INTEGRATING ADDICTION, MENTAL HEALTH & COGNITIVE CARE

2011 Policy Statement

SUMMARY OF RECOMMENDATIONS

1. **Maintain funding levels for behavioral health block grant programs, demonstration projects, and targeted homeless assistance programs identified in the President's FY 2012 budget**
2. **Strengthen the integration of behavioral health and primary care services among HCH projects and other service providers**
3. **Establish policies and programs that incorporate a broad recovery model of behavioral health care**
4. **Ensure that individuals with substance use disorders who meet current Social Security disability criteria receive SSI/SSDI benefits**
5. **Identify and evaluate individuals with Traumatic Brain Injury**
6. **Maximize Health Center funding opportunities to expand mental health, cognitive rehabilitation, and addictions services**

Addiction and mental illness—which are frequently co-occurring—often lead to and prolong homelessness and tend to be exacerbated by life on the streets or in shelters. Among those surveyed, 39% report a mental health problem, 38% report alcohol use problems, and 26% report problems with other drugs.[1] A 2010 survey conducted by the U.S. Conference of Mayors found 24% of homeless adults have a serious mental illness, and listed both mental health and substance use as primary causes of individual homelessness.[2] Recent evidence indicates a significant percentage of persons experiencing homelessness have a history of brain injury, which adds to the complexity of behavioral health issues homeless services providers must address to achieve successful outcomes.

Homelessness presents serious barriers to treatment for these conditions. People without stable housing often are impoverished, uninsured or underinsured, and alone. Lack of documentation, lack of transportation, and difficulty adhering to treatment regimens prevent many homeless individuals from succeeding in mainstream behavioral health care. In 2004, homeless individuals accounted for more than 175,300 admissions to addiction treatment facilities (13% of all such admissions). People who are homeless are more than twice as likely as their housed counterparts to have had five or more previous treatment episodes.[3] Untreated addictions and mental illnesses present serious barriers to employment and permanent housing, perpetuating an ever-worsening cycle of poor physical health, hospitalization, social dysfunction, avoidable incarceration, poverty, and homelessness.

Many people experiencing homelessness are arrested for conduct that is often exacerbated by untreated mental illness or addiction. Nationally, 15% of inmates were homeless prior to their incarceration and 56% of all inmates have a mental illness. As such, jails and prisons have become a primary provider of behavioral health services.[4] According to the U.S. Bureau of Justice Statistics, the Los Angeles County Jail has become the nation's largest mental health institution, and more than half of all prison and jail inmates nationally have mental health problems.[5] Lack of connection to services and inadequate discharge planning may lead some people to cycle through the jail system hundreds of times.[6] Without stable housing, even those who are *recovering* from

addiction or are *managing* a mental illness often will return to the same high-risk environment following release from incarceration or hospital discharge, thus increasing the potential for relapse. Similarly, individuals with Traumatic Brain Injury who are mis-diagnosed with mental illness and are otherwise unable to obtain appropriate cognitive rehabilitation services experience functional impairment that complicates medical and social improvement.

Mainstream behavioral health care that is universally affordable, readily accessible, and linked to housing would reduce the incidence of homelessness; achieving this goal must be paramount. People who are already experiencing homelessness, however, present complex challenges for which mainstream providers may be ill-equipped or untrained. To reach and treat these individuals, assertive outreach combined with a coordinated service approach that includes support services is most effective.

Behavioral Health Recommendations in Detail

1. Maintain funding levels for behavioral health block grant programs, demonstration projects, and targeted homeless assistance programs identified in the President's FY 2012 budget.

Early and prompt intervention is critical when treating persons with addiction and mental health disorders. Due to the stress brought on by the economic downturn in recent years, services are needed more than ever to help meet a growing need for treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) allocates funding to states through both mainstream and targeted homeless programs to provide treatment in community programs. The President's budget proposal for FY 2012 contains some modest increases in the following key programs:

	FY 2011	FY 2012 (Proposed)
Mental Health Block Grant	400	414
Substance Abuse Block Grant	1,376	1,420
PATH Homeless Program	65	65
Grants for the Benefit of Homeless Individuals	43	47
Services in Supportive Housing Grants	32	40
Housing and Services for Homeless Persons Demonstration	0	16

Note: All figures in millions.

The Substance Abuse Block Grant, the Mental Health Block Grant, and the targeted homeless programs form the core of the behavioral health safety net. Congress should adopt these proposed budget levels and resist any reductions in these areas. As Medicaid is expanded in 2014 (or sooner at state option), the targeted outreach available from PATH and services available through grants for homeless individuals will be the key to enrolling vulnerable adults in entitlements and to engaging them in services. This is especially true for those with disabling behavioral health issues. Additionally, incentives should be incorporated into the Block Grant process to encourage providers to integrate care for those with cognitive impairments. Doing so would provide critical support to behavioral health providers to improve outcomes for those with cognitive deficits.

The Housing and Services for Homeless Persons Demonstration project is an interagency collaboration between HHS, HUD and the Department of Education. The goal of this demonstration is to provide supportive housing to 4,000 chronically homeless individuals (through HHS) and 6,000 children and families (through Education). This project is essential to the goals of the Federal Strategic Plan to Prevent and End Homelessness, was included in the President's FY11 and FY12 budgets, and should be included in the final budget passed.

2. Strengthen the integration of behavioral health and primary care services among HCH projects and other service providers

The integration of primary health care and behavioral health services is absolutely vital to serving individuals who are homeless. Mental illness and addictions do not occur in a health vacuum—diabetes, asthma, cardiovascular disease, and a host of other chronic and acute disease are often co-occurring disorders that complicate treatment. Not only should a full care regimen ideally be onsite, but staff should strive to work in teams to coordinate a service delivery plan focused on linking appointments, lab tests, prescription medications, and routine exams. These "health home" models help improve health and quality of care, reduce costs, and better link a wide variety of community providers (including hospitals) to improve communication and reduce errors and duplication. Individuals with limited transportation, limited ability to navigate complex discharge plans, and multiple care plans put together by numerous providers will have a more difficult time engaging in recovery, and maintaining successes achieved.

Systemic challenges to integration might include how services are funded, and whether mental health has achieved true "parity" with traditional primary care services (or whether payment for services is separate from primary care). States should remove these barriers and ensure full parity in reimbursement, scope and duration of services. Additionally, broader reimbursement for cognitive rehabilitation would further develop this area of practice.

As community mental health clinics and other behavioral health providers learn how to integrate primary care into their practices, and likewise, as Health Care for the Homeless providers learn how to introduce or strengthen mental health and addictions services, it is important to understand that integration is more than simply co-location. Training across disciplines, engaging both clinical and non-clinical staff to participate in teams, and transforming an organizational culture may be needed in order to ensure all services are working together well. Staff at HCH projects might look for opportunities to build these partnerships wherever possible within their community to enable a larger availability of resources for those in need.

3. Establish policies and programs that incorporate a broad recovery model of behavioral health care.

Public education has produced positive outcomes in reducing the demand for illicit drugs. For many, however, the narrow focus upon abstinence-only programming within the publicly funded addiction services system is a barrier to successful recovery. Effective treatment systems must include outreach and engagement, "harm reduction" strategies, a "housing first" approach with appropriate supports, multidisciplinary treatment teams, integrated treatment for co-occurring disorders, motivational enhancement interventions, risk reduction, and the active involvement of consumers in planning and delivery of services. To that end, SAMHSA's Strategic Initiative will guide its work from 2011 to 2014 and incorporates a broad framework around recovery that includes trauma-informed care, and a recovery support system that is tied to health care,

permanent supportive housing and other needed supports. The Strategic Initiative also includes a focus on prevention, the needs of those in the criminal justice system, and the role that health reform and health technology will play in connecting people to better access to services and health outcomes. We urge other Federal agencies—as well as State and local governments—to also adopt similar policies and programs, consistent with emerging evidence-based practices that respond to the needs of the full range of people with addiction and mental illness.

4. Ensure that individuals with substance use disorders who meet current Social Security disability criteria receive SSI/SSDI benefits.

Welfare reforms in 1996 terminated SSI/SSDI eligibility for individuals whose substance dependence is "a contributing factor material to the determination of their disability" but it was not intended to disqualify individuals with other impairments that meet Social Security disability criteria. We urge SSA and Congress to make the following policy changes:

- **Ensure those individuals who have both substance disorders and co-occurring impairments who meet current Social Security disability criteria are able to receive SSI/SSDI benefits.** The Drug Addiction or Alcoholism (DAA) policy has been inconsistently interpreted and applied at all stages of disability determination. The intent of Congress was not to exclude people who are dealing with co-occurring impairments from receiving SSI/SSDI benefits. Congress and the Administration should restate this intent and provide sufficient oversight to ensure that SSI/SSDI eligibility is more consistently granted to persons whose disability is not materially affected by their alcohol or drug use.

- **Restore SSI/SSDI eligibility to persons whose alcohol or drug use is material to their disability.** In 2009, Health Care for the Homeless Projects cared for approximately 21,700 individuals whose primary diagnosis was an alcohol-related disorder and nearly 24,000 whose primary diagnosis was another substance-related disorder. While this represents a relatively small number of HCH patients overall (2.6% and 2.9%, respectively), it includes many individuals who are unable to access treatment due to lack of insurance or limited availability of subsidized treatment programs. The continuing exclusion of such persons from benefits fails to recognize medical knowledge about the nature of addictions and creates a barrier to accessing medical services and treatment for patients suffering from progressive and often fatal disorders.

5. Identify and evaluate individuals with Traumatic Brain Injury.

Traumatic brain injury (TBI) is a serious public health problem in the United States and appears to disproportionally affect persons experiencing homelessness. The CDC estimates that, on average, approximately 1.7 million people sustain a TBI annually. TBIs are generally caused by falls, automobile accidents, and other injuries that bump, blow or jolt the head or cause a penetrating head injury that disrupts the normal function of the brain. The severity of a TBI may range from mild (i.e., a brief change in mental status or consciousness) to severe (i.e., an extended period of unconsciousness or amnesia after the injury). There is mounting evidence that mild and moderate TBI have long-reaching effects in cognitive and psychosocial functioning that may contribute to an individuals ability to sustain housing.[7, 8] About 75% of TBIs that occur each year are concussions or other forms of mild TBI, but the number of people with TBI who are not seen in an emergency department or who receive no care is unknown. Individuals experiencing homelessness have been shown to have high rates of TBI with one study documenting a 53% lifetime prevalence for any TBI (for 12%, the injury was moderate or severe).[9] There is increasing awareness of the impact that TBI has on health status and on risks for further injury, particularly among returning veterans from the wars in Iraq and Afghanistan.[10] At the same time there is little to no access to

neuropsychological evaluations or a cognitive rehabilitative approach to serving persons with TBI. Neuropsychological evaluations and/or cognitive rehabilitation services would provide individualized information that would help care providers target plans and interventions to more effectively achieve desired treatment outcomes.

Most commonly, persons are mis-diagnosed with a behavioral health disorder. Identifying and evaluating individuals with TBI histories could help guide medical care and behavioral health treatment plans as well as better inform providers about functional impairments that may be present, but overlooked. Congress and the Administration should consider increasing funding for research in this area.

6. Maximize Health Center funding opportunities to expand mental health, cognitive rehabilitation and addictions services.

The investments for Community Health Centers contained in the health reform law ($9.5 billion over five years for expanded operational capacity) should include allowances to broaden both mental health and addictions services, especially for projects that serve special populations that are more likely to be in need of behavioral health services and supports for clients with complex health conditions. Expanding these services will allow for a broader, more integrated care model as well as be able to enhance existing services by reducing wait times and strengthening community provider partnerships using this new funding availability. Congress should continue annual health center appropriations in addition to the health reform funds to enable these expansions.

Cognitive rehabilitation, especially when combined with other behavioral health services, offers strategies to help patients with overall living skills. These skills can include memory improvement, sequencing, learning new material, effective communication skills and executive functioning. HRSA and SAMHSA might consider adding these important services into their funded programs to ensure community providers have the needed resources to treat those with cognitive impairments.

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