

Building Bridges

*Co-Occurring Mental Illness and Addiction:
Consumers and
Service Providers,
Policymakers, and Researchers
in Dialogue*



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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Disclaimer

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Introduction

The growing number of persons with co-occurring mental and substance use disorders in the United States has precipitated a crisis. In 2002, Charles G. Curie, Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (DHHS), announced that addressing the needs of persons with co-occurring disorders had become one of the highest priorities for the agency. The problems have not been easy to solve, however. The crisis has been exacerbated by previously established separate systems of care for mental health and addictions.

The two systems of care have different approaches to (1) identifying key symptoms, (2) making assessments or diagnoses, (3) deciding between quite disparate treatment approaches, and (4) figuring out which State block grant funding category should be used to obtain coverage and reimbursement for services. The systems, at Federal, State, and local levels, challenge consumers and service providers alike, and, in some cases, create divisions between providers and consumers, and between the providers themselves.

In addition to SAMHSA, many other agencies also are working on this issue. The Centers for Medicare and Medicaid Services (CMS) have pilot projects that demonstrate simpler ways of administering services for co-occurring disorders. Several States have found ways to integrate substance abuse and mental health funding, to improve access to services by mandating nondiscrimination of persons with co-occurring disorders, and to certify consumers to assist in service delivery. The National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) have jointly developed a conceptual framework for identifying and addressing the needs of persons with co-occurring disorders.

On December 2, 2002, U.S. Department of Health and Human Services Secretary Tommy G. Thompson sent Congress a comprehensive report on treatment and prevention of co-occurring substance use and mental disorders. This congressionally mandated report, developed by SAMHSA, emphasizes that people with co-occurring disorders can and do recover with appropriate treatment and support services. It identifies many longstanding systemic barriers to such treatment and services, and the need for various Federal agencies, State

agencies, providers of services, researchers, recovering persons, families, and others to work together to create a system that addresses both disorders as primary conditions. It also outlines a 5-year blueprint for action to improve the opportunity for recovery by increasing the availability of quality prevention, diagnosis, and treatment services for people with co-occurring disorders.

In addition, SAMHSA awards large State infrastructure grants to address co-occurring disorders and awards multiple grants that focus on various target populations with co-occurring mental and substance use disorders.

SAMHSA is promoting other efforts to help individuals with co-occurring disorders. In fall 2003, SAMHSA created the National Co-Occurring Disorders Prevention and Treatment Cross-Training Center (COCE) to foster improvement in treatment and services to individuals with co-occurring mental and substance abuse disorders. In April 2004, SAMHSA sponsored the first National Policy Academy on Co-Occurring Mental and Substance Abuse Disorders in Baltimore, Maryland. Ten State teams and more than 150 individuals participated. The policy academy was designed to assist States and local policymakers in developing an action plan to improve access to appropriate services for people with co-occurring substance abuse and mental disorders. SAMHSA anticipates conducting two additional policy academies in FY 2005.

SAMHSA has extensive resource information on co-occurring disorders on its Web site, including reports, publications, and documents, and maintains an electronic discussion list. Finally, SAMHSA is providing technical assistance on this issue through the convening of national conferences and other activities.

The Center for Mental Health Services (CMHS), within SAMHSA, has been given the lead in implementing the policies to improve the coordination of treatment and services identified by President George Bush's New Freedom Commission on Mental Health. The Commission's Final Report highlights the importance of convening participatory dialogues—a process that CMHS has used since 1997 to bring together consumers of mental health services and professional service providers. In 2003, the crisis level of co-occurring disorders made it clear that CMHS should convene a dialogue between consumers with co-occurring mental health and substance use concerns and service providers, policymakers, and researchers. This report summarizes the meeting and the recommendations made by the participants.

Meeting Participants and Process

Twenty-three people gathered in May 2003 for the dialogue. Paolo del Vecchio and Chris Marshall of the SAMHSA Center for Mental Health Services welcomed the group and emphasized the importance that SAMHSA places on promoting interaction and dialogue between consumers and other stakeholders in mental health and substance use policies and programs.

The process of the dialogue, designed by a planning committee of several participants and CMHS staff, and the meeting objectives were straightforward and supportive of participants. After the participants introduced themselves, the discussion focused on three topics:

- *Person-centered factors that hinder or promote recovery.* These included personal experiences, values, and beliefs; consumer and provider expectations; and concerns related to age, ethnicity, and culture.
- *System-level factors that hinder or promote recovery.* These included administrative structures and services coordination; research knowledge about models and best practices; funding and regulatory issues; and core competencies and training.
- *Recommendations for improved understanding and service delivery.* These covered nine different areas and focused on themes such as consumer-driven policymaking, research, and services delivery; the whole-person focus; public awareness and education; and coalition building.

The dialogue was conducted as a roundtable discussion. At the close of each discussion topic, participants offered summary comments to help pull together the group's thinking to that point.

Dialogue Themes and Findings

Whole-Person Focus

A principal theme—one that participants returned to several times, from several perspectives—is that any and every individual seeking services must be considered in the context of his or her entire background—*as a whole person*—rather than as a set of individual problems to solve or resolve. Each person develops uniquely and has individual physical, mental, and spiritual concerns; all of these factors must be considered if the process of recovery is to be successful. Above all is the need to treat people with dignity. A whole-person focus represents a commonsense approach to understanding how best to design effective methods for assessment, treatment, and recovery. A symptom, even if severe, cannot be treated effectively in isolation from other aspects of a person's being.

Several participants noted that during the assessment process in the service delivery system, questions related to the whole person rarely are asked. A person seeking services, in addition to exhibiting symptoms, may have a spouse or partner, a parent, child, or sibling; may have experienced trauma; may have legal, employment, or housing problems; may have concerns related to his or her sexual life; and may have important, rich background information to share, but this information is rarely discovered or taken into account. Other participants noted that sometimes background questions are asked only in the narrow context of filling out an assessment or intake form, or within narrow guidelines of a research project or program.

The context within which assessments are conducted is a crucial issue. "Assessments based on the medical model focus on what's wrong with the person; in recovery, it's more important to focus on what's right with the person," said one participant. However, working with strengths-based approaches that focus on the whole person and ask questions sensitively and fully, may require increased interaction between a provider and a consumer. This may be difficult, not only because of time constraints, but also because focusing on these areas may expose the need for a long-term commitment to the process by both the consumer and provider, or may stretch beyond the current limits of any single provider's expertise.

Working with the whole person also requires attention to the internal process of recovery. Hope and community—one's personal dreams and expectations, and one's network of relationships—play key roles in recovery. A person's spirituality also is crucial to a person's recovery because it helps an individual develop his or her perspective on the world. Yet, these topics are difficult for consumers and providers to talk about or to really understand, let alone measure for efficacy.

Adopting a whole-person focus will require a basic shift in how services are developed, structured, and funded. Services must become more person-centered, rather than symptom-centered. An individualized, holistic approach to recovery may include services related to housing, employment, and other needs, as well as to the specific symptoms of one or more co-occurring disorders. One participant, emphasizing the need for an integrated, holistic approach, said that "it's more than co-occurring, it's 'all-occurring.'"

Genuine Collaboration with Providers

Closely related to the theme of focusing on the whole person is the importance of involving people with co-occurring disorders in the design, implementation, and evaluation of all processes that affect them. Obtaining consumer "input" is not enough; those who are affected by the treatment system must be invited to help create the system. This is not only an issue of fairness and inclusiveness; it is directly related to making improvements in service delivery systems. Consumers have a distinctive and crucial role in determining appropriate, effective approaches precisely because recovery is an internal as well as an external process—because it involves the whole person—and because of their firsthand knowledge of what works. People with co-occurring disorders should be regarded as peers throughout every aspect of the system, and partnerships based on peer relationships should be established in building reimbursement systems, research design, program implementation and evaluation, training, service provision, and policy development.

Forming respectful, personal relationships between providers and consumers becomes a priority with this orientation. An approach that integrates services focused on the whole person and based on collaboration between providers and consumers, requires more respectful and involved relationships—getting to know each other and "not hiding behind our systems or labels." Although progress has been made, more needs to be done.

Training/Education

In response to the need for basic shifts in the service delivery system, training/education was a key theme with several different components:

- Changes in professional and clinical health care education and requirements for State licensure will be needed to support a collaborative model of care that considers the whole person. Several participants spoke of key gaps in their education and training—for example, few or no classes on mental health or substance abuse, or on the differences in medication.
- Peer-based approaches to treatment need to be seen as basic components of a whole-person, collaborative approach to services. Peer support is critical to help people in recovery become engaged in the community; the firsthand experience of other consumers can provide tools and wisdom on a person's path to recovery. One participant asked, "How [else] do we learn the personal interventions, techniques, and affirmations that are powerful in a person's recovery?" and stated that the principle of "each one teach one" is crucial.
- Another participant noted that the State of Georgia has trained peers to serve as certified peer support specialists who can help consumers set recovery goals, teach self-directed recovery skills and social skills, and provide assistance with obtaining decent and affordable housing. Georgia has been able to obtain reimbursement for such services provided by certified peer support specialists through the Medicaid Rehabilitation Option.
- People with co-occurring disorders need to be trained how to discover what services are available and how to assist in their own recovery. They need to learn what is possible for them to achieve. One participant spoke of the need for vocational programs to get beyond the idea that the four "F's"—food, flowers, filth, and filing—are the only kind of jobs people with mental disorders can handle. These types of jobs are fine, but they are not the only jobs people with mental or co-occurring disorders may be qualified to perform.

Stigma/Public Image

The media continue to reinforce negative stereotypes of people with co-occurring disorders. To change these stereotypes, basic changes in relating to the media are required. One participant stated, "Until we change the images of people with psychiatric

conditions and of drugs in Hollywood, and portray people with these conditions as real people, we will not see major change. We need different images and different stories.” It was noted that even supposedly sympathetic portrayals rely on mistaken implications and images; for instance, a few participants noted that the film “A Beautiful Mind” contained several inaccurate depictions of John Nash’s disorder and treatment.

A different context, with different terms and definitions, is required to understand illness. Several participants stated:

- “We perpetuate the perception barrier of dual disorders by focusing on crisis interventions and more severe disorders,” said one participant. The term “wellness diversity” is a better way to describe the continuum of wellness and illness that is mental health.
- The term “family” should be defined according to the individual’s circumstances to ensure that services are not limited, especially during crisis situations.
- Even the term “recovery” should be better defined, as it encompasses both growth (emotional recovery) and development (skill-building).

Participants challenged each other to become more involved in changing images. One participant suggested a series of public service announcements showing “recovered faces in high places” and “the many faces of mental illness.” Another stated that it is crucial for consumers and consumer advocates to develop more media contacts, in order to engage in direct dialogue with media representatives and to become more visible in the media. Still another participant noted that “we do too much ‘preaching to the choir’ in anti-stigma campaigns,” and conduct such events in remote places. “We need to get out to other groups and into the center of the community with such efforts.”

Substance Abuse and Mental Health Systems Divisions

Participants noted a number of examples of how the mental health and substance abuse treatment systems are narrowly focused and ineffective. “Our programs, systems, and organizations operate in ‘silos,’” said one participant, noting that “when real silos don’t get air, they explode.” It is difficult to find or obtain resources because of the narrow focus of treatment systems. In addition to the difficulties in obtaining services

through different systems, consumers find that each system places a different value on specific types of behavior, so they constantly must conform their behavior to particular treatment approaches. (For instance, in treatment for substance use disorders, you might be allowed to get angry, but in treatment for mental disorders, you should never get angry.)

The meeting participants discussed the problems associated with the existing mental health and substance use treatment and service delivery systems that focus too heavily on crisis-oriented services and give relatively little priority to the promotion of recovery. Although it is important to be able to access services at a time of dire need resulting from acute exacerbation of illness, participants expressed their preference to see these systems focus more on teaching individuals how to maintain and promote their own health. The goal is to promote recovery and prevent a crisis at which time individuals may not only experience severe symptoms of mental illness, but may also experience preventable losses of personal relationships, housing, and employment.

While noting these shortcomings and divisions within the present system of delivering services, participants chose to focus on how to build relationships between the substance abuse and mental health systems. It was suggested that cultural diversity approaches be used to bridge differences. “We must realize that the mental health and substance abuse systems have different cultures,” stated one participant. The systems have different mandates, histories, language, and rationales for funding. “What is needed is cultural competency in working with each system, to help stop the prejudice and blame about the respective fields and language.”

Research

A good deal of attention was given to the perceptions and possibilities surrounding research into co-occurring disorders. Many participants voiced concern about three major questions: First, what qualifies as research? Second, how should research be designed and conducted? Third, how do learning and innovation get broadly applied?

On the first question, several participants were concerned about the increased emphasis on “evidence-based” research. Very little research actually qualifies as “evidence-based,” since the term refers to “a large body of research in a particular field with a particular population.” However, many requests for

research proposals require or prefer programs that are “evidence-based.” As one participant stated, “Having ‘evidence-based’ as a prerequisite for funding knocks out many proposals in certain populations,” including older adults, gender and sexual minority persons, and persons with eating disorders. Very little research has been done with these populations, and an “evidence-based” preference continues to lock them out of further possible research.

On the second question, participants strongly objected to research programs that do not involve people with co-occurring mental and substance use disorders in a meaningful way. Evidence-based research shifts power to institutions and academic researchers, and cuts into innovation. “Laboratory,” “top-down,” or “medical-model” research keeps consumers in the role of test subjects. Also, research and evaluation too often focus on the program, rather than on the recovery process—on how people integrate their own recovery with programs. It looks at the system dynamics, not the personal dynamics. The conventional view of research, with a bias toward institutions and programs, regarding people as test subjects, and using a narrow definition of “evidence-based,” reinforces an adversarial relationship between the researcher-observer and those being observed or tested.

On the third question, participants agreed that getting research results out to the field happens too slowly. There is a “literature lag” between formal research and what is happening in the field. At times, the research and academic literature do not even recognize current terms and approaches being used in the field. For instance, you cannot find references linking “dual disorders” with “marriage counseling” or “employee assistance programs.” And while research may be very good, “we don’t teach the people in our programs what we’re finding out,” one participant said. “We don’t let people *in* programs understand what is being discovered.”

What is needed, participants agreed, is a more collaborative and field-based approach to research. “In our field, a lot of change happens in the field, through trial and error,” said one participant. “The research doesn’t have to be evidence-based,” said another. “There is a need for research on innovative techniques, because that tells us about what’s really happening in the field.”

One of the most critical elements is to have consumer advice and involvement at every step, from program design through research implementation and evaluation. “Consumers need to be trained to do research, and to be on Federal [and other] advisory

boards,” said one participant. This will lead to improvements in data quality and increased innovation, as well as to a better image of research. One participant stated, “I go around and ask researchers questions they’re not asking, because they only ask questions defined in the study—yet they know a lot more information that is very useful.”

Also, as one participant reminded the group, research findings can help change policymakers’ minds, leading to legislative changes and funding for improved services. Cost-benefit analyses help legislators understand not only that treatment works, but that investment in research results in more effective and less expensive care.

SAMHSA can play a leadership role in this area. Participants recommended a closer relationship between SAMHSA and the National Institutes of Health (NIH) in order to move science to services more quickly.

Research can be a partner, if researchers are concerned about practice in the field and see consumers as collaborators in innovation, and if research funding is not limited to overly narrow definitions of “evidence-based.” Research is needed to identify practices that will actually influence training competence, service guidelines, and funding directions; that focus on the whole person; that rely on consumer input at every stage of research; and that include cost/benefit considerations about research and co-occurring issues.

Nondiscrimination and Underserved Populations

Another theme was the importance of serving all persons affected by co-occurring disorders. This involves ensuring that access is not denied because of discrimination, and focusing attention on those groups that have been historically underserved.

The State of Texas was held up as a model for establishing regulatory language and an administrative system to ensure nondiscrimination in access to care. In Texas, although there are parallel systems, people seeking treatment are assumed to have co-occurring disorders. The State has established rules and used language of nondiscrimination in the regulations to support this assumption, and has also established minimum standards of competence. To help mitigate the silo effect of separate funding streams, the State has placed engagement strategy specialists

throughout the service system, to assist people who have not been helped in the existing system. The State has adopted the following regulatory language:

State of Texas

Standards for Services to Individuals with Co-Occurring Psychiatric and Substance Use Disorders (COPSD), Chapter 411, Subchapter N, Section 411.657:

- (a) In determining an individual's initial and ongoing eligibility for any service, an entity may not exclude an individual based on the following factors:
 - (1) the individual's past or present mental illness or substance use diagnosis or services;
 - (2) medications prescribed to the individual in the past or present;
 - (3) the presumption of the individual's inability to benefit from treatment;
 - (4) the specific substance used by the individual;
 - (5) the individual's continued substance use; or
 - (6) the individual's level of success in prior treatment episodes.
- (b) Entities must ensure that an individual's refusal of a particular service does not preclude the individual from accessing other needed mental health or substance abuse services.
- (c) Entities must ensure that individuals have access to staff who meet specialty competencies described in Section 411.658 of this title (relating to Specialty Competencies of Staff Providing Services to Individuals with COPSD).
- (d) Entities must establish and implement procedures to ensure the continuity of screening, assessment, and treatment services provided to individuals.

While most participants were impressed with the explicit regulatory language the State has adopted, several participants urged caution when using statutory and regulatory strategies. There is some risk, especially at State levels, of legislation that

places *more* restrictions and allows fewer community-based approaches, thus causing more problems than might be solved.

Participants also expressed concern that several populations have been significantly underserved, including older adults, youth, persons with eating disorders, gender and sexual minority persons, Native Americans, and ex-inmates.

Older adults are at risk for late-life mental illness and addiction, particularly depression and alcoholism, and dependence on or overuse of medication, because physiology changes with age. Yet service providers do not respond adequately to these issues, especially because many people suffer at home and may also suffer from dementia and physical disability. **Youth** are usually not viewed as being at risk for co-occurring mental illness and addiction.

Persons with eating disorders also suffer from, or are at risk of, co-occurring disorders, but are usually left out of consideration, while **sexual minority persons** have particular issues that may affect mental and substance use disorders.

Native Americans historically have been underserved for co-occurring disorders as well as for many other medical, social, and economic issues, while **ex-inmates** are perceived by providers as being difficult to work with and have a high occurrence of both substance use and mental disorders.

Not only are these populations traditionally underserved for co-occurring disorders, but more information also is needed to understand the risk or extent of co-occurring disorders among them. Participants advocated that more attention be paid to these populations in terms of both services and research, at the same time recognizing the tension, or balance, between focusing on underserved populations and integrating everyone with co-occurring disorders into the community-at-large. As one participant said, “We sometimes ‘ghetto-ize’ people by putting them into special population groups.” The group understood that both sides of this balance need to be emphasized: the need to focus attention on those who have been neglected or denied access, and the need to make sure that all community members are genuinely integrated into the life of the community.

Funding

Woven throughout the discussion on the themes above was recognition that a new system of reimbursement for services to persons with co-occurring disorders is a critical need. “We need

to dismantle the silo effect of separate funding systems,” said one participant. Participants discussed the importance of:

- Establishing new billing codes for co-occurring.
- Reimbursing multidisciplinary team approaches to service delivery.
- Using simpler documentation for billing.
- Providing certification and funding for peer specialists.
- Including incentives for building coalitions, for serving underserved populations, and for funding innovations in block grants.
- Ensuring adequate technology for data sharing across systems.

Participants also noted that the present methods for financing services for mental health and substance use disorders promote dependency and are provider-focused. Once again, the key strategy is to ensure much greater consumer involvement in the design of appropriate and effective policies and mechanisms. This includes exploring consumer-directed or self-determination models of financing.

Recommendations

The second day of the dialogue focused on consolidating the themes and individual ideas into specific recommendations. Participants outlined specific, action-oriented steps under each of nine major recommendations. These are the nine recommendations:

1. Form and maintain healthy, consumer-driven partnerships in policymaking, research, and service delivery.
2. Embed a whole-person focus in research and service delivery.
3. Transform workforce development, emphasizing peer-based approaches.
4. Expand programs to reduce stigma and discrimination against underserved populations.
5. Create incentives for coalition building.
6. Engage actively in public awareness and education.
7. Support appropriate policy for systems change.
8. Support collaborative research.
9. Redesign the reimbursement system.

Many recommendations were directed to SAMHSA in particular. However, a number of recommendations were directed to providers and consumers, and to the field in general.

1. Form and Maintain Healthy, Consumer-Driven Partnerships in Policymaking, Research, and Service Delivery.
 - 1.1. Include consumers as partners in the development, implementation, and evaluation of programs. Move beyond getting “consumer input” to using actual consumer-driven approaches.
 - 1.1.1. Develop accountability mechanisms that track consumer involvement. Mandate use of these mechanisms in requests for proposals for research and programs funded by SAMHSA, NIH, NIDA, and other Federal agencies.

- 1.1.2. Use the Ryan White Act as a model to assure consumer participation when allocating funds.
 - 1.2. Increase the number of consumers/survivors participating on advisory councils and panels.
 - 1.2.1. Review the guidelines for consumer participation on advisory panels and councils during SAMHSA's reauthorization process
 - 1.2.2. Include at least two consumer/survivor representatives on the SAMHSA and CMHS National Advisory Council (in addition to participation on any subcommittees that have been formed).
 - 1.3. Increase consumer involvement at State and local levels in the design and conduct of research, in the development of toolkits, in participation on boards of mental health centers, in working with local providers, and in other areas.
 - 1.4. Train and support consumers asked to serve on advisory groups and participate in partnerships. Consumers may be inexperienced with these kinds of jobs; do not support tokenism, or set people up for failure. Mentors, orientation programs, and other supports should be available for those asked to participate.
 - 1.5. Include consumers as grant reviewers to help in the scoring of SAMHSA grant applications. Ask grantees to demonstrate, account for, and evaluate consumer involvement in grants.
 - 1.6. Clarify the definition of "consumer." Assume that most people have a disorder, and ask people to disclose that they are a *non*-consumer. The thinking should be changed to "we're all co-occurring until proven otherwise."
2. Embed a Whole-Person Focus in Research and Service Delivery.
- 2.1. Create a resource pool of effective screening and assessment tools, particularly those that help providers and consumers understand the whole person.

- 2.2. Use a treatment team approach; encourage providers to assess a person's strengths as well as weaknesses, and to follow up with each other and the consumer about how strengths are being reinforced and weaknesses are being addressed.
- 2.3. Ask research questions and clinical questions about the inner dynamics and personal experience of recovery that drive the recovery itself.
- 2.4. Require data sharing across systems.
- 2.5. Train consumers in the Wellness Recovery Action Plan (WRAP) program, and train them to become facilitators and trainers, so consumers can teach other consumers about these tools.
- 2.6. Improve general medical health care coordination with substance abuse and mental health issues.
 - 2.6.1. Incorporate ceremony and ritual into treatment.
 - 2.6.2. Recognize people as "multiply-abled" and not "multiply-disabled."
 - 2.6.3. Include vocational rehabilitation in the continuum of care—not as a collateral or extra type of service.
- 2.7. Use advance directives in all co-occurring treatment and services programs, and develop national standards for advance directives.
- 2.8. In vocational rehabilitation service programs, focus on the development of *careers*.
- 2.9. Create "one-stop shopping" for co-occurring services.
- 2.10. Create incentives for communities/neighborhoods to allow housing programs for persons in recovery from co-occurring illnesses.
3. Transform Workforce Development, Emphasizing Peer-Based Approaches.
 - 3.1. Initiate a 10-year SAMHSA workforce development plan. The plan would include scholarships and loan forgiveness programs for serving in the field. The plan would also call on SAMHSA to demonstrate leadership in changing accreditation requirements of

the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and other accrediting organizations to ensure that co-occurring disorders are included in service delivery.

- 3.2. Design and support a recruitment campaign for peer support specialists. Actively recruit people with addictions and psychiatric conditions to work in the field. Create specialized training and certification for people in recovery to work in the field.
- 3.3. Place a strong emphasis on new curriculum development on co-occurring disorders across academic social work, psychology, psychiatry, nursing, and other programs at colleges and universities.
- 3.4. Develop licensure requirements for behavioral health and substance abuse treatment in collaboration with university graduate programs.
- 3.5. Establish credentials for specialists in substance abuse/mental health fields, that is, for professionals who work with special populations.
 - 3.5.1. Increase education about special populations, particularly older adults.
 - 3.5.2. Support gender minority and sexual minority sensitivity training.
- 3.6. Increase block grant flexibility to add workforce development plans; rely on incentives rather than sanctions in proposed plans. Design incentives to look beyond Quadrant IV (of the National Association of State Alcohol and Drug Abuse Directors (NASADAD)/National Association of State Mental Health Program Directors (NASMHPD) conceptual framework), e.g., early identification/prevention and marital counseling.
- 3.7. Assure that workforce development programs apply to rural areas. Base workforce development initiatives regionally.

4. Expand Programs to Reduce Stigma and Discrimination Against Underserved Populations.

The following recommendations recognize the importance of balancing the need for focusing on specific needs of underserved populations, while at the same time moving toward genuinely including all special populations in the community-at-large.

- 4.1. Adopt, at Federal and State levels, through legislation or regulation, the language on nondiscrimination adopted by the State of Texas.
- 4.2. Improve access for underserved populations by encouraging multidisciplinary team approaches to outreach, evaluation, and treatment, including training of gatekeepers to obtain access to these specialized services.
- 4.3. Address the needs of special populations in the publication of co-occurring toolkits.
- 4.4. Recognize older adults as a special population. The differences between the needs of older adults and the regular population are as significant as the differences between children and the regular population. “Nondiscrimination” is not sufficient; older adults must be identified as a special population.
- 4.5. Compile data on sexual minority and gender minority discrimination. Gender and sexual minorities experience discrimination “in all four quadrants,” yet sufficient information has not been collected about this issue.
- 4.6. Increase training, education, and outreach for Native Americans.
- 4.7. Reduce the stigma of being an ex-inmate. Professionals may prefer not to deal with, or may not trust many ex-inmates.
 - 4.7.1. Allocate funding for housing and provide training for ex-inmates.
 - 4.7.2. Implement life skills and other training programs for incarcerated persons while they are still in jail/prison.

- 4.8. Train agency and program staff in “Therapeutic Community,” “Milieu Management,” and other approaches that welcome persons with co-occurring disorders and support consumer-driven programs.
- 4.9. Ensure that persons with co-occurring disorders are represented in all SAMHSA activities and groups, rather than seeing them as a sub-specialty group.
- 4.10. Support interpretation of the Americans with Disabilities Act (ADA) as covering mental and substance abuse disabilities.
5. Create Incentives for Coalition Building.
 - 5.1. Include coalition building as a grant incentive or requirement.
 - 5.2. Create incentive grants, like the State Incentive Grants (SIGs), for national substance abuse and mental health advocacy organizations to work together on co-occurring issues.
 - 5.3. Form coalitions with the vocational rehabilitation disability community.
 - 5.4. Create a resource pool of materials that relate what organizations and agencies in other States are doing in regard to policy, training, and curriculum.
 - 5.5. Ensure that the requests for proposals for SAMHSA/CMHS funded Consumer and Consumer Supporter Technical Assistance Centers require these centers to focus on co-occurring issues and cultural competence.
6. Engage Actively in Public Awareness and Education.
 - 6.1. Enter into direct dialogues with media representatives. Develop more contacts to change media stereotypes.
 - 6.2. Emphasize the message that “recovery is possible,” and show the face of co-occurring in public awareness campaigns, using media and the arts.
 - 6.2.1. Create campaigns such as “Recovered Faces in High Places.”
 - 6.2.2. Encourage the pharmaceutical companies’ advertising campaigns to place a softer,

gentler face on psychiatric and co-occurring issues.

- 6.3. Become more visible and assertive in the community. Avoid “preaching to the choir” in anti-stigma campaigns; go to other groups and into the center of the community.
- 6.4. Think strategically about the use and impact of language.
 - 6.4.1. Distinguish “recovery,” which is a personal, individual process, from “wellness,” which involves families and the whole community. The community must buy into wellness for appropriate policy to be adopted.
 - 6.4.2. Think in terms of three simultaneous levels of impact—individual, family, and community/society.
 - 6.4.3. Make sure that the language we use, and the way we phrase things, does not get us into a box. For example, “substance abuse” has become merely a catch-all phrase for all addictions and reinforces an image of willful misconduct, while “substance dependence” is more strongly associated with mental illness in co-occurring disorders.
 - 6.4.4. Define “family” according to the individual’s circumstances to ensure that services are not limited, especially during crisis situations.
- 6.5. Apply a co-occurring agenda to the Emergency Medical System.
- 6.6. Conduct assessments of co-occurring disorders to get an adequate picture of the situation across society—the incidence of co-occurring is much greater than what is normally portrayed.
- 6.7. Identify appropriate Web sites and develop a process to efficiently exchange links and get information to organizations.
- 6.8. Encourage local efforts that integrate people with co-occurring issues into the community and encourage

direct interaction with others to help increase their quality of life.

6.8.1. Conduct all community outreach alongside people with co-occurring illnesses.

6.8.2. Have professionals and people in recovery jointly make presentations to community groups and others.

7. Support Appropriate Policy for Systems Change.

7.1. Include language in Federal policy proposals that supports or requires co-occurring approaches, including SAMHSA's reauthorization, as well as authorization for the National Institutes of Health (NIH) and the Centers for Medicare and Medicaid Services (CMS).

7.1.1. Look for opportunities to include appropriate language in Federal and State policy similar to that used in Texas. Use caution, because there is some risk, especially at State levels, of policy that places *more* restrictions and allows fewer community-based approaches.

7.1.2. Become more proactive in reviewing and developing policy in general.

7.2. Encourage substance abuse/mental health planning committees to work together in developing block grant proposals. Develop guidelines that allow States flexibility in designing specific mechanisms that support co-occurring approaches, and that take differences in substance abuse and mental health funding into account. Specific ideas to consider:

7.2.1. Have block grant proposals reviewed by a consumer committee.

7.2.2. Allocate the same amount of funding for older adults as for children.

7.2.3. Establish an advisory and planning council when designing a State's substance abuse Performance Partnership Grant (PPG), or add substance abuse to the mental health planning council.

- 7.3. Advocate for Medicaid guidelines on co-occurring that do not support the mental health/substance abuse departmental split at the State level—to reduce the administrative nightmare of working with two systems.
 - 7.4. Examine the need for paramedics to be able to petition for involuntary treatment.
 - 7.5. Develop guidelines within SAMHSA for encouraging consumer advocate input on policy.
 - 7.6. Change SAMHSA's Center for Substance Abuse Prevention's (CSAP's) authorization to include prevention of behavioral health disorders.
8. Support Collaborative Research.
- 8.1. Promote research as an active, accountable partnership between providers and consumers, and create funding mechanisms that support this concept. Research and evaluation should be an ongoing, building process, integrating what is being learned with training of personnel.
 - 8.2. Establish a “*toward* evidence-based research” funding track to discover where innovation is happening, so that research is not limited to traditional, academic approaches.
 - 8.3. Provide funding or other support for demonstration projects so that they can be sustained after the research/demonstration phase.
 - 8.4. Encourage NIH to develop its own “blueprint,” a 5-year plan to respond to co-occurring disorders as SAMHSA has done.
 - 8.5. Create a mechanism to support collaboration between NIH research funding and SAMHSA service funding.
 - 8.6. Set up projects with and through the Veterans Administration (VA).
 - 8.7. Focus research efforts on ways to understand the *process* of treatment—what is happening to a person's self-esteem and personal growth during the treatment process—as well as treatment outcomes. What are appropriate personal growth indicators?

- 8.8. Demonstrate how cost—and cost savings resulting from research and service delivery innovations—influences policy and planning.
- 8.9. Disseminate research findings to a wider audience beyond professionals to consumers, to be more relevant and inform practice more quickly.
 - 8.9.1. Present research results at conferences interactively to allow more dialogue between consumers and providers.
 - 8.9.2. Write, publish, and present research results in plain language.
- 9. Redesign the Reimbursement System.
 - 9.1. Convene a SAMHSA Work Group—including provider and consumer stakeholders—to comprehensively review the reimbursement structure for co-occurring disorders and to develop a funding plan that supports the blueprint in the SAMHSA Report to Congress (RTC).
 - 9.1.1. Review the list of recommendations from this meeting and construct a model of a system that focuses on the whole person, is multidisciplinary, and is consumer-driven in approach.
 - 9.1.2. Determine the principal bottlenecks in the present system and then assess the cost factor/waste of maintaining the present system. Make it possible to say, “Because of the various Federal and State requirements, in each State, to provide \$1 of service, it is costing us \$X.”
 - 9.2. Support some level of reimbursement of substance abuse services as well as expand mental health services through Medicaid and Medicare reform.
 - 9.3. Do *not* change Medicaid into a block grant.
 - 9.4. Establish a new billing code, a new rate, and new program certification for co-occurring services.
 - 9.5. Permit SAMHSA and CMS reimbursement for multidisciplinary treatment planning.

- 9.6. Fund SAMHSA demonstration projects that make use of both private and State treatment funds.
- 9.7. Construct a data system that can track funding across the various “silo” agencies and systems. Make better use of technology.

Dissemination Strategies

Dialogue participants suggested that the “Co-Occurring Mental Illness and Addiction: Consumers and Service Providers, Policymakers, and Researchers in Dialogue” and “Mental Health Consumers and Members of Faith-Based and Community Organizations in Dialogue” monographs be disseminated to the groups listed below. The list also can serve as a checklist of groups to involve in future co-occurring initiatives at the State and local levels.

Public Sector

- Department of Health and Human Services leadership and relevant agencies
- Department of Housing and Urban Development leadership and relevant agencies
- Department of Veterans Affairs leadership and relevant agencies
- National Institutes of Health leadership and relevant institutes
- Tribal communities
- Bureau of Indian Health
- Elected officials at all levels of government
- State mental health and substance abuse agencies

Faith-Based Organizations

- National leadership of faith organizations
- American Association of Pastoral Counselors
- Faith-based media outlets

Providers/Associations

- First responder groups (Red Cross, Salvation Army)
- Guilds for psychiatrists, psychologists, social workers, and nurses
- Consumer and family member organizations, CONTAC, the Self Help Clearinghouse, DBSA, NAMI, NMHA, and others
- International Association of Psychosocial Rehabilitation Services
- Law enforcement/criminal justice systems

- Community-based social service providers
- Immigrant services
- Rosalynn Carter Institute for Human Development
- Housing advocates
- Homeless support groups
- Social service systems that address substance abuse issues
- Minority mental health organizations (e.g., National Asian American Pacific Islander Mental Health Association)
- Associations of medical schools
- Vocational workers
- Self-help consumer groups and consumer-operated services
- Community support programs, including drop-in programs
- SAMHSA/CMHS Consumer and Consumer Supporter Technical Assistance Centers
- American Medical Association
- Organizations that advocate for the Americans with Disabilities Act
- Recovery support programs
- SAMHSA ATTCs
- National Association of State Mental Health Directors (NASMHD) and National Association of State Alcohol and Drug Abuse Directors (NASADAD)
- SAAS Therapeutic Communities of America
- American Psychological Association
- American Psychiatric Association
- Eating disorders associations
- LGBT (Lesbian, gay, bisexual, and transgender) groups
- HIV and AIDs-related organizations
- American Public Health Association
- Disability organizations

Schools

Academic training programs for mental health care providers

Residency training programs

Media

General media

Ethnic media

Conclusion

The dialogue on co-occurring issues provided an opportunity for consumers to engage service providers, policymakers, and researchers on the topic of co-occurring mental health and addiction disorders. All groups learned from hearing firsthand experiences of living with disorders and receiving services, of providing services, and of studying the issue. The dialogue format provided a level playing field for all participants to freely exchange ideas, knowledge, and solutions that promote recovery.

Dialogue participants identified and discussed the many longstanding systemic barriers to appropriate treatment and support services for people with co-occurring disorders, including separate administrative structures, eligibility criteria, and funding streams, as well as limited resources for both mental health services and substance abuse treatment. In addition, participants provided recommendations that support successful partnerships between the two groups, address the barriers to effective services, and promote recovery. The dialogue recommendations represent the united voice of those who receive services and those who provide them, build on the findings of the SAMHSA Report to Congress, and emphasize that people with co-occurring disorders can and do recover.

References and Resources

Publications

National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors. (2002). *Exemplary Methods of Financing a Service Program for Persons with Co-occurring Mental Health and Substance Use Disorders*. Alexandria, VA, and Washington, DC: NASMHPD/NASADAD.

New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD.

U.S. Department of Health and Human Services. (2002). *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*. Rockville, MD: SAMHSA. Online: www.samhsa.gov/reports/congress2002/index.html

Federal Resources

The National GAINS Center
<http://gainscenter.samhsa.gov>

Substance Abuse and Mental Health Services Administration
www.samhsa.gov/reports/co_occur_home.htm

SAMHSA's National Mental Health Information Center
www.mentalhealth.samhsa.gov

SAMHSA's Center for Substance Abuse Treatment
Treatment Improvement Exchange
<http://tie.samhsa.gov>

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