Bill as Introduced

HB 196 – AS INTRODUCED

2003 SESSION

03-0981
01/09

HOUSE BILL ***196***

AN ACT establishing a commission to study means to integrate services for people with co-occurring disorders.

SPONSORS: Rep. MacKay, Merr 39; Rep. Emerton, Hills 48; Rep. Batula, Hills 58

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill establishes a commission to study the feasibility of integrating services for people with co-occurring disorders.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 196 – AS INTRODUCED

03-0981
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Three

AN ACT establishing a commission to study means to integrate services for people with co-occurring disorders.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Commission Established. There is established a commission to study the feasibility of integrating services for people with co-occurring disorders. For purposes of this act, "co-occurring" means substance abuse and mental illness disorders.

2 Membership and Compensation.

I. The members of the commission shall be as follows:

(a) Two members of the house of representatives, appointed by the speaker of the house.

(b) Two members of the senate, appointed by the president of the senate.

(c) Five members of the public, appointed by the governor.

II. Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

3 Duties. The commission shall study how to integrate divisions within the department of health and human services that deal with substance abuse, mental illness, and infectious diseases. The commission shall include in its study an examination of the relationship between these populations and the services provided in correctional facilities. The commission shall also identify how integration of services may affect outcomes.

4 Chairperson; Quorum. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named house member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Six members of the commission shall constitute a quorum.

5 Report. The commission shall report its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the senate president, the house clerk, the senate clerk, the governor, and the state library on or before November 1, 2003.

6 Effective Date. This act shall take effect upon its passage.

Committee Minutes

Date: April 15, 2003
Time: 4:15 p.m.
Room: LOB Room 101

The Senate Committee on Public Institutions/Health and Human Services held a hearing on the following:

HB 196 establishing a commission to study means to integrate services for people with co-occurring disorders.

Members of Committee present: Senator Boyce
Senator O'Hearn

The Chair, Senator Boyce, opened the hearing on HB 196 and called on Representative MacKay, prime sponsor, to introduce the legislation.

Representative Jim MacKay: Thank you, Mr. Chairman, and members of the Committee. For the record, my name is Jim MacKay. I represent Merrimack 39, which is the City of Concord. I live exactly one mile from this spot that we are in right now. Let me tell you first that I've got an amendment. I'll hang onto it and see if you want it or not or I can give it Josh. **Please see Amendment 2003-1168h, attached hereto and referred to as Attachment #1.**

Let me first define co-occurring illnesses. In the old days, we used to call this dual diagnosis or co-morbid. The in word now is co-occurring. Essentially, this delineates two types of human difficulties. One is addiction and the other is mental illness. Separately, those things are complicated and they are difficult to deal with in their lives. When you have one individual who has both of these kinds of conditions and maybe more, you've got a person at very high risk.

Recent research has been focusing on these particular individuals and we're lucky in New Hampshire. We have a series of individuals who have a national reputation both at the Dartmouth Psychiatric Research Group and the Dartmouth Medical School, Department of Psychiatry. So that the date

that this takes effect... People said, why do this in one year? We've got the resources in New Hampshire to do it.

Essentially, what this bill really looks at is the way the Department of Health and Human Services and its various divisions, look at this co-occurring illness. In the old days, I have a background in both alcoholism and mental health, so I am not prejudiced one way or the other. There is always turf battles about is one group - mental health - trying to take something away from the addiction group and visa versa. There is no intention in this bill to take anything except the best possible way in which we can deal with this extremely serious problem.

When I was originally trained, and I was actually Director of Alcoholism in New Hampshire way back in 1960's, so I am not prejudiced at all about mental health is better than alcoholism or visa versa, but I was trained in the field of mental health. Essentially, back in the old days, somebody would come in drinking and you would say, "Go home and straighten out your drinking and then come back and we'll deal with your problem." The person would look at you and say, "I came because I can't stop drinking." That was dumb and we recognize nowadays that that particular approach is less than useful.

The difficulty is getting systems to collaborate, to get the people who are trained in the field of addictions to collaborate with the people who are trained in the mental health. And these are individuals who, if they are not treated correctly and the longer time goes by, these are costing us huge amounts of money. The intention of this bill is not only scientific, but it should be cost-effective. We should be able to bring to bear the resources that we have in a way that is based on scientifically based treatment procedures, and not just that we think that this is the right thing to do.

This bill starts out by saying, what is the major department in New Hampshire that deals with all of these kinds of conditions? What is their attitude about collaborating and working together? How do you work across the systems? I became very interested in the whole notion of systems theory as I began to work on this.

There was one concern. Nobody that I have talked to opposes this concept and I recently talked from people NAMI and from New Futures and several others, all of whom are here today to speak in favor. On line 11, under duties, the commission should study how to integrate divisions within the Department of Health and Human Services and so on. I submitted this bill about two hours before the three o'clock deadline. When I looked back at this, I could see that that implies that one of the ways of solving this problem

is to integrate divisions, meaning collapse them and put them into one or the other.

The amendment that I gave to Josh changes that to say how we work in the various divisions to collaborate with each other. It is not my intention to scare people or to say that this is a bill that is trying to reorganize the Department of Health and Human Services. That is the Governor's concern and I think he is interested in that subject. I have talked to him about this bill and he is very interested in it.

Recently I have been doing some volunteer work with people with HIV Aids. Again, the hard core people who we're having the most difficulty dealing with are people who are people that are probably living down by the Merrimack River in a tent, whose outside of the tent is decorated by empty liquor bottles and they are there winter, summer, and all the time. These are individuals that not only have HIV Aids, but they also have addictions and they also have mental illness. They are very high risk because of their illness and the fact that they are intoxicated means that that HIV Aids is at a high risk of being spread.

We also know, but just on another subject that, in the Department of Corrections, there is an extremely high percentage of these kinds of individuals who find their way into the prison system because of their addictions and also their mental illness.

This doesn't cost anything; it's just a study. Two members of the House, two members of the Senate, five members of the public appointed by the Governor. That is essentially because it is an executive department. I don't need to go beyond there if you don't want to, and I would be glad to answer any questions. It is a complicated subject but, in some ways, it's not all that complicated.

Please see Representative MacKay's submission, "Health Policy Tracking Service, attached hereto and referred to as Attachment #2.

Senator Robert K. Boyce, D. 4: Thank you. Any questions? Senator O'Hearn?

Senator Jane E. O'Hearn, D. 12: Co-occurring, co-morbid. I can relate to ADHD where I know that is a co-morbid, but now a co-occurring disorder. I'm not sure what to call it because I don't necessarily consider that mental illness.

Representative MacKay: Do you mean ADHD?

Senator Jane E. O'Hearn, D. 12: ADHD.

Representative MacKay: I think all of us have a touch of it, particularly those who get into politics.

Senator Jane E. O'Hearn, D. 12: And yet, that is considered a co-occurring disorder. But there is something else that goes with this and it is not something that deals with substance abuse, but that could be the third piece to it.

Representative MacKay: Nowadays, I think that they are trying to use this co-occurring term as essentially dealing with mental illness and addictions. My experience for many years is that there are more than those two things almost always. But, that ADHD, which I think is very prevalent, in that we have the Ritalin pills that we hear all about again and again and again. So, I think that's why they came up, and I say they, it's mostly NIMH and those groups in Washington that are now using this term. But there is a psychiatrist that will be testifying who maybe has some information about why they use that term. I don't like labeling individuals under any conditions if we can avoid it. I think this is for the purpose of getting some legislation through, but I wouldn't want to go and say that Senator so and so has some co-occurring illness or something because he may be smoking and drinking or something like that.

The other part to this bill that I have not mentioned at all. I have talked about the severity end and the other part of this is prevention. As you begin to see, early in people's lives, the tendency towards the beginnings of mental illness and the beginnings of addictions, that's where you can really make a difference in people's lives if you catch this early so have we prevented these people from becoming a huge problem. The other parts that are complicated with individuals with severe mental illness, let's say bi-polar or manic-depressive illnesses, those individuals are taking very complicated medications. You add alcohol to that and other things, then you've really got a tremendous trauma going on within the physical system.

Senator Robert K. Boyce, D. 4: Follow up.

Senator Jane E. O'Hearn, D. 12: Because this is so difficult to deal with, why should the Legislature be studying this? Because this, I can understand your concern, but why is this a legislative duty and why not have some of these organizations do their own study and bring it back to us?

Representative MacKay: Mostly, the studies are done and there is a huge amount of research that is available. This study is to say how much of that information that is available already in the state is the Department using? Are they setting up systems within the Department? Because see the Department gives out all these community grants to mental health centers, to alcoholism groups so that what I'm looking for is not to trickle down in a sense, but to say that, if the Department sets certain policies about the way that their money is being spent and we're using that money in the best way so we're not wasting money with these individuals.

So this is to say, in the federal government and in the state of New Hampshire, there are experts already who have committed themselves to me that they will come to these study meetings. They would be glad to serve on the commission or they would be glad to come and testify free of charge, of course. Therefore, in a sense, it is to force the issue, to say, is the Department using the most up-to-date scientifically based information that they could get to be sure that they are doing this. I haven't met with a huge amount of resistance from the Department. To a certain extent, there is that anxiety that there is something up my sleeve beyond what the bill says, but there isn't.

Senator Robert K. Boyce, D. 4: Follow up.

Senator Jane E. O'Hearn, D. 12: One final question. Why a commission and not a study?

Representative MacKay: I just want to get someone from the Governor's office involved on the Governor's side. Usually a study, and I'm not sure if this, a study usually is House and Senate. This one, because I thought we are really adding in the Department of Health and Human Services that comes under the Executive Department, that we should give him some representatives.

Senator Jane E. O'Hearn, D. 12: Does the Governor have a commission on drug and alcohol abuse?

Representative MacKay: Yes. Bill Leber. Bill is still here. Representative Leber is on that.

Senator Jane E. O'Hearn, D. 12: Why not pull this into that one?

Representative MacKay: As far as I know, I think that is one of the systems. There also are people from the mental health side of things that are state organizations. So, if you chose one over the other instead of saying we

will include all those groups in the study. That was my idea. I know that nobody likes to add studies and commissions, but this one, I think, is extremely important because we've got populations who are not being reached and, at the same time, we can save money doing it, by giving the best treatment we can.

Senator Jane E. O'Hearn, D. 12: Thank you, Representative.

Senator Robert K. Boyce, D. 4: Thank you very much. Next in line I see Representative Pilliod.

Representative James Pilliod: Thank you, Mr. Chairman. Jim Pilliod, Belknap District 31. I speak in favor of this bill.

I think the question is a very good one. Why these two? I think the answer is because sometimes you need.... We have very, well-defined bureaucracies, if you will, that have to do with substance abuse. I think to say that we know these things occur so often together that it adds a little something to add legislative urgency or push, if you will, to have them start working it out so that they, in fact, are integrating their services better. Not forcing it, but I think the amendment says to learn how to collaborate, if you will, between the two different areas. I think that is worthwhile.

The alcohol, tobacco and drug abuse section are talking with the Governor's commission on that and discusses substance abuse pretty much individually. Although we perfectly well know that there may be some mental illness attached to folks that are subject to addiction, we don't see a whole lot working together with the mental health industry and alcohol, tobacco and drug abuse. Most times those are health preventative measures and so forth. Whereas this, in fact, is treatment measures, perhaps augmented by something that by collaboration between the bureaucracies could be done better. So I support it.

Senator Robert K. Boyce, D. 4: Further questions? Thank you.

Representative Pilliod: Thank you, Mr. Chairman.

Senator Robert K. Boyce, D. 4: Next I have Palmer Jones.

Palmer Jones: My name is Palmer Jones, with the New Hampshire Medical Society.

I have just one brief comment and I think that comment would be directed to your question. I think that there still are some misunderstanding and fears

about alcohol and substance abuse. It took us a year and a half to be able to work something out in mental health parity because of these misunderstandings and confusions. I think that's why the commission was to take the time to make sure that the people understood these issues and how we could best integrate them and be able to deal with the people who have any fears about that. That is why the commission, as opposed to doing something immediately.

There is no question that these are co-morbid or co-occurring, or whatever you want. There is a lot. And, if you look into the juvenile records, you will see that a significant number of the individuals who have been incarcerated are related to these two particular issues. So, I think it is an issue that's going to be able to benefit, not only the individuals, but the state and the way we do the things in New Hampshire.

So, I would support this and I think it's an important issue and I think that getting the people appointed that really have an interest in this on a commission, I think is really very, very important. Thank you.

Senator Robert K. Boyce, D. 4: Next we have Alexander de Nesnera.

Alexander de Nesnera: I have handouts. If you want, I can just pass them out. **Please see letter from Alexander de Nesnera, Board Member, NAMI NH addressed to Senator Andre A. Martel, attached hereto and referred to as Attachment #3.**

I'm Alexander de Nesnera and I am here as a NAMI board member. National Alliance for the Mentally Ill. I'm not going to repeat what has already been said. I just wanted to point out to you that National Alliance for the Mentally Ill strongly supports this House bill. We are a grassroots coalition of people and families coping with mental illness. We focus on providing support for families and advocate for individuals with mental illness to get appropriate treatment, and also advocate for equitable funding in policies and research into causes and treatments of mental illness.

We believe that this bill would be very helpful in helping the state look at policies in ways to integrate services for people that have co-occurring disorders. You may have heard of dually diagnosed. We, as family members, have dealt with the pain and suffering that some of our families go through in trying to find treatment for individuals who have both mental illness and substance abuse. There are a number of different systems that try to address a variety of different problems, and we believe that, here in New Hampshire, we have a wonderful group of individuals, highly trained and experts, that would be able to help the Legislature to look at ways to better integrate

services for dually diagnosed, co-occurring disorder individuals. So, we support this bill.

Senator Robert K. Boyce, D. 4: Any questions? Senator O'Hearn?

Senator Jane E. O'Hearn, D. 12: I applaud the work of NAMI and I have been to some of the NAMI meetings and I know what good work they do. But, it almost seems like we are stepping on the feet of professionals by doing this. To me, as I read your last sentence on the first page, what is needed is an integrated treatment, where mental illness and addictive disorders services and interventions are delivered simultaneously. I don't believe there is very many of us that are qualified to even make a decision like that as to what the needs are and how to treat. It appears to me this would be better handled by those people in dealing with these addictive disorders as well as mental illness. Is there a concern that you have that the Legislature would be dealing with that?

Mr. de Nesnera: No, actually, part of that sentence is my professional status coming through. I also happen to be a psychiatrist, and I am also part of the board of NAMI. These issues have been discussed openly in our board meetings. We, as an organization, NAMI has no desire to step on anyone's toes. Rather, we want to make sure that we work more collaboratively together. In the past, there has been a history of perhaps professionals and psychiatrists being at odds with other organizations, NAMI being one of them.

I happen to be one that is in both parts, both as a physician and also part of NAMI, and this is a bridge. I see myself as a bridge. NAMI has always been very interested in working collaboratively. So, I don't think it is our, and certainly speaking as a NAMI board member, it's not NAMI's attempt to overstep its bounds. It is rather supporting and advocating for better treatment for their families and, in so doing, working with professionals in a collaborative manner.

Senator Jane E. O'Hearn, D. 12: Just to follow up on that. I am certainly not saying that NAMI would be stepping on toes. I would think NAMI would be better served working with psychiatrists, psychologists rather than the Legislature, because the Legislature, I don't believe, is qualified to make decisions on issues such as this.

Mr. deNesnera: I would agree that the Legislature isn't qualified to make decisions, but I believe that it can certainly look at all the information and all the expertise that's available in New Hampshire, to look at what kind of

programs may be available, and could help develop programs that ultimately would help the citizens.

Senator Jane E. O'Hearn, D. 12: Thank you.

Senator Robert K. Boyce, D. 4: Thank you.

Mr. de Nesnera: Thank you.

Senator Robert K. Boyce, D. 4: The last person I have down here who wants to speak is Joe Harding. For New Hampshire?

Joe Harding: Yes, it is. I am Joe Harding and I am the Director of Friends in Recovery in New Hampshire or For New Hampshire and we are a grassroots volunteer organization of people in recovery from alcohol and drug problems. I apologize I have a cold, so I am a little foggy here. People in recovery from alcohol and drug problems and family members and other allies. I also have the pleasure of serving as a puppet member on the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment. I am here to testify in support of this bill.

It's our concern that people who suffer from alcohol or co-occurring disorders, alcohol and drug problems and mental health problems, have a particular difficulty accessing treatment, because most practitioners are not trained to provide services for addiction and mental health disorders. It seems historically there's not been a lot of cooperation or collaboration between the mental health and addiction fields in addressing these issues. Hopefully, that is starting to change a little bit. I know our organization is working together with NAMI, New Futures, Dartmouth Research Center. We submitted a proposal to address co-occurring disorders. So, we are trying to do some things to change the way things are now. Quite frankly, I think that the system could benefit from input from the Legislature to make this happen because there needs to be, I don't know if stepping on toes is the right phrase, but it seems like people need a little push in the direction.

The science is out there, the technical skills are out there, but the practitioners need to come together and the systems need to come together to better service those that are suffering from these disorders. We think that integrating services would be helpful to that effect. We know that 40% of adults with alcohol and drug problems also have mental health disorders, suffer from mental health disorders, and about 50% of adolescents with mental health disorders have also co-occurring alcohol and drug problems. Thank you.

Senator Robert K. Boyce, D. 4: Questions? Senator O'Hearn?

Senator Jane E. O'Hearn, D. 12: Thank you, Mr. Chairman. Just one question. The Governor's Council for Drug and Alcohol Abuse, is there anyone on the Council that is from the mental health field?

Mr. Harding: I believe there is actually. I know there is and actually, I'm a certified alcohol and drug counselor and certified clinical supervisor in the area of addictions. The Governor's Commission did a series of public forums throughout the state - nine public forums. And, as a result of those forums, one of the priorities established was that there is need for services for people with co-occurring disorders. Quiet frankly, our Commission is, I think, doing some great work, but it is primarily focused on alcohol and drug problems. If there was a Commission for mental health disorders, I think that they could focus on those issues and maybe we could come together to collaborate on some of these issues and bring some of the skill based to this service delivery system.

Senator Jane E. O'Hearn, D. 12: Follow up?

Senator Robert K. Boyce, D. 4: Follow up.

Senator Jane E. O'Hearn, D. 12: Because of what you do, is there a lot of people that are alcohol and drug addicted and quite often are self-medicating with their alcohol and drugs?

Mr. Harding: Yes.

Senator Jane E. O'Hearn, D. 12: Is there any statistic that you can give or any idea of how many of these addictions are caused by self-medicating where maybe the Governor's Council on Alcohol and Drug Abuse needs to take, or any council dealing with this, needs to take a different view of how to deal with alcohol and drug abuse?

Mr. Harding: I think it's a good point to make. I think we do need to look at that.

Tape change.

Mr. Harding: I think we do need to take a better look at it and certainly, a lot of people with alcohol and drug problems, are self-medicating. It's awfully hard to know what comes first - the mental health problems or the addiction and which causes which. But, we certainly do know that there is a lot of co-occurring disorders. So, I'm not sure exactly how to answer your question

except that I think we do need to do more on the Commission in that area. I think this could be a way of doing that, quite frankly, if we were to work together in both of these commissions, much like NAMI has come together with Friends of Recovery of New Hampshire, to try to address these issues.

Senator Jane E. O'Hearn, D. 12: Thank you.

Mr. Harding: Thank you very much.

Senator Robert K. Boyce, D. 4: I see no one else signed up to speak. Is there anyone else who wishes to speak? Thank you. I will close the hearing on HB 196.

Hearing concluded at 4:45 p.m.

Respectfully submitted,

L. Gail Brown

Recorded by Merideth Chandler
Transcribed by L. Gail Brown
7/9/03

3 Attachments

ATTACHMENT #1

Rep. MacKay, Merr 39
April 4, 2003
2003-1168h
01/10

Amendment to HB 196

Amend the title of the bill by replacing it with the following:

AN ACT establishing a commission to study the services for people with co-occurring disorders.

Amend the bill by replacing section 1 with the following:

1 Commission Established. There is established a commission to study the services for people with co-occurring disorders. For purposes of this act, "co-occurring" means substance abuse and mental illness disorders.

Amend the bill by replacing section 3 with the following:

3 Duties. The commission shall study ways that the divisions within the department of health and human services which deal with substance abuse, mental illness, and infectious diseases can collaborate in the provision of services for people with co-occurring disorders. The commission shall include in its study an examination of the relationship between these populations and the services provided in correctional facilities. The commission shall also identify how integration of services may affect outcomes. In addition, the commission shall determine whether the treatment interventions are scientifically based.

2003-1168h

AMENDED ANALYSIS

This bill establishes a commission to study the services for people with co-occurring disorders.

ATTACHMENT #2

Health Policy Tracking Service

SUBJECT: Behavioral Health

TITLE: Co-occurring Mental Illness and Drug Addiction Treatment: Overview and Bibliography

DATE: 11/05/2002

BY: Allison C. Colker, Esq. and Eileen Crean, Esq., with special recognition to the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol/Drug Abuse Directors (NASADAD) for their comments.

Introduction

Treatment of co-occurring mental and addictive disorders is an issue requiring state and local agency action, in collaboration with state legislators, who can play a role in monitoring, financing and evaluating co-occurring treatment services and encouraging the broad collaboration between state mental health and substance abuse authorities that is necessary to improve systems of care. This issue brief is intended to provide the reader with a general overview of the issues involved in designing and maintaining an adequate system of care for individuals with co-occurring disorders, based on the recent work of the NASMHPD-NASADAD Task Force on Co-occurring Mental Health and Substance Use Disorders.[1]

One promising approach now emerging within the public mental and addictive disorders treatment systems is the use of a conceptual framework that places individuals with co-occurring disorders within one of four quadrants, based on the severity of their mental illness and alcohol and drug addiction. Using the framework as a foundation for discussion, providers of treatment for mental and addictive disorders, funders, policymakers, consumers, family members and others can consider whether their service systems offer the necessary mix of consultation, collaboration and fully integrated treatment required by individuals who are receiving care within primary health care settings, substance abuse treatment agencies, mental health treatment agencies, corrections facilities and hospital facilities (including emergency rooms).

Overview

The root of the problem in coordinating treatment for people with co-occurring mental and addictive disorders can be traced to at least the late 18th and early 19th centuries, when American medical leaders called for the creation of separate asylums for the "insane" and "inebriates." Inebriates might be excluded from psychiatric institutions because their substance abuse was thought to be willful behavior and not treatable, although, in practice, psychiatric hospitals often were the sole housing or treatment option available.

A series of federal legislative actions represent important contemporary benchmarks in the development of treatment systems of care for mental and addictive disorders.

P.L. 88-164. The Community Mental Health Centers Act of 1963. [2]
P.L. 89-793 The Narcotic Addict Rehabilitation Act (NARA) of 1966.[3]
P.L. 91-616. Created the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1970. [4]
P.L. 92-255. Created the National Institute of Drug Abuse (NIDA) in 1971.[5]

P.L. 93-282. Placed NIMH, NIAAA, and NIDA as equal partners under the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA).[6]
P.L. 97-35. The Omnibus Budget Reconciliation Act of 1981, Combined State Formula Grants and many categorical grants into an Alcohol, Drugs and Mental Health (ADM) Block Grant to each state.[7]
P.L. 102-321. The Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) was reorganized in 1992 into a new health service agency, the Substance Abuse and Mental Health Services Administration (SAMHSA).[8]

States have responded in their own unique ways to accommodate this federal legislative history. All states continue to incorporate both substance abuse and mental health authorities within state government, although the particular location, structure and functions of these authorities vary widely. All states have some capacity to treat people with co-occurring mental and addictive disorders, although the nature, extent and effectiveness of that capacity vary widely. The development and maintenance of effective services for people with co-occurring disorders are directly related to available financing, legislative and regulatory constraints, and readiness of both fields to bring about the necessary changes to treatment systems.[9] Virtually all states experience a significant gap between the number of individuals in need of publicly supported treatment of mental and addictive disorders, and the number that can effectively be served within existing resources. Some experts contend that redistribution of existing resources to programs designed exclusively for co-occurring clients may broaden that treatment gap.

The SAMHSA-funded Integrated Data Base Project recently conducted a comprehensive review of data from a sample of three states (Delaware, Oklahoma and Washington), that were selected for their ability to provide integrated data on substance abuse, mental health treatment and Medicaid expenditures.[10] Two of the study's most significant findings included: (1) people with co-occurring disorders were more likely to be treated under state mental health and substance abuse agencies than under Medicaid; and (2) among those individuals treated by state agencies, about half were treated under both the mental health and substance abuse agency, while the other half were treated almost exclusively by the mental health agencies. Much local alcohol and other drug treatment providers (AOD) report a capability to treat clients who suffer from both mental and addictive disorders. According to SAMHSA's Drug and Alcohol Services Information System (DASIS) Report (May 24, 2002), nearly half the nation's specialized substance abuse treatment facilities provided programs for dually-diagnosed clients.[11]

Although some attempts have been made to integrate the treatment of mental and addictive disorders within community mental health centers, the fields of mental and addictive disorders treatment have ultimately developed separately, fueled by their separate histories, ideologies and funding streams. Now, at the dawn of the 21st century, an increased ability to identify people with co-occurring disorders and a greater consciousness of the full range of their needs are challenging the limited available resources as never before. Many of these individuals are homeless, have multiple significant health problems (e.g., HIV/AIDS) and have been incarcerated at some point in their lives. In general, long-term health outcomes are poor for people with co-occurring mental and addictive disorders. Because co-occurring disorders exact an immense economic and human toll on society, they should be given high priority when states are designing effective health care delivery systems.

Until quite recently, the evolution of clinical response to the challenges presented by this population has tended to be idiosyncratic to individual local treatment providers or, in some limited cases, consistent with guidelines established through individual state co-occurring project initiatives (e.g., Connecticut, Missouri, New Jersey, Pennsylvania and Texas). The NASMHPD-NASADAD Task Force and the conceptual framework represent not only a significant departure from previous independent or isolated program development efforts, but also represent the first nationally organized attempt to develop informed strategic plans that then may be applied to improve co-occurring services at the national, state and local levels.

As of October 2002, the NASMHPD-NASADAD Task Force has met on three separate occasions, approximately once per year since its establishment. At its first meeting in June 1998, the task force focused on development of the conceptual framework. The resulting publication, *National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders*, elaborated on the nature of the problem, then presented and explained the conceptual framework.[12] At its second meeting in June ,1999, the task force identified mechanisms to both finance and market the conceptual framework to interested constituents (including legislators and other policymakers) and established the expectation that comprehensive and coordinated systems of care for individuals with co-occurring disorders should be developed. The resulting publication, *Financing and Marketing the New Conceptual Framework for Co-Occurring Mental Health and Substance Abuse Disorders: A Blueprint for Systems Change*, was produced in April 2000. Later that same year, the task force oversaw development of a publication that represented one of the earliest efforts to identify state examples of effective co-occurring service programs: *Successful Programs for Individuals with Co-Occurring Mental Health and Substance Abuse Disorders: Examples from Five States* (August 2000). Programs in 5 states--Massachusetts, New York, Pennsylvania, Washington and Wisconsin--are profiled in this publication.

The most recent meeting of the task force occurred in November 2001. Task force members considered the results of case studies that were conducted at nine sites during the previous year under its sponsorship. Programs in 9 states--Maine, Colorado, Virginia, Ohio, Tennessee, Pennsylvania, Illinois, Texas and Maryland--were the subject of in-depth case studies. These sites in each state were selected on the basis of their demonstrated success in financing and delivering fully coordinated co-occurring mental and addictive disorders services.

In addition to the state mental health agency directors, state substance abuse agency directors, national provider organizations and federal agency representatives that were involved in previous task force meetings, the 2001 site-specific participants included the executive directors of two of the nine case study sites. Their experience and perspective contributed significantly to the discussion as the task force sought to review project findings and assist in identifying and synthesizing the key program and fiscal elements that crosscut the case studies. The publication that resulted from that meeting, *Exemplary Methods of Financing Integrated Service Programs for Persons with Co-Occurring Mental Health and Substance Use Disorders*, will be published in November 2002. The final report has been selected as an appendix to the recently completed "Report to Congress" regarding delivery of services to people with co-occurring mental and addictive disorders, that was authored, as required by Congressional Order, by the Substance Abuse and Mental Health Services Administration.

Creating an Effective System of Care

According to the task force:

> The needs of persons with co-occurring mental and addictive disorders are varied and complex. Historically, the nation's treatment systems for mental and addictive disorders have responded to these needs in a fragmented and uncoordinated fashion. Our responses have reflected significant differences in the way co-occurring disorders are understood and defined, as well as in the way that co-occurring treatment services are developed, financed and delivered. While differences of opinion and approach remain, mental and addictive disorders professionals increasingly recognize an urgent need to create more responsive systems of care. Without more effective care, individuals with co-occurring mental and addictive disorders will continue to cycle repeatedly through service systems, enter jails and judicial systems and generally go without the services and supports they need to relieve and resolve their disorders.[13]

In these four reports, the task force outlines a series of challenges to creating an effective system of care, explains the conceptual framework, identifies some of the characteristics of successful treatment

5. The National Institute of Drug Abuse (NIDA) was created within NIMH in 1973, assuming the operational responsibilities of the Special Action Office on Drug Abuse Prevention, given responsibility for the research, training and services grants directed at this disease, and for a State Drug Formula Grant to each state. States were required to designate a Single State Authority (SSA) for Drug Abuse to plan for and administer the State Drug Formula Grants.

6. The Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment Act Amendments of 1974.

7. The amount of services funding was reduced by twenty five per cent as the change in grant format reduced Federal reporting requirements. The requirements for States to designate a State alcohol or drug abuse authority to plan for and administer the formula grants were also repealed and the Governor was designated as responsible for meeting the block grant requirements.

8. The Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) was reorganized in 1992 into a new health service agency, the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Public Health Service of the U.S. Department of Health and Human Services (DHHS). SAMHSA's mission is to reduce the incidence and prevalence of alcohol and other drug use and mental disorders, improve treatment outcomes for people who suffer from these disorders, and diminish consequences for their families and communities. SAMHSA consists of three centers: the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP) and the Center for Mental Health Services (CMHS). Coordination is provided by the Office of the Administrator. The three research institutes that were part of ADAMHA when it was created in 1974--NIMH, NIAA and NIDA--were transferred to the National Institutes of Health. The Alcohol, Drugs and Mental Health (ADM) Block Grant was split into the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant.

9. For example, the Community Mental Health (CMH) Block Grant explicitly permits payment for co-occurring services to be delivered only to those consumers who meet criteria for severe and persistent mental illness or severely emotionally disturbed children. The Substance Abuse Prevention and Treatment (SAPT) Block Grant allows treatment for co-occurring disorders, but only if funds are expended for purposes for which they were authorized by law and can be tracked for accounting purposes.

10. SAMHSA, *Mental Health and Substance Abuse Treatment: Results from a Study Integrating Data from State Mental Health, Substance Abuse and Medicaid Agencies*, (Rockville, Md.: SAMHSA, 2001).

11. SAMHSA, *The DASIS Report*, (Rockville, Md.: SAMHSA, May 2002).

12. This and all other publications produced by the task force are included in the bibliography of this issue brief.

13.NASMHPD and NASADAD, *Exemplary Methods of Financing Integrated Service Programs for Persons with Co-Occurring Mental Health and Substance Use Disorders* (Alexandria, Va. and Washington, D.C.: NASMHPD and NASADAD, November 2002).

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ATTACHMENT #3

NAMI New Hampshire

New Hampshire's Voice on Mental Illness

April 15, 2003

Senator Andre A. Martel
Chair
Public Institutions, Health, and Human Services Committee
NH State Senate

Re: HB 196

Dear Committee Members:

The National Alliance for the Mentally Ill NH strongly supports House Bill 196. As a grassroots coalition of people and their families coping with mental illness, NAMI NH's efforts focus on support to families, advocacy for non-discriminatory and equitable funding and policies, research into causes, symptoms and treatments of mental illness and education to eliminate stigma.

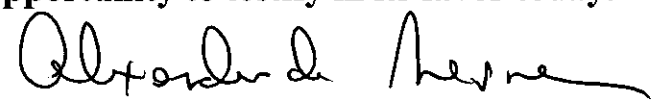
Establishing a commission to study ways to integrate services for individuals with co-occurring substance abuse and mental illnesses is a significant, positive step toward developing programs that will provide comprehensive treatment for this population.

Historically, individuals with co-occurring disorders have received sequential or parallel treatment from the separate mental health services and substance abuse treatment systems. Neither system has developed the capacity to provide both mental health and substance abuse treatment within a single program. Fragmented and uncoordinated services create a service gap for persons with co-occurring disorders. What is needed is integrated treatment, where mental illness and addictive disorders services and interventions are delivered simultaneously at the same treatment site, ideally with cross-trained staff.

15 Green Street ★ Concord, NH 03301
InfoLine: (800) 242-NAMI ★ PH: (603) 225-5359 ★ FX: (603) 228-8848
E-Mail: info@naminh.org ★ www.naminh.org
AFFILIATES ★ Berlin ★ Claremont ★ Concord ★ Derry ★ Dover ★ Franklin ★ Keene ★ Laconia
Lebanon ★ Littleton ★ Manchester ★ Nashua ★ Peterborough ★ Portsmouth ★ Greater Salem

Research has shown that combined treatment is effective at engaging people with co-occurring disorders in outpatient services, maintaining continuity and consistency of care, reducing hospitalization, and decreasing substance abuse, while at the same time improving social functioning.

NAMI NH supports this bill, and thanks this committee for the opportunity to testify in its favor today.



Submitted by,

Alexander de Nesnera, Board Member, NAMI NH

Speakers

SENATE PUBLIC INSTITUTIONS, HEALTH & HUMAN SERVICES COMMITTEE

Date: **04/15/03** Time: **4:15 PM** Public Hearing on **HB 196**

establishing a commission to study means to integrate services for people with co-occurring disorders.

Please check box(es) that apply. SPEAKING	FAVOR	OPPOSED	*NAME (Please print)*	*REPRESENTING*
1. ☒	☒	☐	Representative James MacKay	Prime Sponsor
2. ☐	☒	☐	Rep Peter Batula	
3. ☐	☒	☐	Rep Richard J. Bourque	
4. ☒	☒	☐	Palmer P. Jones	
5. ☒	☒	☐	Alexander de Nesnera,	FOR NAMI NH
6. ☑	☑	☐	Joe Harding	FOR NH
7. ☑	☑	☐	R. Jim Allen	Dist 31 BELKNAP-
8. ☐	☐	☐		
9. ☐	☐	☐		
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18. ☐	☐	☐		
19. ☐	☐	☐		
20. ☐	☐	☐		

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: April 22, 2003

THE COMMITTEE ON Public Institutions/Health and Human Services

to which was referred House Bill 196

AN ACT establishing a commission to study means to integrate services for people with co-occurring disorders.

VOTE: 3-1

Having considered the same, report the same with the following resolution:
Resolved, that it is: **INEXPEDIENT TO LEGISLATE.**

Senator Andre Martel
For the Committee

HB196 Docket

Next|Prev|Results List|Main|Bill Status

Bill Title: establishing a commission to study means to integrate services for people with co-occurring disorders.

Date	Body	Description
1/9/2003	H	Introduced and ref to Health HS&EA; HJ8, p110
1/9/2003	H	Copy to Chairman on 1/9/2003
1/9/2003	H	Hearing Jan 21 11:30 RM205,LOB
1/22/2003	H	Maj Report OTP for Jan 30 (Vote 15-0;CC)
1/30/2003	H	Passed; HJ 12, p217 + 231
3/27/2003	S	Introduced and Ref. to Public Institutions, Health and Human Services; SJ 10, Pg.216
4/4/2003	S	Hearing; April 15, 2003, Room 101, LOB, 4:15 p.m.; SC17
4/28/2003	S	Committee Report; Inexpedient to Legislate [05/08/03]; SC21
5/8/2003	S	Inexpedient to Legislate, MA, VV === KILLED ===; SJ 15, Pg.362

Next|Prev|Results List|Main|Bill Status

Docket Abbreviations