Report to Congress on Co-Occurring Disorders Calls for Systems Change, Integrated Treatment

"Individuals with co-occurring disorders should be the expectation, not the exception, in the substance abuse treatment and mental health service systems." With this statement, Health and Human Services Secretary Tommy G. Thompson released the *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse and Mental Disorders.*

The report, which was requested by Congress in 2000 and prepared by the Substance Abuse and Mental Health Services Administration (SAMHSA), identifies co-occurring disorders as a serious public health problem that cannot be solved without changes in current treatments, programs, and systems. It describes evidence-based practices in the treatment of co-occurring disorders and prevention strategies that have been found to be effective. The report also details SAMHSA's ambitious "Five-Year Blueprint for Action" to address co-occurring disorders.

According to the report, a major factor in the escalation of this public health problem is the long-standing separation between the substance abuse and mental health treatment systems—a thoroughgoing division in funds, regulations, treatment philosophies, language, training and credentialing of staff, medical staff resources, assertive community outreach capabilities, and routine types of evaluations and testing. The report does not recommend the creation of a separate system of care for people with co-occurring disorders. Rather, it calls for the expansion of each system's capacity to treat these individuals and to ensure that "any door is the right door" to receive treatment for co-occurring disorders.

According to the report, seven to ten million people in the United States have at least one mental disorder as well as an alcohol or drug use disorder. Because of the double burden of their disorders, these individuals have particular difficulty seeking and receiving diagnostic and treatment services—a problem that is compounded by the existence of two separate treatment systems. When one of the co-occurring disorders goes untreated, both disorders usually get worse and additional complications often arise. As noted in the report, the combination of disorders can result in poor response to traditional treatments and increases the risk of other serious medical problems, suicide, criminalization, unemployment, homelessness, and separation from families and communities. As a result, individuals with co-occurring disorders often require high-cost services, such as inpatient and emergency care.

Funding is a significant barrier to meeting the needs of people with co-occurring disorders, the report emphasizes. Mental health and substance abuse treatment are supported through a patchwork of separate federal, state, local, and private sources. Chapter 2 of the report focuses on the two federal block grants that are used by states to fund substance abuse and mental health treatment. Although funds from the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant can be used to support integrated services, providers must comply with regulations that govern how the funds from each block grant can be spent. The funds can be "braided" as long as the integrity of the separate funds is maintained for reporting and auditing purposes—a challenging task for many providers, according to the report. Chapter 2 presents reports from 15 states that have used block grant funds in flexible and innovative ways to provide services to people with co-occurring disorders.

A major objective of the report is to make it clear to Congress and to the public that effective treatments exist for people with co-occurring disorders. Chapter 4 extensively documents evidence-based practices for treating people with co-occurring disorders—adults, elderly persons, and children and adolescents as well as special populations. On the basis of research findings, integrated treatment is the most effective for persons with co-occurring disorders.

The report describes integrated treatment as a constellation of interventions used in combination to meet the needs of an individual client. In integrated treatment programs the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. The agency or direct providers take responsibility for combining the treatment and service interventions into one coherent package. Integrated treatment programs can exist in either the mental health or the substance abuse treatment system and require only that treatment and services for the co-occurring disorders are delivered by appropriately trained staff and occur within the same setting.

The report presents SAMHSA's "Five-Year Blueprint for Action," which includes:

- Creating a new SAMHSA-funded State Incentive Grant for Co-occurring Disorders to help enhance state infrastructure and treatment systems
- Establishing a national prevention and treatment technical assistance and cross-training center for co-occurring disorders
- Increasing federal agency collaboration within the Department of Health and Human Services to enhance research attention to co-occurring disorders
- Increasing collaboration between SAMHSA and the Centers for Medicare and Medicaid Services, in conjunction with the Agency for Healthcare Research and Quality, to explore ways to use existing reimbursement mechanisms for services to people with co-occurring disorders
- Convening a National Summit on Co-occurring Disorders to help states and communities share lessons learned and to discuss initiatives and

cross-funding opportunities

♦ Continuing work to improve, refine, test, and apply consistent outcome measures for co-occurring disorders

♦ Disseminating successful strategies for appropriate use of the Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grants to serve individuals with co-occurring disorders

The full text of the *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse and Mental Disorders* is available on the SAMHSA Web site at www.samhsa.gov.

Bazelon Center Focuses on Policy Options for Increasing Access to Children's Mental Health Services

Despite a deepening crisis in the public mental health system, states are underutilizing policy options that would increase children's access to mental health services, according to a report by the Bazelon Center for Mental Health Law. The report, *Avoiding Cruel Choices: A Guide for Policymakers and Family Organizations on Medicaid's Role in Preventing Custody Relinquishment,* explains how two options under Medicaid regulations can be used to increase families' access to services.

More than 15 percent of the nation's children are uninsured, and many of them lack access to mental health services, the report notes. Many uninsured children who have at least one working parent are ineligible to receive such services through Medicaid because the family income, while far short of the level needed to pay for care, is still above the low levels required for Medicaid eligibility. Even children who are covered by private insurance routinely experience difficulties in obtaining mental health services because of limits on both inpatient and outpatient care.

Families who do not qualify for Medicaid have no alternative but to pay out of pocket for services not covered through their private insurance. Children with serious emotional disturbances often need long-term treatments and services, and many families reach the end of their resources. In at least half the states, according to the report, such families are told to place their children in state custody in order to obtain the services covered through public programs. One study cited in the report found that about one of every five families of children with mental or emotional disorders were advised to give up custody so they could get help. Families who relinquish custody to the child welfare system risk losing their children, because federal law sets strict time limits for states to place these children through adoption or return them to families. Other families are told to call the police and turn their children over to the juvenile justice system to get mental health care.

The report describes two Medicaid policy options that would allow states to provide greater coverage to children and reduce pressure on families to relinquish custody. They are the TEFRA option, named after the Tax Equity and Fiscal Responsibility Act of 1982 that created it, and the Medicaid home- and community-based services waiver. Only 12 states use either option to improve access to services for families of children who have a serious mental or emotional disorder, and even in these states the number of children who benefit from these policies is very small, according to the report.

The TEFRA option allows states to cover home- and community-based services for children with disabilities who are living at home and who would otherwise need skilled care provided in a medical institution. Eligibility for TEFRA is based on the child's disability and care needs, not on family income. The Medicaid home- and community-based services waiver allows states to provide an expanded array of home- and community-based services to children or adults with physical or mental disabilities as an alternative to institutional care that would otherwise be paid for by Medicaid.

Avoiding Cruel Choices provides information that families, providers, and mental health advocates can use to persuade legislators and policy makers to adopt these policies. The full text of the report, along with detailed fact sheets for advocates, is available on the Bazelon Center's Web site at www.bazelon.org.

NEWS BRIEF

2003 NARSAD Independent Investigator Award: The National Alliance for Research on Schizophrenia and Depression (NARSAD) announces award opportunities of up to $50,000 a year for two years (maximum, $100,000) for the scientist at the academic level of associate professor or equivalent who has won national competitive support as a principal investigator. Research must be relevant to schizophrenia, major affective disorders, or other serious mental illnesses. Guidelines are available on the NARSAD Web site at www.narsad.org. The submission deadline for applications is March 5, 2003; notifications will be made in August 2003. For more information, contact Audra Moran, director of the research grants program, at 516-829-5576 or amoran@narsad.org.