

Funding Gaps, Training Shortages Create Barriers for Dual Diagnosis SUD, SMI Treatment

By **Morgan Gonzales** | February 14, 2025

Almost 50% of patients with serious mental illnesses (SMI) also have a substance use disorder (SUD). Yet few providers offer specialized care for patients with co-occurring SUD and SMI.

Clinical challenges and problems with training and reimbursement make providing much-needed care for this population difficult, resulting in too few high-quality, specialized care programs.

“In order to get high-quality care for [co-occurring SUD and SMI], you need somebody that is specialized in substance use disorder and in these more severe forms,” Caroline Fenkel, co-founder and chief clinical officer of Charlie Health, told Addiction Treatment Business. “Even if you do have the luck to get into care, is it going to be high-quality care? Because this population is difficult to treat, and you need much more training to treat it. ... It’s very inaccessible in a lot of ways, and it’s why we started Charlie Health.”

Bozeman, Montana-based Charlie provides virtual intensive behavioral health treatment programs in 37 states. About half of Charlie’s patients use substances at the time of intake.

SMI is an umbrella term for several mental health conditions, including bipolar disorder, schizophrenia and major depressive disorder. There is no one-size-fits-all approach to this population, experts told ATB, but SMI often intertwines with substance use issues.

The large overlap between SMI and SUD is due to both genetic and environmental factors, according to Fenkel. People with SMI may self-medicate with substances. Inversely, substance use can trigger mental illnesses. For example, marijuana use can trigger early-onset schizophrenia.

Patients with co-occurring SMI and SUD require specialized care, experts told ATB.

Traditional mental health treatment involves insight-based interventions, Fenkel said; for example, clinicians gain insights into a patient’s trauma or childhood and seek to restructure thought patterns. This insight-based care is not possible when a patient’s brain is “hijacked” by SUD, she said. Providers must first work with a patient behaviorally before moving to insight-based work.

For Lewis Zeidner, CEO of SUD treatment provider Meridian Behavioral Health, treating both conditions simultaneously is crucial.

“The historic model of treatment for SUD was one of sequential care,” he told ATB. “We used to say, people deal with your substance use, and we’ll deal with your mental health subsequently because we believe that for many patients, their mental health challenge was triggered by their substance use. ... What we learned is that sequencing doesn’t work.”

New Brighton, Minnesota-based Meridian operates 654 beds across 13 inpatient and eight outpatient facilities in Minnesota. The provider, which recently [acquired Gateway Recovery Center](#), has several specialty programs, including one dedicated to SMI care.

Patients with SMI may be unable to stay in SUD treatment, Zeidner said, necessitating treating both simultaneously.

Growing need

Care has become increasingly scarce for patients with more extreme mental health conditions who also have SUDs, Zeidner said.

“These are patients that historically might have been treated in a more traditional psychiatric hospital,” Zeidner said. “But as we see the number of beds drop and the number of hospital systems that are reducing their involvement in psychiatry, we’re seeing more patients come to us who have more intense symptomology.”

Psychiatric hospitals have faced [mounting pressures](#), including regulations, challenging payer relations and inflation, leading to swaths of closures.

Treating patients with co-occurring SMI and SUDs presents certain challenges.

One of these barriers is the time it takes for patients to stabilize on psychotropic medication. Most patients have to titrate to a therapeutic dosage, which can take several weeks.

“If they give us 30 days to treat somebody, and the first two or three weeks are about getting up to a therapeutic dose, [that] doesn’t leave a lot of time to do some of the other work,” Zeidner said.

Need for training

Clinicians require more training to meet the more specialized needs of patients with co-occurring SUD and SMI – but specially trained clinicians are not always available.

“Nobody wants to touch these cases,” Fenkel said. “No business wants to touch them. They’re really tough. It’s a high-risk population.”

Increased training could improve care access, according to Erin Kelly, associate professor and director of the Jefferson Mental Illness, Addiction, and Primary Care Fellowship at Thomas Jefferson University.

Behavioral health training programs and graduate training programs should include information about both SMI and SUD and how to treat patients with both conditions, she said. This training does not always occur.

A [study](#) led by Kelly and published in the Journal of Substance Abuse Treatment found “serious gaps” in the implementation of training, programs and interventions geared at treating SUD among individuals with SMI. A lack of funding hinders progress toward more comprehensive training models, Kelly said.

Fenkel, who holds a master’s degree and PhD in clinical social work, said that SUD care was an elective in her master’s program.

“It’s bizarre that people who are providers and practitioners don’t necessarily have the skills or expertise that they need,” Fenkel said.

Improving the standings

Increasing pay could help alleviate the problems associated with clinician training. Low reimbursement rates for SUD services often present challenges for providers. More specialized, integrated care is no different.

Higher reimbursement rates for specialized SUD and SMI care, and paying for inter-specialty coordination, would result in more effective, efficient patient care, ultimately improving health and well-being and reducing mortality, Kelly said.

“To truly change the system to treat both conditions, we need payment models to support innovative, evidence-based, and sustainable services that recognize care needs to be whole person focused,” Kelly continued.

Funding models for community mental health centers also cause problems. While these providers are increasingly focusing on integrating substance use care for patients with SMI, funding comes from different sources, Kelly said. Agency requirements and guidelines differ, which “perpetuates the piecemeal issues” with SMI/SUD care.

While challenges abound for providers treating patients with co-occurring SUD and SMI, effective care leads to positive outcomes, providers said.

“This is not a hopeless population,” Fenkel said. “Substance users, the earlier that you catch it, the longer that they are sober, the more intervention that they have with their family, ... they have a much better chance of getting and staying sober.”