

**Is it feasible to integrate mental health promotion
and addiction prevention within the Indiana
Division of Mental Health and Addiction?
Desirable, yes. Feasible, yes. Necessary, yes.**

**Prepared for the
Transformation Work Group
Division of Mental Health and Addiction
Indiana**

Robert M. Levy

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Is it feasible to integrate mental health promotion and addiction prevention within DMHA? Desirable, yes. Feasible, yes. Necessary, yes.

Section I: Project description, executive summary, and recommendations

Prologue

The report of the *President's New Freedom Commission* released in July 2003, identified fragmentation as one of the most critical issues facing behavioral health services throughout the United States. Regardless of the evidence-based programs that promote mental health and strengthen personal assets to resist substance abuse, promotion and prevention programs are not integrated into most behavioral health systems. The Commission called on the federal government and the states to conduct comprehensive planning to address behavioral health fragmentation.

The Commission's report (p. 4) also states: *"For consumers of all ages, early detection, assessment, and links with treatment and supports will help prevent mental health problems from worsening."*

One response to the *President's New Freedom Commission* was that the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) requested proposals in 2004 to provide funds to states to transform their behavioral health care systems. The purpose of the funding was to develop *"Comprehensive Mental Health Plans To Be Implemented. Grantees will create, implement, evaluate, and sustain statewide Comprehensive Mental Health Plans that build a solid foundation for delivering and sustaining effective mental health and related services. Grantees have considerable flexibility, but the Plan must take a cross systems, life span approach, and it must contain a continuum of promotion, prevention, early intervention, treatment, and recovery services for the grantee's entire population."*

Indiana was not one of the nine funded states; however, the Indiana Division of Mental Health and Addiction has proceeded with its own Transformation initiative of which this project is a part.

Within Indiana's Division of Mental Health and Addiction (DMHA) there is the Bureau of Mental Health Promotion and Addiction Prevention, i.e., structural integration. However, structural integration does not necessarily mean functional integration. The purpose of this document and project is to explore the feasibility of functional integration.

In October, 2007, John Viernes, SSA Director, requested technical assistance from CSAP to study the feasibility of integrating mental health promotion and substance abuse prevention. He wanted to include the information in a strategic plan the SSA hoped to develop by September, 2009. The State requested that Dr. Robert Levy serve as the consultant. (Although John Viernes left DMMHA in November 2008, the project

has continued to be supported within the Transformation Work Group and by the current SSA, Diana Williams.) Work on the study was done in 2008 and 2009.

Although the “charge” for this project was to study the integration of mental health promotion and substance abuse/addiction prevention, the charge must be considered in the broader context not only of mental health and substance abuse/addiction services but also of health services in general. Current national discussions and efforts toward national health care reform, with their emphasis on wellness, public health, integration, and prevention further support the timeliness of integrating mental health promotion and substance abuse/addiction prevention in Indiana.

An environmental scan/literature review was conducted, June to September 2008, to establish the national and international context and to help frame the discussion for Indiana. Interviews were conducted with twenty-six key informants, November 2008 to March 2009, both within and outside Indiana to inform the discussion and to begin vesting ownership within representative stakeholders. The detailed results of these are presented in Sections II and III, respectively.

Executive Summary and Recommendations

The environmental scan and literature review was not comprehensive; however, it was sufficient to provide guidance to Indiana. Several points emerge:

- The prevalence of co-occurring disorders on the treatment side, together with the evidence for the primacy of mental health disorders, reinforces the logic to integrate mental health promotion and substance abuse/addiction prevention.
- State, national, and international works identify common issues: silos, funding, collaboration, fragmentation, public policy, workforce development and training, cultural issues, evaluation, consumer and family involvement, etc.
- Mental health promotion is a more central part of the health agenda among the European Union countries and others such as Australia and New Zealand.
- The development of evidence-based practices legitimizes promotion and prevention efforts.
- There were no explicit discussions of the processes for integrating mental health promotion and substance abuse and addiction prevention. However, it might be considered as implicit in the discussions of the public health model, whether at SAMHSA or within several state organizations as well as discussions outside the United States.
- The discussions reflected in the minutes of the SAMHSA National Advisory Council cited below could lead to the development and adoption of policies that are intentional with regard to integration and the entire continuum of care and, in turn, to addressing the challenges/barriers that funding raise.
- Finally, there is no “how to” manual for accomplishing the integration.

The key informant interviews suggest:

- All key informants support integration. Generally they supported a high “ideal” level of integration, although for some their perceived “attainable” level was less. There is always a need for specialized services. Many informants were from

treatment perspective, which was reflected in their responses.

- Funding, silos, cultural differences, etc. are highlighted barriers to integration.
- Treatment drives the DMHA system. The current and future *raison d'être* for mental health promotion and substance abuse/addiction prevention must be seriously considered.
- Leadership and recognition that change takes time are fundamental.
- The challenge of workforce development is integral to overcoming cultural barriers as well as the need for cross training, and the necessary changes in the curricula in general to meet the needs of workers in an integrated system, whether for mental health and addiction treatment or mental health promotion and substance abuse/addiction prevention or, better yet, in a totally integrated system built on a wellness model that includes all aspects of health.

The feasibility recommendation

Desirable, yes. Feasible, yes. Necessary, yes. The model for integration envisions starting with the population served and, second, the delivery of services—a continuum of care. The ultimate goal is to improve the quality of life for the citizens of Indiana. To this end, change must be tied to outcomes and, where appropriate, to the SAMHSA's National Outcome Measures (NOMs).

The barriers identified in the environmental scan/literature review and in the key informant interviews are non trivial. However, these barriers can be addressed with sufficient commitment and leadership. The single most important requirement may well be to adopt a public health wellness model rather than a disease-oriented treatment model and to develop the concomitant policy and organizational development that also overcome the funding-based, but artificial, silos. For example, rather than an Addiction Planning Council, organized into separate units for Addiction Treatment and Addiction Prevention, there might be a Wellness Planning Council that incorporates the entire continuum of care.

Workforce development is essential because:

- To work in an integrated environment will require new roles for providers, for example, both treatment and mental health promotion or addiction prevention.
- To work in an integrated environment new knowledge and skills are necessary
- To overcome the existing work-related cultural differences requires a spirit of cooperation and collaboration as well as mutual respect and patience.

However, workforce development must be prescient, meeting and anticipating future needs, not simply modifying what has been done in the past. To be effective and efficient, the curriculum and pedagogy are both critical (some people use the term “andragogy” to refer to learning strategies for adults and “pedagogy” to use those for more traditional age students). The Workforce Development Workgroup, which the Transformation Work Group established in February 2009, is an important first step toward addressing this central issue that crosses all areas of health care. In addition to identifying current and anticipated workforce needs, it can help identify the current and anticipated knowledge and skills, such as cross-training and collaboration, to serve people in an integrated services model.

Funding silos, especially at the federal level (for example, SAMHSA), are a frequently-cited barrier. To anticipate a later sentence, “SAMHSA’s National Advisory Council’s 2008 meeting minutes propound integration and may well portend the future national policy direction.”

Possible immediate and intermediate next steps for DMHA to move forward

- Immediate
 1. Mission and Vision
 - Review and, as necessary, align the mission and vision of DMHA with an integrated services model
 - Establish immediate, intermediate, and long-term goals within the context of the mission and vision. For example, short-term goals might be those that can be achieved administratively, while intermediate and long-term goals would be those that require legislative support or federal-level changes.
 - Communicate to and engage stakeholders
 2. Build ownership
 - Identify leadership and establish commitments and responsibilities
 - Continue to develop stakeholder vesting
 - Communicate, engage, ...communicate, engage...
 3. Structural considerations
 - Review and make recommendations with regard to the current structural organization of DMHA to determine its compatibility with an integrated services model. (For example, the State of Washington has proposed, within a public health model, an organization based on five age-related populations: Children Birth to Five, School-Age Children, Youth in Transition to Adulthood, Adults, and Older Adults.)
 4. Address the barriers: Identify and evaluate barriers to determine how they might be addressed
 - Is the barrier policy-based, culture-based, habit-based, or legal-based?
 - Prioritize the barriers to address in terms of the effort, expense, and risk vs. potential gain
 - The funding barrier is a major challenge. The creative braiding, blending etc. of funding may be an intermediate step; however, in the long run the funding sources, especially from the federal government, must set the expectations for integrated services.
 5. Establish outcomes and an evaluation framework for an ongoing DMHA function.
- Intermediate
 6. Align programming within structural organization of DMHA
 7. Support through funding, staffing, and organization
 8. Incorporate evaluation as an ongoing DMHA function

Section II: The Environmental Scan/Literature Review can inform Indiana's project

The purpose of the environmental scan/literature review was to provide a context for Indiana's initiative. Although the review was not comprehensive, it is sufficient to capture the essence of current discussions and to provide guidance for Indiana. (Quotations from relevant documents are used to convey the information.)

In 2004 the National Association of State Mental Health Program Directors issued their *Position Statement on the Integration of Public Health Promotion and Prevention Strategies in Public Mental Health*, which is reproduced in Appendix D. It does not explicitly prescribe the integration of mental health promotion and substance abuse/addiction prevention, possibly because mental health and substance abuse/addiction are organizationally separate in many states. However, the statement does explicitly link prevention with "conditions commonly associated with mental illness including medical illness, substance abuse and trauma." Furthermore, it refers to the cost-effectiveness of prevention relative to treatment and that "public health promotion and prevention are best practices for increasing positive functioning and resilience, decreasing the risk of developing mental illness, and facilitating recovery." (Leadership for the National Association of State Alcohol/Drug Abuse Directors and the National Prevention Network, who were contacted in May 2009, indicated that the organizations did not have comparable position statements.)

The June 2008 Mental Health America annual conference included "The Inaugural Promotion and Prevention Summit." There were several discussion of the project leading to the Institute of Medicine's 2009 publication *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. The Executive Summary states "No concerted federal presence or clear national leadership currently exists to advance the use of prevention and promotion approaches to benefit the mental health of the nation's young people. (p. 5)" The Report Brief for Researchers, published March 2009, states "The report calls on national, state, and local leaders to make the prevention of MEB (mental, emotional, behavioral) disorders and the promotion of mental health among young people a priority (p. 2)" and further states The mental health research spectrum should include not just the prevention of MEB disorders, but also a focus on wellness—the promotion of mental health (p.2)." The Conference also included presentations reflecting the global perspective and initiatives around mental health promotion.

Global initiatives

The World Health Organization (WHO) defines health as "A state of complete physical, mental and social well-being, and not merely the absence of disease". "Mental Health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the definition of health."

"National mental health policies should not be solely concerned with mental health disorders, but also recognize and address the broader issues which promote mental health... This requires mainstreaming mental health promotion into policies and programmes in government and business sectors including education, labour, justice,

transport, environment, housing, and welfare, as well as the health sector. Particularly important are the decision-makers in governments at local and national levels, whose actions affect mental health in ways that they may not realize (WHO Fact sheet #220, 2007)."

In 2005 WHO published the extensive report *Promoting Mental Health: Concepts, Emerging Evidence, Practice*, which, as stated in the Forward "tries to arrive at a degree of consensus on common characteristics of mental health promotion as well as variations across cultures. It also positions mental health promotion within the broader context of health promotion and public health. The evidence provided for the health and non-health interventions for mental health benefits is likely to be useful to health policy planners and public health professionals. The emphasis, however, is on the urgent need for a more systematic generation of evidence in the coming years, so that a stronger scientific base for further planning can be developed."

WHO also defines the distinction between prevention and promotion in mental health.

"The distinction between health promotion and prevention lies in their targeted outcomes. Mental health promotion aims to promote positive mental health by increasing psychological well-being, competence and resilience, and by creating supporting living conditions and environments. Mental disorder prevention has as its target the reduction of symptoms and ultimately of mental disorders. It uses mental health promotion strategies as one of the means to achieve these goals. Mental health promotion when aiming to enhance positive mental health in the community may also have the secondary outcome of decreasing the incidence of mental disorders. Positive mental health serves as a powerful protective factor against mental illness. However, mental disorders and positive mental health cannot be described as the different ends of a linear scale, but rather two overlapping and interrelated components of a single concept of mental health (Detels et al., 2002)."

The World Federation for Mental Health (WFMH) was founded "To advance, among all peoples and nations, the prevention of mental and emotional disorders, the proper treatment and care of those with such disorders, and the promotion of mental health." In 2006 it established the "Office for the Promotion of Mental Health and Prevention of Mental Disorders" to bring together the work that had been carried out in various programs. The WFMH's most recent contribution to the discussion of mental health promotion is the series of four World Conferences it has cosponsored, which have led to the corresponding publications:

1. Mrazek, P. J., & Hosman, D. M. H. (Eds.) (2002). *Toward a strategy for worldwide action to promote mental health and prevent mental and behavioral disorders*. Alexandria, VA: World Federation for Mental Health
2. U.S. Department of Health and Human Services. (2004). *Developing partnerships: Science, policy, and programs across cultures. Proceedings of the Second World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioral Disorders*. Rockville, M.D: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

3. Berger, E., Ed. (2005). *From Research to Effective Practice*. Proceedings of the Third World Conference on the Promotion of Mental Health and Prevention of Mental and Behavioral Disorders, September 15-17, 2004. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
4. The fourth conference was held September 2008 in Melbourne. The Promotion of mental health and prevention of mental and behavioral disorders: From margins to mainstream.

The European Union published the second edition of a paper that presents an overview of the 17 individual countries of the Union's mental health promotion and mental disorder prevention efforts in 2006. The paper's preface states *"Positive mental health is an integral part of the health and well-being of the citizens of Europe. In the European Union, mental ill health is one of the leading causes of disease burden. (Llopis & Anderson, 2006, preface)."*

A valuable Australian resource is Auseinet at <http://auseinet.com>. The website "Australia Network for Promotion, Prevention and Early Intervention for Mental Health" provides up-to-date information and resources on "policy, research, projects and activities in relation to promotion, prevention and early intervention (PPEI) for mental health."

The scan of global activities has shown that in various sectors of the world, there is significant evidence of the utility of an integrated model. The Global Consortium for the Advancement Promotion and Prevention in Mental Health's "Vision 2020" statement captures this perspective:

All nations promote state-of-the-science policies, interventions and research for mental health promotion and the prevention of mental and behavioral disorders as integral to overall individual, family and societal health.

State Initiatives

Several domestic transformation plans were reviewed. The plans and materials provide insight into the issues that the states considered fundamental as they go forward.

- **Alaska.** *"The (Department of Health & Social Services) DHSS Division of Behavioral Health has been integrating the two former DHSS systems that provided community mental health and community drug and alcohol treatment into a single behavioral health system. In addition the BHIP project has worked extensively to develop co-occurring capability ... throughout the behavioral health service system. ... The goal ... is to develop a behavioral health services system that is welcoming, accessible, integrated, comprehensive and continuous, at a client, consumer, clinician, program and system level (p.78)."*
- **Connecticut.** *"There was consensus to consolidate our efforts as we move forward by focusing on four domains: 1) increasing consumer and family involvement, 2) using data to evaluate effectiveness and inform practice, 3)*

educating the community about mental health and transformation, and 4) training the workforce (p.2)."

- **Hawaii.** *Hawaii is following the Public Health Model to develop their Comprehensive Mental Health Plan. One of the seven Transformation Workgroup (TWG) Subgroups help assure broad community and stakeholder input (p. 1): is Promoting & Understanding Mental Health*
- **New Mexico.** *The Vision from their Behavioral Health Strategic Plan is "A single behavioral health service delivery system in New Mexico in which behavioral health consumers are assisted in participating fully in the life of their communities; the support of recovery and development of resiliency are expected; behavioral health is promoted; the adverse effects of substance abuse and mental illness are prevented or reduced; and available funds are managed effectively and efficiently." Three of their five goals, which are relevant to the Indiana project are: "Promote Behavioral Health," "Develop the Behavioral Health Workforce," and "Manage Available Funds Effectively and Efficiently (Excerpt, 3/30/2007 draft, p. 1-2)"*
- **Ohio.** Themes and Selected Goals for Ohio's Mental Health Care System that are relevant to the Indiana project:
 - Theme 1: System Financing Reform:– Re-engineer System Financing*
 - Theme 2: Cross-System Integration & Coordination:– Integrate Physical and Behavioral Health, Establish Partnerships for Prevention, Use Data for Improvement, Implement Strategies for Technology*
 - Theme 3: Access to a Continuum of Appropriate Services:– Increase Public Information to Reduce Stigma, Establish Prevention as a Cornerstone, Promote Early Screening, Address Workforce Issues*
 - Theme 4: Quality, Evidence-Based Practices & Positive Outcomes:– Expand Evidence-Based Practices, Develop Partnerships for Plans of Care (p. 3-4)"*
- **Oklahoma.** *Section I – "Focuses on Oklahomans understanding that being free from addictions and having good mental health are essential to overall health. Stigma elimination and suicide prevention activities are highlighted. Stigma is a tremendous challenge to improving understanding of the importance of mental illness and its influence on physical health. People may not seek care because of the social stigma that is associated with the label of "mental illness". ..."*

Strategies in Section I include:

- *Developing a broad based public information strategy to reduce the stigma associated with mental health and substance abuse treatment and increasing public knowledge that recovery is possible,*
- *Working with post-secondary training programs in a manner to reduce stigma, increase interest in working in the substance abuse and mental health fields, and expand the understanding of recovery and related best practices (excerpt, p. 4-6)."*

- **Texas.** The Vision for behavioral health in Texas (Update, 2007, p. 7)

From Current System	To Transformed System
1. Persons Receiving Services	1. Population-Based; Early Intervention
2. Intra- and Inter-Agency “Silos”	2. Coordinated “No Wrong Door” Care
3. Piecemeal, Fragmented Training	3. Workforce Development Infrastructure
4. Data Compartments	4. Data Sharing and Coordination
5. Consumer and Family Involvement	5. Consumer and Family-driven
6. Falling through Agency “Cracks”	6. Seamless Continuity of Care

- **Washington State.** *“Listed below are projects, the majority of which began in year two of the transformation grant. The examples are illustrative yet show the breadth and depth of activities related to mental health transformation in the state of Washington and the inclusion of intent to integrate services for mental health and substance abuse as well as in other arenas (excerpt, Update 2007, p. 2-5).*

*Primary Care/Mental Health Linkages
Prevention/Early Intervention/Screening
Training
Evidence-Based Practice
Coalition Building
Policy Analysis Activities”*

“In September of 2006, WA submitted to SAMHSA its CMHP (Comprehensive Mental Health Plan). Acknowledging that the public mental health system was in crisis, the CMHP identified key barriers to quality services, such as insufficient leadership to foster meaningful collaboration across agencies, the need for broader understanding and legislative action related to public/private mental health care crossover issues, and inadequate strategic planning involving key stakeholders.

*In short, the CMHP proposes legislative and administrative changes to improve the existing mental health system. **At the same time, the CMHP proposes developing a new system of care using a public health model with focus on prevention, early intervention, wellness, and integration of primary health and mental health services** (Excerpt, Update 2007, p. 1).”*

The plan is described in detail in “Mental Health—A Public Health Approach: Developing a Prevention-Oriented Mental Health System in Washington State.” December 31, 2007, Department of Health Services. They propose, within a public health model, an organization based on five age-related populations: Children Birth to Five, School-Age Children, Youth in Transition to Adulthood, Adults, and Older Adults.

- **Wisconsin.** The State recently (September 23, 2008) issued a Joint Statement: “The Integration of Physical Health, Mental Health, Substance Use, and Addiction.” It reflects Wisconsin’s plans “To enhance collaboration our Divisions are working within a common framework; sharing values, principles, priorities;

and strengthening organizational efforts as a commitment to change. (p. 1)” They define integration “is the creation of linkages between traditionally separate systems, services, resources, people, or processes; making connections. (p. 2)”

Key Lessons from the State Plans

Taken together, the states’ transformation plans and their experiences inform and guide recommendations for this document and for Indiana’s integration initiative. Three points from the excerpts above are especially relevant.

1. Texas’ characteristics of the “Present System” summarize essential barriers within mental health and addiction systems. The “Transformed System” is an essential goal for success and is reflected in several of the excerpts from other states.
2. Washington State’s proposal to develop a “*new system of care using a public health model with focus on prevention, early intervention, wellness, and integration of primary health and mental health services*” importantly emphasizes primary care integration as one way to focus on prevention. More important, in the December 2007 document, they explicitly propose the public health model.
3. The Wisconsin Joint Statement proposes explicitly to integrate physical health, mental health, substance use, and addiction.

What is SAMHSA saying about integration?

Excerpts from the minutes for the March 12, 2008 and September 8, 2008 SAMHSA National Advisory Council meetings are reproduced below (**bold** was added for emphasis).

From the March 12 minutes:

Dr. Cline (Terry L. Cline, Ph.D., Chair, SAMHSA National Advisory Council and Administrator, SAMHSA at the time) stated that the **agency embraces a public health approach** in providing a comprehensive continuum of services from prevention to more acute services to recovery and to maintaining recovery. SAMHSA also focuses on **integrating mental health with primary health care systems** and other practitioners at the Federal, State, and local levels.

Dr. Cline emphasized the **need for moving interventions upstream—concentrating to a greater degree on prevention**—while simultaneously continuing SAMHSA’s mission to serve persons with severe mental health and substance abuse problems.

The Council recommended that SAMHSA support a sustained, intense focus on health promotion, prevention of mental health and substance use conditions, and early intervention structures and strategies through significant investment and collaboration with the public and private sectors for populations throughout the lifespan.

From the September 8 minutes in which a series of interviews were reported on:

“Dr. Broderick (SAMHSA Acting Administrator at the time) and Kana (Kana Enomoto, SAMHSA Acting Deputy Administrator at the time) are particularly interested in making sure that we have an elementary macro level dialogue that talks about health systems

broadly. Make sure there is room for **prevention** in these conversations, lots of context, how do we keep a healthier nation, healthiest nation if you use the CDC language about that.

Many of you have already remarked this morning about **integration**. We know for this first conversation, elevating the role of behavioral health and overall health. Positioning SAMHSA in a changing health environment that **integration** needs to be.”

“I think to a person in the interviews, **all of you mentioned how important it was to talk about integration, integrating mental health and substance abuse services in overall health, leveraging non-traditional partners, key financing levers.**

So focusing on this first one, here are three selected quotes from my interviews with you. There is no attribution that was given. **We must shift to a public health approach model, concerned and focused on wellness.** We have got to use this as an opportunity to move substance abuse and mental health prevention on the public discourse on health system.”

The emphasis on integration reflected in the minutes of SAMHSA’s National Advisory Council, especially the remarks of the Administrator, are likely indicative of the direction future national policy statements will take, which gives weight to the other statements in this document.

Two informing factors

Evidence-based practices are becoming the expected norm in health services throughout the continuum of care. The preponderance of and challenges of treating Co-occurring disorders has taken center stage within the mental health and substance abuse/addiction arenas. These two factors have an impact on the integration of mental health promotion and substance abuse/addiction prevention, which is briefly addressed below.

Evidence-Based Practices:

No single advance may be as important for all aspects of health related programs and services as the development and implementation of “evidence-based practices” (EBP) whether mental health promotion, mental disorder prevention, substance abuse prevention, or, for that matter, any health related program, policy, or strategy.

Jane-Llopis and Anderson (2006) present an informing overview from a global perspective. “The European IMHPA Network (www.imhpa.net) aims to develop a comprehensive strategy to tackle prevention and promotion in mental health, developing an integrated approach to information, intervention, training, policy, advocacy and implementation, combining the support for policy priority-setting with the dissemination of tools and evidence-based knowledge (p. 8).”

SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP) is a searchable data-base of interventions for the prevention and treatment of mental and substance use disorders. The five searchable topics are:

- Co-occurring disorders
- Mental health promotion

- Mental health treatment
- Substance abuse prevention
- Substance abuse treatment

As of September 16, 2008 45 interventions are listed for Mental health promotion and 41 Substance abuse prevention. Of these 18 interventions are on both lists. In other words, if the same programs are designed (and approved) to serve both functions, there must be an underlying model that supports integration, e.g., risk and protective factors. Evidence-based practices are the coin of the realm(s).

Co-occurring Disorders:

One impetus for integration at the treatment level has been the preponderance of co-occurring disorders. The Center for Substance Abuse Treatment's Co-Occurring Center for Excellence (COCE) Overview Paper 8, (2007) provides epidemiological information on co-occurring disorders, substance use and mental disorders. They estimate that there are, conservatively, 5.2 million adults with co-occurring disorder. Of these 53% receive no treatment, 34.3% receive only treatment for mental health problems, 4.1% receive substance use treatment only, and 8.5% receive treatment for both mental health and substance use problems. Clinicians indicate that 50-70% of the adults seeking help have a co-occurring disorder.

On page 4 of the COCE paper there is a statement that goes to the heart of the relationship between mental health promotion and substance abuse and addiction.

“One important preliminary finding from currently available studies is that the onset of a diagnosable mental disorder often precedes the onset of a diagnosable substance use disorder. For the majority, adolescence marks the onset of primary mental health disorders, with substance use disorders occurring some 5 to 10 years later, during late adolescence and early adulthood (Kessler, 2004, p. 731).”

Recent neuroscience research suggests that a common mechanism may underlie co-occurring disorders. For example, a December 2, 2007 press release from the American Psychological Association cited an animal research finding that a common cause may be involved (in the study it was because of surgically induced developmental changes in the amygdala).

The interviews with key informants further reflected this reality. Basically, if the treatment needs to be integrated, shouldn't the “antecedent” mental health promotion and substance abuse/ addiction prevention also be integrated?

Informing the Indiana Integration Feasibility Study

Several points emerge from the environmental scan and literature review:

- The prevalence of co-occurring disorders on the treatment side, together with the evidence for the primacy of mental health disorders, reinforces the logic to integrate mental health promotion and substance abuse/addiction prevention.

- State, national, and international works identify common issues: silos, funding, collaboration, fragmentation, public policy, workforce development and training, cultural issues, evaluation, consumer and family involvement, etc.
- Reflecting a public health model and the cost benefits, mental health promotion is a more central part of the health agenda among the European Union countries and others such as Australia and New Zealand. However, it should be noted that the United States has been a leading participant in the global discussions, with HHS through NIH, NIMH, and SAMHSA also providing financial support.
- The development of evidence-based practices legitimizes promotion and prevention efforts.
- There were no explicit discussions of the processes for integrating mental health promotion and substance abuse and addiction prevention. However, it is implicit in the discussions of the public health model, whether at SAMHSA or within several state organizations as well as discussions outside the United States.
- The discussions reflected in the minutes of the SAMHSA National Advisory Council cited above could lead to the development and adoption of policies that are intentional with regard to integration and the entire continuum of care and, in turn, to addressing the challenges/barriers that funding raise.
- Finally, there is no “how to” manual for accomplishing the integration. However, the Annapolis Coalition’s 2007 *An Action Plan for Behavioral Health Workforce Development: Executive Summary* (and full document) is a valuable resource in addressing workforce development, one of the frequently cited barriers and needs with regard to integration.

Section III: Key informant interviews

The key informant interviews are a critical component of the Feasibility Project. On the one hand, they provide information and a measure of sentiment; on the other hand, they are a step toward vesting ownership within a key set of in-state stakeholders and decision makers.

Method

Questionnaire: The questionnaire was developed with the assistance of Rebecca Smith (Chair, Prevention Committee of Addiction Planning Council) and Dave Bozell (Indiana NPN representative [National Prevention Network] and DMHA Bureau Chief for Mental Health Promotion and Addiction Prevention), and reviewed by Elaine Rogers (CSAP, Regional Services Manager). A common set of questions was used for both in-state and out-of-state respondents with, however, a few supplementary questions for out-of-state respondents. The questions addressed:

The meaning of integration to the respondent;

The ideal and attainable levels of integration;

Perceived barriers to integration and how to address them;

Workforce development and culture issues at the state and provider levels;

The impact of co-occurring disorders and evidence-based practice to inform the discussion of integration;

The “one thing” that must be done for successful integration.

The complete questionnaire is included as Appendix B.

Interviewees: A preliminary pool of interviewees was generated with John Viernes (formerly SSA, Indiana DMHA) and Dave Bozell. Others were added in conversation with Cathy Boggs formerly Director, Indiana DMHA). Still others were solicited at a Transformation Work Group meeting and at Advisory Panel meetings. Elaine Rogers provided a list of the Single State substance abuse authorities that have behavioral health units or substance abuse and mental health in the same organizational unit so Indiana could identify some State representatives to contact for possible interviews.

Eight interviewees were out-of-state, three were state NPN representatives (National Prevention Network), two were national leaders in minority coalitions, one was a former NPN, one headed a state transformation work group project, one is a major researcher on co-occurring disorders. Eighteen interviews were conducted with Indiana informants, one of which was a pilot interview. Five were DMHA staff including the Director of Consumer and Family Affairs, four were prevention program providers, three were treatment providers, three were academic researchers, one the director of a mental health advocacy organization, one is within a related state agency providing prevention services, one chaired a primary care integration initiative. Additional targeted interviews, with a modified questionnaire, will be conducted as the occasion or need arises.

Interviews: Following one pilot telephone interview, twenty-five telephone interviews were conducted with key informants within and outside Indiana. Each interview took 15 to 75 minutes, most lasted approximately 45 minutes. Each interview began with a review of its purpose and “small talk.” Interviewees were emailed the questionnaire ahead of time. During the interview a second person was on the line in order to take notes. Levy read all questions and also took notes. The two sets of notes were then reviewed and integrated to a single set for use in data analysis.

Results and Discussion

With one exception, the data were qualitative. The responses to each question were analyzed for how they would inform the feasibility discussion, for example, recurrent themes. The responses from the pilot interviewee are included where appropriate. For the specific questions that were asked, results are organized around the recurrent themes and with supportive comments underlying the emergent theme.

1. What does the term integration suggest to you? Respondents indicated that integration would focus on the whole person, a continuum of care; that the service systems, i.e., bureaucracy and funding, would be coherent; that service providers would reflect integration in their training; that in fact, integration should be underlying model for all services.

The themes and related comments in quotation marks, some of which are very similar or duplicates but from different respondents, are included:

- The people served: “continuum of care,” “meet whole person needs,” “look at individual as whole,” “healthy community,” “In the community,” “Primary care integration-benefit the patient,” “continuum of care,” “foundation for health,” “foundation for health,” “entire system coherent-holistic approach,” “substance abuse problems often correlated with early mental health problems.”
- Bureaucratic considerations and funding: “bureaucratic integration (working together) – blend funding,” “needs to occur at all levels, advocacy, funding, services, culture,” “same funding sources,” “same leadership,” “integration at leadership, policy, and financing domains”
- Workforce development: “prevention and treatment staff function as one,” “cross training professionals-treatment and promotion/prevention,” “workforce cross trained”
- It’s the only way to go: “cannot talk about one without the other, go hand in hand,” “publically not differentiate mental health and substance abuse services, talk global behavioral health,” “needs to occur at all levels,” “mental health promotion and substance abuse prevention are the same thing,” “treatment and prevention together,” “one voice,” “foundation for health,” “whatever services are provided should be integrated.”

2. Have you experienced such functional “integration” at any organizational level?

Respondents’ experiences with integration varied from none at all to some in practice to a major perspective at a state level.

- Some in-state treatment-focused interviewees related integration to the treatment of co-occurring disorders or a single program, one respondent is integrating treatment provider and prevention provider roles. Prevention providers had no or little experience with integration.
- In-state administrators ranged from “never the twain shall meet,” experienced within another state agency, new leadership reorganizing and consolidating-integrating, examples of primary care integration, integration of public policy and advocacy.
- Out-of-state (with one exception from state or national perspective). Some experience with integrating treatment administration; functionally integrated division, has blended, braided and pooled prevention and early intervention funding; single state authority working to integrate, tries to bridge mental health and substance abuse, slowly building promotion side; Healthy People 2010-2020 emphasizes integration, use of SBIRT for screening has integration qualities, important piece is evidence-based practice; more at program level than policy level, more holistic approach among Latinos; many are providing services and programs that on further analysis could be considered integrated.

3. What one thing must be done to ensure successful integration? Three themes emerged: 1) leadership that is committed and can communicate effectively, 2) workforce development that will build professionalism and collegiality to support integration, and 3) the need to educate and communicate to vest ownership with stakeholders, including the public.

The related comments for the themes included:

- Leadership: “commitment of FSSA Secretary,” “perseverance, 10-15 year

process,” “Every CEO (CMHC) treat both mental illnesses and substance abuse,” “commitment of leadership at state and provider level,” “leadership, believe in it and get message out,” “SAMHSA level leader, provide mental health promotion grants (CSAP and SAMHSA don’t talk to each other),” “charismatic leadership to pull it together.”

- Workforce Development: “Begins with education and training that is research-based,” “professionalize work force, teach treatment and prevention so prevention not lost,” “communicate across disciplines,” professionals in both areas must develop relationships with each other,” “pay people to behave in integrated way, policy should be the answer but in reality its financing,” “get people to see each other as colleagues in same system regardless of who is managing or paying.”
- Vest ownership/communication: “involve people at the community level,” “clearly articulate what mean, talk about wellness,” “convince people that integration benefits the people served,” “involve community in process,” “share successful integration models,” “must do multiple things, need buy in from people carrying it out,” “ need understand that mental illness and substance abuse are public health issues, all fit under public health umbrella,” get buy in to public health philosophy around prevention.”

4. How do you think the preponderance of co-occurring disorders should inform the discussion of integration?

The short answer is that it reinforces the need for integration for not only the treatment services but for the antecedent intervention opportunities, i.e., mental health promotion and addiction prevention.

- It is the reality
 - Area where few people have handle on true prevalence of co-occurring disorders
 - Data are vital to discussion because it validates why it is so important.
 - Individuals rarely have one disorder or condition, which makes it difficult for individual providers to handle all the problems so integration works better than referral
 - Its what we see
 - More common than it isn’t, no wrong door.
 - No brainer. Co-morbidity is the norm. Look at any area of integration, every single place looked at worked better.
 - Prominent in all discussions, segregation into discrete issues is artificial. Outside U.S. launching early intervention project, how not talk about substance abuse, they are intertwined. There should be education of DMHA staff, recognition of integration not isolation of it.
 - Vital to hear that voice
- Better services
 - Billing is difficult, constantly being forced to choose in terms of treatment
 - Frustrating when try to separate MI and SA for treatment payment purposes
 - It makes the point. Treating one without the other is not successful
- Implicit for integration, at the core
 - It is essential. You cannot talk about mental health or substance abuse

without recognizing that they go hand-in-hand.

- At the very core - informed by most recent research that suggests that rather than one causing the other or as independent entities there is a neurobiological substrate that occurs and both need to be addressed simultaneously
- Educate folks on the risk and protective factors and instances of co-occurring disorders and how best practices can impact outcomes.
- Has a great deal to do with discussion of integration.
- It should fully inform the discussion because the hard evidence is good. Clear data looks to inform both spheres. Human body is one entire system
- It would be easier and more efficient and positive for integration
- Part of discussion
- Should be a big part of it
- Should be at its core and first thing talked about, co-occurring disorders are the expectation not the exception
- Think it is a major factor. Leading pieces of evidence as to why we need full integration. Patients don't exist with one or the other, they have both
- Think the discussion of integration began here

5. How do you think evidence-based practice might inform the discussion of integration? The respondents strongly expressed the importance of evidence-based practice both for practice per se but also as the means to provide supportive evidence for programs or practice, which helps build credibility for mental health promotion and substance abuse/addiction prevention. However, there are issues of moving from efficacy (a research sample) to effectiveness (general real world samples), the limits of available EBP, may limit additional innovation, etc. In the broadest sense, however, EBP is the gold standard.

- Evidence-based practice is essential, the only way to go, etc.
 - Use research and literature to inform discussion and use NREPP list
 - Types of data and evidence-based programming will be cornerstone as how to move this forward
 - Put the plan together with what has proved to be effective, evidence based
 - Potential to point to outcomes and cost offsets begin to speak language of leadership and legislature
 - People more supportive if actual evidence that it works
 - Need to have evidence that mental health promotion curriculum, programs, and agencies work in communities. Need evidence to get funding
 - It is what informs us. Cornerstone for moving forward with integration
 - It is the essence of it
 - It is critical. How do you take an EBP and translate to what people can physically do, e.g., go from 10 to 500 people
 - Informing and helping. As more done will start helping define mental health promotion. Give people ideas to start with and see folks working and build from there
 - Good spring board since now seeing more development of EBP for

- integrated approaches
- Evidence-based practice is key because the body of research is growing. Raises level of esteem, purpose and identity in prevention field. Get clinical buy in. Helps define prevention
- Everybody has to be brought up to speed on what they are, make sure we have them to use and know how they work
- Decisions should be guided by literature
- Data definitely important
- Always a good thing and something we want to look to and see what is out there
- But, potential issues and limitations
 - Skewed view of world if that's all that is used
 - Not a lot of models of EBP around integration of services
 - Might work against it. Bias against EBP. It may narrow thinking. Good work may go unrecognized because not EBP
 - If going to invest, need to have foundation of EBP but can not let lack of EBP keep us from moving forward
 - Difficult to find research done on primary care integration but everyone agree it's there

6. What is the ideal level of integration and what is the attainable level and why?

These were the only questions that provided quantitative responses—1 representing no integration and 10 complete integration. Thirteen respondents thought that 10 was the ideal level, the rest indicated ideals around 7 or 8. Three thought 10 was attainable, whereas the majority thought five to seven was attainable. Ideals of less than 10 in some cases reflected the belief that there were instances where specialized services were required. The “attainable” level reflected the respondents’ concerns about the perceived barriers, discussed below. Several emphasized that it will take a long time, perseverance, and, most important, “will.”

7. What are three barriers to integration and how might they be addressed? Each interviewee named three barriers (a total of approximately 75) and then described how each might be addressed. The themes summarizing primary barriers and the frequency of their mentioning are presented in the following table. The barriers fit imperfectly into two broad categories: barriers related to changes that can be thought of as related to people and those related to the system.

Barrier themes and the frequency identified	
Theme	Frequency
People change related barriers	
Philosophical/professional/cultural differences; Mental illness vs. Addiction; Mental health promotion vs. Addiction prevention; Resistance to change	20
Lack of knowledge, e.g., what is mental health promotion; public perception, stigma mental illness vs. addiction	15
Training, workforce development	8

Leadership	5
System change related barriers	
Funding (and turf) related	21
Regulations, public policy, system fragmentation	6

How might the barriers be addressed? Except for “Leadership” and “Regulations, public policy, system fragmentation,” the respondents’ suggestions are broken down into themes and their suggestions, which are either verbatim or a close paraphrase. The following suggestions from those interviewed serve to inform barriers and what others have done or might do to address them. Such information serves as a potential guide to Indiana in its implementation of integration.

People change related barriers

Philosophical/professional/cultural differences

- Professional issues
 - Cross training, i.e., the acquisition of a broader set of skills that prepares someone to work more easily in different contexts
 - Education is the thing, the more we work cooperatively the better it is for clients
 - Need state criteria for what it means to be a prevention professional, need a credential that is more clinical and more substantive, more defined training; Not just something to get to obtain grants
 - Training, people in field a long time so need to train
- Public and provider education
 - Blitz of education on what mental health promotion is; Will take time; Bring in new folks with vision, goals, and orientation
 - Come long way with interest in co-occurring disorders; Lot of professionals and paraprofessionals have not received the message, and have not endorsed or accepted it; Need to force further integration into public policy while recognizing concerns from both sides about capability and being able to address them
 - Different groups come together over joint statements of providers
 - Public education
 - Show effectiveness of mental health promotion, bring in people from community to show what will work, collaboration
 - Support education, people who are “changing” have to be listened to and understand rationale and reason for change; Back with data and efficiency
- Cultural change, integration
 - All the players on the same page and agreeing on an overall strategy and tactics to achieve outcomes; Relationship building and trust, raising community’s level of skill; Patience and willingness to work hard for the win-win; Willingness of community to make it a value
 - Help everyone understand how one affects the other; Need responsible care; Cultural change is needed
 - Problem on professional side, not patients; Merge two cultures on every

- level; Neuroscience evidence may help
 - Work together as a unit so all begin to see that everyone plays an important part
- Leadership
 - DMHA foster understanding by working with providers etc. get word out
 - Do it through funding, providers do what paid to do, change services
 - Leadership is the critical piece, spelling out what it means and looks like; Tie funding to change.
 - State needs to work better to bring prevention, intervention, treatment together

Lack of knowledge

- Education about mental health promotion and substance abuse prevention as well as relationship with treatment
 - Education to providers from people who have already done it
 - Get the message out about mental health and addiction, mental health promotion
 - Lack of definition
 - More education; Need to be more of a partnership so prevention works in conjunctions with mental health providers
 - Potential client population has stigma associated with it; Anti-professional view in most 2 step programs
 - Takes repetitive education, on affective level not just intellectual
 - Training, awareness campaign, marketing etc. start conversation
- System related education and change
 - Incorporate prevention into system as significant and necessary component, need to understand how prevention influences outcomes, e.g., lost time on job
 - Increase understanding of evidence-based practice; Professional development, training, research, white papers, youth letters, every communication tool to reach all audiences, well-coordinated strategy
 - State mental health agencies need to take on role of being public health agency and not just funder of services; Resources in Indiana DMHA focus on treatment, especially as resources tightened; MHA and NAMI took on education and promotion
 - Unified approach to educate all stakeholders about the issues and what the goals are

Training and workforce development

- Systemic change
 - Cultural change could take many years; Need training level reorganization and funding; Need more faculty to talk about integration. (Medical school psychiatrists, etc.)
 - Develop cross training so have new army of individuals who can do both or pair experts to work as a team
 - From basic level of training in psychology and psychiatry, addiction disorders treated separately; Elitism; Has to be woven into curriculum

- Tie funding to it; Fund comprehensive behavioral health approach
- Targeted needs and approaches
 - Identify technology transfer centers (Great Lakes, for example), technical assistance from CSAT and CSAP
 - Make cross training a requirement; have specific credential for treating co-occurring disorders with each site having a percent of credentialed staff; After the degree needs to be an intervention to retrain, consider how to get it into curriculum
 - Mental health promotion and substance abuse prevention technical assistance and training

Leadership

- Clear expectations from leadership, if not willing to meet, find a new job (remember this is a interviewee's suggestion); At DMHA make sure that staff know that DMHA aims for evidence-based practice and decisions based on evidence-based practice; Look at and visit other states
- Leadership continuity
- Publically communicate importance of and commitment to mental health promotion
- Consider merging funding for a single state agency, put it all in one pot
- Get rid of poor leadership at all levels; Need leadership that is receptive, knowledgeable, and willing to address integrated system; Federal government needs to convene state leadership to draw attention to the issues

Addressing system change related barriers

Funding

- Silo related comments
 - Begin by developing collaboration and then communicating with federal government and working out how to do the programming without crossing regulations
 - Financing/leadership issue, bring stakeholders together for input
 - Funding is driven by legislators, typically specific issues
 - Funding is siloed, which does not reinforce that treatments should be integrated
 - Funding should provide the services the person needs and not just funded services
 - Through advocacy to get blended funding streams
 - Within SAMHSA, CMHS (Center for Mental Health Services) put money into mental health promotion, have single mental health promotion and substance abuse/addiction prevention
- Use outcomes, etc.
 - Be able to communicate strong outcomes to those holding the purse strings, funding tied to outcomes
 - Discuss cost/benefits, impact of mental health promotion on future treatment costs
 - Encourage collaboration and for SAMHSA to set aside funds for mental health promotion

- Incorporate into planning, demonstrate positive results of prevention
- Through education have the fortitude to make decisions that will shift funds and decision making authority
- Avoid pitfalls
 - Has to be done so that professionals don't see that anything is taken away from them
 - When change system, pump money in to make it plastic during change, ultimately integration is more efficient and cost of care drops

Regulations, public policy, and system fragmentation

- Some regulations limit what funding can be used for or covered; For example, Medicaid clinic services option that that only people who can be served off site are the homeless; Need to review policies and institutions that have been around for years
- State needs to address too much fragmentation
- Different service providers, different training; Need cross training; Recognize the value of the Strategic Prevention Framework; System change

8. What public policy issues might integration raise?

- Services, payment, parity
 - How we deal with substance abuse offenders – legal issues, treatment for kids who get in trouble in school, people who are arrested, varies among communities, involve corrections, who handles what and should they be a part of whole process
 - Make sure that billing codes are equitable and foster integration (the respondent was focused on primary care integration)
 - Parity to fund addictions services
 - Policy issues around stigma, parity; So many people have no coverage
 - Prevalence of co-occurring disorders greater than anyone realizes yet you can not get SSI for substance abuse
 - Problem of the needs exceed the resources, how target services
 - Standards to run a stand alone addiction centers should require mental health care
 - Streamline the work, more efficient and effective
- Funding
 - Assign dollars for prevention
 - Blending funding, impact of two workforces
 - Distribution of tobacco settlement money-correlation of smoking with other problems, possible intersections
 - Need to be pragmatic not ideological
- Time and priorities
 - Connect to priorities of other agencies
 - Prevention and promotion are long term investments, where will the dollars come from for people with serious problems and where does the prevention and promotion money go
 - Priorities and competition for money
 - Problem that funding goes to highest immediate need, need to see

- prevention as a significant need
 - Problem that prevention and promotion take time
 - Training tends to get tracked and specialized; providers tend to follow funding, e.g., SBIRT trains interventions and referrals from general medicine to behavioral health
 - Education and requirements
 - Certification
 - Expectation that training and collaboration will be required, need education campaigns to get buy-in
 - Legislators need to understand issues of cross training and related professions such as police
 - Problem of “I drink, what is the problem?”
 - Promote an environment that promotes mental health and educates about addiction, overcome stigma
9. What workforce development issues at the state level and at the provider level might integration raise? (Some of the respondents were focused on treatment issues)
- Integrated approach
 - Curricula need to be changed; Mental health favors academic training, substance abuse/addiction favors personal experience; State should play a role with educational institutions to change curricula to foster integration
 - Evidence-based practices need to be the norm, inherently “integrated”
 - State needs integrated approach and to insist on integration
 - Training and services related
 - Mental health promotion and prevention need to be viewed as important
 - Need for criteria for prevention professionals, caveat is that certification has its limitations
 - There are already shortages, need 50 psychiatrists, only 6 graduate; psychiatrists not trained substance abuse
 - Who will train the existing workforce, how will it be funded
 - Workforce now treatment focused
10. What work related cultural issues at the state level and at the provider level might integration raise? (Again, some of the respondents were focused on treatment issues)
- Two cultures
 - At state level, desegregate; at provider level to have true integration, need to rearrange the furniture, collocate, build integration into all discussions and agenda
 - At state, historically a division between mental health and addiction, ask people to partner, but it is a new culture; at provider level need to develop a culture of respect for the knowledge that each has and openness to learn what you don’t know, cross training
 - Culture is an issue at the provider level
 - Difference in provider culture-mental health more medical model and formal education, substance abuse more peer to peer education
 - Different level backgrounds lead to friction and disagreements

- DMHA staff understand the issues, providers view the world differently
- Each has its own culture, words, standing, state is segregated at DMHA, bring terms, standards, treatments together at state, grants need to emphasize integration in funding; at provider level “not my patient,” client suffers
- History and belief of how it has always been done and the difference in cultures between addiction and mental health training
- Continuum of care
 - At state level, senior management that never remember to include prevention in documents working on; Develop a culture in state that prevention is a part of it; Integrate within whole division; At provider level, communication, collaboration, and coalition building
 - Need to embrace continuum of care
 - State needs to utilize funding for mental health promotion and not just crises
 - State, understanding the culture of prevention vs. treatment; at the provider level, challenge of billable vs. non-billable hours (if in the community)
- Leadership and education for integration
 - At state level how you bill for things
 - Nature of bureaucracy not conducive to integration; At provider level, everything is supported by old traditional approach, which reflects how they were trained; They will catch up eventually if positive outcomes.
 - State play a role in educating system; at provider level, all kinds of resistance overcome with education and money
 - Territoriality-stakeholders at state invested in protecting turf; Clear leadership incentives and direction for building bridges and merger; Providers feeling under the gun and often react defensively

Informing the Indiana Integration Feasibility Decision

All key informants support integration in spite of the perceived barriers. Some of the recommendations that follow from their responses and experiences are:

- Generally key informants support a high “ideal” level of integration, although for many their perceived “attainable” level was less. There is always a need for specialized services. Many informants were from the treatment perspective, which was reflected in their responses.
- Funding, silos, cultural differences, etc. are highlighted barriers to integration.
- Treatment drives the DMHA system.
- Strong and committed leadership as well as recognizing that change takes time are fundamental.
- The challenge of workforce development is integral to overcoming cultural barriers as well as the need for cross training, and the necessary changes in curricula in general to meet the needs of workers in an integrated system, whether for mental health and addiction treatment or mental health promotion and substance abuse/addiction prevention or, better yet, in a totally integrated

Section IV: The Feasibility of Integration

Desirable, yes. Feasible, yes. Necessary, yes. Integration is feasible, in fact, not integrating is not an option for the long run. Indeed, SAMHSA's National Advisory Council's 2008 meetings' minutes propound integration and may well portend the future national policy direction.

The barriers that were identified in the environmental scan/literature review and in the key informant interviews are nontrivial. However, these barriers can be addressed with sufficient commitment and leadership. Although some states are moving toward an integrated wellness model, countries around the globe are successfully doing so. The single most important requirement may well be to adopt a public health wellness model rather than a treatment model and to work toward the concomitant policy and organizational development that overcome the funding-based, but artificial, silos. A small example might be that rather than having the current Addiction Planning Council, organized into separate units for Addiction Treatment and Addiction Prevention, there might be a Wellness Planning Council that incorporates the entire continuum of care.

Workforce development is essential because:

- To work in an integrated environment will require new roles for providers, for example, both treatment and mental health promotion or addiction prevention.
- To work in an integrated environment new knowledge and skills are necessary
- To overcome the existing work-related cultural differences requires a spirit of cooperation and collaboration as well as mutual respect and patience.

However, workforce development must be prescient, meeting and anticipating future needs, not simply modifying what has been done in the past.

Funding silos, especially at the federal level (for example, SAMHSA), are a frequently-cited barrier. To repeat the earlier sentence, "SAMHSA's National Advisory Council's 2008 meeting minutes propound integration."

As the Indiana Division of Mental Health and Addiction moves forward with strategic planning and with its Transformation Work Group-based initiatives, this study and its recommendations are consistent with and reflect the current impetus for national health care reform and the focus on wellness.

Section V: Appendices

Appendix A – Bibliography and Resource List

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Two updates on the IOM report were presented.

Appendix B – Questionnaire

(Questions for out-of-state respondents only are preceded with OUT)

Date of interview
Interviewers
Last name
First name
Title/Position
Organization
Address
Telephone
Email
Indiana Y/N
Informant, Stakeholder, Decision Maker
Background
Q1. The State of Indiana DMHA is considering the feasibility of integrating its mental health promotion and substance abuse/addiction prevention functions. What does the term integration suggest to you in this context?
Q2. Have you experienced such functional "integration" at any organizational level? If so, please describe.
Q3. On a scale of 1 to 10 with one meaning no integration and 10 meaning full integration, what is your personal view of the ideal level of integration for Indiana DMHA?
Q4aOUT. If your State that has some level of integration, why did the State decide to make that systems change (i.e., cost savings, limited resources, better outcomes, improved service delivery)?
Q4bOUT. If your State that has some level of integration, what outcomes did they intend to impact as a result of that systems change when the system change was being considered and then implemented?
Q4cOUT. If integration has only occurred for MH treatment & SA treatment, why were MH Promotion and SA Prevention not included? Are there plans to expand to MH promotion and SA prevention?
Q5. On the same scale of 1 to 10, what do you think the attainable level of integration would be? Why
Q6. How do you think the preponderance of co-occurring disorders should inform the discussion of integration?
Q7. What are the three major barriers you see to achieve integration of MH Promotion & SA Prevention?
Q7a: Barrier 1
Q7b. Barrier 2
Q7c. Barrier 3
Q8a. How might Barrier 1 be addressed?
Q8b. How might barrier 2 be addressed?
Q8c. How might barrier 3 be addressed?
Q9. What additional barriers are there and how should they be addressed?

Q10. What public policy issues might integration raise?
Q11a. What workforce development issues at the state level might integration raise?
Q11b. What workforce development issues at the provider level might integration raise?
Q12a. What work related culture issues at the State level might integration raise?
Q12b. What work related culture issues at the provider level might integration raise?
Q13. How do you think evidence-based practice might inform the discussion of integration?
Q14. What one thing must be done to ensure successful integration?
Q15. Whom, whether by position or name, would you suggest we bring into this discussion of feasibility?
Q16aINSTATE. Thinking about the Division of Mental Health and Addiction for the State of Indiana, what would the integration of mental health promotion and substance abuse and addiction prevention look like to you?
Q16bOUTOFSTATE. If the interviewee is in a State where integration has occurred to some degree, is there any outcome data available that suggests that integrating MH Promotion and SA prevention at the State or provider levels has a positive impact on State or National Outcome Measures, and if so what measures?
Q17. Any additional comments or suggestions?

Appendix C – Key Informants

In or Out-of-State	Last Name	First Name	Title/Position	Organization
in	Adams-Wolf	Meri Beth	Executive Director	Our Place Drug and Alcohol Services
in	Babcock	Dean	Associate Vice President	Midtown Mental Health Center
in	Black	Parri	President and Chief Executive Officer	Youth First
in	Bond	Gary	Psychology	Indiana University Purdue University Indianapolis
in (pilot)	Brenner	George	Director of Addiction Services	Behavior Care Services
in	Chambers	Andy	Assistant Professor, Psychiatry	Institute of Psychiatric Research, Indiana University School of Medicine
in	Mays	Willard	Assistant Deputy Director for Public Policy	Division of Mental Health and Addiction
in	McCaffrey	Steve	Chief Executive Officer	Mental Health America of Indiana
in	McCarthy	Heather	Network Administrator/Project Director	Geminus Corporation
in	McGrew	John	Department of Psychology	Indiana University Purdue University Indianapolis
in	Moore	Kevin	Bureau Chief, Children and Family Services	Division of Mental Health and Addiction
in	Perez	Gilberto	Director, Bienvenido Program	Northeastern Center
in	Snobarger	Amanda	School Counselor/Consultant	Indiana Department of Education
in	VanDusen	Bruce	Program Director, Office of Consumer and Family Affairs	Division of Mental Health and Addiction
in	Winternheimer	Lisa	Executive Director, National Call Center (formerly, CEO, Primary Care Association)	AmeriChoice, (United Health Care)

In or Out-of-State	Last Name	First Name	Title/Position	Organization
in	Fazekas	Robe	Executive Director of Clinical Services	Hamilton Center
in	Lummus	Sue	Deputy Director, Policy, Planning, and Information Technology	Division of Mental Health and Addiction
in	Williams	Diana	Deputy Director, Office of Addiction and Emergency Preparedness	Division of Mental Health and Addiction
out	Balderamma	Hank	Program Administrator	State of Washington, Department of Health and Recovery Services
out	Casto	Diane	NPN Alaska, Manager, Behavioral Health Prevention and Early Intervention	Alaska, Department of Health and Social Services
out	Harnad	Dianne	NPN, Director of Prevention Services	Connecticut, Department of Mental Health and Addiction Services
out	Maestas	Don	Former Director (NPN)	Office of Substance Abuse Prevention, New Mexico Department of Health
out	McGovern	Mark	Associate Professor of Psychiatry	Dartmouth Medical School
out	Oppor	Lou	Service Area Coordinator, Prevention Coordinator	Wisconsin, Division of Mental Health and Substance Abuse Services, Bureau of Prevention Treatment and Recovery
out	Sandoval	Fred	President	National Latino Behavioral Health Association (New Mexico)
out	Stark	Ken	Director of Human Services	Snohomish County, Washington

Appendix D – NASMHPD Position Statement

POSITION STATEMENT ON THE INTEGRATION OF PUBLIC HEALTH PROMOTION AND PREVENTION STRATEGIES

IN PUBLIC MENTAL HEALTH

Prevention science has demonstrated that prevention practices can *reduce risk factors and enhance protective factors*. Further, these interventions represent a *cost-effective use of resources* relative to more expensive, treatment-based approaches.

Public health promotion and prevention are *best practices* for increasing positive functioning and resilience, decreasing the risk of developing mental illness, and facilitating recovery. These practices have been underemphasized and underutilized in the public mental health sector.

The members of the National Association of State Mental Health Program Directors (NASMHPD) believe individuals of all ages are entitled to lives of optimal mental health and well-being.

To achieve this goal, members of NASMHPD will lead public mental health systems in the development of policies and practices for the:

- Promotion of positive mental health,
- *Earliest possible* identification and intervention in mental health problems,
- Reduction of the incidence of mental illness and suicide,
- Prevention of disability due to mental illness and co-occurring conditions, and
- Prevention of conditions commonly associated with mental illness including medical illness, substance abuse and trauma.

NASMHPD members are, therefore, committed to:

- Educating health professionals and the general public about the importance of mental health promotion and mental illness prevention practices,
- Adopting proven promotion and prevention strategies, and incorporating them into the State mental health plan.
- Supporting new initiatives with appropriate policies and dedicated resources.

NASMHPD members further commit to sustaining and improving performance in promotion and prevention activities, while meeting the demands of serving a public mental health population, by:

- Monitoring program implementation,
- Evaluating program outcomes and effectiveness, and
- Conducting surveillance of population-level indicators.

State Mental Health authorities must work with consumers, families and their advocates and providers and develop new partnerships to be successful in these efforts.

Approved by the NASMHPD Membership on September 17, 2004.

