



Testimony of

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At the Oversight Hearing: Integrated Dual Disorder Treatment
and Co-Occurring Disorders

The Committee on Mental Health, Mental Retardation,
Alcoholism, Drug Abuse and Disability Services

Hon. G. Oliver Koppell, Chair

Subcommittee on Drug Abuse

Hon. Annabel Palma, Chair

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INTRODUCTION

Chairman Koppell, Chairwoman Palma, distinguished members of the Committee, thank you for allowing us the opportunity to testify before you today on the need for integrated dual disorder treatment for individuals with co-occurring psychiatric and addiction disorders. My name is Michael Polenberg, and I am the Director of Policy & Advocacy for the Coalition of Voluntary Mental Health Agencies, the trade association and umbrella advocacy organization of New York's mental health community, representing over 115 non-profit community-based behavioral health agencies in New York City and surrounding areas. Our members constitute a broad cross section of service providers – all sizes from very small to very large; treatment and rehabilitation-oriented; outpatient and residential; focused on linguistically and culturally specific populations and on many special-needs – serving more than 350,000 individuals in the five boroughs of New York City and its environs.

The testimony you just heard from Dr. Beitchman, and the testimony you will hear from the other providers gathered here today, speaks to the struggle that agencies face in trying to provide effective treatment to a client population with many complexities. “Silo-ed” funding streams; separate and distinct licenses; lack of training for front-line clinicians; underfunded programs; – all of these factors contribute to a fragmented system of care for New Yorkers with co-occurring disorders, and an increased likelihood that these individuals will drop out of treatment altogether.

THE CURRENT PICTURE

What is the likelihood that a person receiving treatment for one disorder might require treatment for another? The Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the Department of Health and Human Services, estimates that 50-75% of individuals in substance abuse treatment programs have a co-occurring mental illness, while up to 50% of those treated in mental health settings have co-occurring addiction disorders. Looked at another way, the prevalence of substance abuse among the general population is approximately 16%; for persons with schizophrenia, however, the prevalence rises to about 45%, while for individuals with bipolar disorders, its nearly 55%. You heard Dr. Beitchman testify that at least half of the 1,100 clients at The Bridge suffer from both afflictions. Sue Buchanan, from the Brooklyn Bureau of Community Services, who will testify later this morning, estimates the same for her clients and you'll hear similar numbers from the other witnesses gathered here today.

Unfortunately, the ability to treat both disorders is limited by rigidly "silo-ed" funding sources and licensing structures. Article 31 programs, licensed by the State Office of Mental Health (OMH), are governed by regulations that require a designated mental illness diagnosis as the basis for admission for services, or as commonly referred to as "the primary illness". In fact, the regulations (NYCRR – Title 14 Mental Hygiene – Part 587) define a designated mental illness as a "DSM-IV diagnosis (or ICD-9 CM equivalent) other than (i) alcohol or drug disorders..." The regulations further note that "Dual diagnosis refers to those individuals with a designated mental illness, in

accordance with this paragraph, and a diagnosis of alcohol or drug disorders, developmental disabilities, or organic brain syndrome. Such individuals are considered eligible for treatment in outpatient programs specifically for treatment of their designated mental illness with consideration of their associated clinical needs. “ The reverse is true for those providers licensed by the State Office of Alcoholism and Substance Abuse (OASAS).

For many clients, particularly those who have endured years of homelessness and disengagement from treatment modalities, it can be difficult at best for clinicians to determine which disorder is “primary” and which is “secondary”. Is the individual’s erratic behavior symptomatic of schizophrenia or the effect of crack cocaine? Is the individual an alcoholic because the drinking helps mitigate the symptoms of depression, or is the individual depressed because she can’t imagine coping without alcohol even as it destroys her life? What are the chances that a mentally ill client with schizoaffective disorder, in an attempt to silence the voices in his head, will choose to self-medicate with street drugs rather than take psychotropic medications which may have unappealing side effects such as excessive weight gain or fatigue?

Inevitably, how a client is diagnosed has a lot to do with which State licensed door the client has walked through. The client with co-occurring disorders who walks in through the mental health door, funded and licensed by OMH, will be assessed by a mental health professional whose focus is to look for and treat a mental illness, and whose training may not have prepared him to recognize the signs of a substance abuse disorder. Accordingly, the client will be diagnosed with a primary psychiatric disorder.

The reverse will hold true if that same client instead walks in through the substance abuse door, funded and licensed by OASAS.

Clinicians who are trained to recognize a substance abuse disorder run up against a regulatory obstacle. The regulations governing OMH licensed programs do not allow for the billing of services not primarily related to the treatment of a mental illness. Moreover should State auditors find that an OMH-licensed program has concentrated its treatment on addressing a clients' resurgent addiction disorder (even as the client has stabilized his or her psychiatric disorder through medication and therapy), the program can be penalized and significant disallowances taken. For providers who are already operating their programs on the tightest of margins, the threat of having to remit money back to the State is a risk few, if any, are willing to take. Financially discouraged from providing the kind of integrated treatment that has produced the best outcomes for these individuals, and struggling to overcome regulatory barriers that do not allow agencies to bill for services, providers will often instead refer clients to other settings, and sometimes to other agencies altogether, to receive the additional services that they cannot afford to provide.

INTEGRATED DUAL DISORDER TREATMENT (IDDT)

Farming clients out between programs, or even between agencies, is disruptive to a client's treatment regimen and rarely produces positive outcomes for both disorders. Instead, it is more likely that clients will drop out of treatment altogether and spend months if not years bouncing between jails, hospitals, shelters and the streets.

They are also at significantly higher risk of contracting diseases like HIV/AIDS, hepatitis and tuberculosis, which only adds to the cost of their treatment.

Integrated treatment, on the other hand, has been shown to produce far better outcomes for these clients. In fact, the Integrated Dual Disorder Treatment (IDDT) model is one of six evidence-based practices endorsed by SAMHSA. Utilizing components such as motivational interviewing, staged interventions and cognitive behavioral therapy, the IDDT model has been proven to reduce hospitalizations and incidences of homelessness and arrests, and instead direct clients along a path of rehabilitation and recovery.

A study done by researchers at Dartmouth University tracked the rates of substance abuse remission among individuals with co-occurring psychiatric and addictive disorders over the course of four years. Researchers found that those individuals who had received integrated treatment were three times more likely to have remained drug-free than those individuals who had received a more fragmented treatment regimen.

Recognizing the importance of this model, the Coalition has proudly offered a year-long training series on IDDT to both mental health and chemical dependency providers who are looking for a more sensible and cost-effective way to treat clients with co-occurring disorders. Funded in part through the continuing generosity of the New York City Council, and the Division of Mental Hygiene, this training series has drawn well over 1,000 clinicians and program administrators from agencies across the city.

Providers who have attended this series (which concludes this Friday with a training on “Group Treatment and Self-Help”) operate clinics, outreach programs, continuing day treatment programs, residential programs, drop-in centers, psychosocial clubhouses, detox centers, half-way houses, medically supervised outpatient chemical dependence treatment clinics and alcohol crisis centers. They work in the community based behavioral sector and they work in hospital settings, both public and private.

In addition to service providers, the training series has drawn policy makers from the State and the City who are looking to develop more integrated systems of care here in New York. We welcome their presence at our trainings and hope that the evidence put forth by our presenters helps pave the way for more unified, holistic treatment down the road.

The Coalition has also been advocating for integrated treatment through its Committee on Co-Occurring Disorders, chaired by Dr. Beitchman of the Bridge. The committee has been very active over the years in trying to persuade policymakers to create alternatives to fragmented service models, and to enhance funding to programs that develop innovative models for working with dually diagnosed clients. The committee is in the process of polling mental health and chemical dependency providers in order to gauge how successful they’ve been in implementing components of IDDT into their treatment programs, and the resources needed to achieve this outcome.

RECOMMENDATIONS

In order for integrated treatment to be implemented by mental health and chemical dependency agencies, barriers must be overcome that prevent programs from working effectively and concurrently with dually diagnosed individuals. Providers should be able to implement SAMHSA identified best-practices without concerns related to billing or audit reprisals. The Coalition thanks the Committees for holding this important hearing, and we will continue to make ourselves available as a resource and to rely on the Council for its efforts to make government work more effectively, and for its decade-long investment in our training series.

Thank you, and we will be happy to answer any questions you may have.