



Testimony of Meggan Christman
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and the Committee on Mental Health, Mental Retardation and
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Public Hearing on Co-Occurring Disorders

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Good Morning. My name is Meggan Christman and I am a policy advocate for The Coalition of Voluntary Mental Health Agencies. The Coalition is *the* umbrella advocacy organization of New York's mental health community, representing more than 100 non-profit community-based mental health providers in the Greater New York City Metropolitan Area, including each of the five boroughs and surrounding counties. Our members constitute a broad cross-section of agencies from large to small, spanning multiple treatment modalities and, serving more than 300,000 clients. I want to thank you, members of the Assembly Standing Committees on Alcoholism and Drug Abuse and Mental Health, Mental Retardation and Developmental Disabilities for allowing The Coalition to testify on the issue of services for persons suffering from co-occurring psychiatric and addictive disorders.

The Coalition has identified five general principals as the basis for improving the provision of services to this population. The first is implementation of several key recommendations proposed by the State's Interagency Workgroup and Quadrant IV Taskforce. The Interagency Workgroup was a joint standing committee created by a Memorandum Of Understanding between the NYS Office of Mental Health and the NYS Office of Alcoholism and Substance Abuse services in 1998. The second is increased funding of housing and wraparound services for individuals with co-occurring disorders creating a continuum of housing services. The third is incentives for providers to implement core competencies and best practices. The fourth is simplification and clarification of regulations and licensing requirements that differ between the Substance Abuse and the Mental Health sectors to remove fiscal, oversight, and regulatory barriers

to providing integrated services. The fifth is the provision of training and curricula for practitioners and the adaptation of several OMH endorsed best-practices to integrated treatment.

SAMHSA's December 2002 report to Congress on the Prevention and Treatment Of Co-Occurring Substance Abuse Disorders and Mental Disorders identified as a guiding principle the need to "promote the expansion and enhancement of service providers' capabilities to treat individuals of all ages who have co-occurring substance abuse disorders and mental disorders." According to this report and several others undertaken in recent years, including the 1999 Surgeon General's Report on Mental Health, the 2002 National Survey on Drug Use and Health, and the NYC Department of Health and Mental Hygiene's report on Prevalence and Cost Estimates of Psychiatric and Substance Abuse Disorders and Mental Retardation and Developmental Disabilities in New York City released this past Wednesday, we have statistical support that, co-occurrence of addictive disorders is the rule not the exception for individuals with serious and persistent mental illness. According to the Surgeon General's Report, "Forty-one to 65 percent of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental disorder, and about 51 percent of those with one or more lifetime mental disorders also have a lifetime history of at least one substance abuse disorder" (U.S. DHHS, 1999). These general principals and this data demonstrating an overwhelming need must now guide us through the implementation of concrete actions taken by government, providers and consumers to improve the delivery system and the continuum of care.

There has been a tremendous amount of thought, thorough investigation, planning, research and preliminary work done on the needs of dual recovery and the barriers to service as well as ways to overcome them. The Interagency Workgroup, I mentioned earlier released a comprehensive report in May, 2001 with many recommendations that we support. The Coalition applauds the State on this initiative and asks them to continue their commitment through to implementation. The Memorandum Of Understanding that created this Interagency Workgroup, which expired at the end of FY 2001, should be renewed.

In the 2002-2006 Statewide Comprehensive Plan for Mental Health Services distributed by the New York State Office of Mental Health, it is stated that the Quadrant IV Taskforce, a subgroup of the Interagency Workgroup assigned to assess the needs and make recommendations for services for individuals with the most severe co-occurring disorders, had “identified systemic and individual program changes which must occur to most effectively meet the integrated care needs of this population” and that a “demonstration project is currently under development.” This demonstration project which was slated to implement these program recommendations has been stalled and should be implemented as soon as possible with a timeline for the evaluation and replication of the project.

The Quadrant IV Taskforce recommended that, “OMH and OASAS, in conjunction with other State agencies if necessary, should develop a continuum of specialized housing

resources that will appropriately address the stages of motivation, change and engagement in treatment for individuals in need of Quadrant IV services.” We fully support this recommendation. There are only 200 beds out of 20,000 in New York State in the mental health system that are designated for individuals with co-occurring disorders. Much of the residential funding for dual recovery services is received through homeless services as an add-on. This puts residences that are treating dual recovery clients dependent on housing dollars and the ever changing and conflicting definitions of homelessness. We are asking for additional mental health dollars specifically designated for dual recovery residential services,

The key to residential services is a “**continuum.**” An effective continuum of housing would include several tiers of support, from a transitional residential program with 24-hour staff including CASACs (Certified Alcohol and Substance Abuse Counselor), to a stepped-down dual recovery residential program with less intensive supports leading to supported housing and finally independence.

Wraparound and support services make the difference between recovery and relapse. Providers must be creative and resourceful in engaging and overseeing clients in order to maintain treatment. Supports necessary to do this include peer advocates, basic skill development, on-site urine toxicology, sober recreation on evenings and weekends and many other services that are not currently reimbursable.

The Quadrant IV report also calls for incentives to be offered to providers for implementing the stated core competencies and best-practices for integrated treatment services. An enhanced rate which would allow providers to incorporate these standards and practices into their programs would be an inducement to participate in integrated treatment. The report outlines and suggests the implementation of Dual Diagnosis Enhanced standards and Dual Diagnosis Capable standards for programs without any fiscal support. These standards are the equivalency of core competencies at the program level, designating programs capable of treating individuals with dual recovery needs. This amounts to an unfunded mandate.

The public substance abuse and mental health service systems differ markedly with respect to staffing resources, philosophy of treatment, funding sources, community political factors, regulations, prior training of staff, credentials of staff, treatment approaches, medical staff resources, assertive community outreach capabilities, and routine types of evaluations and testing procedures performed. This must change. Federal, State, and local infrastructures generally are organized to respond to single, not co-occurring, disorders. Mental health and substance abuse service systems often vie for the same limited resources. Funding mechanisms do not encourage flexible, creative financing across the substance abuse and mental health systems to foster better service capacity for people with co-occurring substance abuse disorders and mental disorders.

The Interagency Workgroup initiated a subcommittee to investigate relief through the reduction of redundancies and conflicting regulations. This group should be re-activated

with input from providers and other stakeholders, creating a continuous partnership of collaboration. In the changing climate of conversion to Medicaid of much of the mental health system, close attention must be paid to the nature of the implementation of integrated services within the new PROS (Personalized Recovery Oriented Services) license initiative. There is currently insufficient information available about integrated services inclusion in this initiative for providers to make informed decisions, prepare to comply and generate input.

Staff licensure requirements vary according to treatment setting; treatment models themselves vary by setting. Clinicians in the two different systems frequently have different credentials, training, and treatment philosophies. Salaries, too, vary widely - an important factor affecting workforce recruitment and retention . In the move towards Assertive Community Treatment teams and Blended Case Management as evidence-based practices, it is important to designate a number of these teams specifically for individuals with co-occurring psychiatric and addictive disorders. Cross-training initiatives throughout the state have been successful and should be replicated. They have so far addressed only a small universe of the necessary providers and are vital to the effective treatment of individuals with co-occurring disorders. It is important that cross-training be offered to all levels of staffing including executive level staff. This will help to create a climate within agencies of understanding and a stronger movement towards the acceptance of integrated treatment services.

The creation of the Dual Recovery Coordinator positions for several Local Government Units within New York State was a step in the right direction. We support this initiative,

its continuation and expansion. We would like to recommend that in urban areas with significantly denser populations, the Dual Recovery Coordinator position be expanded to a Dual Recovery Coordination Team. One coordinator in less dense population areas may be able to coordinate between the Substance Abuse and Mental Health systems, generate training for practitioners, research best practices and impact services for a smaller constituency, but within a Department of Health and Mental Hygiene as large and complex as New York City's, additional staff are needed to complete the required integration.

Lastly, we understand that up until this point the focus has been primarily on Quadrant IV individuals, the most seriously in need of services. We would like to recommend that there are simple and inexpensive tasks that could be undertaken that address the remaining three quadrants and may reduce the number of individuals who reach Quadrant IV status in the long run. One example is the development of a screening and assessment tool for mental health and substance abuse issues that could be used by primary care providers to identify and refer individuals. With input from mental health and substance abuse providers this tool could prove an effective means of identifying these individuals and helping them access treatment at an earlier stage.

Thank you very much for the opportunity to present this testimony today. The Coalition is happy to assist in any way it can in the development of more integrated treatment services for individuals with co-occurring psychiatric and addictive disorders.