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News for policy and program decision-makers

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In This Issue...

OnPoint and other OPCs: How to argue against "crack house" statute

As long as what is referred to colloquially as the "crack house" statute is still on the books, OnPoint and other overdose prevention centers (OPCs) will have to prove they are legal in spite of that law. But Rob Kent, former legal counsel for the federal Office of National Drug Control Policy (ONDCP) and before that, the New York Office of Addiction Services and Supports (OASAS) has ideas for how to do so. "I hate the term," said Kent, but it is what is used, and the 1986 federal law bans the use or maintenance of any place for the purpose of using illegal drugs.

OnPoint has been sanctioned by New York City since November 2021, but it was not recognized by New York state. Last month at a symposium sponsored by the Coalition of Medication-Assisted Treatment Providers and Advocates (COMPA), OASAS director Chinazo Cunningham, M.D. told *ADAW* flatly that the site is illegal, and the state does not recognize or regulate it. When we pointed that Rhode Island has a law allowing OPCs and that there is already a site for one, she correctly responded that it has not started running yet. Case closed for OnPoint, especially when it comes

See **OPCs** page 2

Bottom Line...
Former legal counsel for OASAS and ONDCP shares legal strategy for supporting OPCs in face of "crack house" statute.

Opioid presence rises in L.A. County's methamphetamine-involved deaths

With fentanyl's influence accounting for most of the changes in local and national drug trends, it should come as no surprise that fentanyl appears to be responsible for a major shift in the profile of methamphetamine-related deaths in Los Angeles County. A significant increase in deaths in which opioids were a contributing factor has been accompanied by a drop in deaths with associated cardiovascular factors, a primary danger of stimulant use.

The lead author of a study documenting these changes, published online June 12 in the *Journal of Substance Use and Addiction Treatment*, told *ADAW* that polysubstance use in methamphetamine users in Los Angeles County now stands as their most prominent risk for fatal overdose. As a result, "We've got to get naloxone to those who do not consistently use opioids, or don't think they do," said Chelsea Shover, Ph.D., assistant professor in residence at UCLA's David Geffen School of Medicine.

Shover also pointed out, however, that while the new study

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Bottom Line...
The lead researcher for an analysis of trends in methamphetamine-related deaths in Los Angeles County cites polysubstance use as the main threat that has emerged in recent years.

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to state funding or the use of opioid settlement funds (which are being used to fund Rhode Island's OPC).

To be fair, all agency directors — even high-level ones like Cunningham — must follow the lead of their governor, in this case New York Gov. Kathy Hochul, when it comes to policy.

Kent, who since he left ONDCP (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33744) has been a consultant, told *ADAW* last week that he has some ideas on how to overcome a legal argument based on OPCs violating the crack house statute.

State powers, ADA

If a state were challenged in federal court over its OPC and Kent were representing it, he would invoke the 10th Amendment of the U.S. Constitution, which says "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

Take Rhode Island as a hypothetical example: "Now you have a state law that authorizes OPCs, and the legal argument against it is that it violates the crack house statute," said Kent. "I would argue that by enacting a state law, Rhode Island is using their police powers to protect the health of the public," he said.

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Rob Kent

In Rhode Island, the OPC is a pilot program, and the state law includes rules and regulations, he said.

Kent has paid close attention to OPC litigation, including that surrounding Safe House, a planned program in Philadelphia that has yet to find a site and lost in court due to the crack house statute. What Safe House lawyers are arguing now is that the "predominant purpose of an OPC is not allowing people to use drugs they bring with them, it's health care," said Kent. This health care includes for addiction, mental illness, and other medical problems.

"My working legal theory is that you have to have some basis to overcome the argument that these violate the crack house provisions of the federal Controlled Substance Act," said Kent. "If I were Rhode Island, Minnesota (where the legislature just passed a bill authorizing OPCs), or even New York, I would argue that the government has to authorize these facilities." The strongest argument is in Rhode Island, because a state law is already on the books, he said.

The Americans with Disabilities Act (ADA) is also applicable to OPCs, said Kent, admitting that this is his legal theory which has not yet been litigated. The ADA does not protect illicit drug users and does not the regard them as disabled, although former illicit drug users, and current alcohol, as well as former alcohol users, are protected. "My opinion is, you have a house with a lot of rooms, and in some of the rooms things are going on that are not protected by the ADA, and in some of the rooms there are protections," he said. "So allowing people to actually use drugs would not be protected by the ADA, but there are other things going on in OPCs besides people using their own drugs under supervision, such as health care and that is protected by the ADA."

On President Biden

We have heard OPCs including OnPoint blame President Biden for

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voting for the crack house Statute (a 1986 law). Kent clarified this: "The Biden administration hasn't taken any position one way or another on OPCs," he said. The reason is that there is still active litigation in federal courts in Pennsylvania, said Kent. "The president and the administration don't want to influence the outcome of the legal process."

As for the old voting record, people change. And many of us have changed since the 1980s. What's important is now.

There is a bill in Congress, the EQUAL Act, that would eliminate the increased criminal penalties for crack vs. cocaine powder, a disparity the Biden administration wants to get rid of, Kent noted.

Settlement funds

As for the opioid settlement funds that went to the states, New York has still not spent theirs, noted Kent. "It's sitting there," he said. For 2022–2023, there was $208 million appropriated but not spent. For the new budget adopted a year ago, the full $208 million had to be re-appropriated, which means that none has gone out the door.

The advisory board made its recommendations about how the money should be spent (see tk). "If it were up to me, I would say take all the pots of funds allocated to increase access to services and put them all together into one large pot that is all available to hire staff." The biggest problem in the field is workforce, he said, noting this is true for all health care, but especially true for addiction. "So many programs are operating at reduced capacity," he said. "Increased access will come if programs can hire staff." •

Editor's Note: We were set to visit OnPoint last week, but the meeting was rescheduled due to the facility's observance of Pride Month. Stay tuned for our site visit report.

SAMHSA issues TIP on incorporating peers into treatment

Last week the Substance Abuse and Mental Health Services Administration (SAMHSA) issued TIP (Treatment Improvement Protocol) number 64. This TIP is devoted to integrated peer support services into clinical treatment for substance use disorder (SUD). Coming on the heels of its model standards for peers (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33806), the TIP will provide useful information for treatment programs seeking to use peers, especially during a time of workforce inadequacy. The 237-page document includes many useful resources, as well, but ultimately, states will have to rely on their own systems for reimbursement.

Below are key points:

- Peer support services (PSS) are nonclinical recovery support services that can be used to enhance SUD treatment, extend related services, and improve outcomes for people in or seeking recovery. (The term "recovery" is defined in the "key terms" section of this summary.)
- PSS are increasingly being integrated into diverse SUD treatment settings, as well as in settings that frequently coordinate care with formal SUD treatment programs, such as recovery community organizations, recovery community centers, recovery residences, hospitals and jails/prisons.
- Peer workers are nonclinical professionals who have lived experience with problematic substance use, behavior change, and recovery. These professionals deliver a range of recovery supports designed to improve the treatment experience of individuals who have problematic substance use and their ability to continue on their chosen recovery pathways before, during, and after treatment.
- Peer workers fill a range of roles, such as providers of recovery support, educators, engagement

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IC&RC adopts SAMHSA model standards for peers

Last week, the International Certification and Reciprocity Consortium (IC&RC) announced that it would adopt the proposed SAMHSA's National Model Standards for Peer Support Certification in the form of a new credential. "This national entry-level peer credential will be the first rung of a career ladder that will lead to stronger SUD workforce development, which is greatly needed across the country," according to a press statement. IC&RC is the first nationally recognized peer certification organization to adopt these standards. "Quality and integrity are the foundation of IC&RC's work and our mission to protect the public via credentialing. As the global leader in the credentialing arena, we are pleased to take this step to allow more peers to enter the workforce, bringing their lived experience to those in need of SUD services."

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facilitators, role models and mentors, resource navigators and recovery advocates. In fulfilling these roles, peer workers serve not only individuals in or seeking recovery, but also their families and the community.

- To integrate PSS into SUD treatment programs, administrators should consider their organization's culture, assess staff on their knowledge and attitudes about recovery and PSS, and examine their organization's hiring and retention practices.
- Treatment program administrators and supervisors play key roles in helping peer workers integrate successfully into organizations and in helping other staff understand, accept, and respect their peer worker colleagues. This is extremely important because a lack of staff understanding about peer workers' value and roles can lead to role confusion, role strain, and role drift—all of which make it difficult for

Definitions

Addiction: The most severe form of SUD, associated with compulsive or uncontrolled use of one or more substances despite adverse consequences. Addiction is a chronic brain disease that has the potential for both recurrence of problematic use and recovery.

Individuals in or seeking recovery: People who are actively engaged in or seeking recovery (e.g., independently, via mutual-help groups, or via health-promotion strategies). This term is synonymous with "people in or seeking recovery."

Mutual-help programs: Nonprofessional groups in which members share the same problem, value experiential knowledge, and support one another in recovery from that problem. Recovery from problematic substance use is supported by a wide spectrum of mutual-help programs that may be secular (e.g., Women for Sobriety, Secular Organizations for Sobriety, Self-Management and Recovery Training [SMART] Recovery®, and LifeRing Secular Recovery), spiritual (e.g., 12-step programs like Alcoholics Anonymous® [AA], Narcotics Anonymous® [NA], and Double Trouble in Recovery), or religious (e.g., Celebrate Recovery®; Jewish Alcoholics, Chemically Dependent Persons, and Significant Others; Millati Islami; and Refuge Recovery). The support one receives through mutual-help programs is not the same as the support one receives through peer support services.

Nonclinical role: A staff role that doesn't involve diagnosis, clinical assessment, or treatment of a substance use, mental or other medical disorder.

Peer support services (PSS): The range of services designed, developed, and delivered by peer workers who have lived experience in recovery from problematic substance use and can fill a range of roles to support other people in recovery.

Peer worker: In general, any person (or in the case of a family peer worker, a close friend, family member, or other loved one of an individual) with lived experience in recovery from problematic substance use, mental disorders, or both who provides nonclinical support in establishing and maintaining long-term recovery. The term **peer worker** encompasses peers working in professional (employed) or volunteer capacities, regardless of whether their work is tied to formal, organized treatment or recovery services. Peer workers support people in or seeking recovery, conduct strengths-based outreach and engagement, connect individuals who have problematic substance use with recovery resources, facilitate and lead recovery groups, and help build community, among other activities. They sometimes have such titles as recovery coach, mentor, peer provider, peer navigator, or similar terms. **Peer specialists** (short for peer recovery support specialists) refers specifically to peer workers with some training, including those working in a professional capacity, whether certified or not. Peer workers who have received certification or credentialing to provide peer support services are commonly referred to as **certified peer specialists**.

Problematic substance use: The use of any substance in a manner, situation, amount or frequency that causes harm to the person using the substance or to those around them; it replaces the outdated terms "substance abuse" and "substance misuse." In the case of prescription medications, problematic use is any use other than as prescribed or directed by a health care professional. For some substances (e.g., heroin, cocaine) or individuals (e.g., those who engage in injection drug use), any use constitutes problematic use. Problematic substance use is a broad term and can include use that constitutes an SUD. (All people with SUDs have had problematic substance use, but not all problematic use meets diagnostic criteria for an SUD.)

Source: Substance Abuse and Mental Health Services Administration.

peers to enjoy and successfully perform their jobs.
- Supervision is a critical part of all roles to ensure delivery of high-quality services. Because the peer worker role is so different from that of a clinical professional, supervisors will need training focused on how to effectively oversee and work with peer workers.
- Serving as a peer worker can be a fulfilling career for individuals in recovery who want to support individuals with problematic substance use while enhancing their own recovery. Attending specialized training and seeking certification are often the first steps on this career path.

'Shoulds'

Below are SAMHSA's "should" statements for using peers. The bold is in the original document.
- PSS enhance traditional SUD treatment and services by connecting people who are experiencing problematic substance use to others who have lived experience with problematic substance use and recovery. SUD treatment program providers, supervisors, and administrators (including clinical/program directors) should offer PSS for problematic substance use and ensure that individuals in or seeking recovery are aware of and can access these services. Any setting that offers care and support for individuals who have problematic substance use should also offer or arrange for PSS. Integrating the peer position into SUD treatment programs should supplement PSS that are offered by recovery community organizations (RCOs) and recovery community centers (RCCs)—not replace them.
- PSS are an important part of a recovery-oriented system of care (ROSC) and are associated with improved outcomes. ROSCs are multisystem, strengths-based, person-centered continuums of care in which a variety of coordinated supports is tailored to an individual's needs and chosen recovery pathway.

The 237-page document includes many useful resources, as well, but ultimately, states will have to rely on their own systems for reimbursement.

Be prepared for different field organizations to juggle for top billing in the burgeoning peer industry. •

Telehealth reimbursement by Medicaid continues

Medicaid benefits for New Yorkers continuing post-pandemic were outlined at the Coalition of Medication-Assisted Treatment Providers and Advocates (COMPA) symposium in Albany, New York last month. Medicaid payments to treatment providers for telehealth which were instituted as part of pandemic emergency rules continued after the emergency was lifted in May. Trisha Schell-Guy, director of the division of program development and management at the New York State Department of Health, explained how the flexibilities, many of which apply to buprenorphine, will continue.

Telehealth was instituted during the COVID-19 pandemic, which began in March 2020, to reduce the possibility of transmission of the virus. Like many pandemic-related flexibilities, the policy has caught on among providers and patients, and will continue in New York.

Below are key points:
- The February 2023 "Comprehensive Guidance Regarding Use of Telehealth including Telephone Services After the Coronavirus Disease 2019 Public Health Emergency Special Edition Volume 39-Number 3" was updated on May 8 and is available at: https://www.health.ny.gov/health_care/medicaid/program/update/2023/no03_2023-02_speced.htm.
- All New York state Medicaid providers and providers employed by New York state Medicaid facilities, or provider agencies who are authorized to provide in-person services, are authorized to provide such services via telehealth if such telehealth services are appropriate to meet the needs of the patient and are within the scope of practice of the provider.
- In March 2023 the Drug Enforcement Administration (DEA) issued two notices of proposed rulemaking to allow for prescribing controlled medications pursuant to the practice of telemedicine in instances where the prescribing practitioner has never conducted an in-person medical evaluation of the patient. These rules required checking state prescription drug monitoring programs and an in-person examination of patients who were prescribed buprenorphine within 30 days. Due to unprecedented public comment, effective May 11, 2023, the DEA and Substance

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Abuse and Mental Health Services Administration issued a temporary rule continuing the telehealth prescribing flexibilities that existed during the Public Health Emergency (PHE) while they consider all the comments. (For more, see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33782.)

Services

Effective for services rendered after May 11, 2023:

- Telehealth continues to be broadly allowable post-PHE (where clinically appropriate and when it is the patient's preference) unless otherwise specified in program-specific guidance. Absent program-specific guidance, telehealth is considered allowable.
- Policies are outlined for the new modalities established by regulations (audio-only, virtual check-in, virtual patient education).
- A policy on eConsults is forthcoming.
- Full reimbursement is required when at least one party (patient or provider) is on site.
- New York state Office of Addiction Services and Supports and Office of Mental Health providers are paid at parity, regardless of whether any party is on-site.
- Medicaid Managed Care (MMC) plans may have separate detailed billing guidance, but cover all services appropriate to deliver through telehealth, including audio-only telehealth.

Medicaid Managed Care considerations

MMC plans are required to cover, at a minimum, services that are covered by New York state Medicaid fee for service (FFS) and are included in the MMC benefit package, when determined to be medically necessary, and must provide telehealth coverage as described in this guidance. MMC plans may establish claiming requirements (e.g., specialized coding) that vary from FFS billing instructions in this guidance.

- MMC plans must adhere to the payment parity requirements outlined in Public Health Law and presented in the "Medicaid Update."
- MMC plans may not limit enrollee access to telehealth/telephonic services to solely the MMC plan telehealth vendors and must cover appropriate telehealth/telephonic services provided by other network providers.
- Questions regarding MMC reimbursement or documentation requirements should be directed to the MMC plan of the enrollee. •

Effects of xylazine in illicit fentanyl supply: Report from OASAS

At the COMPA (Coalition of Medication-Assisted Treatment Providers and Advocates) Symposium last month in Albany, New York, officials from the New York Office of Addiction Services and Supports (OASAS) presented information on the effects of xylazine, increasingly present in the street supply of opioids, especially fentanyl. Pamela Mund, M.D., OASAS associate medical officer, and Sarah Gorry, M.S., an Empire State Fellow with OASAS, shared the following information. Xylazine is:

- A non-opioid sedative, anesthetic, muscle relaxant, and analgesic for animals;
- Not approved for human use due to severe central nervous system (CNS) depression; and
- An Alpha-2 adrenergic agonist.

The history of xylazine started in Puerto Rico in the early 2000s and first emerged as a substance of widespread use there.

Research was conducted after local harm reduction programs observed deep sedation and skin wounds within communities of people who use drugs (PWUD). It started appearing in Philadelphia medical examiners' reports in 2006.

By 2021, 91% of "dope" samples contained xylazine. It is an additive in the unregulated drug supply (most often with illicit injected fentanyl) and is described as giving fentanyl "legs."

Data from across the country shows that:

- From 2015 to 2020 in Pennsylvania, based on death certificate data from medical examiners and coroners' offices, overdose deaths involving xylazine increased from 2% to 26%;
- In 2021 in Maryland, xylazine was involved in 19% of all overdose deaths;
- In 2020 in Connecticut, xylazine was involved in 10% of all overdose deaths;
- In 2019, based on the State Unintentional Drug Overdose Reporting System, fentanyl was present in 98% of xylazine-involved overdose deaths; and
- According to the Drug Enforcement Forensic Laboratory Identifications, from 2020–2021there were increases in xylazine-positive samples in all regions, especially in the Northeast.

Effects of xylazine

Xylazine causes "profound sedation" that can last for several hours. The CNS depression means

breathing is reduced, but in addition, there is muscle relaxation of the tongue which can block the airway and prevent breathing. Skin wounds are complex and can progress into severe necrotic skin ulcerations without early intervention wound care.

Xylazine also produces physical dependence, with withdrawal symptoms including non-specific anxiety, high blood pressure, increased heart rate, sweating, restlessness, agitation and irritability.

Best practices

The OASAS speakers recommended the following as best practices for treating the xylazine problem:

- Offering and facilitating medications for opioid use disorder (MOUD) in a low-threshold manner and in low-threshold settings;
- Alternative approaches of initiating buprenorphine and methadone may be required in persons using fentanyl;
- Identification and management of withdrawal from xylazine;
- Treatment for skin wounds, including new delivery models for xylazine-related wound care;
- Rethinking overdose prevention, intervention, and safety planning to include xylazine (and other sedatives) in the unregulated drug supply; and
- Bottom-up harm reduction strategies, meaning, learning, implementing and disseminating best practices from community-based organizations.

The skin wounds from xylazine begin as small, darkened spots with an odd border, which is often overlooked. A flat purple or white spot with a red or purple border, the first wound may look like a bruise. It is possible for wounds to occur in another part of the body, not the injection site, and even in persons who don't inject. The wounds themselves are not infectious but can become secondarily infected with bacteria.

Low-threshold MOUD

Only 22.1% of people with OUD received MOUD in the past year, leading to the federal government calling for buprenorphine only, with no requirement for counseling (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33782.)

The speakers defined low-threshold treatment as an "alternative approach that attempts to remove as many barriers to treatment as possible, including same-day treatment entry (walk-ins), a harm reduction approach and flexibility, so that it is widely available in places where people with OUDs go. •

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shows that opioids contributed to 54% of the county's methamphetamine-related deaths in 2021, that still means nearly half of methamphetamine deaths do not involve opioids at all. This therefore calls for continued attention to improving treatment access and options for individuals with methamphetamine use disorder, she said.

The study is titled "Longitudinal changes in co-involved drugs, comorbidities, and demographics of methamphetamine-related deaths in Los Angeles County" and was supported in part by the National Institute on Drug Abuse. Data from Los Angeles County on this topic is considered highly relevant because the county had the highest number of total drug overdose deaths among counties in 2020, with deaths involving a psychostimulant accounting for 49% of all overdose deaths that year.

Changes over 9-year period

Shover and colleagues accessed data from the Los Angeles County Department of the Medical Examiner and Coroner to analyze longitudinal trends in methamphetamine-related deaths between January 2012 and June 2021. Besides having access to the usual information from death certificates about demographics and cause of/contributor to death, the investigators were able to study the relationship between overdose deaths and housing status because the county's reports indicate if a person was experiencing homelessness at the time of death.

The data showed that the presence of polysubstance use increased significantly over time among the victims of methamphetamine-related deaths.

The analysis encompassed 6,125 methamphetamine-involved deaths during the period, with the annual number growing from 238 in 2012 to 1,385 in 2020 (the researchers looked at 2020 for this statistic because it was the most recent year with full data available). The average age of those who died was 45.1 years. Black individuals made up of a fast-growing proportion of methamphetamine-involved deaths (a five-fold increase over the study period), with percentages decreasing overall for White and Asian individuals. The percentage of victims who had been experiencing homelessness rose from 13% in 2012 to 35% in 2021.

The data showed that the presence of polysubstance use increased significantly over time among the victims of methamphetamine-related deaths. Opioids were

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a contributing factor in 54% of these deaths in 2021, compared with 16% in 2012; most of that increase is attributable to fentanyl and its analogs, the investigators reported. Concomitant use of methamphetamine and cocaine also increased during the study period.

At the same time, cardiovascular involvement in methamphetamine-involved deaths dropped from 47% in 2012 to 26% in 2021. The cardiovascular system did remain by far the most frequently cited organ system in the county death certificates' cause-of-death information, mentioned in 38% of all reports. The respiratory system ranked second, cited in only 8% of reports.

The group experiencing a fentanyl-involved death was, on average, younger than those who experienced a death with cardiovascular causes. That resulted in the investigators offering in their paper this explanation of the decreasing proportion of cardiovascular-related deaths: "With the younger age of death, the sequelae of chronic methamphetamine use such as cardiomyopathy may not be apparent on autopsy. Moreover, the increase in concomitant opioid-related deaths may account for this shift as individuals using methamphetamine with little or no opioid tolerance are being exposed to fentanyl earlier in their drug-using careers and dying before the chronic changes of methamphetamine use can occur."

While the study's numbers show unmistakable trends in the factors associated with methamphetamine deaths, they still suggest that a balanced response to assisting methamphetamine users is needed, Shover said. For patients using stimulants, "We need to continue thinking about prevention and addressing cardiovascular disease, not just the substance use," she said.

Expanding treatment options

With polysubstance use changing the dynamics affecting people who use methamphetamine, "We need to be thinking about how to increase the access to and quality of treatment for people who use multiple substances," Shover said. For patients with stimulant use disorder, that would involve expanding access to contingency management approaches, she said, but also trying medication treatments that have shown some evidence of efficacy (with no medications currently approved for stimulant use disorder).

Shover also sees harm reduction approaches as a critical component of the care continuum. These would include naloxone distribution, low-barrier treatment, and potentially the use of contingency management approaches in which abstinence is not the primary goal at the outset, she suggested. She and her co-authors also mentioned in their paper the potential role of safe consumption spaces.

Naloxone remains the first line of defense in both public health and in treatment, the study's authors wrote. "Though much naloxone provision occurs in the context of harm reduction services, this finding [on polysubstance use] also means that clinicians treating patients who are known to use methamphetamine, regardless of what the reasons for treatment are, should provide or prescribe naloxone as they would to patients known to use opioids," they wrote.

At the same time, they suggested, managing cardiovascular risk through monitoring of blood pressure and cholesterol levels remains an important part of overall care.

Shover credited Los Angeles County's tracking of information on homelessness as part of its cause-of-death reporting, saying that in this context it makes a case for directing more resources to the homeless population. •

Coming up...

The **National Prevention Network conference** will be held **August 15-17** in Birmingham, Alabama. For more information, go to **http://npnconference.org/**

The **Cape Cod Symposium on Addictive Disorders** will be held **September 7-10** in Hyannis, Massacchusetts. For more information, go to **https://www.capecodsymposium.com/**

The **NAADAC annual conference** will be held **October 6-12** in Denver, Colorado. For more information, go to **https://www.naadac.org/annualconference**

In case you haven't heard...

For those readers who are NSDUH (National Survey on Drug Use and Health) nerds, the Substance Abuse and Mental Health Services Administration (SAMHSA) has a new, second survey. The Mental and Substance Use Disorders Prevalence Study (MDPS) includes gaps not covered by the NSDUH: Those who do not reside in households; including homeless, institutionalized or incarcerated populations. These populations, according to SAMHSA, have disproportionately high rates of mental health and substance use disorders. Between October 2020 and October 2022, this study, conducted in partnership with the research organization, RTI International, conducted 5,679 clinical interviews among 18–65-year-olds, including those living in households, prisons, state psychiatric hospitals and homeless shelters. For the MDPS, released last week, click HERE.