and long-term follow-up to prevent relapse. Treatment should include both medical and mental health services as needed. Follow-up care may include community- or family-based recovery support systems.

Data Limitations

N-SUMHSS excludes Department of Defense military MH treatment facilities; individual private practitioners or small group practices not licensed as a SU and/or MH clinic or center; and correctional facilities. The number of Oregon facilities included in the identified National Directories (174 SU, 108 MH) is lower overall than the number included in de-identified published reports and public use datasets (220 SU, 143 MH). However, use of data from the National Directories data allows us to focus on facilities with contact and service information available to clients and service providers on SAMHSA's https://findtreatment.gov/ site, and to inventory available services by name and address across Oregon. Definitions of COD vary, and may include clients with any mental illness or serious mental illness (SMI). The survey data analyzed for this report focus on clients with SMI. Available survey data did not permit a comprehensive assessment of services for clients with intellectual or developmental disabilities. The survey data analyzed for this report provide very limited information relevant to health equity, and no information regarding race or ethnic disparities in clients served, or in specially developed programming.

Appendix C. Detailed Tables