Alaska Mental Health Board
Advisory Board on Alcoholism and Drug Abuse
431 N. Franklin St. Suite 200
Juneau, Alaska, 99801

March 15, 2016

Representative Liz Vazquez
State Capitol Room 432
Juneau, Alaska 99801

Re: HB 234 – Telemedicine and Mental Health Benefits

Representative Vazquez,

The Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse thank you for your efforts to address the need for increased access to behavioral health services across Alaska. Like you, the Boards recognize that telehealth is a key strategy in the improvement of health outcomes and containment of health care costs. We appreciate that HB 234 extends the conversation about tele-behavioral health beyond the Medicaid and tribal health systems to private insurers.

The Boards have long supported the use of telehealth to deliver integrated mental health and substance use disorder treatment and prevention services. Many community behavioral health centers currently provide clinical behavioral health services through telehealth systems. Our hope is that HB 234 will augment the existing services by increasing access to substance use and mental health disorder treatment for Alaskans with private health insurance.

As written, HB 234 only requires private insurers to cover telehealth services for "mental health services," defined in AS 21.54.500(22) as whatever "mental health services" are under the terms of the health care insurance plan. This definition explicitly excludes "benefits for treatment of substance abuse or chemical dependency." The Boards recommend that the language of HB 234 explicitly include substance use disorder treatment, given the high incidence of co-occurring substance use disorders with mental illness (*see* the attached *Policy Statement: Co-Occurring Mental Health and Substance Use Disorders*).

The Boards understand that HB 234 was drafted to limit the ability of private insurers to restrict delivery of telehealth services. We recommend balancing that goal and health care providers' need to adhere to accepted standards of care that may require in-person assessment or other treatment encounter prior to delivery of telemedicine/telehealth services. Expressly including that intent in the legislative record would be an effective way to balance those interests.

Thank you again for your work on behalf of Alaskans experiencing behavioral health disorders.

J. Kate Burkhart
Executive Director

POLICY STATEMENT

Co-Occurring Mental Health and Substance Use Disorders

Advisory Board on Alcoholism and Drug Abuse
abada
amhb
Alaska Mental Health Board

The Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse were created by statute to provide advice and counsel related to mental health and substance abuse to the legislature, executive agencies, and other entities. Pursuant to that statutory responsibility, the Boards restate and expand upon their commitment to the public policy of an integrated behavioral health system that serves the entire person, not merely the diagnosis. The Boards' policy statement is aligned with similar policy statements and initiatives issued by the State of Alaska Department of Health and Social Services, Division of Behavioral Health, Substance Abuse and Mental Health Services Administration (2011), the American Society for Addiction Medicine (2000), the National Associations of State Mental Health Program Directors and Alcohol/Drug Abuse Directors (1999), and the President's New Freedom Commission on Mental Health (2003).

BACKGROUND

Since 1998, the Alaska Mental Health Board (AMHB) and Advisory Board on Alcoholism and Drug Abuse (ABADA) have participated in efforts by the State of Alaska and the providers of mental health and substance abuse prevention, treatment, and recovery services to create an integrated behavioral health system in Alaska. The Boards have, through efforts to operate as collaboratively as possible, strengthened their understanding of the nature of co-occurring mental health and substance use disorders and the most effective ways to prevent, treat, and support recovery from them.

Research and evidence shows that a high proportion of substance use disorders occur along with other substance use disorders and/or mental health disorders. Treatment services that address co-occurring disorders and that include measures to prevent the development of co-occurring disorders are most effective. Similarly, recovery supports that address the individual as a whole and support recovery from diverse behavioral health disorders are most likely to result in improved outcomes.

AMHB and ABADA are committed to Alaska's public behavioral health systems efforts to address the complex needs of individuals and families experiencing co-occurring mental health and substance use disorders, in all levels of care, across all agencies, and throughout the entire process of recovery.

Prevalence

In the United States, an estimated 23.2% of adults with serious mental illness also experience a substance use disorder (three times the prevalence of addiction among individuals without a serious mental illness). Among adults experiencing a substance use disorder, 20.4% are estimated to also experience serious mental illness.[1] The National Co-morbidity Study (2007) reports a lifetime prevalence rate for any behavioral health disorder of 57.4%, and a past-12

month prevalence rate of 32.4%. The National Co-morbidity Study also reports that 41-65% of individuals with a lifetime substance use disorder also have a lifetime history of at least one mental health disorder.[2] More than half of individuals with one or more lifetime mental health disorders also have a lifetime history of at least one substance use disorder.[3]

Youth experiencing major depression are twice as likely to abuse inhalants[4] and nearly three times as likely to abuse stimulants.[5] Research also shows a strong relationship between adverse childhood experiences (which include trauma and problem drinking) and illicit drug use, prescription drug use, and addiction in adulthood.[6]

Individuals with co-occurring disorders are more likely to experience a chronic course of illness and are more likely to seek services than those with only a mental health disorder or only a substance use disorder. The extent of the prevalence of co-occurring substance use and mental health disorders is seen in the nearly 25% growth of Alaskans receiving co-occurring disorders treatment (from publicly funded providers) since 2009.[7]

In addition to the co-occurrence of mental health and substance use disorders, individuals often experience dependence upon or abuse of more than one drug. The National Survey of Drug Use and Health reports that 6% of people age 12 and older who reported drinking alcohol in the past month also reported using an illicit drug at the same time or within a few hours of drinking alcohol.[8] Concurrent illicit drug use was reported by 13.9% of binge drinkers age 12 and older.[9] The prevalence of multiple substance use disorders is important, as this has been associated with increased risk of mental health disorders developing.[10]

While there is little recent research that indicates the prevalence of behavioral health disorders among Alaska Native peoples, there is research that indicates that substance use disorders and mental health disorders are often both present among Alaska Native and American Indian peoples seeking mental health services.[11] Research conducted over the past three decades show that substance use disorders and mental health disorders are often co-occurring among Alaska Native and American Indian populations.[12] Co-occurring disorders may be implicated in suicide data reported by the Alaska Violent Death Registry. During the period 2003-2008, alcohol intoxication was associated with 41.3% of all suicides, and active use of marijuana, amphetamines, antidepressants, cocaine, opiates, and other drugs was documented in 25-35% of cases.[13] The National Survey of Drug Use and Health also reports that Alaska Native and American Indian individuals over age 12 are more likely than people of other ethnicities to report concurrent use of alcohol and illicit drugs.[14]

Prevention

The Institute of Medicine has identified effective strategies that prevent mental, emotional and behavioral disorders from developing among adolescents and adults.[15] Strengthening families by addressing violence and parental substance abuse (both of which are adverse childhood experiences that can contribute to co-occurring disorders later in life) enhances the well-being of children. Early screening and identification of risk factors and early behavioral and emotional issues, when followed by access to services, reduces later onset of behavioral health disorders.[16] Promoting strong parenting skills and supports, social-emotional learning, resilience, and

protective factors in families, schools, and communities also reduces the likelihood of mental illness or addiction.

Coordination of prevention efforts to address the common underlying factors related to mental illness, suicide, and addiction promotes the overall well-being of individuals, families, and communities. It also promotes better use of resources and shared accountability for outcomes.

Treatment

Research and practice both support combined treatment of co-occurring disorders.[17] Integrated treatment is associated with lower costs and better outcomes. These forms of integrated treatment result in reduced substance use, improved psychiatric symptoms and functioning, decreased hospitalization, improved housing stability, fewer criminal justice contacts, and improved overall quality of life.

Substance abuse treatment that is designed to address co-occurring disorders can be effective for clients experiencing general mental health disorders and serious mental illness. It has also been shown to be effective for individuals experiencing co-occurring disorders who are homeless, incarcerated, or victims of trauma.

The "No Wrong Door" approach to treating co-occurring disorders begins with an integrated screening and assessment. When mental health and substance use disorders coexist, each disorder should be considered as a primary diagnosis, and integrated services should include treatment matched to each diagnosis.[18] Ideally, public behavioral health providers can provide both mental health and substance use disorder treatment. If co-occurring treatment is not available, thoughtful and supported linkages to qualified services can be just as effective.

Treatment of co-occurring disorders occurs beyond the clinic setting, often delivered through a range of social services and provider networks. This requires that treatment models be flexible and responsive to the specific clients, providers, and programs.[19] Evidence-based practices shown to be effective for co-occurring disorders include behavioral interventions, motivational interventions, Assertive Community treatment, and certain therapeutic community programs.[20]

Recovery

"Serious psychiatric and substance use disorders are chronic, relapsing illnesses that can be conceptualized by using a disease and recovery model, with parallel phases of treatment or recovery."[21] Understanding the nature of co-occurring disorders, and how they can develop together or separately, is integral to maintaining and enhancing recovery.

In the President's New Freedom Commission on Mental Health Report (2003), services that increase the ability to cope with life's challenges, promote recovery, and build resilience were identified as key to recovery.[22] Recovery and peer support programs that provide meaningful relapse prevention strategies to people experiencing mental health disorders are most effective.

RECOMMENDATIONS

- ✓ The commitment to an integrated public behavioral health care system — evidenced by Alaska's "No Wrong Door Policy," Alaska Screening Tool, trauma-informed care initiative and Co-Occurring Disorders Institute, and other efforts — should continue to be recognized and supported by national, state, and community partners.

- ✓ Funding of public programs should support entirely the mission and objectives of Alaska's behavioral health system and the implementation of integrated care principles.

- ✓ Co-occurring disorders are to be expected in all behavioral health settings. System planning should address the need to serve people experiencing co-occurring disorders and their families in all policies, regulations, funding mechanisms, and programming.

- ✓ Recognizing the need for specialty services such as inpatient psychiatric treatment and detoxification, expanding access to behavioral health services that address multiple substance use disorders and co-occurring disorders should remain a high priority.

- ✓ The values and core practices of both the mental health and addiction fields should inform the integrated behavioral health system.

- ✓ Services should be welcoming, person-centered, and planned and delivered in a way that considers the entire person and all of his or her identified mental health and substance use disorders.

- ✓ Philosophies of treatment should support timely and culturally appropriate treatment of co-occurring disorders. Family members and other sources of natural support should be included in the treatment and recovery process.

- ✓ Evidence-based practices should be implemented whenever possible and appropriate, with emphasis on developing emerging and promising practices into evidence-based practices.

- ✓ Statewide and community prevention efforts should be designed and coordinated in order to address the root causes of mental health and substance use disorders (as well as suicide, violence, and other public health concerns).

- ✓ Stigma associated with all behavioral health disorders, as well as stigma related exclusively to serious mental illness or to addiction, should be addressed to mitigate fear and misunderstanding and promote acceptance and inclusion of individuals experiencing disabilities.

- ✓ The financial and human investment in developing co-occurring disorder capacity should be recognized and continued, so that every publicly funded behavioral health care provider can effectively serve Alaskans experiencing co-occurring disorders.

- ✓ Recovery and peer support services should be responsive to the needs of individuals experiencing and at risk of experiencing co-occurring disorders, as well as their families.
- ✓ The integration of mental health and substance use disorder prevention, treatment, and recovery services should continue to evolve to include services to address the physical health care needs of clients, with a focus on the overall health and wellness of the entire person.
- ✓ Research on the nature of co-occurring disorders and their prevention and treatment should be supported, with a focus on bringing research to practice in a timely manner.

For more information about the Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse, please visit
http://dhss.alaska.gov/amhb/
http://dhss.alaska.gov/abada/

Endnotes

[1] Substance Abuse and Mental Health Administration Treatment Improvement Protocol #42, citing data from the 2002 National Survey on Drug Use and Health.

[2] *Mental Health: A Report of the Surgeon General*, 1999 at 167.

[3] *Mental Health: A Report of the Surgeon General*, 1999 at 167 (*citing* Kessler, R. C. et al.(1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry, 66*, 17-31).

[4] The NSDUH Report: Inhalant Use and Major depressive Episode ad Youths Ages 12-17: 2004 to 2006, August 21, 2009. In most (71.6%) of cases reported, initiation of inhalant abuse occurred at the time of or after the first major depressive episode.

[5] The NSDUH Report: Nonmedical Stimulant Use, Other Drug Use, Delinquent Behaviors, and Depression Among Adolescents, February 28, 2008. *See* Figure 3.

[6] A bibliography of peer-reviewed research on the connection between ACEs and substance abuse is available from the Centers for Disease Prevention and Control at http://www.cdc.gov/ace/outcomes.htm.

[7] Alaska Department of Health and Social Services FY14 Budget Overview at 120.

[8] The illicit drug most often reported by alcohol drinkers was marijuana. The NSDUH Report: Concurrent Illicit Drug and Alcohol Use, March 19, 2009.

[9] The NSDUH Report: Concurrent Illicit Drug and Alcohol Use, March 19, 2009. *See* Figure 4.

[10] Substance Abuse and Mental Health Administration Treatment Improvement Protocol #42 (*citing* Flynn P.M., et al. (1996) Comorbidity of antisocial personality and mood disorders among psychoactive substance-dependent treatment clients. *Journal of Personality Disorders*. 10(1):56–67).

[11] *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*, 2001.

[12] E.g. Westermeyer, J. & Peake, E.: A ten year follow-up of alcoholic Native Americans in Minnesota. (1983) *American Journal of Psychiatry*, 140, 189–194 at 194. ***See also Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*** Chapter 4 Mental Health Care for American Indians and Alaska Natives.

[13] Alaska Violent Death Reporting System, 2003-2008 – August 2011 at 14.

[14] The NSDUH Report: Concurrent Illicit Drug and Alcohol Use, March 19, 2009. *See* Figure 3.

[15] *Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities*, 2009. Institute of Medicine.

[16] Early screening for childhood mental health and behavioral concerns was also identified as a strategy for preventing onset of co-occurring disorders by the President's New Freedom Commission in Mental Health. The President's New Freedom Commission on Mental Health Report (2003) at 17.

[17] *Mental Health: A Report of the Surgeon General*, 1999 at 18.

[18] Minkoff, K. Best Practices: Developing Standards of Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders. (2001) *Psychiatric Services*. 52:5 at 598-599. ***See also*** *Overarching Principles to Address the Needs of Persons With Co-Occurring Disorders.* SAMHSA Center for Co-Occurring Excellence, 2006 at 4.

[19] *Overarching Principles to Address the Needs of Persons With Co-Occurring Disorders,* SAMHSA Center for Co-Occurring Excellence, 2006 at 3.

[20] *Understanding Evidence-Based Practices for Co-Occurring Disorders*, SAMHSA Center for Co-Occurring Excellence, 2007 at 3-4.

[21] Minkoff, K. Best Practices: Developing Standards of Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders. (2001) *Psychiatric Services*. 52:5 at 598.

[22] The President's New Freedom Commission on Mental Health Report (2003) at 7.