



April 8, 2002

James Winarski
Advocates for Human Potential
323 Boston Post Road
Sudbury, MA 01776

Dear Mr. Winarski:

The National Association of State Mental Health Program Directors (NASMHPD) represents the \$23 billion public mental health system serving 6.1 million people in 50 states, four territories, and the District of Columbia. On behalf of NASMHPD, thank you for the opportunity to provide comments to the Substance Abuse and Mental Health Services Administration (SAMHSA) as it develops its report to Congress on prevention and treatment services for individuals who have co-occurring mental illness and substance abuse disorders.

To begin, we wish to express our deep appreciation that SAMHSA's Administrator, Charles Curie, has identified co-occurring disorders as a top priority. Indeed, the challenges associated with treating individuals with co-occurring mental health and substance abuse disorders are among the highest priorities for all state mental health commissioners and directors. The first reason for this is the high prevalence of substance abuse disorders among individuals with severe mental disorders. Second is the extent to which co-occurring mental health and substance abuse disorders, if left untreated, result in multiple adverse outcomes, including relapse, hospitalization, violence, incarceration, family disintegration, homelessness, and physical health issues such as HIV/AIDS and hepatitis. These adverse outcomes place significant additional stress on other systems, such as corrections, and health and social services.

There is a third reason: as Mr. Curie often observes, "the gap between what we know and what we do is fatal." In the mental health field, this observation is especially true with regard to the treatment of individuals with co-occurring mental health and substance abuse disorders. Notwithstanding extensive research documenting the efficacy of integrated delivery of co-occurring mental health and substance abuse services, the nations's mental health and substance abuse services systems have had only limited success with implementation of such services. This fact, of course, underlies Congress' request for a report.

For several years, NASMHPD and the National Association of State Alcohol and Substance Abuse Directors (NASADAD) have worked together to overcome systemic barriers to effective service delivery to persons with co-occurring mental health and substance abuse disorders. The two organizations, with the support of SAMHSA's Center for Mental Health Services and Center for Substance Abuse Treatment, began a formal dialogue in 1998 focused on the needs of individuals with co-occurring addictive and mental health disorders. To date, the NASMHPD-NASADAD collaboration has:

1. Created a joint Task Force on Co-occurring Mental Health and Substance Abuse Disorders, comprised of state mental health directors, state substance abuse directors, representatives of national provider and advocacy organizations and community-based co-occurring service providers. The task force has convened on three occasions, the most recent being in November 2001.
2. Revised the “conceptual framework” originally developed by the New York State Office of Mental Health and Office of Substance Abuse Services, which provides a mechanism for states and communities to examine their co-occurring disorders treatment systems and consider specific ways in which they can be strengthened. The Task Force has received considerable feedback that the conceptual framework is valuable to NASMHPD’s and NASADAD’s respective constituents.
3. Issued several reports on the development, marketing and financing of co-occurring mental health and substance abuse services, with the latest being “Exemplary Methods of Financing Integrated Services Programs for Persons with Co-Occurring Mental Health and Substance Abuse Disorders.”

The most recent Task Force report – now in draft form and slated for release within several weeks – is based upon an in-depth study of nine innovative community-based co-occurring programs that use multiple sources of funds to deliver integrated services.¹ The report will outline the unique financing arrangements of each program as well as their organizational structure, staffing, client population, program philosophy and other characteristics that result in their specialized approach to service delivery. It also will make a series of recommendations for action that will enable the nation’s mental health and substance abuse systems to expand and enhance the delivery of integrated co-occurring mental health and substance abuse services. NASMHPD is confident that the experience of the Task Force over the past several years provides a solid foundation on which to base its observations.

Despite the success of the co-occurring service agencies studied by the Task Force, however, it is important to recognize that these programs have emerged in the face of enormous obstacles. The challenges associated with financing a program that provides integrated services for individuals who are otherwise served through two distinct and separately funded systems are among the most serious barriers these programs face. As noted in the Surgeon General’s 1999 Report on Mental Health (p. 413):

[M]ost of the treatment services for mental illness and for substance abuse are separate..., as are virtually all the public funds for these services. This separation causes problems for treating the substantial portion of individuals with co-occurring mental health and substance abuse disorders who benefit from an integrated approach to treatment.

Although we do not believe that the availability of funding necessarily guarantees that agencies will prioritize co-occurring services and develop services accordingly, we do believe that the absence of sufficient funding significantly lessens that possibility.

For example, one of the most significant roles that the federal government plays in state substance abuse

¹ *These programs were selected from a group of 55 programs representing 35 states that were nominated by state authorities, national organizations and advocates.*

and mental health systems is its administration and funding of the two block grants. Language in the federal legislation that authorizes the block grants aims to keep those funding streams separate.² It is our experience with the state and community programs with whom we have worked in the past several years that, while a number of them utilize Community Mental Health and Substance Abuse Prevention and Treatment Block Grant funds to support delivery of integrated services, guidelines regarding the use of these funds remain unclear. We have been part of a number of discussions in the last year alone where the question has been raised regarding appropriate use of the block grants in funding integrated services – discussions that have involved senior SAMHSA staff as well as state mental health and substance abuse authorities – and the confusion persists. The confusion leads some states and community agencies to entirely avoid the use of block grant funds to support delivery of integrated services, fearing that they may run afoul of rules and expectations that are not clear to them. In those cases where the block grants are used to support integrated services, the agencies administering the programs cannot be certain that their ingenuity will be validated at some future point.

In sum, based on the work of the NASMHPD-NASADAD Task Force, the experience of the state mental health authorities, and the prevailing research, we believe the following to be true:

- The condition of co-occurring mental health and substance abuse disorders among individuals seeking treatment in the nation's mental health services system is the expectation rather than the exception.
- Access to co-occurring services through a fully integrated service model continues to be the exception rather than the expectation.
- Failing to provide appropriate services for individuals with co-occurring disorders results in these individuals' increased involvement in – and costs to – other systems, such as corrections, medical and social services systems.
- Many programs in both the mental health and substance abuse service systems are unable to provide the comprehensive screening and assessment that these individuals require to reach an accurate understanding of their needs. This results in individuals who need the full range of comprehensive and coordinated services not receiving them.
- Services for persons with co-occurring disorders continue to be delivered in a parallel or sequential fashion throughout the country, which we believe to be significantly less effective in meeting the needs of the population, particularly those individuals with the highest severity of mental illness and substance abuse.
- Strong leadership at the federal, state and local levels can result in the reduction or elimination of the fiscal and other disincentives that impede co-occurring services program development; there is clear evidence that agencies in some states have overcome barriers and significantly

² Section 1956 of the Public Health Service Act provides as follows: "States may use funds available for treatment under [the mental health and substance abuse block grants] to treat persons with co-occurring substance abuse and mental disorders as long as funds available under such sections are used for the purposes for which they were authorized by law and can be tracked for accounting purposes."

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improved services delivery to persons with co-occurring disorders through a variety of innovative practices.

- Insufficient funding exists to develop and deliver the integrated co-occurring mental health and substance abuse services needed by the nation's population.

Therefore, as a first step we encourage SAMHSA to consider the following recommendations:

- Participate in and support state mental health and state substance abuse authorities in their ongoing efforts to identify and eliminate any fiscal and regulatory barriers that impede development of integrated services for persons with co-occurring mental health and substance abuse disorders, including those that originate at the federal level.
- Study the experience of state authorities that are engaging in innovative practices to expand and strengthen integrated co-occurring services within their states, and promote these innovations in other states.
- Develop a pilot project that uses mental health and substance abuse prevention and treatment block grant funds to support joint development and delivery of integrated services as part of a federal-state-local partnership.

We also encourage that in preparing its report to Congress, SAMHSA closely review the NASMHPD-NASADAD Task Force reports, especially the most recent report and the details it offers about the nine co-occurring programs. We believe the report will offer a variety of insights on all four topic areas SAMHSA identified in its RFC: Systems Level Issues; Program-Level Issues; Prevention issues; and Research and Evaluation Issues.

We commend SAMHSA for its leadership on this critical issue, as well as its ongoing support of the NASMHPD-NASADAD Task Force on Co-Occurring Disorders. In the course of preparing its report to Congress, we are confident that SAMHSA will identify a number of ways to expand and enhance the availability of treatment services for individuals with co-occurring disorders. We look forward to continuing our work with SAMHSA on this matter and eagerly await issuance of its final report.

Sincerely,



Tom Barrett, Ph.D.
President



Robert W. Glover, Ph.D.
Executive Director