NYSACHO HARM REDUCTION CONFERENCE

Co-Occurring Disorders:
The Missing Link in Primary Prevention

Prevention • Education • Early Intervention • Harm Reduction • Integrated Treatment • Recovery

Stephanie Marquesano, JD | founder & president, the harris project

the harris project

I came to this work differently.

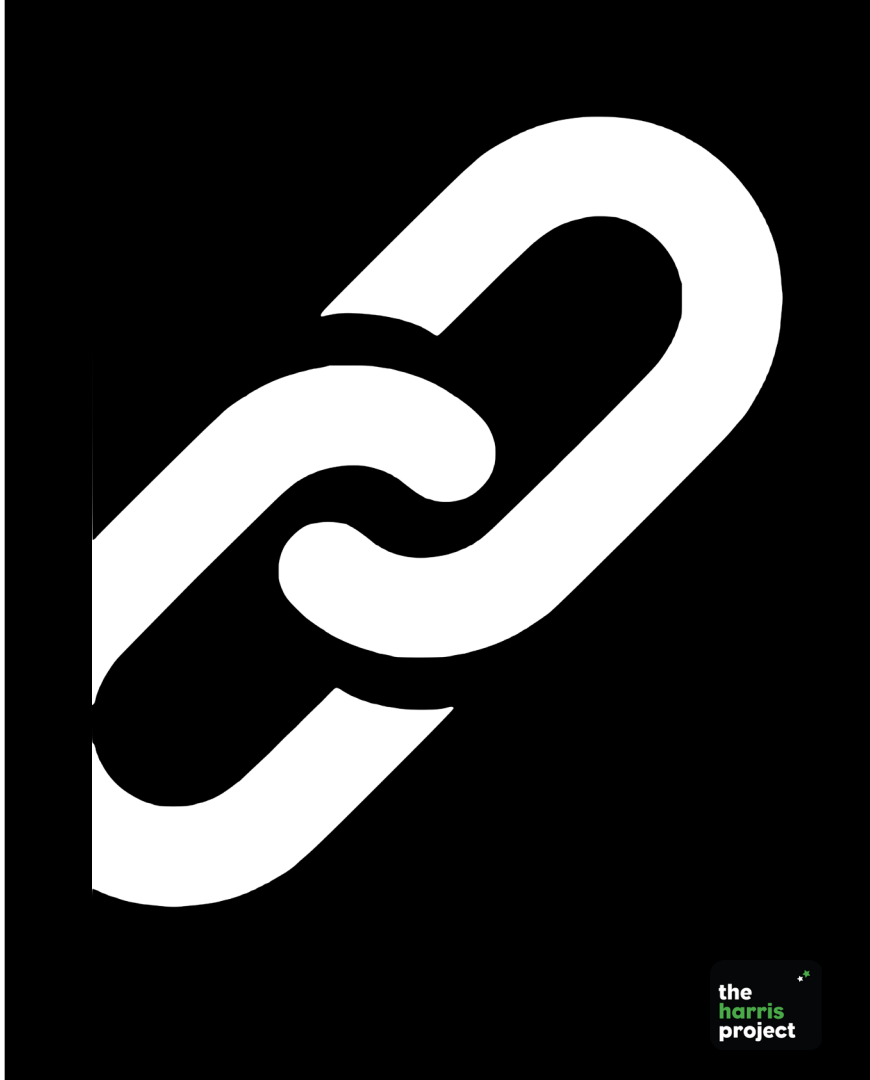
Through lived experience.

Not training.

What I learned…

It’s not one thing.

It’s the missing link.



This is a story about Harris. It is also a story about what systems can learn.

I want to tell his story in the order we lived it, and pause at the moments when the right knowledge, support, or care might have changed the path.





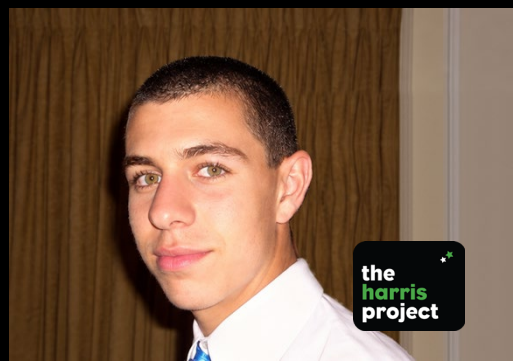




Everyone knows a Harris...









BEFORE ANY DIAGNOSIS

HARRIS WAS MY SON.

- A caring brother and loyal friend.
- An incredible athlete and deep-thinking poet.
- Funny, social, creative, and deeply loved.
- It looked like he had it all. Internally, he struggled.



EARLY CHILDHOOD

AGE 3: ANXIETY ENTERED THE STORY

- Harris began experiencing symptoms of an anxiety disorder at about three years old.
- He had access to mental health professionals throughout childhood.
- But no one ever educated Harris, or us, about the relationship between mental health and substance use.



ELEMENTARY SCHOOL

ANXIETY SHOWED UP IN EVERYDAY LIFE

- Smell aversions made places like the school cafeteria difficult.
- He had an intense fear of throwing up.
- Leaving the house could take an hour.
- The signs were there.
- We did not yet have a shared framework for understanding them or what this might lead to.

REFLECTION

What if the adults around Harris had understood anxiety as something to notice, accommodate, and talk about?

WHAT CAN WE DO DIFFERENTLY?

01 Recognize coping behaviors as clues, not quirks.

02 Help children name feelings and identify strategies and trusted adults before crisis.

03 Professionals tell parents that childhood mental health challenges raise substance use risk.



MIDDLE SCHOOL: GRADES 5-7

ANXIETY DID NOT ALWAYS LOOK LIKE ANXIETY

- In 5th grade, a teacher made fun of the water bottle he carried to cope.
- He increasingly projected confidence.
- Being “cool” became part of the mask.
- A young person can struggle inside while working hard to look fine.

REFLECTION

What if we had understood masking?

WHAT CAN WE DO DIFFERENTLY?

01 Look beyond behavior, personality, popularity, and performance.

02 Ask what a young person may be managing underneath what we see.

03 Give teachers, coaches, families, peers, and faith leaders the language to notice and connect.

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MIDDLE SCHOOL: EIGHTH GRADE

THE PICTURE CHANGED

- Anxiety became so severe that he stopped playing soccer, a game he loved.
- He became more secretive and spent more time alone in his room.
- The highs were high and the lows were low.
- My husband and I grew increasingly concerned about Harris's well-being.

Eighth grade

A MISSED OPPORTUNITY

- At our last appointment with his therapist, we learned Harris was regularly smoking marijuana.
- I hear his words like it was yesterday, “I thought he was just experimenting, but I think he might have a problem.”
- The therapist told us he wasn’t equipped to address Harris’s substance use alongside his mental health challenges.

REFLECTION

What if mental health care had included prevention?

WHAT CAN WE DO DIFFERENTLY?

01 Education about substance use risk, and a clear explanation of self-medication.

02 Not simply “Is he using?” Also: “What is he trying to manage?”

03 Screen for mental health and substance use together.



A NEW DIAGNOSIS. A DRAMATIC IMPROVEMENT.

- A full evaluation identified ADHD alongside the anxiety disorder.
- With treatment and medication, Harris thrived.
- He returned to soccer and became all-league and all-section.

A PERIOD OF IMPROVEMENT

Because he was doing so well, he stopped seeing his therapist, a decision she supported.

We thought his difficulties were behind him.
We were wrong.

REFLECTION

What if “doing better” had not meant “we’re done”?

WHAT CAN WE DO DIFFERENTLY?

01 Continue monitoring across developmental transitions. Keep the door open.

02 Prepare for stress, symptom recurrence, and changes in medication efficacy.

03 Keep prevention and early intervention active during stability.



HIGH SCHOOL: JUNIOR YEAR

PRESSURE RETURNED

- SATs, grades, college decisions, and the possibility of college soccer.
- His anxiety overwhelmed the medication that helped his ADHD.
- He kept it inside.
- At a party, prescription pills were available. He took one. The relief was immediate.

REFLECTION

What if Harris had understood the connection before that night?

WHAT CAN WE DO DIFFERENTLY?

01 How mental health challenges can increase vulnerability to substance use.

02 Why short-term relief can worsen the long-term problem.

03 Refusal skills, help-seeking, and a trusted adult identified in advance.

THE FIRST RESIDENTIAL PROGRAM WAS NOT THE LAST

ONE MONTH BEFORE HIS 18TH BIRTHDAY
Harris entered residential substance use treatment.

FOR THE FIRST TIME
we learned it had a name: co-occurring disorders.

EVERY FACILITY
said they treated it.

Sequential, not integrated.

They always started with the substances, while never getting to the mental health piece.

“I love my family, my friends, my life, but my brain works a million miles an hour.”

“If they don’t help me address my mental health, how am I going to get out of here and not have the same cycle repeat?”

TREATMENT

WHEN HE CAME HOME, WE FOLLOWED EVERY RECOMMENDATION

INTENSIVE OUTPATIENT substance treatment

PSYCHOLOGIST + PSYCHIATRIST therapy & medication

12-STEP mutual aid meetings

SUPPORTIVE routines, including the gym

Simultaneous services existed, integrated care did not.

No one was responsible for addressing Harris's co-occurring disorders as a whole. Harris was subjected to different messages and paradigms.

Within two weeks, Harris began using again.

FRAGMENTED CARE

MANY SERVICES. NO SHARED PLAN.

Within the year and a half before his death, Harris received care across multiple programs, with additional ancillary supports:

1

short-term mental health inpatient program

2

substance use outpatient programs

4

substance use inpatient programs

REFLECTION

What if “co-occurring capable” had actually meant integrated care?

WHAT CAN WE DO DIFFERENTLY?

01 One individualized exploration of what was driving his substance use.

02 Mental health and substance use treated together.

03 Evidence-based care matched to Harris, not simply to the program.

04 Family support, recovery supports, and treatment as one continuum.

Ideally, an individual should receive care from a professional who can address co-occurring disorders in the least restrictive setting.

OCTOBER 23, 2013

Harris died by accidental overdose. He was just 19.

LOOKING BACK

THE MISSED OPPORTUNITIES

01 Mental health care, but no warning about substances

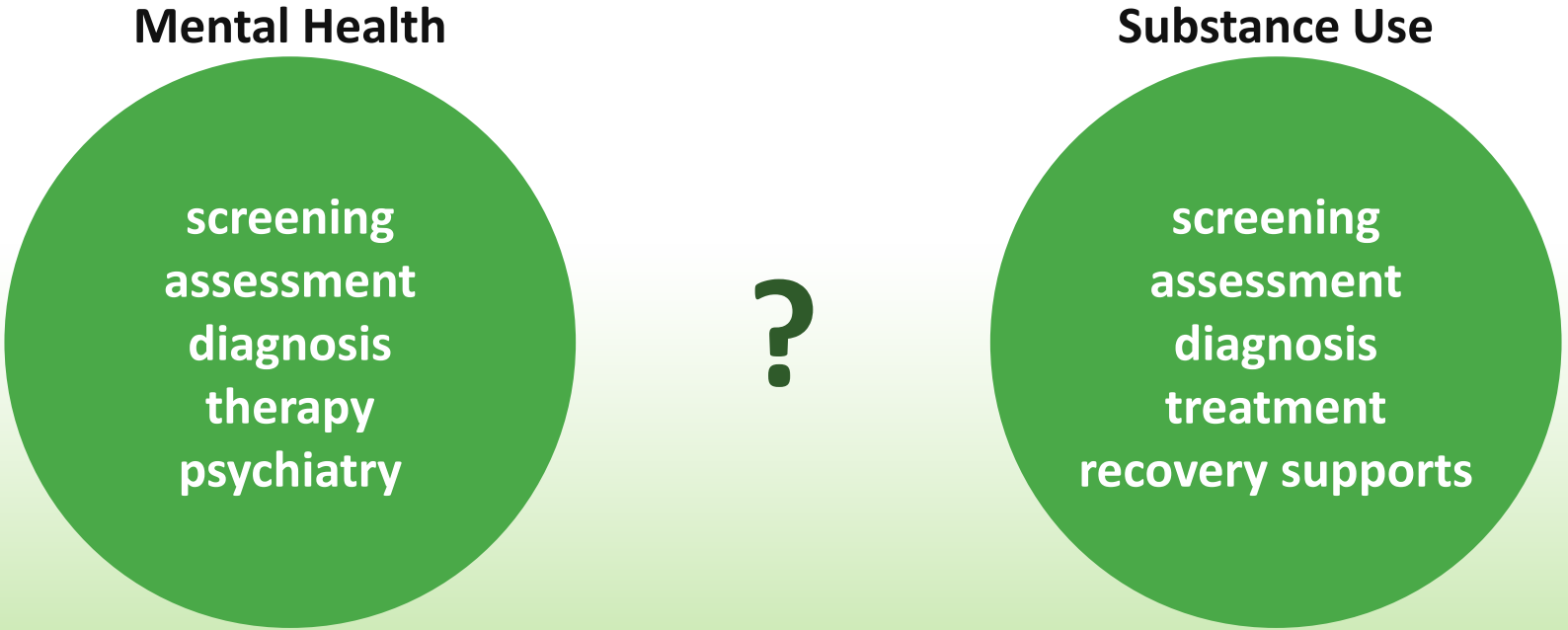
02 A therapist not equipped to address both

03 Treatment ended because he was doing well

04 Struggling again, and no one knew

05 Integrated care promised, never delivered

ONE CONDITION. DISCONNECTED DOORS.



YOUTH DON'T LIVE INSIDE JUST TWO SYSTEMS

Youth move through many systems each day:







- family
- school
- healthcare
- mental health services
- substance use treatment
- community & recreation
- faith
- child protective services
- juvenile justice system







Each system does its part. But no system "owns" the whole person.

DEFINITION

Co-Occurring Disorders (COD)

The combination of a mental health challenge and substance use issue

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FAST FACTS

49.5% of US youth will face a mental health challenge

22% will have a mental health disorder with “significant impact”

50% of lifetime mental health disorders begin by 14 years of age, 75% by 24 years of age

FAST FACTS

≈30% of US youth in need of mental health services receive them

≈50% of US youth receiving mental health services have a co-occurring substance use disorder

≈60–75% of youth receiving treatment for a substance use disorder have a co-occurring mental health disorder

HOW COMMON IS COD AND ITS TREATMENT?

21 million adults in the United States had COD in 2024, including 4.7 million young adults ages 18-25 (13%)

792,000 adolescents (3.2%) ages 12-17 reported symptoms of a co-occurring major depressive episode and a SUD in 2024

632,000 (2.5%) had a major depressive episode with severe impairment and a SUD

AMONG ADOLESCENTS WITH COD

3 in 10

received no treatment for either condition.

Only 18%

received treatment for both SUD and MDE, often not in an integrated, co-occurring competent way.

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COMPARED TO PEOPLE WITH ONLY MHD OR SUD, PEOPLE WITH COD HAVE:



More profound functional impairment



Higher risk for school dropout



Increased treatment costs



Worse treatment outcomes



Higher risk for being unhoused



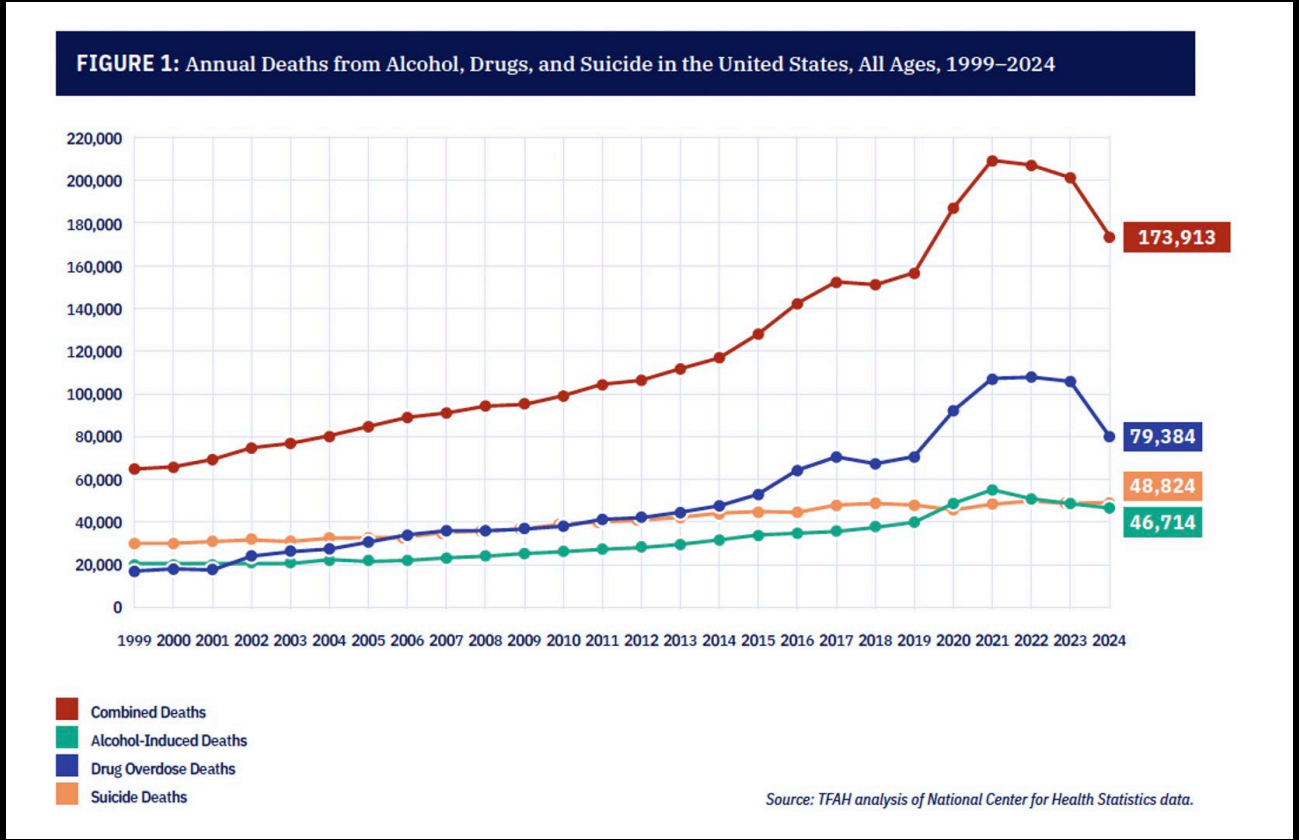
Higher risk for incarceration



Higher risk for sickness and death

Yearly deaths from alcohol, drugs, and suicide in the United States

1999–2024



Why mental health matters when it comes to substance use prevention

The time between onset of a mental health disorder and subsequent substance use disorder is a “key window of opportunity” where COD can be prevented.

Treating Adolescents with Co-Occurring Disorders, Hills, 2007

THREE PATHWAYS TO CO-OCCURRING DISORDERS

01 **Mental health challenges precede substance use**

Some young people use substances in an attempt to manage distress or symptoms.

02 **Shared risk and reciprocal influences**

Genetic vulnerability (family history), environment, trauma, and development can influence both; each may intensify the other.

03 **Substance use can contribute to mental health challenges**

Use may precipitate or worsen anxiety, mood symptoms, or other difficulties.

The pathways to co-occurring disorders may differ. The need to recognize the connection does not.

KNOWLEDGE IS POWER

A 3-year-old with a peanut allergy knows to ask if the birthday cake has nuts, and carries an EpiPen.

We should be arming our children with information about mental health and substance use the same way.

WHAT TO KNOW, AND WHEN

A little one
Parents know

- A mental health challenge in childhood can increase the risk of later substance use.
- Attitudes children form in preschool can shape the decisions they make later.

Ages 5–8
Parents + child

- What alcohol and medicine are, and that prescription drugs can be dangerous when you aren't sick or they aren't yours.
- How to name feelings and who their trusted adults are.

Sources: NIDA, Common Comorbidities with Substance Use Disorders (2020); NYS OASAS, Talk Early and Often

WHAT TO KNOW, AND WHEN

Ages 9–12
Parents + preteen

- Start talking by age 9. Facts, not fear. Role-play and plan responses together.
- How mental health challenges can increase vulnerability to substance use, including self-medication.

Ages 13–18
Parents + teen

- Short-term relief can worsen the long-term problem. Practice refusal skills and help-seeking.
- If there is evidence of use, respond from love and concern, not fear or punishment.

Sources: SAMHSA, Talk. They Hear You.; NYS OASAS, Talk Early and Often; NIDA (2020)

COD
is preventable.

SIX CORE PUBLIC HEALTH SERVICES

New York's 58 local health departments operate under Article 6 of the Public Health Law, which requires:

Family health	**Communicable disease control**	**Chronic disease prevention**
Community health assessment	**Emergency preparedness and response**	**Environmental health**

■ **Highlighted: where COD prevention fits**

Sources: NYSACHO legislative testimony; NYSAC, Investing in New York's Public Health

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MESSAGING AND CONVENING ARE CORE PUBLIC HEALTH SERVICES

3 Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it

4 Strengthen, support, and mobilize communities and partnerships to improve health

7 Assure an effective system that enables equitable access to the individual services and care needed to be healthy

Source: The Futures Initiative: the 10 Essential Public Health Services (de Beaumont Foundation, PHAB, 2020)

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MENTAL WELLBEING AND SUBSTANCE USE

Priorities in this group include:

- **Anxiety and Stress**
- **Depression**
- **Suicide**
- **Adverse Childhood Experiences**
- **Primary Prevention, Substance Misuse, and Overdose Prevention**
- **Alcohol Use**
- **Tobacco/E-cigarette Use**

Also in the Prevention Agenda: Childhood Behavioral Health • Health and Wellness Promoting Schools

Source: NYS Department of Health, Prevention Agenda 2025–2030 (health.ny.gov)

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PREVENTION, HARM REDUCTION, TREATMENT, RECOVERY

- All 62 counties in New York State receive opioid settlement funds.
- The NYS Opioid Settlement Fund supports prevention, treatment, harm reduction, and recovery.
- NYSACHO has emphasized local health departments' role in prevention and harm reduction throughout the overdose epidemic.
- JUUL settlement funds also provide an opportunity

Sources: NY Attorney General (2021); OASAS, 2025 Opioid Settlement Report; NYSAC News

WHERE HARM REDUCTION FITS

ONE CONTINUUM OF CARE

Prevention | **Treatment** | **Harm reduction** | **Recovery**

DOH

Department of Health

Prevention Agenda 2025–2030 groups mental wellbeing and substance use together.

OMH

Office of Mental Health

Mission: to promote the mental health of all New Yorkers.

OASAS

Office of Addiction Services and Supports

1,700+ prevention, treatment, harm reduction, and recovery programs.

We need DOH, OMH, and OASAS, rowing in the same direction.

Sources: NYS DOH Prevention Agenda 2025–2030; NYS Budget, OMH agency mission; oasas.ny.gov/about

NEW YORK IS COMMITTED TO BUILDING A SYSTEM OF INTEGRATED CARE

01 **Integrated Outpatient Services**

02 **Co-Occurring Capable designation**

03 **Integrated behavioral health law (S.3051B)**

WHAT'S NEEDED NOW

A coordinated strategy across OMH and OASAS that aligns:

Workforce development
Core competencies
Regulatory requirements
Operational guidance
Funding

Stephanie Marquesano, July 2026

Sources: OMH, Integrated Services; Governor's 2026 State of the State; OASAS; NYS Senate (S.3051B)

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THE MISSED OPPORTUNITIES BECAME THE BLUEPRINT

Prevention	Know the connection before use begins
Early identification	Notice patterns and screen for both
Integrated treatment	Treat both together, least restrictive setting
Family support	Equip families with skills and connection
Recovery	Build belonging, purpose, recovery capital

COSOCC: A SINGLE SYSTEM OF CARE

Westchester County Department of Community Mental Health, the harris project, and countless collaborators designed a Co-Occurring System of Care Committee across the lifespan.

COSOCC	Cross-system governance and co-occurring competency
CODA + COD Curriculum	Awareness, education, trusted adults, help-seeking
Encompass	Integrated treatment for adolescents and young adults
Invitation to Change	Family support: compassion, connection, skills
Inclure	Prosocial connection, belonging, recovery capital

HOW COSOCC IS ORGANIZED

Four subcommittees:

01
Systems Mapping

02
Licensing & Regulatory

03
Workforce & Training

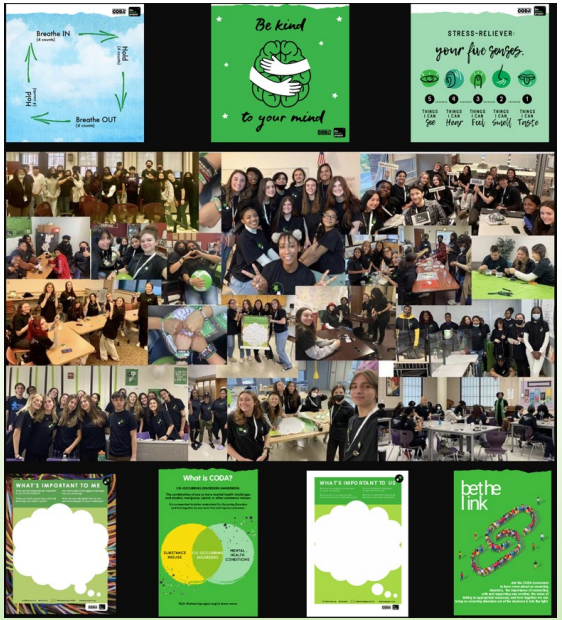
04
Prevention

CODA: A YOUTH-CENTERED PREVENTION MOVEMENT

01 **Engage young people as partners**
Youth summits, awareness games, peer-led activities, school and community initiatives.

02 **Build language and connection**
Make it easier to talk about mental health, substance use, stigma, and asking for help.

03 **Reach trusted adults too**
Equip educators, coaches, caregivers, and community leaders to notice and respond.



#CODAconnects • #BeTheLink

A FOUNDATIONAL FIRST-OF-ITS-KIND EDUCATION EXPERIENCE

THE COD PREVENTION CURRICULUM



01 **Developed with Partnership to End Addiction**
Created through Westchester County's Opioid Response Initiative; designed for youth and adult supports.

02 **Youth and parallel adult learning**
High school: three ≈40-minute sessions; middle school: two. One-hour sessions for parents, caregivers, and other caring adults.

03 **What young people learn**
COD basics, the developing brain, self-medication, refusal skills, a trusted adult, supporting a friend, and help-seeking.

Shared language and understanding across youth, families, schools, and communities.

WHAT EARLY IMPLEMENTATION IS TELLING US

01 **Pilot feasibility and rollout findings**

Gains in COD knowledge and awareness, increased stated likelihood of help-seeking, and greater adult confidence.

02 **What educators reported**

Materials were accessible and easy to use; students are highly engaged; trusted-adult content resonated with students.

03 **What students asked**

Why aren’t more people talking about COD, how to help friends, why alcohol normalization, why fentanyl, where to turn for support, and what can I do to be part of the change.

CONNECT IMMEDIATE SAFETY WITH UPSTREAM PREVENTION

01 **Reduce harms now**

Maintain access to overdose prevention, naloxone, nonjudgmental engagement, and other harm reduction supports.

02 **Ask about the whole person**

Integrate mental health understanding into substance use conversations and service pathways.

03 **Create an earlier on-ramp**

Use schools, public health, and community partners to strengthen prevention before substance use or crisis.

Prevention and harm reduction are complementary, not competing, priorities.

WHAT CAN COUNTY HEALTH LEADERS DO NEXT?

01 **Convene across systems**

County government, schools, healthcare, community and faith organizations, treatment providers, families, and young people.

02 **Start with the connection**

Examine where mental health and substance use prevention are still taught or delivered separately.

03 **Build co-occurring competency and pathways**

Cross-training and shared goals; connect education and early identification to integrated care, family support, and recovery.

WHAT CAN COUNTY HEALTH LEADERS DO NEXT?

04 **Measure and improve**

Track reach, understanding, help-seeking intentions, referrals, access to integrated care, and family engagement.

05 **Lead integrated messaging**

The Prevention Agenda already groups mental wellbeing and substance use together. Public health communication can, too.

No wrong door means more than a referral: it means shared responsibility.

Prevention is not separate from the system of care.
It is where the system begins.

Knowing earlier can change when and how someone asks for help.

CALL TO ACTION

WHAT CAN WE DO DIFFERENTLY?

01 **See the whole young person**

Look beyond the presenting problem, diagnosis, behavior, or substance use.

02 **Ask about both**

When you see mental health challenges, think about substance use risk. When you see substance use, ask what may be underneath it.

03 **Don’t let the silos be the young person’s problem**

Communicate across schools, families, providers, treatment, and community supports.

04 **Connect the dots earlier**

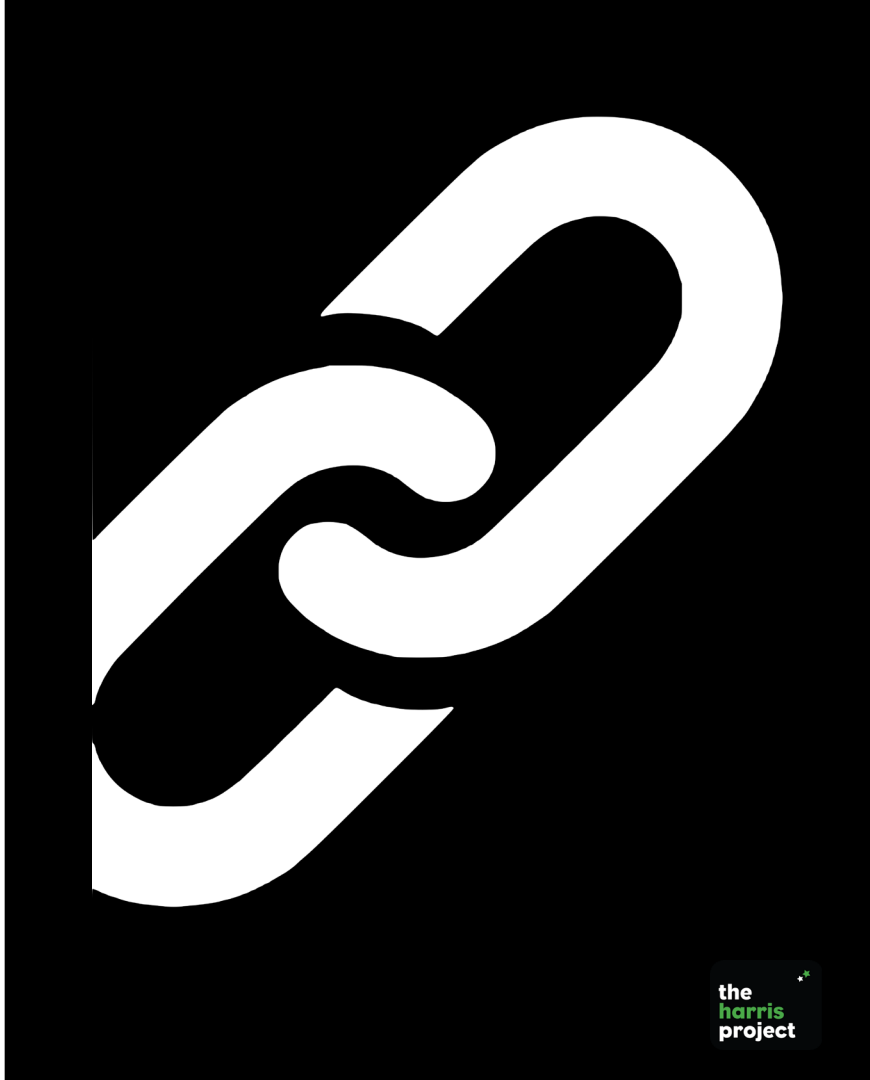
Prevention and education should begin before substance use or crisis.

CLOSING

Be the link.

We cannot change Harris's story.

We can change what the next young person and family experience.



CONVERSATION

Questions?

What are you seeing in your agencies, communities, schools, and organizations?
#CODAconnects • #BeTheLink

Stay connected

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RESEARCH + RATIONALE

Why Co-Occurring Disorders (COD) Prevention Cannot Wait

Mental health challenges and substance use issues are connected. Prevention education should be, too.

21.2 million

U.S. adults lived with co-occurring mental health and substance use disorders in 2024.[1]

1 in 2

people with a substance use issue also struggle with a mental health challenge.[2]

About 50%

of all mental health disorders begin by age 14; 75% begin by age 24.[3]

49.5%

of U.S. adolescents ages 13–18 experience a mental health disorder at some point in their lifetime.[4]

22%

of adolescents ages 13–18 experience a mental health disorder with severe impact.[4]

A Critical Window of Opportunity

The time between the onset of a mental health disorder and a subsequent substance use disorder represents an important “window of opportunity” in which co-occurring disorders may be prevented.[5]

DEVELOPMENT + RESEARCH

From Research to Prevention Practice

Research-informed prevention grounded in lived experience and collaboration.

01 Foundation

Years of COD awareness, education, and lived experience through **the harris project** helped shape the curriculum.

02 Collaboration

Developed with **Partnership to End Addiction** and contributors from clinical care, education, and community prevention.

03 Program Development and Pilot Evaluation

- Supported by Westchester County, New York opioid settlement funds.
- High school curriculum and adult presentations were piloted and evaluated by researchers from Pace University in 2024. Findings available upon request.

04 Dissemination

More than 150 health and physical education teachers, prevention specialists, school administrators, social workers, counselors, and youth-serving community leaders were trained to implement the curriculum during the 2025–26 school year.

Selected Research & References

1. SAMHSA. (2025). 2024 National Survey on Drug Use and Health.

2. National Institute on Drug Abuse. (2020). Common Comorbidities with Substance Use Disorders Research Report. ncbi.nlm.nih.gov/books/NBK571451/

3. Kessler, R. C., et al. (2005). Archives of General Psychiatry, 62, 593–602.

4. National Institute of Mental Health. Mental Illness: Adolescent prevalence estimates (ages 13–18; 49.5% and 22.2%; 22% rounded in handout).

5. Hills, H. A. (2007). Treating Adolescents with Co-Occurring Disorders. Florida Certification Board/Southern Coast ATTC Monograph Series, No. 2, p. 9.

THE HARRIS PROJECT | PREVENTION EDUCATION

Mental Health and Substance Use Are Connected.

Prevention Education Should Be, Too.



EMPOWERING TEENS

Navigating Co-Occurring Disorders for a Resilient Future

3 SESSIONS | APPROX. 40 MINUTES EACH | GRADES 9–12

PREVENTION THAT CONNECTS THE DOTS

A prevention curriculum for schools and youth-serving organizations

WHAT STUDENTS EXPLORE

The connection between mental health challenges and substance use issues.

Coping, resilience, refusal skills, and informed decision-making.

Help-seeking, trusted adults, and how to take action early.

WHAT FACILITATORS RECEIVE

Instructor Guide, slides, videos, interactive activities, exit tickets, and training support.

BEYOND THE CLASSROOM

Complementary adult sessions build shared language and understanding among parents, caregivers, educators, and other trusted adults.

INTERESTED IN IMPLEMENTING THE CURRICULUM?

Learn about facilitator training, resources, and implementation opportunities.

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