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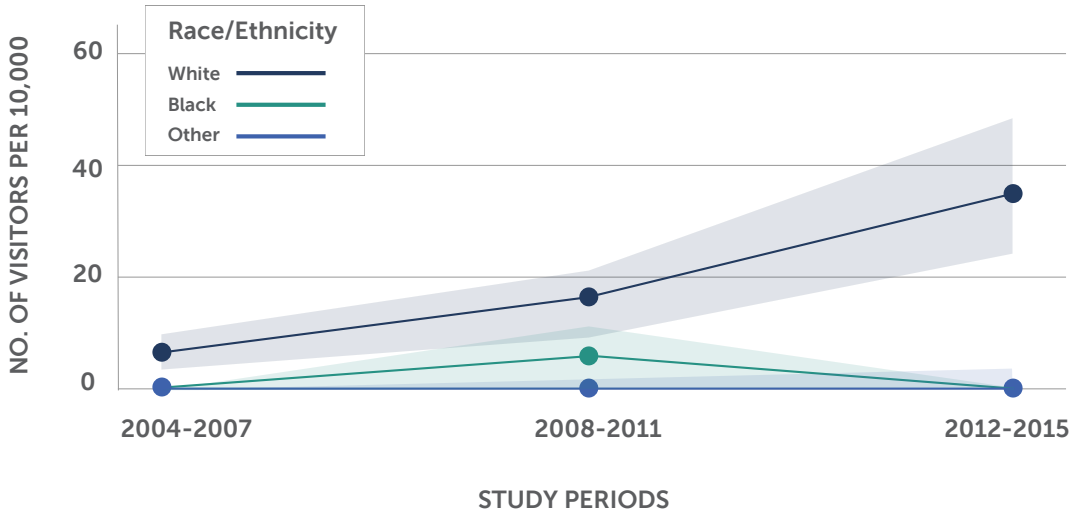
Stronger Than Addiction

Reducing Disparities within Substance Use Disorder and Mental Health Treatment:
The Collaborative Care Model (CoCM)

There are stark racial and ethnic disparities in access to addiction treatment. These disparities are partly driven by inequities in access to the types of addiction medications available to different racial groups. For example, Blacks and Whites have different access to the two medications most used in the treatment of opioid use disorder: methadone and buprenorphine. Methadone dispensing entities are more commonly located in Black neighborhoods, and buprenorphine prescribing providers are more common in White communities. Further, a multitude of studies demonstrate that White individuals are more likely to receive a buprenorphine prescription, a medication for opioid use disorder shown to increase the odds of successful, long-term recovery, than their peers of color.[1] Because of the onerous federal restrictions and severe stigma associated with methadone in comparison to buprenorphine, Black individuals often face more severe barriers than Whites in accessing these medications.[2]

Buprenorphine visits by race/ethnicity



Increasing access to evidence-based treatment for all, particularly within Medicaid, is deeply important to reducing these disparities. The **Collaborative Care Model (CoCM) for SUD** offers an opportunity to achieve health equity through integration of behavioral health services in the primary care setting. CoCM is a care integration approach shown to reduce disparities by race/ethnicity and/or socioeconomic status in access to care, quality of care, and outcomes.[3] CoCM reduces these inequities by delivering behavioral health care in the primary care setting, versus a specialty provider, eliminating the patient burden of finding and seeing another provider.

For example, a 2016 study of community-based health centers in Los Angeles found that CoCM reduces ethnic disparities in care access because treatment occurs in settings where low-income or publicly insured individuals are most likely to obtain other types of care.[4] The mechanism in which the care is delivered is also important to the treatment being delivered; care should be provided in a socially and culturally adapted way to achieve the most positive clinical outcomes.

Special considerations for culturally appropriate interventions in primary care should include adaptations for language and other cultural barriers, such as bilingual providers. A systematic review showed that patients with limited English proficiency, specifically Spanish-speaking patients, had improved outcomes and may benefit as much as, if not more than, English-speaking patients treated with CoCM.[5] While more research is needed on various patient populations, the existing data provides promising evidence that the CoCM offers widespread opportunities for reducing racial and ethnic disparities in behavioral health access and outcomes.

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[1] https://pubmed.ncbi.nlm.nih.gov/31066881/

[2] https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.02261

[3] https://www.jstor.org/stable/pdf/26417893.pdf

[4] https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201600187

[5] https://link.springer.com/article/10.1007/s11606-017-4242-4