SAMHSA: Creating a System of Care That Meets the Needs of People With Mental and Substance Use Disorders

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It has been nearly 2 years since I first wrote in this journal about reform efforts at the Substance Abuse and Mental Health Services Administration (SAMHSA). At that time, I described SAMHSA's plans to better serve Americans living with mental and substance use disorders. Since then, much has been accomplished, but many challenges remain.

In 2018, I spoke of several priorities. These included addressing serious mental illness, the opioids crisis, and the need to train health care practitioners in evidence-based practices in behavioral health. SAMHSA has now created a national network of regionally based technology transfer centers that work together to develop and deliver training and education for specific content areas in substance abuse prevention, addiction, and mental health (https://www.samhsa.gov/practitioner-training). Further, these regional centers, which are mainly academically based, also provide direct implementation training and technical assistance on request to local health care organizations and providers.

SAMHSA has established several national training centers, including the Clinical Support System for Serious Mental Illness, which was awarded to the American Psychiatric Association. This program, known to most as SMI Adviser, provides training and technical assistance on the care and treatment of illnesses such as schizophrenia, bipolar disorder, and major depression. It includes a training course on assisted outpatient treatment (AOT); a psychopharmacology center of excellence; and a unit that focuses on best practice in the use of clozapine, an antipsychotic medication that holds promise for treatment of refractory schizophrenia but that remains underutilized. SAMHSA has also established a national center of excellence focused on training and technical assistance in the care and treatment of eating disorders—mental illnesses with significant mortality rates. The Center of Excellence for Protected Health Information, also newly established, provides training and answers questions related to health care privacy issues, particularly those related to HIPAA and 42 CFR Part 2 (federal regulations governing substance use disorder confidentiality).

To help address the opioids crisis, SAMHSA funded the Opioid Response Network (ORN). This program places a team of local experts—addiction psychiatrists and addiction medicine physicians, nurses, psychologists, social workers, counselors, preventionists, and peers—on the ground in every state to help in addressing the specific needs of communities facing an opioids crisis. I believe that there is no "one size fits all" solution to the opioids crisis and that communities need local health care providers with expertise in behavioral health and knowledge of the locale to best address these issues. Like the regional technology transfer centers, the ORN provides customized training on a wide array of topics on request (opioidresponsenetwork.org).

The goal of this extensive system of training and technical assistance is to meet the needs of the health care practitioners who provide services to patients with mental and substance use disorders and to ensure that patients get the best, evidence-based services possible. In establishing this national network, SAMHSA is also helping to address parity issues arising from a lack of well-trained providers. If we can expand the number of practitioners who are able and willing to provide care for mental and substance use disorders, we will increase access to care for Americans living with these conditions. These resources are offered at no cost to states and communities across the nation, and I believe they serve as a key feature in advancing SAMHSA's mission to address these critical health conditions.

Each year for the past 3 fiscal years SAMHSA has received unprecedented funding (over $1.5 billion) to address prevention, treatment, and recovery issues related to the opioids crisis. These funds have been awarded to states on the basis of the state's opioid overdose death rate and calculated treatment gap for opioid use disorders. We work closely with states on use of these funds and have seen states develop innovative public awareness programs, first responder training, programs for distribution of naloxone,

approaches to the delivery of treatment for opioid use disorder, and community-based programs to support recovery. SAMHSA's discretionary grant programs continue to fund providers of services to pregnant and postpartum women and mothers who are affected by opioids and other substances and their families; juvenile, adult, and family drug courts; peer training programs; and programs that assist with establishing use of medications approved by the U.S. Food and Drug Administration (FDA) to treat opioid use disorder.

SAMHSA has also recently updated and relaunched its treatment locator for individuals with substance use or co-occurring disorders (findtreatment.gov). SAMHSA is responsible for ensuring that providers use well-established evidence-based practices. To that end, it now requires organizations that receive SAMHSA funding to use FDA-approved medications in the treatment of opioid use disorder. Providers that are not able to offer medication treatment must show that they are connected to providers of these medications and that they allow the ongoing use of these medications by those they serve.

Questions have arisen as to whether practitioners should be required to obtain a waiver of the Drug Addiction Treatment Act (DATA) of 2000 to prescribe buprenorphine products for treatment of opioid use disorder. Some have called this requirement an obstacle to care and claim that providers would be more likely to treat opioid use disorder if they did not have to complete the required training. SAMHSA has recommended keeping these training requirements in place until medical education organizations decide to require training in substance use disorders as part of undergraduate and graduate medical education (inclusive of all health care professions eligible to obtain the DATA waiver). Evidence is lacking for the narrative that the education requirement for buprenorphine treatment inhibits practice. Since 2019, practitioners completing the waiver education can treat up to 100 patients and those with existing waivers can notify SAMHSA and serve up to 100 patients. Practitioners with special qualifications and those who work in qualified practice settings can treat up to 275 patients after 1 year. There are 2 million individuals with opioid use disorders in this country; a large and growing infrastructure, including over 82,000 providers with the DATA waiver, to provide treatment for this disease; and expanding access to telehealth services to provide more access for Americans in rural locales. I'll let readers do the math—but the DATA waiver requirement is not the obstacle to care for people with opioid use disorder.

Although the high mortality rate of opioid use requires our focused attention, I also recognize that we must focus on more than one substance. Other substances—such as marijuana, the most used illicit substance—must also remain a priority. We have spent time educating Americans about the risks of marijuana use and have also taken great strides to ensure that SAMHSA takes no action to support claims of the purported benefits of marijuana as a treatment for mental or substance use disorders. To that end, SAMHSA revised its notices of grant award in 2019 to prohibit the use of marijuana or THC-containing products for the treatment of these disorders. There is no evidence that marijuana is a treatment for any of these illnesses, and there is accumulating evidence of substantial harm from chronic marijuana/THC use.

Serious mental illness continues to be a major priority for the agency. Increasingly, Americans are coming to realize that those living with serious mental illness are some of our most vulnerable citizens. Often their illness is so severe that they are unable to understand that they have a mental illness and, as a result, may not be able to care for themselves successfully in our communities. The mental health care system has been severely affected by the loss of inpatient beds for those most acutely ill. In many cases, the patient's illness requires innovative approaches outside of the traditional clinic setting, but such treatment is often not available. Our emergency departments (EDs) are not equipped to assist those experiencing an exacerbation of serious mental illness. Jails and prisons have become de facto mental institutions where those suffering with severe mental illness are unlikely to receive the care and services they need.

SAMHSA is addressing serious mental illness on many fronts. It is my belief that we must start with the mental health needs of our children. We know that most serious mental illness has its onset in adolescence and young adulthood, with research indicating that approximately 75% of people who develop these illnesses show evidence of disease by age 25. To that end, SAMHSA funds a program known as Project AWARE, which trains school staff on signs and symptoms of mental health issues, provides funding for establishment of programs that focus on positive environments in schools, and allows for funding of direct service provision in school settings. SAMHSA's technology transfer centers have established a learning collaborative to address implementation and ongoing service provision from school-based mental health programs. The Centers for Medicare and Medicaid and SAMHSA published a joint advisory in 2019 on school-based mental health services and Medicaid reimbursement requirements.

SAMHSA recognizes that people living with serious mental illness have multiple health care needs. SAMHSA funds an integrated care program known as Certified Community Behavioral Health Clinics (CCBHCs), which provides integrated care for mental and substance use disorders and general medical conditions. These programs are also required to provide 24/7 behavioral health crisis services with a goal of helping persons with serious mental illness to avoid the ED and, for many, avoid hospitalization. Crisis intervention services are critical to providing appropriate care and treatment to those with acute mental health crises. SAMHSA also encourages the establishment of 24/7 crisis intervention services in community mental health centers and permits mental health block grant funding to be used for that purpose. SAMHSA supports AOT through a grant

program that has shown strong positive results in reducing hospitalizations, ED visits, and interactions with the criminal justice system. In 2019, SAMHSA initiated a grant program in assertive community treatment (ACT). Both AOT and ACT use a community-based, multidisciplinary team approach to meet a person's needs with regard to serious mental illness, but unlike ACT, participation in AOT is legally mandated.

SAMHSA also recently clarified that mental health block grant funds can be used to bring community mental health providers into jail and prison settings to provide person-centered, individualized mental health care to those with mental illness who are incarcerated. The goal is to assist those with serious mental illness who are incarcerated to obtain necessary care and develop relationships with providers that will help in continuing this care upon release so that people can live successfully in their communities.

To improve integration of care for those living with substance use disorders, SAMHSA is in the process of revising regulations in 42 CFR to improve the ability to share information between providers with patient consent. SAMHSA has established bed registries in 23 states to assist with more rapid receipt of services by persons with the most serious mental illnesses. SAMHSA is in the process of increasing lifeline and texting resources for those in acute crisis and recently sent a report to the Federal Communications Commission recommending implementation of a three-digit, easily remembered mental health crisis telephone number (988).

SAMHSA also recognizes the need to better understand mental and substance use disorders in the United States. It has been over 40 years since the Epidemiologic Catchment Area study was completed. It is long past time to complete a new survey of mental illness prevalence—and to conduct a study that reaches members of society who are difficult to see, including persons with mental and substance use disorders, who are often confined in jail, living in nursing homes, hospitalized, or experiencing homelessness.

There is much going on at SAMHSA, but we know that we will not be the provider of all of these services nationally. Our goal is to demonstrate effective programs, collect data on outcomes associated with these programs, and disseminate findings from these programs. We then encourage states and communities to adopt these practices and approaches. Ultimately, understanding mental illness in our nation will lead us to provide the right resources to those in greatest need. In doing so, we help our nation to realize its true greatness by demonstrating caring for those who had once been forgotten but will be no longer.

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