

VIA EMAIL:

TO: Steven.Randazzo@SAMHSA.hhs.gov

cc: Pam.Hyde@SAMHSA.hhs.gov, SAMHSA Administrator

DATE: June 23, 2010

RE: SAMHSA White Paper on Modern Addictions and Mental Health System

Thank you for the opportunity to share our thoughts on the draft SAMHSA white paper providing a "Description of a Modern Addictions and Mental Health Service System." The National Association of Psychiatric Health Systems (NAPHS) represents more than 600 psychiatric hospitals, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care throughout the United States. Our members deliver all levels of care, including 24-hour inpatient and residential treatment, partial hospitalization services, and extensive outpatient services.

We're pleased to see SAMHSA take on the challenge of describing a "modern" system, and we think that you've made many important points throughout this document. The paper is a good starting point for ongoing discussions – particularly as healthcare reform is implemented.

As private-sector healthcare providers, however, we would like to offer a few suggestions that we think could strengthen this paper to reflect the full scope of the needs of individuals experiencing mental and addictive disorders as well as the full range of services responding to those needs in both the private and public sectors.

SUGGESTIONS

The starting point throughout this entire paper is an emphasis on health promotion and prevention. We are fully supportive of this direction for our health system overall. Just as general medicine works to prevent heart attacks, we believe that prevention and early intervention with mental and addictive disorders is critical to helping reduce the burden of disease on individuals and on society. We all hope there will be far fewer people with mental illnesses and addictions in the future. But just as the general healthcare system requires intensive, acute hospital services – and potentially longer-term rehabilitation – for people who (despite the best efforts at prevention) have a heart attack, we need a similar range of services in behavioral health.

In this draft of the white paper, there is virtually no mention of acute care services. If we build a system totally without attention to the most critically ill psychiatric patients, it is like setting up a cardiac care system that ignores the fact that some people will have heart attacks no matter how good the other services are. Just as we have to keep improving our emergency services for cardiac patients, we need to do the same for individuals with mental and addictive disorders.

1. We would urge you to include a section on inpatient care, including hospital and residential treatment, as part of service elements. The service element section of the paper currently includes everything *except* inpatient psychiatric care, which is an essential part of a full continuum of care. Even as we move to a greater emphasis on prevention and early intervention, there will remain some

individuals who – at various points throughout the course of their illness – will require the intensity and security of a 24-hour treatment setting. This level of care needs to be explicitly mentioned as part of the overall service elements.

Here are some examples of specific sections within the white paper that need to include a specific mention of inpatient-level services.

On page 6 in the second paragraph beginning “The good and modern system....,” the second sentence listing the “various parts” of the system mentions only general hospitals, state mental hospitals, etc. There is no mention of psychiatric hospitals or residential treatment. This paragraph should specifically insert into the second sentence both **non-governmental psychiatric hospitals** and **residential treatment facilities** (for addictions and for child and adolescent mental health).

Also on page 7, you further describe the different service elements. We recommend adding a paragraph on the most intensive service element – inpatient hospital and residential treatment.

On page 9, where you list acute intensive services, we suggest you add”such as inpatient psychiatric, inpatient addiction, and residential treatment for addictions and for child/adolescent mental health treatment.”

To give you an idea of the number of inpatient hospitals and residential treatment centers nationwide, here is a summary chart from a 2010 report on “[The Economic Impact of Inpatient Psychiatric Facilities](#)” developed by Dobson DaVanzo and Associates:

	Inpatient psychiatric hospitals			Residential treatment centers	Total Inpatient Psychiatric Facilities
	1,749			508	
Region	Non-governmental inpatient psychiatric hospitals ¹	General hospital inpatient psychiatric subunits ²	State psychiatric hospitals ³	Residential treatment centers ⁴	
National	225	1,274	220	508	2,257

¹ Medicare Cost Reports for inpatient hospitals. All facilities with a provider number between xx.4000 and xx.4999 were selected. State psychiatric hospitals were also selected from the Medicare Cost Reports.

² Medicare Cost Reports for inpatient hospitals. All facilities with a provider number for sub-providers with a third digit of “S” or “M” were selected.

³ National Association of State Mental Health Program Directors (NASMHPD) Web site, retrieved from: http://www.nasmhpd.org/state_hospitals.cfm.

⁴ U.S. Department of Health and Human Services. (2004). *Mental Health, United States, 2004*.

2. Make clear the difference between treatment and “support services.” In the chart on the last page, some of the categories could confuse the difference between *treatment* and *support services*. We suggest deleting the heading of “intensive support services” altogether. For example, from our perspective both **substance abuse intensive outpatient services** and **partial hospital programs** should be moved to the category of “outpatient and medication services.” Intensive outpatient services and partial hospital programs are active treatment programs. They are staffed, paid for, and regulated as outpatient services and not as *support services*. Similarly, elements such as assertive community treatment, intensive home-based therapy, and multi-systemic therapy are outpatient services. They also could be moved to the “outpatient and medication services” category.

On page 1 in the second paragraph, there is mention that “a modern mental health and addiction service system provides a continuum of effective treatment and SERVICES” that includes employment, housing, and education. We would assume that this sentence is not intended as a statement about how these services (e.g., employment, housing) are to be funded; we assume that not all are coming from the healthcare dollar, but that the point you are trying to highlight is the various ways HHS can coordinate to provide a continuum. You may want to clarify this somewhat. In general healthcare, for example, it’s

important for someone trying to recover from a debilitating disease to have appropriate housing, transportation to medical appointments, etc.

3. The concept of psychiatric liaison services should be incorporated into the white paper. We suggest you specifically mention the concept of psychiatric liaison into the service elements (pages 6 or 7) and/or mention psychiatric liaison in the context of integration between medical and mental health. One of the great opportunities is for increasing use of behavioral health expertise within the general healthcare setting to assist with early identification and intervention in medical care (e.g. with transplant patients, cardiac care, etc.). Many of our members are already providing strong and effective psychiatric liaison services. However, this is an area that has no formal funding mechanism. Far more could be done if payment systems were reformed to recognize and reward this type of intervention.

4. Recognize that behavioral disorders are medical disorders and should be treated no differently. In the third paragraph on page 6 (beginning “The system should develop improved strategies...”), there is a statement about individuals who consume significant resources—and the conclusion that this is an indication of being underserved or poorly served in the current system. That could be taken several ways—perhaps they are underserved by being at the wrong level of care, or it could be that they are genuinely in need of “significant resources” because of the nature of their illness. If we truly believe that behavioral disorders are on par with the rest of medicine, we need to recognize that some people truly need significant resources because they are very ill.

Thank you for the opportunity to provide perspective from the real-world experience of our members. If you have any questions or if we can provide any additional information, please feel free to call me at 202/393-6700, ext. 100.

Sincerely,



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