

Too Significant To Fail:

The Importance of State Behavioral
Health Agencies in the Daily Lives of
Americans with Mental Illness, for
Their Families, and for Their
Communities

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About NASMHPD

The National Association of State Mental Health Program Directors (NASMHPD) is home to the only member organization representing state executives responsible for the \$37 billion public behavioral health service delivery system serving nearly 7 million people annually in all 50 states, 4 territories, and the District of Columbia.

NASMHPD serves as the national representative and advocate for state behavioral health agencies and their directors and supports effective stewardship of state mental health systems. NASMHPD informs its members on current and emerging public policy issues, educates on research findings and best practices, provides consultation and technical assistance, collaborates with key stakeholders, and facilitates state-to-state sharing of new approaches and information on improving care for people with serious mental illnesses.

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Prior to his role at NASMHPD, Mr. Miller served as Senior Vice President at the National Coalition on Health Care, where he oversaw the evaluation, preparation and dissemination of innovative research and policy analysis about the nation's healthcare system.

At the National Alliance on Mental Illness (NAMI), Mr. Miller led NAMI's State Policy team, dedicated to improving the financing and delivery of mental health services at the state level for people with mental illness, and addressing mental illness issues across the lifespan.

He has published over 50 articles and reports on behavioral health and healthcare delivery and financing, the healthcare workforce, cost management, medical practice assessment, quality improvement, insurance exchanges, and public/private health insurance programs.

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Preface

In serving as the chief executive officer over the last 18 years with the National Association of State Mental Health Program Directors (NASMHPD), it never ceases to amaze me to observe the abilities and special talents of the State Behavioral Health Authorities (SBHAs) to address, and in many cases exceed, the needs and expectations placed upon them by state policymakers and their citizens. These actions are even more impressive because they usually occur under extraordinary and dynamic financial circumstances and the under-funding of the agencies.

SBHAs are responsible for the behavioral health needs for nearly 7 million people across the nation, and are recognized by public statewide government agencies for coordinating and assuring the provision of high quality behavioral health services and supports for individuals with behavioral health conditions. An overarching role of the SBHA is to be a visible and accountable leader across state government – and a skilled resource – integral to the coordination of public behavioral health care across multiple agencies, involving many funding streams and delivery systems.

Despite massive funding cuts that SBHAs have incurred over the last 10 years, the agencies have witnessed at the same time significantly increased demand for behavioral health services. To address the needs of consumers during two recessions, they have performed Houdini-like skills to make the public behavioral health system operate as efficiently and effectively as possible. The result: millions of people lead better lives and contribute to society despite many personal hardships.

These skills are highlighted in this report, *Too Significant to Fail*, which provides a comprehensive review of the roles, responsibilities, and coordinating efforts that comprise the SBHA enterprise in order to provide high quality care at many levels for people with serious and moderate behavioral health conditions. As you review this report, I believe you will also be amazed, as I am, by the incredible number of roles the SBHAs play to improve the daily lives of many Americans with mental health conditions, and without much fanfare.

But make no mistake: if continued state and federal funding cuts are the norm over the next few years, several programs that SBHAs manage, will certainly be significantly curtailed or eliminated altogether to the detriment of our most vulnerable and sickest individuals, as well as for their families, and those individuals who have less severe conditions, but who suffer from their illnesses nonetheless. Many people with complex clinical and social needs will have to fend for themselves if services disappear and their conditions go untreated due to funding cuts. Despite their heroic efforts, the public behavioral health safety net that SBHAs stitch together every day is rapidly fraying.

SBHAs recognize that untreated behavioral health issues will cause unnecessary disability, unemployment, substance abuse, family disruption, homelessness, and inappropriate incarceration. That is why they fight so hard for increased funding in order to help people with serious behavioral health disorders.

Caring for people with serious mental illnesses is a critical issue for state government. SBHAs stand ready to make sure this dedicated responsibility is met every day on behalf of our most vulnerable citizens, their families and our communities. They are too significant – in their dedication, in their compassion and caring for those who suffer, and in their overarching concern for serving the general welfare – to fail.

Robert W. Glover, Ph.D.
Executive Director
National Association of State Mental Health Program Directors (NASMHPD)

EXECUTIVE SUMMARY

State Behavioral Health Agencies (SBHAs) are the recognized public statewide government agencies responsible for coordinating and assuring the provision of high quality behavioral health services and supports for individuals with behavioral health conditions such as depression and substance use disorders. An overarching role of the SBHA is to be a visible and accountable leader across state government and a skilled resource focused on coordinating public behavioral healthcare across multiple agencies, involving many funding streams and delivery systems.

Behavioral health affects everyone. About one-half of all Americans will meet criteria for mental illness at some point. Over one-half of Americans know someone in recovery from a substance use problem. Positive emotional health helps individuals maintain physical health; engage productively with families, employers, friends; and respond to adversity with resilience and hope. **(Appendix 1)**

Behavioral health affects the health of entire communities. Adults with mental disorders experience high rates of unemployment and disability. Unemployment rates are 3 to 5 times higher for people with mental disorders. Nearly 45 percent of children in special education with emotional disturbances drop out of school – the highest of any category of disability. Substance use disorders reduce the ability to parent and work; increases the chances of involvement in criminal justice system – 50 percent of all incarcerated people have a mental illness – and 60 percent have substance use problems; and one in three has both these disorders *(as reported by the Substance Abuse and Mental Health Services Administration, 2012 www.samhsa.gov)*

SBHAs play dynamic roles in their respective states on a daily or regular basis to address the needs of Americans with a mental illness, and serve as the central organizing entity for coordinating the public behavioral health system across numerous state, county, and municipal agencies. The agencies are responsible for the behavioral health needs for nearly 7 million people across the nation. But through their work, SBHAs reach millions of family members who also provide for, and attend to, the 7 million clients they directly serve, through supportive programs.

While the demanding roles are expected and for most part not recognized by policymakers and the public, behavioral health agencies and systems are also experiencing a changing environment due to a multitude of factors that were reported in NASMHPD's *Cornerstones for Behavioral Healthcare Today and Tomorrow*. The *Cornerstones* report is kind of a GPS system for SBHAs in response to several health care legislative and regulatory initiatives recently implemented at the federal level. The roles embodied in *Cornerstones* serve as another layer of responsibilities on top of the current roles they play which are described in this report, *Too Significant to Fail: The Importance of State Behavioral Health Agencies in the Daily Lives of Americans with Mental Illness, For Their Families, and For Their Communities*. **(Appendix 2)**

Roughly 23 percent – or nearly 72 million Americans (57 million adults and 15 million children) – are affected by mental illness or substance use disorders in any given year.¹ Demand for behavioral healthcare, and the complexity of the circumstances affecting individuals seeking treatment for behavioral health services, is growing. However, at the same time, state funding has been constrained, largely as a result of the worst recession since the Great Depression.

The Impact of Spending Cuts on Behavioral Health

The National Association of State Mental Health Program Directors (NASMHPD) estimates that in the last four years, states have cut \$4.35 billion in mental health services, while an additional one million people sought help at public mental health facilities during this period. To meet the growing demands and needs of individuals with mental illness and play several collaborative and pivotal roles, SBHAs need additional resources – not further cuts to their programs at the federal and state levels.

In particular, the largest Federal-State grant programs dedicated to financing behavioral health services are the Community Mental Health Services Block Grant (MHBG), which allocates grants to states to support and enhance community behavioral health systems for individuals with serious mental illness and other behavioral health conditions.

The second grant initiative is the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), which provide funding for prevention in schools and communities along with modern treatment and recovery services for people with substance abuse disorders and their families.

Stemming from a long history of financing and delivering mental health and substance abuse, other state and local funds finance a range of services for mental health and substance abuse services in the nation.

However, if Congress specifically reduces the mental health and substance block grant allocations, that action could have far-reaching consequences downstream throughout the behavioral and healthcare systems in each state in the form of: Increased emergency room visits, re-hospitalizations, increased medication costs for people with serious mental illness in the Medicaid program and the overall public financing system, as well high costs for law enforcement agencies, educational systems, and state criminal justice, corrections and child welfare systems. Additional funding cuts to general screening and treatment programs, programs that integrate behavioral health and primary care services, as well as specialized supportive initiatives such as housing and employment, through federally sponsored Projects of Regional and National Significance (PRNS) through SAMHSA, would also have deleterious effects for state public behavioral health clients.

The Business Case for Investment in Behavioral Health and the Return

The vast majority of individuals with serious mental illness and/or substance abuse disorders, if appropriately diagnosed and treated, will go on to live full and productive lives. And the return on investment (ROI) is significant.

- It is estimated that the economic benefits of expanded diagnosis and treatment of depression has a return of investment (ROI) of \$7 for every \$1 invested. It is penny-wise and pound-foolish to continue down the dangerous path of state behavioral health spending cutbacks.
- Health-services research also shows that comprehensive community-based mental health services for children and adolescents can cut public hospital admissions and lengths of stay and reduce average days of detention by approximately 40 percent.
- A review of the prevention literature by found that school-based substance abuse prevention is generally very cost effective, for example, “Life Skills Training” returned \$21 dollars for every dollar spent on the intervention.
- A number of cost benefit studies of substance abuse treatment have found returns of \$4 to \$7 per dollar spent. These studies have looked at public treatment systems operated by States (e.g., Washington, California, Oregon, Kentucky, South Dakota) and drug courts (New York, Oklahoma, Texas).
- Antidepressant treatment reduces overall healthcare costs not only for persons with depression alone, but also for persons with depression and co-morbid medical illnesses such as cancer and heart disease. Researchers used claims data for nearly 1700 patients from a large health insurer to compare healthcare costs one year before and one year after initiation of antidepressant treatment. Those remaining on antidepressants for at least six months were 74 percent more likely to experience a large reduction in medical care costs, and patients with depression and heart disease who were taking antidepressants, were 72 percent more likely to have a large reduction in medical care costs.
- On average, substance abuse treatment costs \$1,583 and is associated with a monetary benefit to society of \$11,487, representing a greater than 7:1 ratio of benefits to costs. These benefits were primarily because of reduced costs of crime and increased employment earnings. Even without considering the direct value to clients of improved health and quality of life, allocating taxpayer dollars to substance abuse treatment is a wise investment.

It is clear: a “Prevention-First Public-Health” orientation could improve health and prevent the onset of mental illness, and save money for federal and state programs that fund behavioral and healthcare services.

We describe three overarching roles in this document and several responsibilities under each of those overarching roles that demonstrate the breadth and depth of the SBHA’s work, in order to address the needs of Americans with mental illness and the behavioral health needs of local communities.

SBHAs Perform Several Management and Coordinating Roles That Fall Under Three Major Categories:

Manage and Coordinate Behavioral Health Public Policy, Public Safety and Public Welfare

Develop and Implement Behavioral Health Public Policy: Due to its unique behavioral health experience, resources, and expertise, the SBHA has been, and should continue to be, involved in all state behavioral health policy and related matters.

Ensure Public Safety and Public Welfare: SBHAs are often responsible for managing psychiatric emergency screening services, detoxification services, and other public safety functions to ensure the safety of citizens and communities at large.

When a person with a history or current diagnosis of serious mental illness is involved in a high-profile, tragic incident, as was the case of in the shooting of Congresswoman Gabrielle Giffords (D-AZ) in Tucson in January 2011, state behavioral health commissioners work with public and private agencies and organizations, legal groups and the state legislature, key policymakers and officials, and the media. Commissioners are called on to explain the workings of the state public mental health system, the degree of mental illness in the state, and to explain the system’s role in preventing or responding to such incidents.

SBHA Disaster Behavioral Health Preparedness Programs are an integral part of the overall effort of SBHAs to ensure public safety and welfare of citizens in their states – in case of a natural disaster like a tornado – and the public health, behavioral and medical preparedness, response, and recovery systems. Disaster behavioral health planning aims to provide a continuum of services and activities—ranging from communication, education, and basic support to promoting access to behavioral health treatment—in order to mitigate the progression of adverse reactions into more serious behavioral health conditions.

SBHAs also support and collaborate with crisis hotlines to ensure individuals at risk for suicide or in crises resulting from substance abuse can readily access high quality crisis support services.

Provide Direct Service: Many SBHAs directly provide care in state-operated community behavioral health centers, substance abuse treatment programs, psychiatric hospitals and

forensic centers. Others contract with non-profit community providers. Through these systems, and crisis intervention services, SBHAs serve as safety-net providers for vulnerable populations with serious behavioral health disorders.

Protect Human and Civil Rights: SBHAs are often recognized by other agencies as responsible for assuring the civil rights of people with mental illnesses and substance abuse disorders, and advising and partnering with governmental and non-governmental entities on civil rights issues. SBHAs consider implementation of the Olmstead decision an urgent priority, and have developed robust community supports and recovery-oriented services to transition children and adults with serious behavioral health illnesses from institutional settings to communities.

Monitor and Oversee the Regulatory Process: SBHAs have key regulatory and monitoring responsibilities to ensure the provision of safe, high quality services to consumers.

Blend Youth Behavioral Health Services and Programs: Through the application of policies, programs, and practices aimed at reducing risks and increasing strengths, SBHAs help reduce new cases of behavioral health disorders and significantly improve the lives of young people. SBHAs work to improve community behavioral health systems that balance health promotion, disease prevention, early detection, and treatment. SBHAs embrace the “System of Care” approach for the delivery of children services that seeks to promote the full potential of every child by addressing their physical, behavioral, emotional, cultural and social needs. SBHAs also embrace the “Strategic Prevention Framework” model for preventing substance abuse and its terrible consequences.

Promote Better Understanding of the Unique and Complex Needs of Older Adults: SBHAs address the behavioral health needs of older adults through collaboration with other state agencies such as the Medicaid agency and Department of Aging, as well as working with boards of individual provider, family and consumer groups. SBHAs work to provide services in homes and other community-based settings which are easier to access and less stigmatizing for older adults. Education and advocacy efforts include the promotion of wellness programs and psychiatric advance directives for older adults.

Manage and Coordinate Financing and Coverage

Harmonize Funding Streams: SBHAs bring together separate entities to coordinate complex behavioral health funding streams into programs that work for people with behavioral health disorders. For example, SBHAs use the federally-funded Mental Health Block Grant and the Substance Abuse Prevention and Treatment Block Grant to finance and enhance community behavioral health systems and programs for individuals with serious mental illness, and provide funding for prevention in schools and communities along with modern treatment and recovery services for people with substance abuse disorders and their families.

Implement Behavioral Health Parity: With state insurance departments, SBHAs are promoting education about and compliance with parity requirements, monitoring results,

facilitating handling of consumer complaints, enhancing transparency and accountability, and expanding consumer protections.

Prioritize Funding Related to Non-Medical Services

Provide Affordable, Safe and Quality Housing: SBHAs utilize the Mental Health Block Grant to fund critically important supportive services such as housing and employment. SBHAs offer financial assistance through grants or low to no-interest loans to help people with serious mental illness and substance abuse disorders find permanent affordable housing. SBHAs also use funds to provide job assistance as people with behavioral health conditions transition into the workforce (see supported employment).

SBHAs promote housing policies and programs to ensure that people served by the public behavioral health system are able to make informed choices among safe and permanent affordable housing options that are linked with high quality services and are available in the most integrated setting in the community.

Secure Meaningful Work through Supported Employment Initiatives: Supported employment is a well-defined approach to helping people with mental illnesses find and keep competitive employment within their communities. SBHAs are leading current efforts in partnership with foundations, employers and local government officials, to improve supported employment programs for people with serious mental illness.

Manage, Improve and Coordinate Quality of Care and Delivery of Services

Accelerate Integration of Primary Care, Behavioral Health and Prevention: To improve access to physical health care services and preventative measures, SBHAs require, regulate and lead the public behavioral health system to ensure appropriate screening, treatment and integration of general healthcare and behavioral healthcare as well as integrating substance abuse and mental health services. SBHAs have been champions and leaders in support of integration efforts by sponsoring statewide programs for sharing and learning about new and emerging integration initiatives.

Address Behavioral Health Integration Issues among Racial and Ethnic Minorities: SBHAs have been initiating efforts to support greater racial diversity and cultural competency in the mental health workforce and making this area a priority in their overall strategic efforts. In many minority communities, SBHAs are helping community health workers provide needed assistance with interpretation and translation services and culturally appropriate health education and information.

Measure and Encourage Improved Behavioral Health Performance and Outcomes: SBHAs have developed cutting-edge programs that health plans use to analyze and aggregate data on behavioral health provider practices, and feed this information back to providers so they can understand how well they meet standards of care for consumers. SBHAs have played a major

role in developing national outcome measures with the goal of establishing a more robust way of assessing performance and improvements in the behavioral health system.

Design and Implement Evidence-based Practices (EBPs): SBHAs play a major system-wide role in implementing evidence-based prevention, treatment and recovery-oriented practices and supports such as supportive housing, that produce positive clinical outcomes for consumers and savings for taxpayers.

Promote Peer Support Services: As part of building a recovery-based system, SBHAs lead efforts that support the widespread adoption and coverage of peer support as a specific type of service and/or provider.

Reduce the Behavioral Health Impact of Trauma: SBHAs address the behavioral health impact of trauma by developing public health approaches to trauma that strengthens surveillance, screening, and treatment, in order to better respond to people who have experienced trauma.

Empower Consumers to Maximize Control of Their Recovery: SBHAs offer appropriate education, enforcement of respect for self-determined choices, useful information for making relevant choices, and specific tools that help people take and retain control of their recovery.

Strengthen Behavioral Health Services for Military Service Members, Veterans, and Their Families: SBHAs have long recognized that strengthening behavioral health prevention and early intervention services for soldiers currently serving in the military may reduce the demand placed upon the Veterans Administration (VA) once these soldiers are discharged. Building partnerships between the federal, state, and local governments to expand service capacity may ensure veterans who have a significant behavioral health disorder and need treatment, permanent supportive housing, and/or vocational rehabilitation and employment, receive those services in a timely manner.

Initiate Suicide Prevention Programs: To reduce the toll from suicidal behaviors among persons with behavioral health conditions (and many in the general population will benefit), SBHAs ensure suicide prevention programs and practices are in place, and work closely with other principals on state suicide prevention advisory councils and local initiatives.

To address and enhance these responsibilities and roles highlighted in this report, SBHAs have embraced a new role that entails creating competencies among public behavioral health and healthcare entities, forming new alliances and managing complex inter-governmental enterprises in order to deliver a comprehensive continuum of behavioral healthcare services and improve overall health outcomes for behavioral health clients.

This report not only describes in detail the comprehensive roles that SBHAs play on a daily basis to address the needs of people with behavioral health conditions, but includes throughout the document, recommendations that policymakers at all levels should consider to

improve care and save dollars in the short and long term: Two critically important areas are childhood disorders and prevention programs:

Recommendation: The early-life onset of behavioral health disorders supports the need for a major funding injection for prevention and behavioral health promotion in childhood and early adolescence, and involvement of child-serving settings such as schools and primary pediatric healthcare. We are learning more about the devastating impact that trauma can play in the early onset on mental health disorders among children and youth.

SBHAs know that addressing trauma must be central and pivotal to public health and human service policymaking including fiscal and regulatory decisions, service systems design and implementation, workforce development, and professional practice. Unless trauma is addressed, the damage to individuals and our society will continue.

Increased federal and state funding should focus on developing a comprehensive public health approach to trauma with the goal of reducing the impact of trauma on children and families.

Recommendation: The inclusion of behavioral health concerns, behavioral health promotion and behavioral health disorder prevention into an integrated public health model that fully recognizes the interrelationships of physical and behavioral health well-being, will be critical to advancing effective and cost-effective interventions for the greatest societal benefit.

A combination of well-targeted prevention-related funded programs will help people with developing behavioral health disorders avoid years lived with disability, reduce the stigma attached to behavioral health disorders, increase considerably their social capital, and help reduce poverty and promote our nation's development.

Increased federal funding for health promotion and prevention programs should focus on building emotional health from early childhood to young adulthood, and to implement universal, selective, and indicated prevention activities for mental health disorders among the most vulnerable populations.

Conclusion

SBHAs recognize that untreated behavioral health issues will cause unnecessary disability, unemployment, substance abuse, family disruption, homelessness, and inappropriate incarceration. That is why they fight so hard for increased funding in order to take on critically important responsibilities to help people with serious behavioral health disorders.

Caring for people with serious mental illnesses is a critical issue for state government. SBHAs stand ready, as they always have, to make sure this dedicated responsibility is met every day on behalf of our most vulnerable citizens, and all those affected by mental illness.

They are too significant – in their dedication, in their compassion and caring for those who suffer, and in their overarching concern for serving the general welfare – to fail.

TOO SIGNIFICANT TO FAIL: THE IMPORTANCE OF STATE BEHAVIORAL HEALTH AGENCIES IN THE DAILY LIVES OF AMERICANS WITH MENTAL ILLNESS, FOR THEIR FAMILIES, AND FOR THEIR COMMUNITIES

This report serves as a primer of the myriad roles of State Behavioral Health Agencies (SBHAs) in a rapidly changing economic, political and healthcare environment. The report is intended to inform and guide executive, legislative and judicial decision-makers at all government levels, as well as provider organizations and other stakeholders, regarding the role, scope of authority, and expertise of SBHAs in managing and coordinating the public behavioral healthcare system.²

SBHA placement and structure in state government vary across the country. NASMHPD recognizes each state must determine its own agency placement and organizational structure for SBHAs given that there is no one optimal approach. Given the diversity of states across the country, it is not unexpected that SBHAs appear in various configurations across the nation. Regardless of each State's structure, placement or configuration, NASMHPD supports state policies that empower each SBHA with the ability to efficiently collaborate and coordinate between mental health, substance abuse, public health, criminal justice, child welfare and other state agencies, in order to ensure effective outcomes for individuals with serious mental illness and substance abuse problems.

State Behavioral Health Agency Leadership in a Changing Ecosystem

State Behavioral Health Agencies³ have evolved into a skilled resource integral to ensuring a coordinated approach to publicly funded behavioral health services. Scientific advances in the field of behavioral health, effects of the worst federal and state budget crises since the Great Depression, and the changing healthcare landscape, make the role of the SBHAs more important than ever in ensuring an accessible, high quality and cost efficient system of services supported by government programs.

State behavioral health agencies recognize that a successful behavioral health system will be built on partnerships with key federal and state agencies and stakeholders and providing value throughout the behavioral health system. These partnerships minimally include the U.S.

Departments of Health and Human Services, Housing and Urban Development, Labor and Education at the federal level; and Medicaid, Housing, Employment, Education, Information Technology and Insurance at the state level, in order to design and implement systems of behavioral, physical health care and recovery supports, that meet the complex needs of individuals with behavioral health disorders and their families.

State Behavioral Health Authorities (SBHAs) have evolved into a skilled resource integral to ensuring a coordinated approach to publicly funded behavioral health services.

An overarching role of the SBHA is to be a visible and accountable leader across state government focused on coordinating behavioral healthcare across multiple agencies, involving many state and federal funding systems.

An overarching role of the SBHA is to be a visible and accountable leader across state government focused on coordinating behavioral healthcare across multiple agencies, involving many state and federal funding streams, and continuing to regulate the provision of behavioral health services required by state statute, that improves the overall well-being of clients with behavioral health disorders.

While the roles of the SBHAs will evolve in this

changing healthcare environment, they will continue to play a critical leadership role in key areas highlighted in this report.

Mental Illness – Causes and Costs

The causes of most mental illnesses lie in some combination of genetic and environmental factors, which may be biological or psychosocial. Socio-economic factors such as poverty are widely recognized as affecting an individual's vulnerability to mental illness and mental health problems. The total economic costs of mental illness were estimated at \$317 billion in 2008. This excludes costs associated with co-morbid conditions, incarceration, homelessness, and early mortality. The negative economic consequences of mental illness far exceed the direct costs of treatment, thus making it critically important to treat behavioral health conditions at the on-set of symptoms.

Rates of mental health problems are significantly higher for patients with certain chronic conditions such as diabetes, asthma and hypertension. Failure to treat both physical and mental health conditions results in poorer health outcomes and higher healthcare costs. There are substantial benefits associated with early intervention in mental health disorders.

Behavioral Health Disorders – An All-Encompassing Condition

Behavioral healthcare encompasses a broad array of services for people with mental health or substance abuse problems (or both). These problems range in severity: at one end of the spectrum, individuals face situational problems that disrupt their everyday lives but are short-term while at the other end, individuals have chronic, sometimes disabling behavioral health disorders (e.g., major depression, schizophrenia, bipolar disorder, or drug dependence).

Nearly a third of adults in the United States have met diagnostic criteria for a behavioral health problem in the past year, and over half meet that criteria at some point in their lifetime. The most common type of disorder among adults is anxiety disorder, which includes such diagnoses as phobia, panic disorder, anxiety disorder, and post-traumatic stress disorder (among others).

Nearly a third of adults have met diagnostic criteria for a behavioral health problem in the past year, and over one-half meet criteria at some point in their lifetime.

Mood disorders (e.g., major depressive disorder, dysthymia, or bipolar disorder) are a common mental health problem among adults affecting one in five adults at some point in their lifetimes. Co-morbidity – or simultaneous diagnosis of more than one illness (such as depression co-occurring with diabetes) – is common, affecting about 14 percent of adults within the past 12 months and nearly 28 percent over their lifetime.⁴

Excessive alcohol use and illicit drug use also are linked directly to the increased burden from chronic disease such as diabetes, lung disease and cardiovascular problems. In 2008, nearly three (3) million persons aged 12 and older used an illicit drug for the first time within the past 12 months, an average of 8,000 initiates per day.⁵

In 2009, an estimated 24 million Americans aged 12 and older needed treatment for substance abuse problems.⁶ The annual total estimated societal cost of substance abuse in the United States is \$510.8 billion.⁷

Children also experience behavioral health problems. The most common disorders among children and youth include: depression, anxiety disorders, eating disorders, attention-deficit/hyperactivity disorder, and substance abuse disorders. Studies show that these problems are fairly common among children, with approximately one in five reporting symptoms, and one in ten reporting serious behavioral health difficulties.⁸

The most common disorders among children include: depression, anxiety disorders, eating disorders, attention-deficit/hyperactivity disorder, and substance abuse disorder.

Children's behavioral health is clearly a public health issue. One estimate puts the total economic costs of behavioral health disorders among youth at nearly \$250 billion annually.⁹ Behavioral health disorders among young people burden not only traditional behavioral health programs, but also multiple state service systems that support young people and their families – most notably the education, child welfare, foster care, primary medical care and juvenile justice systems. Over half of all lifetime cases of behavioral health disorders begin by age fourteen (14).¹⁰ If we are going to address as a society the healthcare delivery and economic burdens that behavioral healthcare place on our system, we must address the early onset of these disorders.

The early-life onset of behavioral health disorders supports the need for a major thrust for prevention and behavioral health promotion in childhood and early adolescence, and involvement of child-serving settings such as schools and primary pediatric healthcare.

Paying the Societal Toll – A Tragedy Runs Through It

On a societal level, a conservative estimate of nearly \$3.2 trillion represents the total economic burden of mental illness in the most recent full decade (direct care costs and indirect costs) from 2001 to 2010.¹¹ But this burden and estimate *excludes* the costs of incarceration, homelessness, co-morbid conditions, and early mortality associated with the lack of access to behavioral health care services.

On a societal level, a conservative estimate of nearly \$3.2 trillion represents the total economic burden of mental illness in the most recent full decade (direct care costs and indirect costs) from 2001 to 2010.

According to the *Global Burden of Disease* study conducted by the World Health Organization (WHO), 33 percent of the years lived with disability (YLD) – without mortality, are due to behavioral health disorders, a further 2.1 percent due to intentional injuries.¹² Unipolar depressive disorders alone lead to 12 percent of years lived with disability, and rank as the third (3rd) leading contributor to the global burden of diseases.¹³

Of the 10 leading causes of disability worldwide, measured in years lived with a disability, five are behavioral health conditions: unipolar depression, excessive alcohol use, bipolar disorder or manic depression, schizophrenia, and obsessive-compulsive disorder. Behavioral

Of the 10 leading causes of disability worldwide, measured in years lived with a disability, five are behavioral health conditions.

health disorders collectively account for more than 15 percent of the overall burden of disease from all causes and more than the burden associated with all forms of cancer.¹⁴

Research has shown that 60 percent of Americans with a behavioral health disorder received no treatment for their ailment at all.¹⁵ SBHAs recognize that untreated behavioral health disorders are costly to society and cause unnecessary disability, unemployment, family disruption, homelessness, and inappropriate incarceration.¹⁶

The U.S. Centers for Disease Prevention and Control (CDC) found that substance abuse is linked to three of the top ten causes of actual deaths of Americans each year. In particular, tobacco, alcohol and illicit drugs combined to contribute to 537,000 actual deaths in the United States in 2000. Other causes making the list included motor vehicle crashes (43,000) and incidents involving firearms (29,000).¹⁷

But the most shocking finding is that people living with serious mental illnesses die 25 years earlier than people with similar demographic characteristics in the general population, in large part due to unmanaged yet treatable *physical* health conditions.¹⁸

These conditions are frequently caused by modifiable risk factors such as smoking, obesity, substance abuse and inadequate access to medical care.

And according to recent studies, individuals with addiction and co-occurring mental illness die, on average, 37 years earlier than Americans without severe addictions and mental health problems.¹⁹

Individuals with severe behavioral health disorders not only have higher mortality rates, but their healthcare costs throughout their lives are substantially higher, primarily due to preventable emergency department visits and hospital admissions and readmissions.²⁰

Stigma, an inadequate workforce supply, and decreased state funding have played a large role in preventing individuals with behavioral health conditions from seeking needed care.

*People living with serious mental illnesses die 25 years earlier than people with similar demographic characteristics in the general population, in large part due to unmanaged yet treatable **physical** health conditions.*

No Public Health without Behavioral Health

The evidence of the enormous burden of behavioral health adult and child disorders in terms of both human suffering and economic hardship underscores the need to apply the tools and strategies of public health practice in an integrated physical health and behavioral health agenda. Several reports support the need for moving the behavioral health focus into the core priorities of our nation's public health agenda.²¹

The inclusion of behavioral health concerns, behavioral health promotion and behavioral health disorder prevention into an integrated public health model that fully recognizes the interrelationships of physical and behavioral health well-being, will be critical to advancing effective and cost-effective interventions for the greatest societal benefit.

Behavioral Healthcare Treatment Saves Money –The Business Case for Investment and the Return

The tragedy that runs through the statistics spotlighted above is that the vast majority of individuals with serious mental illness and/or substance abuse disorders, if appropriately diagnosed and treated, will go on to live full and productive lives.

And the return on investment (ROI) is significant. It is estimated that the economic

The economic benefits of expanded diagnosis and treatment of depression has a return on investment (ROI) of \$7 for every \$1 invested.

benefits of expanded diagnosis and treatment of depression has a ROI of \$7 for every \$1 invested. Imagine that taxpayers for public insurance programs like Medicaid, save \$7 for every \$1 spent on treatment and \$5.60 for every \$1 spent on prevention, as a result of increased productivity, reduced healthcare, criminal justice, and social service costs.²²

Several studies demonstrate the positive financial impact of treatment:

- Health-services research has show that comprehensive community-based mental health services for children and adolescents can cut public hospital admissions and lengths of stay and reduce average days of detention by approximately 40 percent.²³
- A review of the prevention literature found that school-based substance abuse prevention is generally very cost effective, for example, “*Life Skills Training*” returned \$21 dollars for every dollar spent on the intervention.²⁴
- A number of cost benefit studies of substance abuse treatment have found returns of \$4 to \$7 per dollar spent. These studies have looked at public treatment systems operated by States (e.g., Washington, California, Oregon, Kentucky, South Dakota) and drug courts (New York, Oklahoma, Texas).²⁵
- Antidepressant treatment reduces overall healthcare costs not only for persons with depression alone, but also for persons with depression and co-morbid medical illnesses such as cancer and heart disease. Researchers used claims data for nearly 1700 patients from a large health insurer to compare healthcare costs one year before and one year after initiation of antidepressant treatment. Those remaining on antidepressants for at least six months were 74 percent more likely to experience a large reduction in medical care costs, and patients with depression and heart disease who were taking antidepressants were 72 percent more likely to have a large reduction in medical care costs.²⁶
- On average, substance abuse treatment costs \$1,583 and is associated with a monetary benefit to society of \$11,487, representing a greater than 7:1 ratio of benefits to costs. These benefits came primarily due to reduced costs of crime and increased employment earnings. Even without considering the direct value to clients of improved health and quality of life, allocating taxpayer dollars to substance abuse treatment is a wise investment.²⁷

A combination of well-targeted prevention, health promotion and treatment programs in the behavioral health field, within a public health strategy, could avoid years lived with disability and early mortality, reduce the stigma attached to behavioral health disorders, increase considerably the social capital, and help reduce poverty and promote our nation’s development.

Impact of Mental Illness on Productivity – A Domino Effect

Young people with serious emotional and behavioral disorders may diminish the productivity of others closely involved in their lives, particularly family members. For example, the stress and unpredictability of having a child with a serious behavioral health disorder can interfere with parents work lives and personal family issues, or a disruptive child in a classroom can interfere with other students' learning. There may also be significant costs to the work or educational productivity, as well as substantial costs downstream, of siblings.

The indirect and long-term consequences are also likely to be significant. These conditions interfere with a young person's ability to invest in their own human capital via education. Many studies and reports show that poor mental health and substance abuse among people young people are negatively related to participation and performance in school as well as high school completion – important determinants of productivity in adulthood. A large number of studies, many of which focus on depression, document that adults with mental health and substance abuse disorders are less likely to be employed, and those who are employed, work fewer hours and receive lower wages and salaries.

Mental, emotional, and behavioral health disorders among young people burden not only traditional mental health and substance abuse programs, but also multiple other service systems that support young people and families – most notably the education, child welfare, primary care, and juvenile and criminal justice systems. According to one estimate, more than one quarter of total costs for children who have these mental health disorders are incurred in the school and juvenile justice systems.

Some studies report that up to 75 percent of children that need mental health care services never receive appropriate services. It is high time that we figure out ways to close the gap between the need and the actual receipt of services.

Source: *National Research Council and Institute of Medicine. (2009). Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Committee on the Prevention of Mental Health Disorders and Substance Abuse Among Children, Youth, and Young Adults. Washington, DC: The National Academies Press.*

Behavioral Healthcare Services in a Changing Landscape

Behavioral health systems are experiencing a changing environment due to a multitude of factors. Roughly 23 percent – or nearly 72 million Americans (57 million adults and 15 million children) – are affected by mental illness or substance use disorders in any given year.²⁸ Demand for behavioral healthcare, and the complexity of the circumstances affecting individuals seeking treatment for behavioral health services, is growing. Funding to address these conditions has been constrained, largely as a result of the worst recession since the Great Depression.

Roughly 23 percent, or nearly 72 million Americans (57 million adults and 15 million children), are affected by mental illness or substance use disorders in any given year.

NASMHPD estimates that in the last four years (2009-through part of FY 2013) states have cut \$4.6 billion in mental health services, while an additional 700,000 people sought help at public mental health facilities. **(Exhibit 1)**

Over the same time frame, recent data shows that states have been required to close nearly 4,000 public psychiatric hospital beds. **(Exhibit 2)**

During this critically important period when state revenues were declining significantly, 56 percent of SBHAs have documented that demand for community-based services is climbing, as well as demand for emergency room and crisis-related services, and state hospital and emergency psychiatric care.²⁹ **(Exhibit 3)**

Pressure to address cost and quality in the healthcare system will result in the redesign of the delivery system and will likely impact the way care is delivered for people with behavioral health disorders. Civil rights, community integration for people with serious mental illnesses, are growing social problems that create additional pressure points on the behavioral healthcare system.

Myriad governmental entities at the federal, state, county and local levels have a role in supporting people with behavioral health conditions through activities such as funding, program operations, regulatory oversight, and advocacy.

SBHA's are the recognized public statewide government authorities responsible for coordinating and assuring the provision of high quality behavioral health services and supports for individuals with severe mental illness.

SBHAs are the recognized public statewide government authorities responsible for coordinating and assuring the provision of high quality behavioral health services and supports for adults with severe mental illness, children with severe emotional disturbances and individuals with substance abuse disorders. These agencies are responsible for the behavioral health needs for nearly 7 million people in all 50 states, four (4) territories and the

District of Columbia.³⁰ Tens of millions more are served through comprehensive public behavioral health education prevention programs sponsored by SBHAs that impact entire communities.

While the role of SBHAs will evolve, they will continue to function as the critical coordinating entities for publicly funded behavioral health services.

Exhibit 1



Level of SMHA Budget Reductions:

FY2009 to FY2013 Total \$4.6 Billion in Cuts

Year	Average	Median	Minimum	Maximum	Total
FY 2009 (39 states)	\$36,849,116	\$13,226,000	\$0	\$554,003,000	\$1,216,020,843
FY 2010 (38 States)	\$29,123,575	\$12,300,000	\$0	\$213,591,000	\$1,019,325,136
FY 2011 (36 states)	\$35,294,953	\$11,633,953	0	\$132,000,000	\$1,270,618,291
FY 2012 (41 states)	\$28,074,541	\$9,040,000	\$0	\$242,500,000	\$842,236,221
FY 2013 (15 states)	\$17,709,032	\$13,700,000		\$82,000,000	\$247,926,447

Preliminary Results based on 41 SMHAs Reporting Winter 2011-2012

Source: NASMHPD/NRI

Exhibit 2



Closing State Psychiatric Hospitals & Hospital Beds (2009-2012)

	SMHA Has Closed	SMHA is Considering Closing	Total Closed or Considered
State Psychiatric Hospitals	8 States 9 State Hospitals	4 States 6 State Hospitals	12 States 15 State Hospitals
State Hospital Beds	29 States 3,222 Beds	10 States 1,249 Beds	4,471 Beds*

** 4,471 beds represents over 9% of State Psychiatric Hospital Bed Capacity*

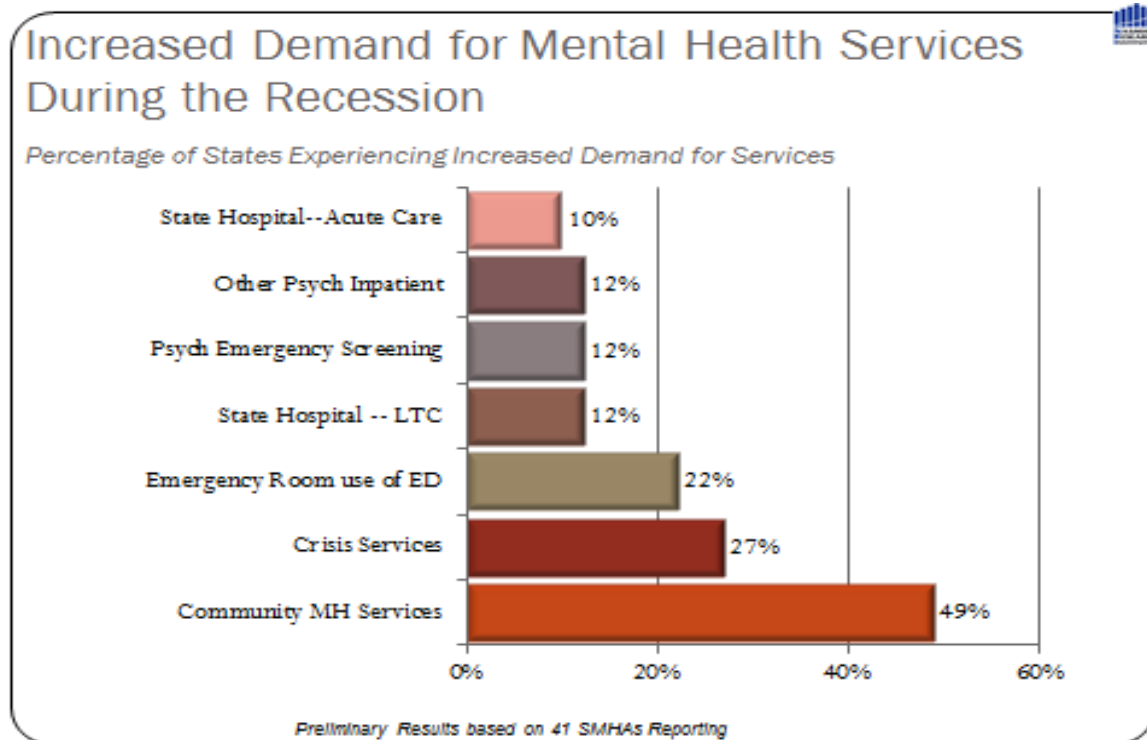
Types of Beds SMHAs are Closing	Acute Care	Long-Term Care	Forensic
Children	5 States	4 States	1 State
Adults	9 States	11 States	6 States

- 3 SMHAs were able to retain all the savings from closing state hospital beds to use within their MH System.
- 11 SMHAs were able to retain a portion of savings to use for MH.

Preliminary Results based on 41 SMHAs Reporting Winter 2011-2012

Source: NASMHPD/NRI

Exhibit 3



Source: NASMHPD/NRI

Key Responsibilities of State Behavioral Health Agencies

Behavioral health issues span all aspects of government. SBHAs have dynamic roles in their respective states and are the central organizing entity for coordinating the public behavioral health system across numerous state, county, and municipal agencies. For purposes of this report, the public behavioral health system is defined as:

The SBHA role has taken on a new level of coherence, coordination, and leadership needed within the state government to best support policy changes, and assure the well-being of people with behavioral health disorders.

The policies, programs, services and funding mechanisms developed through coordinated, intergovernmental efforts necessary to provide a continuum of evidence-based services and supports for people with mental illness and substance use disorders.

Without SBHAs as the recognized state government authorities for guiding the public behavioral health system, it will be increasingly difficult for other agencies – due to their positions in state government – to comprehensively address the complex psychosocial and socio-economic challenges facing individuals with behavioral health condition and their families.

Absent this centralized coordination, a fragmented array of services creates a disorganized system of care that is inefficient and yields poor individual outcomes and is significantly more costly.

SBHAs perform several key functions under their coordinating role. We describe three overarching roles in this document and several responsibilities under each of the overarching roles that demonstrate the breadth and depth of the SBHA function.

SKILLED RESOURCE AND LEADERSHIP ROLE #1: MANAGE AND COORDINATE PUBLIC AND BEHAVIORAL HEALTH POLICY, PUBLIC SAFETY, AND PUBLIC WELFARE

The following key responsibilities fall under this major role.

Develop and Implement Behavioral Health Public Policy:

Due to its significant position, resource knowledge management base and experience, the SBHA is involved in essentially all state behavioral health policy and related matters. The SBHA should be consulted when regulations are developed in another state agency that involves behavioral health issues. In states that opt not to have all funding related to behavioral health managed by the SBHA, funding decisions administered by other agencies should be coordinated with the SBHA.

While other state agencies such as child welfare and veterans affairs will address mental health and addictions problems, all decisions affecting the public behavioral health system should be coordinated through the SBHA in order to ensure a comprehensive, organized approach. The SBHA possesses, and has access, to the expertise necessary to shape policy; design, implement and monitor programs; and guide funding decisions, for all other state and county agencies that participate in and fund behavioral healthcare.

The SBHA role has taken on a new level of coherence, coordination, and leadership needed within state government to best support policy changes, and assure the well-being of people with behavioral health disorders, in an environment of shared responsibility between the SBHAs and other state, local and private entities.

An analysis of behavioral health policymaking does reveal several qualities that, in kind or degree, help to differentiate it from other public policy involvements and define its special challenges. These have to do with the nature of the problem of mental illness, the benefits distributed by the public behavioral health system, the political interests that populate the behavioral health environment, intricacies of service delivery and supports, and the cyclicity of behavioral health policy and program development. Behavioral health policy is generally perceived as primarily of value to a small group in our society having aberrant emotional and behavioral health conditions, which increase the complex policymaking and service delivery systems surrounding this ecosystem. As we have highlighted, the number and scope of people who have serious behavioral health conditions defies that perception.

SBHAs have taken on a centralizing leadership role within state government to best support policy changes to assure the wellbeing of people serious behavioral health conditions. A host of services and social, medical and economic supports should be made available to people with severe behavioral health conditions that can respond in a

systematic way to the demands of this population while promoting the fullest realization of human potential at varying levels.

Depending on the needs of the individual, this spectrum of assistance might encompass income support, housing aid, healthcare services, employment training and placement, education programs, and recreational activities. The complexity of the SBHAs role is to assure that behavioral health services are delivered appropriately by working with other state entities in a coordinating role such as Medicaid, housing, education, children's agencies, criminal justice and corrections, education, foster care, and primary care associations.

SBHAs are addressing a number of *policy initiatives* that will likely drive their work for the next several years. Some of these policy initiatives include:

- Coping with ongoing state fiscal crises – nearly every state has experienced major budget shortfalls during the 2009-2012 period which has required SBHAs to cut staff, reduce administrative costs, reduce services, or close hospitals and wards.
- Integrating behavioral health/medical services -- SBHAs have launched several studies and initiatives to address premature mortality among behavioral health consumers and develop recommendations for new physical health screening initiatives for new patients entering behavioral health systems.
- Addressing behavioral health needs of returning veterans – SBHAs are working with National Guard Units and Reserves to ensure that the behavioral health needs of veterans and their families are being met.
- Increasing evidence-based practices (EBPs) – SBHAs are working to overcome barriers to expanding the availability of EBPs that address recovery and behavioral health-physical services.
- Collaboration with Medicaid and other state agencies – the state Medicaid agency through the use of state options and waivers has had a major impact on systems of care. In addition, SBHAs are working with Corrections officials and other agencies such as Housing authorities to make sure that all funds are used efficiently.

Specific SBHA policy initiatives aimed at improving behavioral health services include:

- Performing behavioral health screening and assessments and making referrals to detect mental illnesses early;

- Developing trauma-informed services;
- Eliminating behavioral healthcare disparities based on gender, race/ethnicity, age, or other cultural identities;
- Providing culturally appropriate and competent;
- Ensuring every behavioral health consumer receives an individualized treatment plan;
- Ensuring behavioral health services are consumer and recovery-based; and
- Providing jail diversion programs to keep persons with mental illness out of the criminal justice systems.

To reduce the impact of behavioral health disorders on individuals, families and communities, SBHAs employ evidence-based prevention strategies through support centers and community coalitions.

Ensure Public Safety and Public Welfare:

SBHAs are often responsible for managing psychiatric emergency screening services, detoxification services, and other public safety functions to ensure the safety of citizens and communities at large. Every state has involuntary commitment statutes that vest in the SBHA the responsibility of insuring the public’s safety by authorizing the commitment of individuals deemed dangerous to themselves or others.

To reduce the impact of behavioral health disorders on individuals, families and communities, SBHAs employ evidence-based prevention strategies through support centers and community coalitions. Delaying the initiation of behavioral health disorders among young people has a significant impact on health, wellness, safety, and success later in life.

SBHAs have established crisis management response teams to be prepared for the possibility of a high profile, tragic incident (e.g., shootings,) involving a person with a history or current diagnosis of mental illness or substance abuse disorder.

To reduce the toll from suicidal behaviors among persons with behavioral health conditions, most SBHAs ensure that suicide prevention programs and practices are in place, and by working closely with other principals on state suicide prevention advisory councils. Individuals with serious behavioral health illness conditions – 8 percent of the U.S. population – account for several times that proportion of the 33,000 suicides

that occur each year in the U.S.³¹ (See section on Suicide Prevention Programs.)

An increasing number of states also have outpatient commitment statutes that require people to participate in mental health treatment as a condition of living in their

communities. Forensic services are provided to persons found in need of mental health services by a court, through the criminal justice system. These court-based services involve the provision of individual statutory and non-statutory SBHA evaluations regarding persons with substance abuse and mental health disorders as well as mental health liaisons to adult and juvenile justice courts.

Responding to High-Profile Tragic Incident Involving a Person with a Mental Illness

When a person with a history or current diagnosis of serious mental illness is involved in a high-profile, tragic incident, as was the case of in the shooting of Congresswoman Gabrielle Giffords (D-AZ) in Tucson in 2011, state behavioral health commissioners work with public and private agencies and organizations, legal groups, the state legislature, other key state policymakers and officials, and the media. Commissioners are called on to explain the workings of the state public mental health system, the degree of mental illness in the state, and to explain the system's role in preventing or responding to such incidents.

SBHAs at the Forefront– Responding to Tragic Incidents

SBHAs are prepared to provide an effective response to a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness and have the ability to identify and garner resources from other agencies within the state. SBHAs are aware of applicable limits on authority and relevant mandates.

To keep several operations on track, SBHA Commissioners have taken steps in case of a tragic incident:

- Established a crisis response contact within the governor's office;
- Identified an internal crisis management team;
- Identified an internal crisis communications team;
- Created crisis management and crisis communications plans;
- Created lists of emergency contacts, including key contacts in the SBHA, in the state, the media and external content experts;
- Familiarized themselves with the state's mental health policies and laws on such hot-button topics as involuntary commitment, firearms regulations/gun control laws and privacy laws; and
- Created meaningful and strong relationships with state experts on crisis situations, and other potential third-party organizations to lay the groundwork needed when a crisis occurs.

After a high-profile tragic incident, SBHAs face several challenges to provide accurate and complete information while addressing understandable public concerns. In particular, commissioners must balance their responsibility to respond appropriately to an individual tragedy, serve in their role as a champion for the principles of recovery for individuals with serious mental illnesses, and their commitment to public safety.

Often, incomplete and/or inaccurate information can quickly spread not only about the incident, but also about the likelihood of violence among individuals with mental illnesses. This is often fueled by community members' mistaken assumptions that mental health treatment is ineffective and that most people with mental illnesses are violent. Though only a finite number of individuals with serious mental illnesses will ever be violent the vast majority live successfully in the community with adequate treatment, housing and supports, the fear that high-profile, tragic incidents engender often leads to public debate, adequate funding for mental health services and new laws.

Disaster Behavioral Health Preparedness Programs (DIBHPP's)

SBHAs also are regularly involved in responding to large and small-scale natural disasters (e.g., tornados, hurricanes, and wildfires) in partnership with state and local offices of emergency management. Specifically, SBHAs directly provide or coordinate the behavioral health response in order to help victims and first responders manage the psychological impact of events.

SBHA Disaster Behavioral Health Preparedness Programs (DIBHPP's) are an integral part of the overall effort of SBHAs to ensure public safety and welfare of citizens in their states, and the public health, behavioral and medical preparedness, response, and recovery systems. It includes the many interconnected psychological, emotional, cognitive, developmental, and social influences on behavior, mental health, and substance abuse, and the effect of these influences on preparedness, response, and recovery from disasters such as tornadoes and earthquakes, or other traumatic events.

To reduce the toll from suicidal behaviors among persons with behavioral health conditions, most SBHAs ensure that suicide prevention programs and practices are in place.

SBHAs at the Forefront- Disaster Resources

The Vermont Department of Mental Health has developed Disaster Response Teams in each of the ten Community Mental Health Centers statewide to provide mental health services to the survivors of disasters of all types such as natural, technological, bio-terrorist, and other critical incidents. These teams can respond to local events independently and to regional or statewide events as part of the comprehensive State Emergency Operations Plan.

The Disaster Response Teams are comprised of a core group of agency employees as well as a variety of professionals and volunteers from the community. They can be contacted through the crisis services of each agency for local events and through a local agency or Vermont Emergency Management for regional and statewide events.

Key Mental Health Services that are provided include:

- Psychological First Aid*
- Crisis Counseling
- Psycho-education
- Sudden Death Notification
- Community Outreach
- Mental Health Consultation, Assessment, and Referral

Every State Behavioral Health Agency in the U.S. has in place a response team similar to the Vermont effort.

*Psychological First Aid is the application of the three basic concepts of “protect, direct and connect”. It embraces the following elements:

- Address immediate physical needs;
- Comfort and console affected individuals;
- Provide concrete information about where to turn for help;
- Listen and validate feelings;
- Link individuals to support systems;
- Normalize stress reactions to trauma and sudden loss; and
- Reinforce positive coping skills.

Provide Direct Service:

Many SBHAs directly provide care in state-operated community behavioral health centers, psychiatric hospitals and forensic centers. Behavioral health authorities serve as safety-net providers for vulnerable populations who have serious substance abuse and mental disorders.

States will continue to play a major role in providing direct behavioral health services at the local level. However, as states seek to decrease costs of health insurance and pensions associated with civil service, some may have chosen to contract for services. It will be critical for SBHAs to shape these transitions, when and if they occur. While SBHAs will continue to ensure availability of safety net services, an increasing number of people with behavioral health conditions will be treated in more integrated settings, and states will operate fewer psychiatric hospitals. For agencies that continue to operate those entities, they will predominantly become forensic (individuals who are very ill who are deemed a threat to themselves and others) in nature versus traditional settings for civil commitments. SBHAs have taken on a major responsibility in this regard for sexually violent predators.

Although mental health parity and other pieces of legislation hold the promise for improving access and reducing fragmentation for people with behavioral health disorders, some groups will lack access to behavioral health coverage. Given the prospect of lower numbers of uninsured people, states may be tempted to reduce direct (non-Medicaid) financing of behavioral health services, particularly in light of cuts to discretionary spending that were negotiated as part of the recent Congressional debt-ceiling deal. These funds account for a much larger share of behavioral health spending in relation to overall health spending and drastic cuts could threaten the viability of safety-net providers.³²

It will be critical to preserve direct-service funds to provide care for the remaining uninsured and for the evidence-based services, such as assertive community treatment, rehabilitation, and supportive services such as supported employment, that are not typically reimbursed but can improve the well-being of people with more severe disorders.

Some studies show that an additional 3 million lower-income persons with serious behavioral health conditions will be served by the public behavioral health system in 2014. That equals a nationwide increase of 30 percent in the number of consumers receiving behavioral health care from the SBHAs. If the agencies are forced to continue to reduce intensive community-based services and close psychiatric hospital beds, the necessary infrastructure, services and workforce to meet existing demands, let alone a

Some studies show that an additional 2-3 million lower-income persons with serious behavioral health conditions will be served by the public behavioral health system in 2014. That equals a nationwide increase of 30 percent in the number of consumers receiving behavioral health care from the SBHAs.

growing demand for these various services expected with recent federal legislative efforts, will not be in place.

In order to meet the increased demand for services and the necessary capacity in place, SBHAs are beginning to provide technical assistance to help provider organizations with retention and competency of staff, including continuing education opportunities, strengthening career ladders and targeting front line supervisors. Further, SBHAs are collaborating to develop pilot reimbursement models that incorporate on-going training and supports (especially those linked to evidence-based practices), including reimbursement for clinical supervision, into rate structures. SBHAs facilitate collaboration between workforce development partnerships and local educational institutions, provider groups, and behavioral health organizations to reinforce state planning and implementation activity and promote career development opportunities.

Protect Human and Civil Rights:

SBHAs are often recognized by other agencies as responsible for assuring the civil rights of people with mental illnesses, and advising and partnering with governmental and non-governmental agencies on civil rights issues. In addition to the obvious suffering due to mental disorders, there exists a hidden burden of stigma and discrimination faced by those with mental disorders. SBHAs are important agencies that ensure adequate and appropriate care and treatment for people with mental illnesses, protection of their human and civil rights, and promotion of both mental and physical health of populations.

SBHAs are often recognized by other agencies as responsible for assuring the civil rights of people with mental illnesses.

The landmark Supreme Court ruling in *Olmstead v. L.C.* (1999) found that unnecessary segregation and institutionalization of people with disabilities constitutes discrimination under the Americans with Disabilities Act.³³ The *Olmstead* decision confirmed that states must ensure that Medicaid-eligible persons do not experience discrimination by being institutionalized when they could be served in a more integrated (community) setting. SBHAs consider implementation of the *Olmstead* decision an urgent national priority.

In order to prevent unnecessary institutionalization and promote community integration, SBHAs have developed several necessary community supports and recovery-oriented services to transition children and adults with serious behavioral health illnesses from institutional settings to communities.

In order to prevent unnecessary institutionalization and promote community integration, SBHAs have developed several necessary community supports and recovery-oriented services to transition children and adults with serious behavioral health illnesses from institutional settings to communities.

To reduce the barriers to community integration for individuals with mental illness SBHAs work to:

Increase funding streams for community-based supports: SBHAs work to take full advantage of all opportunities for funding, including Mental Health Block Grants, Temporary Assistance to Needy Families (TANF), the State Children's Health Insurance Plan (S-CHIP), and the Individuals with Disabilities Education Act (IDEA). Community-based care under Medicaid is increasingly important in enabling individuals with disabilities to live in the community.

Increase affordable housing: SBHAs support decent, safe, affordable housing in integrated settings, coordinated among state, local and federal agencies. Without adequate housing, states will be unable to meet the Olmstead mandate to avoid unnecessary institutionalization. States are continuing to develop a range of affordable housing options for individuals with mental illnesses in order to promote community living and recovery.

Increase necessary employment supports: SBHAs support transitional employment, supported employment, social enterprises, supported self-employment, employment through consumer-operated programs, and supported education as essential services to help people develop the skills that will allow them to prosper in communities.

Monitor and Oversee the Regulatory Process:

SBHAs have key regulatory and monitoring responsibilities in order to ensure the provision of safe, high quality services through evidence-based, performance standards. SBHAs have statutory and regulatory authority over many providers of behavioral health services to consumers. Separate standards apply depending on the type and level of

SBHAs have statutory and regulatory authority over many providers who provide behavioral health services to consumers.

service provided. The type of service is usually organized in the following manner: Inpatient Psychiatric Service Providers, Community Mental Health Centers, Substance Abuse Treatment and Prevention Programs, and Residential Facilities.

A key regulatory responsibility for SBHAs are state-owned and state-operated psychiatric hospitals, which are used for persons who are in need of the most intensive level of behavioral health services. Inpatient Psychiatric Service Providers require licensure if they are private psychiatric hospitals providing acute inpatient mental health services.

Community Mental Health Agencies require certification by SBHAs when they provide behavioral health services that are funded by a community mental health board or when they are subject to department licensure of a residential facility.

Residential Facilities require licensure by the SBHAs if they operate a publicly or privately operated home or facility serving individual with mental illness. There are several types of Residential Facility License that ODMH can issue.

SBHA regulatory activities in regard to these services include on-site surveys, inspections and reviews to determine compliance with standards. Depending on the provider, behavioral health providers and agencies are certified one to three years.

Other SBHA activities include technical assistance on the application and survey process; maintenance of a certification and licensure database; responding to and investigating complaints and concerns related to health and safety and other administrative rule violations; and following up on Private Psychiatric Hospital Incident Notification reports and Community/Residential Incident Notification reports.

Community mental health agencies also are required to develop and implement performance improvement activities as part of the certification and/or accreditation process.

SBHAs also provide guidance and technical assistance to other agencies with regulatory oversight of specific programs. For example, SBHAs provide recommendations on the design and implementation of behavioral health programs in vocational rehabilitation programs or correctional settings, prescription drug monitoring and Opioid-drug treatment/regulatory activities.

The purpose of the Prescription Drug Monitoring program in many states is to: 1) foster the establishment of state-administered controlled substance monitoring systems in order to ensure that healthcare providers and law enforcement officials and other regulatory bodies have access to accurate, timely prescription history information that they may use as a tool for the early identification of patients at risk for addiction in order to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction; and 2) develop, based on the experiences of existing state-controlled substance monitoring programs, a set of best practices to guide the establishment of new programs, and the improvement of existing programs.

By requiring standards for security, privacy, confidentiality and interoperability, SBHAs share information internally and regionally with neighboring states, which has the potential for assisting in the early identification of patients at risk for addiction. Early identification of individuals in need of treatment is a key public health concern and leads to enhanced substance abuse treatment interventions.

Opioid-Drug Treatment/Regulatory activities address the nation's rise in methadone-associated deaths that has been spurred by misuse/abuse, and fatal drug interactions involving methadone and other prescription medications, over the counter medications, and illicit drugs.

Coordinate Children’s and Youth Behavioral Health Services:

We believe that children’s mental health is clearly a public health issue for several reasons:

- One estimate puts the total economic costs of behavioral health disorders among youth in the U.S. at nearly \$250 billion annually.
- Behavioral health disorders among young people burden not only traditional behavioral health programs, but also multiple state service systems that support young people and their families – most notably the education, child welfare, foster care, primary medical care and juvenile justice systems.
- Over one-half of all lifetime cases of behavioral health disorders begin by age (14) fourteen.

Numerous national reports underscore the importance of addressing child and adolescent mental health from a population-based approach that is comprised of a continuum of programs and services ranging from health promotion and prevention to treatment. Behavioral health promotion and prevention efforts need to start early in fostering optimal social and emotional development.

Research indicates that starting prevention efforts early may help protect children from behavioral health problems in adolescence and young adulthood. In order to effectively address children’s mental health, SBHAs work to improve community behavioral health systems that balance health promotion, disease prevention, early detection and intervention, and treatment.

SBHAs work to ensure that effective home and community-based services – that help children and youth succeed at home, in school and in their communities – are developed. SBHAs also identify and divert youth living with serious mental health and substance use conditions from detention to appropriate community treatment.

SBHAs coordinate community-level systems that are needed to support the behavioral health needs of young people.

SBHAs through the application of programs and practices aimed at eliminating risks and increasing strengths have reduced the number of new cases of behavioral health disorders and significantly improve the lives of children. One example is the promotion -- through public education efforts – of smoking cessation programs.

In order to effectively address children’s mental health, SBHAs work to improve community behavioral health systems that balance health promotion, disease prevention, early detection and intervention, and treatment.

When children are recipients of behavioral health services, primary caregivers are often responsible for making decisions that support their child’s recovery. “Family involvement” is a key element of a child’s success, especially for children in residential treatment. SBHAs are fully engaged in family-driven behavioral services and believe critical characteristics include, but are not limited to the following areas:

When children are the recipients of behavioral health services, primary caregivers are often responsible for making decisions that support their child’s recovery.

- Family and youth experiences, goals, and perceptions are used to steer decision-making in all aspects of service and system design, operation, and evaluation;
- Administrators and staff actively demonstrate partnership with all families and youth by sharing power, resources, authority, responsibility, and control, and
- Families and youth have access to understandable information, as well as sound professional expertise when making decisions about treatment.

SBHAs also support the development of comprehensive, community-based systems of care for children and adolescents with serious emotional disorders and their families. “Systems of Care” is an approach to the delivery of services that recognizes the importance of family, school and community, and seeks to promote the full potential of every child by addressing their physical, emotional, intellectual, cultural and social needs. National program evaluation data collected for more than a decade indicate that systems of care are successful, resulting in many favorable outcomes for children, youth and their families, including:

- Sustained behavioral health improvements, including improvements for participating children and youth in clinical outcomes after six months of program participation;
- Improvements in school attendance and achievement;
- Decreases in utilization of inpatient care and reduced costs due to fewer days in inpatient care; and
- Significant reductions in contacts with law enforcement officials and agencies.

Children with serious behavioral health conditions and their families need services from many different child- and family-serving organizations. Often, these organizations are serving the same children and families.

By creating partnerships among these groups, SBHAs are able to coordinate services and supports that meet the ever-changing needs of each child, youth, and family.

Prevention of substance abuse is a critical priority of the SBHAs. They work with prevention resource centers and coalitions under the Strategic Prevention Framework model of assessment and data-driven action.

Juvenile Mental Health

Each year, more than 2 million children, youth, and young adults formally come into contact with the juvenile justice system, while millions more are at risk of involvement with the system for myriad reasons. Of those children, youth, and young adults, a large number (65–70 percent) have at least one diagnosable mental health need, and 20–25 percent have serious emotional issues.

System of care communities focusing on meeting the mental health and related needs of this population through comprehensive community-based services and supports have the opportunity to not only develop an understanding around the unique challenges this population presents, but also to decide how best to overcome those challenges through planned and thoughtful programs, strong interagency collaboration, and sustained funding.

Unfortunately, collaboration between the juvenile justice and mental health systems can be a challenging endeavor. Some of the most common barriers to collaboration, as well as concrete strategies for overcoming these barriers, are discussed below.

Source: 2010. Shufelt, J. L., Cocozza, J. J., & Skowrya, K. R. Successfully Collaborating With the Juvenile Justice System: Benefits, Challenges, and Key Strategies. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health.

Promote Better Understanding of the Unique and Complex Needs of Older Adults:

There is a tempest on golden pond.

Mental health and substance abuse and problems among older adults are associated with poor health outcomes, higher health care utilization, increased complexity of the course and prognosis of many mental and physical illnesses, increased disability and impairment, compromised quality of life, increased caregiver stress, increased mortality, and higher risk of suicide.

Demographic projections indicate that the aging percent of the “baby boom” generation will increase the proportion of persons over age 65 from 13 percent currently to 20 percent by the year 2030.

Today’s older adults, along with aging baby boomers, already present major challenges to the country’s public and private delivery systems for behavioral health, primary care, and long term care. **(Exhibit 4)**

By the year 2030, the number of older persons with psychiatric disorders, including substance abuse disorders, will equal or exceed the number with mental illness in younger age groups.

Exhibit 4

Older Adults and the Extent of Mental Illness

- 20 percent of adults age 55 and older have a mental health disorder (such as anxiety, cognitive impairment, or mood disorder) that is not part of normal aging.
- 15–20 percent of adults older than age 65 in the United States have experienced depression.
- 7 million adults aged 65 years and older are affected by depression.
- Chronically ill Medicare beneficiaries with accompanying depression have significantly higher health care costs than those with chronic diseases alone.
- People aged 65 years and older account for 20 percent of suicide deaths.

(Source -- Centers for Disease Control and Prevention, “CDC Promotes Public Health Approach to Address Depression among Older Adults”).

SBHAs at the Forefront – Addressing the Needs of Older Adults #1

The Pennsylvania Share the Care Program is a collaboration between the county mental health offices and the “Area Agencies on Aging” to improve consumer services and outcomes for older adults. Initially begun in 2005, it was a complex care review process between Aging and the SBHA to assist with complex care resolution in three specific counties. Share the Care evolved into a statewide initiative to foster county/AAA partnership to address broader needs of older adults with behavioral health and other social needs.

An example of the effective working partnership between the SBHA and Aging agency in Columbia, Montour, Snyder and Union counties is a program named –Project HELP (Helping Elders Live Productively). Project HELP focuses on three key concepts:

- Mental Health and older consumers have unique needs;
- Staff need ongoing training, education and support; and
- Outreach to older adults is critical to providing effective care.

A Resource Coordinator serves as a liaison between the two systems to create awareness of service gaps and identify opportunities to promote better understanding of the unique and often complex needs of older adults. The Resource Coordinator engages other service systems and provides training on protective services, depression screening, music therapy and other supports that assist caretakers for older adults.

The Older Adult Subcommittee of the SBHA Advisory Committee was established as a significant step in assuring appropriate, adequate services that promote recovery for older adults. Memorandums of Understanding between the SBHA and the Pennsylvania Department of Aging were developed to outline services for older adults. A new curriculum was created for Certified Peer Specialists that included specialized training on support for older adults.

According to the *Surgeon General's Report on Mental Health*, and coinciding with these demographic changes, "disability due to mental illness in individuals over 65 years old will become a major public health problem." As examples:

- The risk of suicide increases with age. One in five suicide deaths in the U.S. (20%) occur for persons ages 65 and over, despite the fact that only 13 percent of the general population has reached age 65+.
- High rates of co-occurring mental health and substance abuse disorders are reported in specialty geriatric psychiatry outpatient and inpatient settings (20% and 38%, respectively).
- Alzheimer's disease is often complicated by behavioral symptoms such as psychosis, agitation, depression, and wandering

SBHAs address the behavioral health needs of older adults through collaboration with other state agencies such as Medicaid agencies and Departments of Aging, as well as boards of provider, family and consumer organizations. Specific programs offer depression screenings and approaches to managing not only depression and anxiety but also chronic disease.

SBHAs at the Forefront – Addressing the Needs of Older Adults #2

The **Oklahoma** Department of Mental Health and Substance Abuse Services (ODMHSAS) joined SAMHSA in identifying older adults as a unique population that underutilizes behavioral health services due to stigma and the lack of mental health insurance parity. Through efforts to address the needs of older adults, ODMHSAS coordinates the following programs:

Pre-Admission Screening & Resident Review (PASRR)

Federal law requires that all persons with a serious mental illness and or mental retardation must be screened and assessed for appropriate placement before being admitted to a nursing facility. ODMHSAS is responsible for the mental illness side of PASRR in Oklahoma. The PASRR evaluation system is designed to determine if a person actually has a nursing home level of care need before they are admitted.

Oklahomans Learning to Direct Recovery (OLDR)

Older adults may develop depression or anxiety disorders as a result of life changes and challenges that are typical in the aging process. While these illnesses are highly responsive to treatment, older people underutilize the behavioral health resources that already exist.

SKILLED RESOURCE AND LEADERSHIP ROLE #2 MANAGE AND COORDINATE FINANCING AND COVERAGE

The following key responsibilities fall under this major role.

Harmonize Funding Streams:

SBHAs coordinate multiple funding streams, including Medicaid, federal block grants, county taxes, third party insurance, corrections, entitlements, housing programs, vocational rehabilitation, and other fund sources.

Public behavioral health systems are comprised of multiple funding streams, including, Medicaid, federal block grants, county taxes, third party insurance, corrections, entitlements, housing programs, vocational rehabilitation and other funding sources.

SBHAs are extremely capable of coordinating these complex funding streams and managing collaboration with federal, state and local officials.

The largest Federal-State grant programs dedicated to financing behavioral health services are the Community Mental Health Services Block Grant (MHBG), which allocates grants to states to support and enhance community behavioral health systems for individuals with serious mental illness.

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The second grant initiative is the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) that provide funding for prevention in schools and communities along with modern treatment and recovery services for people with substance abuse disorders and their families. Stemming from a long history of financing and delivering mental health and substance abuse, other state and local funds finance a range of services for mental health and substance abuse services in the nation.³⁴

In addition to receiving direct state appropriations for its operations, the SBHA is the agency that brings separate entities together in order to coordinate several complex funding streams (**Exhibit 5**) into programs that work for people with behavioral health disorders.

The financing system for behavioral health services differs from that for general medical services. Most notably, public sources play a larger role in financing behavioral health care (representing 61 percent of expenditures) than they do in overall health services (representing 46 percent of expenditures).

The federal-state Medicaid program is currently the largest source of financing for behavioral health services in the nation, covering over a quarter of all expenditures. Medicaid plays a large role in financing behavioral health services because its eligibility rules reach many individuals with significant need; it covers a broad range of benefits; and its financing structure allows states to expand services with federal financial assistance.

Medicaid coverage of behavioral health benefits has been pivotal to deinstitutionalization and adoption of new treatment modalities. Medicare’s role in financing behavioral health care (covering 7 percent of spending) is much smaller than its overall role in the health system, where it finances nearly a fifth of spending.

The SBHA directly manages Medicaid and other funding in order to align payments with multiple programs, services, and practices to the extent possible.

As Medicaid becomes a larger payer for persons with behavioral health disorders, it is important to understand that Medicaid is primarily a health insurer, thereby requiring other funding sources to support critical services. In some states, the SBHA directly manages Medicaid and other funding in order to align payments with multiple programs, services, and practices to the extent possible.

Private insurance coverage covers the majority of Americans but finances only about a quarter of spending on behavioral health care. While nearly all (98%) of those with employer-sponsored coverage have mental health benefits included in their health plan, most have limits on these services.

Exhibit 5



SBHAs at the Forefront- Developing Creative Payment Solutions

Like many SBHAs, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has been seeking creative solutions to improve provider performance in the face of state budget cuts. Through a collaborative process – “The Oklahoma Enhanced Tier Payment System” – with the Community Mental Health Center (CMHC) provider community, the Oklahoma Health Care Authority (OHCA), and the state’s Medicaid agency, ODMHSAS was able to accomplish something that many cash-strapped state agencies are seeking to do; that is, improve quality of care, increase provider payments, and serve more people in need.

The Oklahoma Enhanced Tier Payment System provides very important lessons for SBHAs, Medicaid agencies, providers, clients, and stakeholders. Even for those states for which an Upper Payment Limit (UPL) incentive system is not an option, this approach still provides lessons applicable for all states. It demonstrates that states and providers can engage in a mutually beneficial process to improve quality and that it is the partnership between the state and provider community that helps reach that goal.

It challenges the common assertion that provider rates already include payment for quality or that providers should have been performing in a certain way all along; therefore, additional payment is not needed. By shining a spotlight on what was most important to the state enhancing outcomes – the state improved how its system performed. Oklahoma was able to demonstrate that agencies provided something extra for that money -- and those extras were the key to important changes in their system.

The Oklahoma Enhanced Tier Payment System provides a template for how mental health authorities, substance use authorities, and Medicaid agencies can address mutual goals. Promoting health improvement and aligning financial incentives to pay for outcomes, not simply volume of service provision is essential. The expertise of the mental health and substance use authorities to shape system performance in this area is essential to a state Medicaid program. Medicaid authorities are acutely aware that persons with untreated mental health and substance use issues lead to increased Medicaid costs; and therefore could benefit greatly in partnering with their sister agencies to implement mental health and substance use specific performance benchmarks that improve the system.

Although they have a long history of funding mental health in the United States, charitable and philanthropic sources account for a small share (4%) of current financing for behavioral health services. Most of these funds are strategically targeted to pilot innovative programs or provide incentives for systems change.

The SBHA can directly manage Medicaid and other funding in order to align payments with multiple programs, services, and practices.

SBHAs directly contract with private local community-based behavioral health providers and/or fund local government services (city, county, or multi-county) and managed care entities, which in turn, operate and contract for community behavioral health services. SBHAs are actively involved, often in partnership with the courts, in keeping persons with severe mental illness and addictions out of prisons and jails through criminal justice diversion and reentry programs, drug courts, and outpatient commitment statutes.

States “blend” or “braid” their state or block grant funds with Medicaid dollars. Through blending strategies or “pooled financing” of Medicaid, state general funds, block grants, and other categorical funds, SBHAs promote flexibility and the optimum continuum of services for patients. Braided funds can lead to uniform benefits for insured and uninsured populations, and can also reduce the clinical and administrative barriers between programs in some state behavioral health service systems. SBHAs work closely with other major state payers (e.g. criminal justice, child welfare, education) to determine what populations and services are covered by other sources within the state. These assessments help SBHAs target their funding and programs to fill gaps in care.

SBHAs at the Forefront – Blend and Braid Funding

Perhaps one of the best, but also most challenging, ways to overcome structural barriers in traditional systems silos is to combine funding from multiple systems. State Behavioral Health Agencies blend funding and pool dollars from multiple sources and make these dollars, while braided funding is a resource allocation strategy that results in combined funds remaining visible, allowing them to be tracked more closely. Wraparound Milwaukee, for example, blends funds from a variety of sources, including case rates from child welfare and juvenile justice, Medicaid payments, and other insurance sources, to create a pool of funds that can be used to cover any services a youth or family may need. Combining funds facilitates the long-term sustainability of a collaborative structure.

Given the array of payers with different funding objectives, reporting demands, and administrative mandates, it can be difficult to link consumers (sometimes with multiple

eligibilities and conflicting payer requirements) with appropriate funding sources even when the clinical need is great. This hampers access to care and impedes the development of broad evidence-based clinical pathways, as programs are often developed to align primarily with payer specifications, which may not always align with evidence-based care or consumer needs and preferences.

Meeting the needs of people with serious behavioral health conditions means addressing their “total care” needs, and that can include stable and secure housing, job training, providing transportation to their providers, and educational programs. Given today’s state budgetary climate, ensuring the funding needs of people with mental illness are met through an array of supportive services like housing can be extremely challenging. The cost of inaction – not addressing the healthcare and social needs of people with serious mental illness – can result in greater financial costs and most importantly, can put consumers at risk.

Meeting the needs of people with serious behavioral health conditions means addressing their “total care” needs, and that can include stable and secure housing, job training, providing transportation to their providers, and education programs.

SBHAs utilize the Mental Health Block Grant to fund critically important supportive services such as housing and employment. Lack of decent and safe housing is one of the most significant barriers to full participation in the community for people with serious mental illnesses. SBHAs offer financial assistance through grants or low to no-interest loans to help people with serious mental illness and substance abuse disorders find permanent affordable housing. SBHAs also provide job assistance funds they transition into the workforce.

SBHAs at the Forefront - Corrections and Criminal Justice

State spending on Corrections has risen faster over the last 20 years than spending on nearly any other state budget item. People on probation, on parole, or in prison have high rates of mental illnesses and substance use disorders compared to offenders without these disorders. SBHAs are working with criminal justice agencies that focus on “back-end” investment in people with behavioral health disorders already involved in the criminal justice system, specifically individuals under probation or parole supervision. Offenders with a behavioral health diagnosis on probation/parole are far more likely to be returned to prison. State officials with substantial funds to reinvest want to have an immediate impact on crime and prison admissions, and back-end investment appears to be a straightforward mechanism through which to impact this growth. Under the back-end investment process SBHAs, as part of their analysis, allocation and management roles, are responsible for funding to local and community mental health providers once they have decided on target populations and infrastructure improvements such as increased staff capacity.

Once the SBHA decides on a funding strategy to community mental health provider agencies, the SBHA is also responsible for the administration of community-based initiatives supported through this funding. SBHAs also develop formalized mechanisms for monitoring whether behavioral health providers that receive reinvestment funding meet obligations and achieve outcomes for the target populations. Such SBHA mechanisms could include developing automated data collection systems, utilizing performance-based contracting, and creating legislation to expand positive reinforcements for completion of behavioral health programs. Finally, SBHAs are responsible for how reinvestment initiatives will operate day-to-day. SBHAs develop screening protocols to enable behavioral healthcare providers and corrections agencies to identify individuals in the target population on an ongoing basis. The agencies also help develop preferred service delivery models and methods. These strategies ensure the integration of specialized services for probationers/parolees into existing community behavioral healthcare service delivery system.

Implement Behavioral Health Parity:

The Mental Health Parity and Addictions Equity Act (MHPAEA) passed in 2008, requires most health plans that already offer coverage for mental health and addiction services to increase coverage and eliminate discriminatory rules and payments, making benefits for behavioral health treatment comparable to the coverage provided for all other health conditions.

SBHAs play a role in ensuring that qualified health plans provide benefits in compliance with parity.

The Mental Health Parity Act of 1996, revised and expanded by the Mental Health Parity and Addiction Equity Act of 2008, broadly addresses the problem of discrimination against behavioral health disorders in both benefit design and plan administration. The original legislation addressed parity only in relation to annual and lifetime dollar limits on coverage; the 2008 amendments extended the concept of parity to reach a broad range of coverage limitations and exclusions.

The 2010 parity regulations affect many of the health benefit design and management practices described above. The rules clarify that parity can be violated through discriminatory medical necessity criteria that utilize more restrictive tests of necessity in the case of mental illness and through other design techniques such as tiered cost-sharing, tiered network arrangements, and utilization management procedures that are applied in a discriminatory fashion. Federal agencies not only have directly addressed the range of plan design and administration practices, but have identified many types of practices that must be held to nondiscrimination standards, including specific benefit definitions, broad definitional terms such as medical necessity, the use of practice guidelines, and the use of provider network and cost sharing tiers.

SBHAs play a role in ensuring that qualified health plans provide benefits in compliance with parity, and should advocate that state Health Insurance Exchange advisory boards – and other oversight bodies – monitor compliance with parity law.

For parity to achieve its intended goals, it is important for SBHAs to work closely with their state insurance divisions. Together, SBHAs promote education of, and compliance, with parity requirements, monitor results, facilitate handling of consumer complaints, enhance transparency and accountability, and expand consumer protections.

SBHAs monitor parity implementation by assessing health plan performance related to access and quality, in addition to monitoring coverage and costs; examining the breadth of diagnoses covered by health plans; and mounting a campaign to educate consumers about their insurance benefits.

SKILLED RESOURCE AND LEADERSHIP ROLE #3: PRIORITIZE FUNDING RELATED TO NON-MEDICAL SERVICES

Provide Affordable, Safe and Quality Housing:

A decent, safe and affordable place to live is essential for anyone to achieve full participation in community life. For people with serious mental illness, having a home of one's own, and choosing that home – the neighborhood, the type of housing, and who (if anyone) it is shared with – is also a critically important element of self-determination, full community integration, and a pathway to recovery.

SBHAs promote housing policies and programs to ensure that people served by the public behavioral health system are able to make informed choices among safe and permanent affordable housing options that are linked with high quality services and are available in the most integrated setting in the community.

SBHAs promote housing policies and programs to ensure that people served by the public behavioral health system are able to make informed choices among safe and permanent affordable housing options.

The affordable housing challenges in which SBHAs continue to confront to achieve this vision and goal include the following:

Poverty: People with serious mental illness are disproportionately poor and cannot afford even modestly priced rental housing without housing assistance. The bi-annual housing affordability study, *Priced Out in 2010*, just released by the Technical Assistance Collaborative (TAC) confirms that in 2010, people who relied on Supplemental Security Income (SSI) payments have incomes equal to only 18 percent of median income – more than 20 percent below the federal poverty level. In 2010, more than two (2) million people with mental illness were receiving federal SSI payments and tens of thousands of chronically homeless people with mental illness were potentially eligible for SSI.

Housing Costs: The *Priced Out in 2010* study found that people with the most significant and long term disabilities continue to be completely priced out of the nation's rental housing market. Nationally in 2010, people receiving federal SSI payments would have needed to pay 112 percent of their entire monthly income in order to rent a one-bedroom apartment priced at the HUD Fair Market Rent.

At the state level, SBHAs work closely NASMHPD to support the development of new or expanded partnerships with State Housing Finance Agencies (HFAs), including their full participation with State HFAs in the first competitive funding round for Section 811 expected during 2012. These activities will include the preparation and dissemination of Section 811 materials, webinars and other distance-learning techniques covering the Section 811 regulatory process and the release of the Section 811 HUD Notice of Funding Availability. SBHAs are involved in the full range of State HFA and State and local PHA activities, including the conversion/revitalization of HUD public and assisted housing

units/buildings to mixed income communities as opportunities to encourage Permanent Supportive Housing (PSH) and the full integration of consumers into the community.

During the foreseeable future, there will be both challenges as well as opportunities for NASMHPD and its members within federal, state and local affordable housing policy. Nonetheless, SBHAs have demonstrated that it is possible to establish successful housing partnerships at the state and local level to expand the PSH approach in local communities, including during years when new HUD funding is in short supply.

SAMHSA's Evidenced-Based Practice Toolkit on PSH defines the key elements of the PSH model:

- Integrated, community-based permanent housing that is safe and secure;
- Housing that is affordable with tenants paying no more than 30 percent of their income toward rent and utilities;
- Leases that are consistent with local landlord-tenant law and held by the tenants without limits on length of stay as long as the tenant complies with lease requirements;
- Individually tailored and flexible supportive services that are voluntary, accessible where the tenant lives, available 24 hours a day/7 days a week, and are not a condition of on-going tenancy; and
- On-going collaboration between service providers, property managers, and tenants to preserve tenancy and resolve crisis situations that may arise.

SBHAs and NASMHPD are calling on HUD, SAMHSA, HHS's Office of Civil Rights, and DOJ to initiate discussions to collectively develop new federal policies which would promote and incentivize the targeting of federal housing assistance programs for *Olmstead* settlement agreements. These policies are essential because it is federal action which is holding SBHAs accountable for providing housing assistance to low income individuals who should be assisted through low income housing programs.

SBHAs believe that people with mental illness currently residing in restrictive settings, such as nursing homes and public institutions, are extremely disadvantaged in terms of applying for federal housing assistance.³⁵

Secure Meaningful Work through Supported Employment Initiatives:

Most consumers with severe mental illness want to work and feel that work is an important goal in their recovery. When they identify work as a goal, consumers usually mean *competitive employment*, defined as community jobs that any person can apply for, in integrated settings (and in regular contact with nondisabled workers), and that pay at least minimum wage. Unfortunately, assistance with employment is a major unmet need in most mental health programs: less than 15 percent of consumers with serious mental illness are competitively employed at any time (www.nami.org)

Supported employment is a well-defined approach to helping people with disabilities participate in the competitive labor market, helping them find meaningful jobs and providing ongoing support from a team of professionals. First introduced in the psychiatric rehabilitation field in the 1980s, supported employment programs are now found in a variety of service contexts, including community mental health centers and psychosocial rehabilitation agencies.

Research has shown that substantial evidence demonstrating the importance of meaningful employment for individuals with serious mental illness. Quality of life for the population with mental illness is positively impacted, thereby impacting the larger community by decreasing the financial burden on mental health systems and reducing poverty.

Research from diverse fields has shown that substantial evidence demonstrating the importance of meaningful employment for individuals with serious mental illness.

Through supported employment programs, quality of life for the population with mental illness is positively impacted by the improvement of psycho-social health and well-being, thereby impacting the larger community by decreasing the financial burden on mental health systems and reducing poverty.³⁶

The public policy considerations related to this population are vast and need to include an understanding of how funding should include not only vocational but clinical services.³⁷

The President's New Freedom Commission on Mental Health (2003) emphasized that work serves as a vehicle for people with mental illness to move forward in the process of recovery. Work in regular community settings helps to reduce disability, boredom, fear, social isolation, discrimination, and stigma. Employment alongside others who do not have disabilities is the most concrete way that people with severe mental illness can become truly integrated into their communities.

SBHAs are leading current efforts in partnership with foundations, employers and local government officials, to improve supported employment programs for people with serious mental illness.

SBHAs at the Forefront- Supported Employment

Adopting Best/Evidenced-based Practices for Supported Employment Programs Individual Placement and Support Model.

The New York State Office of Mental Health (OMH) has desired to raise employment rates among consumers with serious mental illness by implementing the Individual Placement and Support (IPS) model of supported employment within Personalized Recovery-Oriented Services (PROS) programs throughout the state. OMH has adopted IPS model of supported employment, which has consistently demonstrated high rates of competitive employment for consumers. Implementation of this approach will require a workforce that is competent in knowledge and skill in providing these services.

NYS has recently created a newly licensed multi-service program referred to as Personalized Recovery Oriented Services (PROS). One of the high priority service areas in PROS is supported employment. PROS programs provide employment related services in ways that align with the IPS approach.

One very promising strategy to assist staff in faithfully implementing a practice has been to include the use of guidebooks as part of the service provision process. Increasingly, treatment and rehabilitation services are employing guidebooks to insure that practitioners are following recommended approaches (e.g., Illness Management and Recovery, Wellness Self-Management). These approaches have been well received and valued by staff and consumers. Guidebooks that belong to the consumer are especially empowering and valued. These resources promote learning and retention of information because consumers take the material with them.

The goal of this project was to develop an IPS guidebook used by vocational staff members who are working with consumers who have expressed a clear interest in seeking employment.

Accomplishments: A 100- page, 13 topic guidebook, plus 9 appendices, has been developed, reviewed by stakeholders and expert consultants, and finalized. The guidebook is oriented from the perspective of the user.

Topics include:

- Introduction to the guidebook
- My decision to work
- My hopes and concerns about working
- My job preferences
- My work goal – figuring out what I would like to do
- Finding a job

Appendices currently include:

- Basics of benefits counseling
- Sample resumes
- Sample cover letters
- Sample job applications

Pilot Project:

The pilot project has 4 sites: 2 near Rochester; 1 in New York City; and 1 on Long Island. The pilot started in February 2012. All are in community-based services rehab programs. There are 70 such PROS programs statewide. Feedback is taking place via surveys, and focus groups occurred in May/June 2012. Data reports are being regularly delivered by the Pilot Sites, and implementation is intentionally being carried out in a non-proscriptive fashion – as a result a diverse set of uses has arisen. After the second iteration of the Guidebook is finished, the program may expand beyond PROS to residential treatment.

SKILLED RESOURCE AND LEADERSHIP ROLE #4: MANAGE, IMPROVE, AND COORDINATE QUALITY OF CARE AND DELIVERY SERVICES

The following key responsibilities fall under this major role.

Accelerate Integration of Primary Care, Behavioral Health and Prevention:

SBHAs are addressing new challenges in helping individuals with chronic diseases of persistent and serious mental illness and other behavioral health conditions, receive care that is integrated, cost-effective, and achieves the best outcomes.

Why is integration of primary care and behavioral health important?

- Over 12 million visits to emergency departments on an annual basis are due to individuals with mental health and substance use disorders; many people are unable to make an appointment to see a primary care physician.³⁸
- Over 70 percent of primary care visits stem from psychosocial issues. Most primary care physicians are not equipped or lack the time to fully address the wide range of psychosocial issues that are presented by patients.³⁹
- As reported in this document, Americans with severe mental illness (SMI), on average, only have a 53-year lifespan – 25 years younger than the average lifespan for Americans without mental illness. And those Americans with co-occurring disorders (substance use) are dying, on average, according to one study, at age 45.⁴⁰
- Nearly half of all cigarette consumption is by individuals with behavioral health disorders.⁴¹
- Healthcare expenditures of Americans with serious mental illness are two (2) to three (3) times higher than other patients due to preventable chronic conditions.⁴²
- Over 50 percent of all lifetime cases of substance use disorders begin at age 14 (essentially the same for mental health disorders) and three-fourths by age 24.⁴³
- Nearly three in four individuals receiving Medicaid coverage with significant mental health and substance use disorders had at least one chronic health

condition, nearly half had two chronic diseases and almost one-third had three or more conditions. When individuals have three or more physicians, those physicians usually do not talk with another or share information.⁴⁴

Behavioral health conditions are under-diagnosed and under-treated in the U.S. despite their high prevalence in the population and solid research pointing to the fact that treatment works, prevention is possible, and recovery is achievable.

Behavioral health conditions commonly co-occur with other chronic health conditions in adults and yet services are rarely delivered in concert. These findings suggest the importance of having screening, evaluation and diagnostic services available at multiple access points in primary care and behavioral health care networks.

The acute shortage of both behavioral health and primary care providers in many areas makes the provision of care, particularly integrated services, difficult. This problem is compounded by the fact that both primary care and behavioral health providers often are not trained or educated about how to work in an integrated setting, resulting in a disconnect between the two cultures of care. In spite of these challenges and barriers, SBHAs are working with safety net systems to help bridge the gaps in primary care and behavioral health delivery systems and promote integration.

SBHAs also are working to identify incentives and other supports in contracting and purchasing standards to encourage behavioral health providers to treat multiple symptoms within an episode of care. SBHAs that jointly create a plan for integrating behavioral health treatment with medical care will increase the chances for successful implementation.

New efforts that create strong bi-directional linkages between primary care and preventive services, and addiction and mental health services is a critical step to achieving improved patient outcomes. SBHAs are targeting technical assistance at the community level, and aligning fragmented prevention programs into one cohesive, holistic approach, that are realizing significant cost savings and reducing the emergence of chronic and debilitating disorders.

SBHAs have become champions and they also identify champion leaders that support integration efforts including the identification, development and acceleration of best practices, providing forums for sharing and learning about integration initiatives, and fostering relationships that promote the integration of primary care services and behavioral health care.

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SBHAs in many states have supplied primary care physicians with materials on expanding integration efforts.

SBHAs are working with Medicaid officials and health care providers to provide the means and incentives necessary to integrate medical and behavioral health services to improve the overall quality of patient care. For example, SBHAs have worked with the state Medicaid plan to eliminate barriers to integrate behavioral health and medical care, such as policies that prohibit billing multiple services on the same day.

SBHA Medical Directors are disseminating data at the state/local level on the association of behavioral health issues with health risk and chronic disease in the general population. Additionally, they have supported steps to integrate mental health screening and treatment into primary care and public health activities and work with the State Medicaid authority, to leverage quality improvement programs that are being implemented at the state level, to assure inclusion of people living with serious behavioral health conditions.

SBHAs also have promoted and helped pediatric practices create a framework strategy for integration.

Address Behavioral Health Integration Issues among Racial and Ethnic Minorities:

As the changing healthcare landscape focuses on a central role for primary care in the delivery and coordination of health care services, especially for the chronically ill, it is timely to consider how mental health services could be better integrated into primary care, and how the implementation of new approaches in the changing healthcare landscape could optimally deliver this.

Achieving this goal would make a substantial contribution toward expanding access to mental health services, improving the physical health of people with mental illness and the mental health of people with chronic physical illnesses, and addressing current health care inequalities for people with mental health problems, especially for those who are from racial and ethnic minorities.

Disparities exist in both access to and the quality of mental health care for racial and ethnic minority groups in the United States. Examples of these disparities include:

- the underutilization of psychiatric services by persons from ethnic minority groups,
- problems in treatment engagement and retention of persons from minority groups,
- the over-diagnosis of schizophrenia among African Americans and depression among Latinos,

- the inappropriate use of antipsychotic medications among African Americans (and the use of these medications at higher dosages among African Americans and lower dosages among Latinos), and
- very high rates of substance use disorders and completed suicide among Native Americans. In addition to access barriers, such as inadequate insurance coverage and health workforce shortages, other factors that affect minority patients' utilization of mental health services include: inadequate detection of psychiatric conditions by primary care physicians, under referral of these patients to psychiatric care, early dropout rates from treatment, and high rates of missed appointments.⁴⁵

The consequences are dramatic:

- African Americans are 30 percent more likely to report having serious psychological distress than non-Hispanic whites.
- Older Asian-American women have the highest suicide rate of all women over age 65 in the United States.
- In 2005 suicide attempts for Hispanic girls in grades 9–12 were 60 percent higher than for white girls in the same age group.
- While the overall death rate from suicide for American Indian/Alaska Natives is comparable to the white population, adolescent American Indian/Alaska Natives have death rates two to five times the rate for whites in the same age groups.

Addressing Providers' Bias and Stereotyping

Discrimination by race/ethnicity is a complex behavior that can stem from a number of sources—some malevolent, some not. Physicians may be especially vulnerable to the use of stereotypes in forming impressions of patients since time pressure, brief encounters, and the need to manage very complex tasks are common characteristics of their work. The effectiveness of communication between patient and doctor can be compromised when patient and doctor come from different ethnic, racial, or language groups.⁴⁶

Providing More Diversity in the Mental Health Workforce

More than one-fourth of all Americans are from minority groups, but these groups are greatly underrepresented in the health workforce. The percentage of racial and ethnic minorities in the mental/behavioral workforce was estimated in 2004 to be: 6.2 percent for psychology, 8.7 percent for social work, 24.2 percent for psychiatry, 17.5 percent for

psychiatric nursing, 15.4 percent for counseling, 5.5 percent for marriage and family therapists, and 5.3 percent for school psychology. These data reveal the need to increase the pipeline of racial and ethnic minorities in mental and behavioral health professions.

State Behavioral Health Agencies (SBHAs) have been initiating efforts to support greater racial diversity and cultural competency in the mental health workforce and making this area a priority in their overall strategic efforts. In many minority communities, SBHAs are helping community health workers provide needed assistance with interpretation and translation services and culturally appropriate health education and information. SBHAs offer informal counseling and guidance on health behaviors and be advocates for individual and community health needs.

SBHAs also are better collecting and using data as an essential initiative to drive improved understanding of health care disparities.

Measure and Encourage Improved Behavioral Health Performance and Outcomes:

SBHAs have developed cutting-edge systems and programs that health plans use to collect, analyze and aggregate data on behavioral health provider practices, and feed this information back to providers so they can understand how well they meet standards of care for people they serve. The result of these efforts has been particularly important for plans to use the data to identify and intervene with those providers whose practices represent outliers in terms of quality. In addition, these initiatives identify individuals at risk of adverse health outcomes and higher utilization of services because of substandard care.

The creation of a National Behavioral Health Quality Framework by SAMHSA represents an important step in achieving the overarching purpose of SAMHSA to realize an integrated national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.

SBHAs have developed cutting-edge systems and programs that health plans use to collect and analyze data on behavioral health provider practices, and feed information back to providers.

As improving the quality of behavioral health care is a primary aim, SBHAs have begun to develop state-specific quality strategies to help meet the priorities of the National Quality Strategy. SBHAs have begun to prioritize the many behavioral health metrics into a smaller and focused set of measures.

SBHAs also are working with Medicaid, Medicare and other private payers to analyze information collected from quality data measurement systems to improve behavioral health quality.

SBHAs are leading public quality transparency initiatives that tend to build on a broad base of stakeholders – including providers, payers, purchasers, consumers and policy makers – from the earliest stages of program design. SBHAs have been engaging providers, in particular at the beginning of these efforts, which has increased participation in voluntary transparency initiatives. This strategy has helped ensure clinical and practical relevance of the measures, and increase acceptance by providers of the program’s measures and methods.

SBHAs are working with Medicaid, Medicare and other private payers to analyze information collected from quality data measurement systems to improve behavioral health quality.

SBHAs are working closely with SAMHSA to identify several national indicators to supplement the state-specific outcome performance measures. "Information dashboards" have emerged as a vital tool for health care entities to promote quality improvement within their organizations. Research has shown that there is a correlation between dashboard implementation and quality performance. SBHA will use dashboards to provide a quick, high-level view of the overall behavioral healthcare quality in various settings and associated with various types of care.

The Agency for Healthcare Research and Quality (AHRQ) is identifying areas where gaps exist in behavioral health quality measurement reporting. AHRQ will make recommendations about which existing quality measures need improvement, updating, or expansion, ensuring that these recommendations are consistent with the National Quality Strategy. AHRQ will also award grants to entities for purposes of developing, improving, updating, or expanding quality measures. SBHAs are collaborating with behavioral health providers to apply for AHRQ grants to develop new innovative behavioral health quality measures.

As states blend and braid current and future funding streams and methodologies, SBHAs have been working with partners and stakeholders – including representatives of diverse ethnic, racial and sexual minority populations – to incorporate behavioral health into the design, implementation and use of electronic health records (EHRs). In addition, SBHAs have developed a set of quality and performance indicators identified to improve outcomes and accountability, while eliminating redundancy and burden in reporting.

To achieve optimum individualized care, a modern behavioral health system should include a structure in which all holistic outcomes, measures and indicators of care are collected, stored and shared with the individual and all of those providers who are associated with care of the individual. To that end, SBHAs support and participate in the development of interoperable, integrated electronic health records that will be necessary, as will community-wide indicators of behavioral health disorders.

SBHAs support a framework that contains several performance measures (some with multiple parts) and balanced across structure, process, and outcomes, as well as across behavioral health conditions. The measures could be applied to any health care setting. There are complexities associated with the delivery of behavioral health treatments that point to the need for careful stewardship to achieve a consensus on what quality domains are most important to measure, and to coordinate studies aimed at gathering evidence to build a more robust portfolio of measures. Other than SBHAs, no entity at the state level is now providing leadership to help gain consensus for the development of behavioral health measures.

SBHAs have undertaken many initiatives to make information about recovery, self-help services, and data on services available to consumers, family members, and advocates via the Internet and other means including information on:

- Supports to consumers and family members;
- Identifying behavioral health conditions;
- Behavioral health care treatments;
- Evidence-based practices (EBPs);
- Outcomes of SBHA providers;
- Specific recovery initiatives by SBHAs; and
- Performance measures on SBHA providers.

SBHAs at the Forefront—Outcomes Measurement

The Maryland Department of Health and Mental Hygiene have developed the Outcomes Measurement System (OMS) Datamart. It is designed to track how individuals receiving out-patient mental health treatment services in the Maryland Public Mental Health System are doing over time in various life domains, including housing, employment/school, psychiatric symptoms, functioning, substance use, legal system involvement, and general health. The system was created with the involvement of consumers, caregivers, mental health providers, and other stakeholders.

The OMS, has been in operation since 2006, and was developed to collect information on individuals, ages 6-64. Outcomes analyses have continued to progress through a collaborative effort of the University of Maryland Systems Evaluation Center (SEC) and the Mental Hygiene Administration. They have developed analytical structures for comparing individual consumer progress over time (e.g., definitions for increase, decrease, and maintenance of scores have been developed). At the individual consumer level, responses from the first OMS interview are compared to responses from the most recent OMS interview and change-over-time scores are calculated. Data is then aggregated at the State level.

Design and Implement Evidence-based Practices (EBPs):

SBHAs play a major system-wide role in designing and implementing evidence-based prevention, treatment and recovery-oriented practices that produce positive clinical outcomes for consumers and savings for taxpayers. Leadership in disseminating knowledge of EBPs to system partners is one key component of the SBHA's role as a change agent. SBHAs facilitate education and learning about science and empirical evidence related to clinical services and their connection to improving behavioral health client outcomes.

SBHAs play a major system-wide role in designing and implementing evidence-based prevention, treatment and recovery-oriented practices that produce positive clinical outcomes for consumers and savings for taxpayers.

For example, one key evidence-based service is supportive housing. To promote independence and support recovery, a key SBHA goal is to ensure that people served by the public behavioral health system have access to decent, safe and permanent affordable housing of their choice, linked with the full range of high quality services they may need to support successful tenancies.

An often-debated issue surrounding evidence-based practices is the importance of “fidelity to the model.” Fidelity of implementation refers to adherence to specific programmatic standards or principles. For example, when implementing a program such as assertive community treatment (ACT), certain components need to be measured to assess fidelity, including caseload (staff to client ratio), frequency of contact, and the presence of a psychiatrist on staff.

Fidelity issues need to be addressed when implementing an EBP, namely, how fidelity will be insured and providers trained and held accountable for correct implementation of the EBP. SBHAs work to insure that when implementing EBPs, the implemented practice holds close to the model (i.e., the greater the fidelity of the practice) that results in better outcomes.

Significant advances have been made in the understanding and treatment of mental illness. Despite these advances, experts believe that many Americans are not benefiting from improved behavioral health care. The lag between discovering effective forms of treatment and incorporating them into routine patient care is long, lasting on average about 15 years – not too dissimilar to the physical healthcare sector.

Use of evidence-based practices can be affected by coverage decisions. Payers can be reluctant to cover new treatment modalities, even when there is evidence for their effectiveness, possibly because the new modalities are not yet considered to be mainstream or may be more expensive. Second, providers are often not trained in the newly discovered evidence-based practices. Research findings are not disseminated in a manner that enables providers to easily incorporate them in their practice.

SBHAs at the Forefront - Demonstrating Value

SBHAs and providers are demonstrating the value of behavioral health's role in emerging systems, and providing leadership on new types of delivery models a state should move toward. To have a viable seat at the table on providing value and robust quality of care, SBHAs have identified the following conditions that should be in place in a behavioral health provider organization: Accessibility to treatment; The ability to identify an entity's costs and demonstrate that the organization understands the composition of those costs -- cost effectiveness and efficiency; The ability to provide episodic care under bundled rates, rather than a more open-ended approach. The term "treat to target" is being used to describe a scenario in which agencies and providers can, for example, document a client's concrete improvement in 6 to 12 months, rather than simply renewing a client's static treatment plan over and over again; Health information technology capacity to allow full communication with primary care; and The ability to produce "Outcomes to our Outcomes" where it can be shown that a community provider's effective services, directly reduces the need for higher-cost, more disruptive treatments for behavioral health consumers.

Despite barriers, SBHAs have been driving dramatic changes in clinical practice and EBP reforms through regulatory and policy changes that have spurred widespread change with service delivery systems. EBP reforms have come about because SBHAs also have explicitly and extensively focused on both the organization and financing of care and the content and quality of direct clinical care simultaneously.

Many SBHAs are using limited resources to sponsor conferences to reach many people about the use of EBPs. They are at the forefront of facilitating education and learning about science and empirical evidence related to clinical services and its connection to patient outcomes. SBHAs have been engaging providers in an open dialog about ideas for transformation with EBP reforms front and center. SBHAs work closely with academia in their states to accelerate the movement of research findings into practice, and establishing "centers of excellence" to train providers.

Promote Peer Support Services:

As part of building a recovery-based system, SBHAs have led efforts to support the widespread adoption and the coverage of peer support as a specific type of service and/or provider, even in the Medicaid program. Peer-support – services from behavioral health staff and consumers who have experienced a serious behavioral health disorder and who relate to participants based on their experience in the recovery process – plays a valuable role in recovery.

The Centers for Medicare & Medicaid Services (CMS) has declared peer support an “evidence-based mental health model of care” and has specified requirements for Medicaid-funded peer support.

SBHAs provide networking opportunities for peer-specialists and use those opportunities to continue and refine:

- Definitions of peer support,
- How peer support differs from mutual support,
- Training, certification, and accreditation,
- Whether to bill Medicaid, and
- Resources on how to manage and promote a peer support system.

SBHAs spread the word about peer support via journal articles, conferences and workshops, as well as continue the development of evaluation instruments, competency assessments, and provider recovery skills. In addition, SBHAs model the incorporation of peers and families in system development. State-level Offices of Individual and Family Affairs that support peer-related initiatives are commonly housed within SBHAs. Peer providers teach social and coping skills essential to increasing resiliency and provide a model of recovery.

SBHAS at the Forefront- Peer Support Services

There is a unique opportunity for the development of peer support services in state behavioral health care systems. Medicaid is a viable funding source; however the development and implementation barriers are substantial. SBHAS have been leaders of the Pillars of Peer Support Services initiative, funders and supporters of that initiative, participants of two major Summits, and working other key stakeholders to continue to push the goal of having high quality peer support services available in all states. Peer support is a fundamental component of recovery and resiliency, and the development of such services should be a high priority for all funders, providers, and stakeholders in state behavioral health care systems.

Reduce the Behavioral Health Impact of Trauma:

Individuals with histories of violence, abuse, and neglect from childhood onward comprise the majority of clients served by public behavioral health systems.

- Over 90 percent of public behavioral health clients have been exposed to trauma, and most have multiple experiences of trauma.⁴⁷
- Three-quarters (75%) of women and men in substance abuse treatment report abuse and trauma histories.
- Nearly 100 percent of homeless women with mental illness experienced severe physical and/or sexual abuse, 87 percent experienced this abuse both as children and as adults.

Trauma can occur from a variety of causes, including maltreatment, separation, abuse, criminal victimization, physical and sexual abuse, natural and manmade disasters, war, and sickness. Although some individuals who experience trauma move on with few symptoms, many, especially those who experience repeated or multiple traumas, suffer a variety of negative physical and psychological effects. Trauma exposure has been linked to later substance abuse, mental illness, and an increased risk of suicide, obesity, heart disease, and early death.

SBHAS address the behavioral health impact of trauma through the development of public health approaches.

SBHAs address the behavioral health impact of trauma by developing public health approaches to trauma that strengthens surveillance, prevention, screening, and treatment and supports trauma-informed systems that better respond to people who have experienced trauma, and are less likely to cause trauma through their interventions.

SBHAs play an active role in information dissemination about trauma by developing targeted educational materials, including:

- Resources developed by consumer/survivors;
- Information designed for families;
- Information about the role of spirituality in trauma recovery;
- Information for communities about normal responses to trauma; and
- How to respond in a trauma-sensitive manner in times of disaster.

SBHAs have developed performance indicators on trauma, and coordinate with disaster response groups to share data and encourage cooperation in the field.

SBHAs also have developed strategies for working with judges and mental health courts to educate them about trauma and to reduce the use of all forms of coercion. They also emphasize workforce and training issues to articulate a new skill set for behavioral health staff based on the lessons learned from the 9/11 terrorist attacks, and implement human resource development strategies, including partnerships with higher education.

SBHAs know that addressing trauma must be central and pivotal to public health and human service policy making including fiscal and regulatory decisions, service systems design and implementation, workforce development, and professional practice. Unless trauma is addressed, the damage to individuals and our society will continue.

The Magnitude of Trauma in America

According to SAMHSA, trauma-informed health care is services that recognizes the vulnerabilities of trauma survivors and the distress that traditional healthcare can trigger in them. Trauma-informed care aims to avoid re-traumatization.

Over one-half (51 percent) of women in the United States and over 60 percent of men in the U.S. experience at least one traumatic event in their lives ranging from childhood sexual abuse, combat exposure, physical abuse, domestic violence and/or the witnessing of violence, terrorism and disasters.

According to the National Institute of Justice, 20 million American women are raped during their lifetime. As exposure to violence can lead to serious and long-term medical problems, this finding alone had critically important implications for the healthcare system.

Management of health problems can be complicated by a history of trauma, especially sexual trauma. Medical procedures that involve the pelvic, genital, rectal, oral, or breast, areas may terrify a sexual trauma survivor and can result in avoidance of important examinations or interventions.

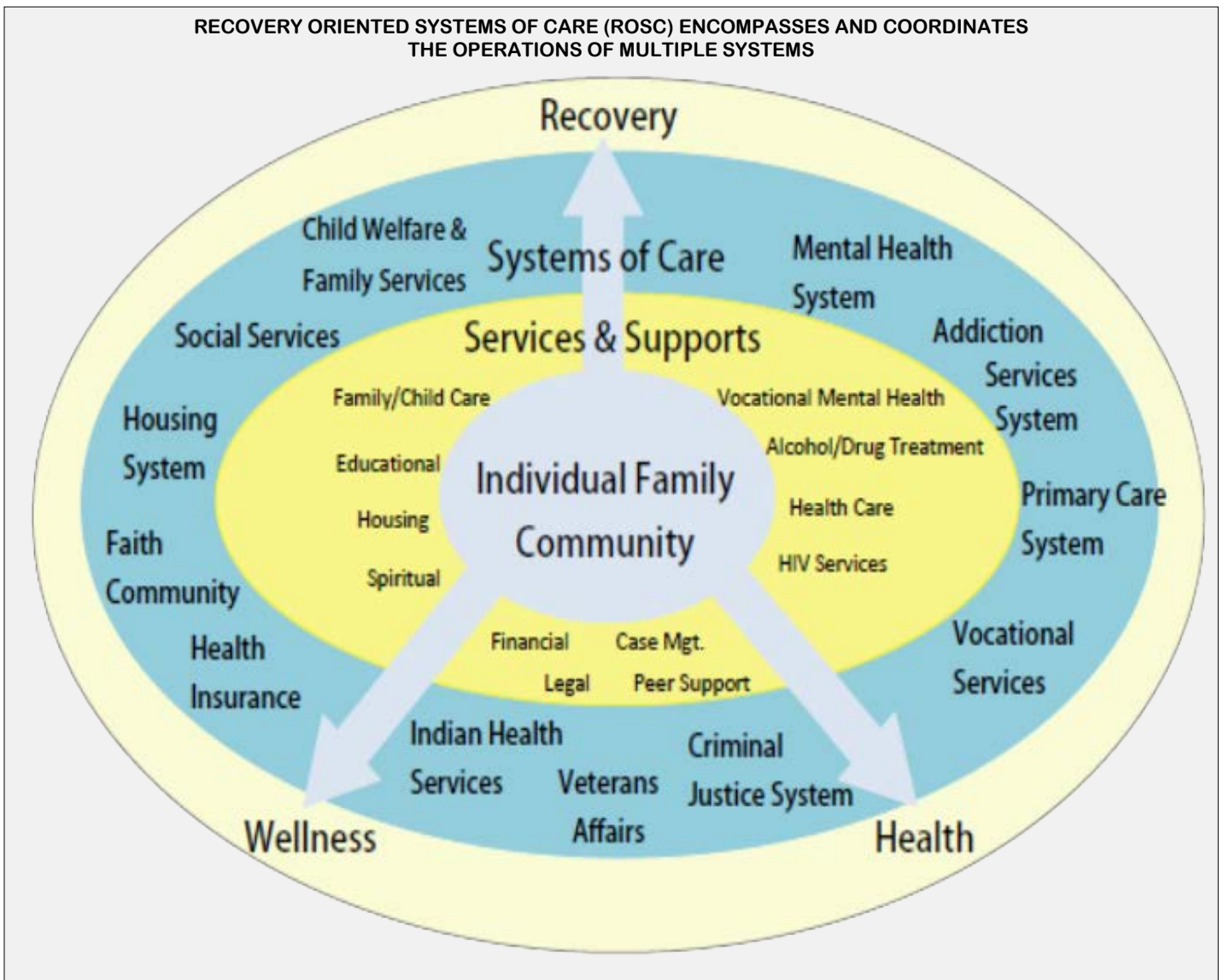
Empower Consumers to Maximize Control of Their Recovery:

An empowered consumer can exercise maximal control over her or his recovery, including choosing which behavioral health professionals are on the team, sharing in decisions, and having the option to agree with, modify, or reject the service or treatment plan.

SBHAs offer appropriate education, enforcement of respect for self-determined choices, useful information for making relevant choices, and specific tools and models that help people retain control of their recovery (e.g., shared decision making tools and person centered planning).

Health care consumers and families will need information and tools to allow them to promote and reinforce their role as the center of the behavioral health care system. **(Exhibit 6).**

Exhibit 6



At a minimum, this will include a system that supports health literacy, shared decision making, and strategies for consumers and families to direct their own behavioral health care.

Health literacy is the first building block of self-care and wellness. Shared decision-making should become the standard of care for all treatment services. Participant direction of services allows individuals and their caregivers (when appropriate) to choose, supervise and in some instances, purchase the effective supports they need rather than relying on professionals to manage these supports.

SBHAs have been working diligently to implement the recommendations of the New Freedom Commission especially related to enhancing recovery and promoting consumer involvement in their care. SBHAs recognize that self-directed care, implemented on a large scale, offers the potential of helping the behavioral health system move in this direction.

Self-directed care is of particular importance to the behavioral healthcare system because it represents one tool that can help transform the system to achieve the intent of the Olmstead decision and the President's New Freedom Commission on Mental Health.

As we have reported, the U.S. Supreme Court, in its 1999 *Olmstead v. L.C.* decision, determined that the unnecessary segregation of individuals with disabilities in institutions – such as public hospitals may constitute discrimination based on disability. The Court ruled that the Americans with Disabilities Act may require states to provide community-based services rather than institutional placements for consumers with disabilities.

The New Freedom Commission on Mental Health's Goal #2, "Mental Health Care is Consumer and Family Driven" incorporates a series of recommendations, several of which relate to self-directed care:

- Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance;
- Involve consumers and families fully in orienting the behavioral health system toward recovery;
- Align relevant Federal programs to improve access and accountability for behavioral health services; and
- Protect and enhance the rights of people with behavioral health conditions.

In the Commission's vision, these plans "should form the basis for care that is both consumer-centered and coordinated across different programs and agencies. The funding for the plan would then follow the consumer, based on their individualized care plan."⁴⁸

In its already classic report, *Crossing the Quality Chasm*, the Committee on Quality of Health Care in America of the Institute of Medicine (IOM) of the National Academy of Sciences proposed six major aims for the healthcare system. It should, they said, be "safe, effective, patient-centered, timely, efficient, and equitable." The report, focused primarily on the physical healthcare system, and identified several dimensions of patient-centered care including:⁴⁹

1. Respect for patients' values, preferences, and expressed needs;
2. Coordination and integration of care;
3. Information, communication, and education; and
4. Physical comfort.

SBHAs apply many of the principles of self-directed care highlighted in the NFC and IOM reports in their programs and policies. The Comprehensive Community Mental Health Services Program for Children and Their Families (Systems of Care) that SBHAs promote, include involving families of children, and children themselves when feasible, in making decisions about services.

SBHAs emphasize peer-to-peer recovery support services that help prevent relapse and promote sustained recovery from severe behavioral health disorders.

SBHAs are developing and helping behavioral healthcare consumers access user-friendly information on the effectiveness of available services so they may truly make informed healthcare decisions.

Strengthen Behavioral Health Services for Military Service Members, Veterans, and Their Families:

There are an estimated 23.4 million veterans in the United States as well as approximately 2.2 million military service members (including National Guard and Reserve) and 3.1 million immediate family members. Since 2001, more than 2 million U.S. troops have been deployed to Iraq and Afghanistan. A significant proportion of returning service men and women suffer from PTSD, major depression, and substance abuse (particularly alcohol and prescription drug abuse). And many die from suicide.

A growing body of research exists on the impact of deployment and trauma-related stress on military families, particularly spouses and children. Military service is likely to affect other family members as well, including parents of service members and others who may provide supports such as child care during deployments and other service-related disruptions. Although active duty troops and their families are eligible for care from the U.S. Department of Defense (DoD), a significant number choose not to access those services due to fear of discrimination or the harm receiving treatment for behavioral health issues may have on their military career or that of their spouse.

SBHAs at the Forefront – Addressing the Needs of Veterans #1

With many service members returning home from overseas duty and given the risk for justice system involvement posed by untreated posttraumatic stress disorder (PTSD) and trauma-related disorders, SAMHSA launched the Jail Diversion and Trauma Recovery – Priority to Veterans initiative. This program supports the implementation of trauma-integrated jail diversion programs for justice-involved veterans and other individuals with PTSD and trauma-related disorders through community-based pilot jail diversion programs and statewide infrastructure building activities (United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008). Since September 2008 SAMHSA has awarded five-year grants to 13 state behavioral health authorities. Two RFAs have been issued, with six grants each awarded in 2008 and 2009. The SBHAs in Colorado, Connecticut, Georgia, Illinois, Massachusetts, and Vermont were awarded in September 2008, followed by the September 2009 awards to the SBHAs in Florida, New Mexico, North Carolina, Ohio, Rhode Island, and Texas. The Commonwealth of Pennsylvania was awarded a grant in March 2010. These grants supported activities at both the community and state levels to address service access, systems integration, workforce development, training, and policy development. The two-pronged approach of community pilot programs and statewide infrastructure building activities is necessary because jail diversion occurs in communities but states have the opportunity to develop and promulgate policy and to disseminate knowledge and practices by working with communities throughout the state.

National Guard and Reserve troops who have served in Iraq and Afghanistan (approximately 40 percent of the total) are eligible for behavioral healthcare services from the VA, but many are unable or unwilling to access those services.

National Guard, Reserve, veterans, and active duty service members as well as their families do seek care in communities across this country, particularly from State, Territorial, Tribal, local, and private behavioral health care systems, often with employer-sponsored coverage.

The capacity of the Department of Veterans Affairs (VA) to meet the behavioral health, housing, and vocational rehabilitation and employment needs of all veterans has been stretched significantly.

Deployment is an especially stressful time for all families, but may be particularly difficult for families in the reserve components and National Guard. Children experience various emotional and behavioral problems when parents are deployed. Families of soldiers serving in the reserve components and National Guard are not well connected to traditional military family support structures, which help with the stresses of deployment.⁵⁰

SBHAs have long recognized that strengthening behavioral health prevention and early intervention services for soldiers currently serving in the military may reduce the demand placed upon the VA once these soldiers are discharged. Building partnerships between the federal, state, and local governments to expand service capacity may ensure veterans who have a significant behavioral health disorder and need treatment, permanent supportive housing, and/or vocational rehabilitation and employment services receive those services in a timely manner. Reducing eligibility and enrollment barriers may increase the number of veterans who receive needed state behavioral health, housing, and vocational rehabilitation and employment services. SBHAs have been in the vanguard in strengthening family support networks for families in the reserve components and National Guard to reduce the stress associated with deployment.

SBHAs have been providing support and leadership through collaborative and comprehensive approaches to increase access to appropriate services, prevent suicide,

SBHAs at the Forefront – Addressing the Needs of Veterans #2

The family members of soldiers who are deployed to combat situations experience significant stress during all phases of a soldier's deployment. Some children exhibit emotional and behavioral problems. Some soldiers return from deployment with a significant mental health issues, such as post-traumatic stress disorder, depression and anxiety. These changes in behavior are part of the stresses associated with deployment. Resilience is an important factor in a family's ability to cope with the stresses associated with a loved one who is deployed. Family readiness is considered to be a key factor in resilience. Family members of the individuals serving in the reserve components and National Guard are often isolated from the traditional military family support structure. In California, the Department of Mental Health funds organizations that support and advocate for families who have children and other family members with a serious emotional disturbance or serious mental illness. The Department funds these organizations to build family support networks for veteran and military families in the reserve components and National Guard.

promote emotional health, and reduce homelessness. SBHAs are facilitating innovative community-based solutions that foster access to evidence-based prevention, treatment, and recovery support services for military service members, veterans, and their families at risk for or experiencing mental and substance use disorders through the provision of state-of-the-art technical assistance, consultation, and training.

Minority populations are heavily represented in the military and in the enlisted ranks of the military services.

Meeting the behavioral health needs of these populations within the military will require service providers that are attuned not only to the culture of the military context but to the cultures of these individuals who have also dedicated service to the military and their country. This reality has been complicated by the fact that minority populations have been historically underserved by the behavioral health field. Efforts to address the needs of returning veterans and their families from a variety of backgrounds will have to meet their unique needs, while contending with the existing workforce shortage.

Initiate Suicide Prevention Programs:

For people with virtually every behavioral health category of, suicide is a leading cause of death, with lifetime risks ranging from 4-8 percent. Inadequate assessment of suicide risk and insufficient access to effective treatments are major contributing factors. Still, a large majority of those with serious behavioral conditions neither attempt nor die by suicide and predicting those who will presents a daunting clinical challenge. Suicide attempts and deaths by suicide send ripples through the U.S. economy, costing up to \$25 billion per year.⁵¹ However, the cost cannot be measured solely in dollars. One must also factor in the emotional toll extracted from attempt survivors and the family members and friends who are so deeply affected by both attempted and completed suicides. To reduce the toll from suicidal behaviors among persons with behavioral health conditions (and many in the general population will benefit) SBHAs ensure suicide prevention programs and practices are in place, and work closely with other principals on state suicide prevention advisory councils.

SBHAs support and collaborate with crisis hotlines to ensure individuals at risk for suicide, including those who have made a suicide attempt, can readily access high quality crisis support services.

SBHAs lead efforts to improve collaboration and information sharing and surveillance between and among systems of care for all persons, but especially for persons with serious mental illness.

SBHAs, in collaboration with other agencies, initiate policies and practices that promote improved continuity of care for individuals at heightened risk for suicide following discharge from emergency departments for suicide attempts and inpatient psychiatric hospitalization.

The SBHA strengthens psycho-education programs in communities and for at-risk populations. SBHAs, in collaboration with state agencies, develop and promote new models for providing evidence-based services over the life span for those who have attempted suicide, particularly for those who have made multiple or medically serious attempts.

SBHAs at the Forefront - Suicide Prevention

SBHAs have has been instrumental in mitigating certain environmental risk factors for suicide. For instance, occasionally clusters of suicides occur among certain communities or sub-populations that appear to be the result of a contagion. These require a coordinated response from several state agencies—including mental health—depending on the specifics of each cluster. Additionally, sudden and major economic downturns can produce the kinds of loss that increase suicide risk across an entire sub-population. When this occurs, those with mental illness will likely be most harshly affected. News of plant closings or other causes of major declines in employment opportunity should prompt the SBHA to collaborate with other state officials in providing additional community-level support and services, including additional mental health prevention and treatment. There is growing recognition of the importance of managing yet another environmental risk factor, access to lethal means of suicide. SBHAs understanding of this risk factor's potency and the methods that mitigate it is perhaps stronger than any of the other environmental risk factors. The SBHA, in collaboration with public and private sector groups, develops and implements key strategies to reduce rates of suicidal behaviors.

Conclusion

SBHA's, through their capabilities, experiences, and expertise in creating "whole" health systems, have embraced a new role that entails creating sequences of synergistic competencies among public and private behavioral health and healthcare entities, generating shared visions, serving as change agents, forming new partnerships and broad alliances, and managing complex inter-governmental enterprises in order to deliver a comprehensive continuum of behavioral health care services in their states.

This elevated responsibility for SBHAs will likely take on an even greater role as healthcare is reformed, and as SBHAs address the challenges of developing initiatives to slow down escalating healthcare costs, increase quality and improve outcomes. Additionally, state system transformation that fully involves consumers and families in orienting systems toward recovery will not succeed in improving access, reducing costs and improving quality without the full inclusion of behavioral health in financing and delivery reforms.

SBHAs stand ready to make this happen on behalf of all people with behavioral health disorders.

Appendix 1: Fact Sheet Series on Behavioral Health Conditions

Behavioral Health Disorders – All-Encompassing Condition

Behavioral health care encompasses a broad array of services for people with mental health or substance abuse problems (or both). These problems range in severity: at one end of the spectrum, individuals face situational problems that disrupt their everyday lives but are short-term while at the other end, individuals have chronic, sometimes disabling behavioral health disorders (e.g., schizophrenia, bipolar disorder, or drug dependence). Nearly a third of adults have met diagnostic criteria for a behavioral health problem in the past year, and over one-half meet criteria at some point in their lifetime.

The most common type of disorder among adults is anxiety disorder, which includes such diagnoses as phobia, panic disorder, anxiety disorder, and post-traumatic stress disorder (among others). Mood disorders (e.g., major depressive disorder, dysthymia, or bipolar disorder) are a common mental health problem among adults affecting one in five adults at some point in their lifetimes. Co-morbidity – or simultaneous diagnosis of more than one illness (such as depression co-occurring with diabetes) is common, affecting about 14 percent of adults within the past 12 months and nearly 28 percent over their lifetime.⁵²

- Excessive alcohol use and illicit drug use also are linked directly to the increased burden from chronic disease such as diabetes, lung disease and cardiovascular problems. In 2008, nearly three million persons aged 12 and older used an illicit drug for the first time within the past 12 months, an average of 8,000 initiates per day.⁵³
- In 2009, an estimated 24 million Americans aged 12 and older needed treatment for substance abuse problems.⁵⁴ The annual total estimated societal cost of substance abuse in the United States is \$510.8 billion.⁵⁵
- Children also experience behavioral health problems. The most common disorders among youth include depression, anxiety disorders, eating disorders, attention-deficit/hyperactivity disorder, and substance abuse disorder. Studies show that these problems are fairly common among children, with approximately one in five reporting symptoms and one in ten reporting serious behavioral health difficulties.⁵⁶
- Children’s behavioral health is clearly a public health issue. One estimate puts the total economic costs of behavioral health disorders among youth at nearly \$250 billion annually.⁵⁷ Behavioral health disorders among young people burden not only traditional behavioral health programs, but also multiple state service systems that support young people and their families – most notably the education, child welfare, foster care, primary medical care and juvenile justice systems. Over half of all lifetime cases of behavioral health disorders begin by age fourteen (14).⁵⁸

Paying the Societal Toll – A Tragedy Runs Through It

On a societal level, a conservative estimate of nearly \$3.2 trillion represents the total economic burden of mental illness (direct care costs and indirect costs) from 2001 to 2010.⁵⁹ This burden excludes the costs of incarceration, homelessness, co-morbid conditions, and early mortality associated with the lack of access to behavioral health care services.

- According to the Global Burden of Disease study conducted by the World Health Organization (WHO), 33 percent of the years lived with disability (YLD) – without mortality, are due to behavioral health disorders, a further 2.1 percent due to intentional injuries.⁶⁰ Unipolar depressive disorders alone lead to 12 percent of years lived with disability, and rank as the third (3rd) leading contributor to the global burden of diseases.⁶¹
- Of the 10 leading causes of disability worldwide, measured in years lived with a disability, five are behavioral health conditions: unipolar depression, excessive alcohol use, bipolar disorder or manic depression, schizophrenia, and obsessive-compulsive disorder. Behavioral health disorders collectively account for more than 15% of the overall burden of disease from all causes and more than the burden associated with all forms of cancer.⁶²
- Research has shown that 60 percent of Americans with a behavioral health disorder received no treatment for their ailment at all.^{63,64}
- The Centers for Disease Prevention and Control (CDC) found that substance abuse is linked to three of the top ten causes of actual deaths of Americans each year. In particular, tobacco, alcohol and illicit drugs combined to contribute to 537,000 actual deaths in the United States in 2000. Other causes making the list included motor vehicle crashes (43,000) and incidents involving firearms (29,000).⁶⁵
- People living with serious mental illnesses die 25 years earlier than people with similar demographic characteristics in the general population, in large part due to unmanaged yet treatable physical health conditions.⁶⁶ These conditions are frequently caused by modifiable risk factors such as smoking, obesity, substance abuse and inadequate access to medical care. Individuals with addiction and co-occurring mental illness die, on average, 37 years earlier than Americans without severe addictions and mental health problems.⁶⁷
- Individuals with severe behavioral health disorders not only have higher mortality rates, but their health care costs throughout their lives are substantially higher, primarily due to preventable emergency department visits and hospital admissions and readmissions.⁶⁸

Behavioral Health Care Treatment Saves Money: The Business Case for Investment and the Return

The vast majority of individuals with serious mental illness and/or substance abuse disorders, if appropriately diagnosed and treated, will go on to live full and productive lives. And the return on investment (ROI) is significant.

- It is estimated that the economic benefits of expanded diagnosis and treatment of depression has a ROI of \$7 for every \$1 invested. Imagine that taxpayers for public insurance programs like Medicaid, save \$7 for every \$1 spent on treatment and \$5.60 for every \$1 spent on prevention, as a result of both increased productivity, and reduced health care, criminal justice, and social service costs.⁶⁹
- Health-services research shows that comprehensive community-based mental health services for children and adolescents can cut public hospital admissions and lengths of stay and reduce average days of detention by approximately 40 percent.⁷⁰
- A review of the prevention literature found that school-based substance abuse prevention is generally very cost effective, for example, “Life Skills Training” returned \$21 dollars for every dollar spent on the intervention.⁷¹
- Cost benefit studies of substance abuse treatment have found returns of \$4-\$7 per dollar spent.⁷²
- Antidepressant treatment reduces overall healthcare costs not only for persons with depression alone, but also for persons with depression and co-morbid medical illnesses such as heart disease. Researchers used claims data for 1,661 patients from a large insurer to compare healthcare costs one year before and one year after initiation of antidepressant treatment. Those remaining on antidepressants for at least 6 months were 74 percent more likely to experience a large reduction in medical costs.⁷³
- On average, substance abuse treatment costs \$1,583 and is associated with a monetary benefit to society of \$11,487, representing a greater than 7:1 ratio of benefits to costs. These benefits were primarily because of reduced costs of crime and increased employment earnings.⁷⁴
- Behavioral health systems are experiencing a changing environment due to a multitude of factors. Roughly 23 percent – or nearly 72 million Americans (57 million adults and 15 million children) – are affected by mental illness or substance use disorders in any given year.⁷⁵ Demand for behavioral healthcare, and the complexity of the circumstances affecting individuals seeking treatment for behavioral health services, is growing.

Appendix 2: Cornerstones for Behavioral Healthcare Today and Tomorrow

<p><u>Cornerstone I</u></p> <p>Improve the Coordination of Behavioral Health Services with Primary Care and Supportive Services and Maximize the Use of Available Resources to Effectively Address Behavioral Healthcare Needs by Reducing Fragmentation and Ensuring a Full Spectrum of Care</p>	ROLE 1	Accelerate the necessary linkages between <u>physical health care and behavioral health services</u> to promote and achieve recovery for people with mental illnesses and/or substance abuse who also have chronic physical diseases.
	ROLE 2	Provide content expertise in the development and implementation of behavioral health aspects of <u>service delivery system</u> reforms such as medical homes, health homes and accountable care organizations, and related payment initiatives such as bundling and capitation.
	ROLE 3	Accelerate the necessary linkages between <u>behavioral healthcare services and the array of supportive services</u> (supported housing, employment, transportation, education and training, etc.) essential to promote and achieve recovery for persons with persistent mental illness and/or substance use.
<p><u>Cornerstone II</u></p> <p>Leverage Mental Illness Prevention, Mental Health Promotion, and Public Health Resources – and Identify and Promote New Public Health Strategies and Practices to Reduce Risks for Behavioral Health Problems – with an Emphasis on Children and Youth</p>	ROLE 4	Develop and implement effective behavioral <u>health promotion</u> , wellness and prevention activities.
	ROLE 5	Continue the development and expanded provision of services and supports, including <u>safety-net services that are provided by or under the control of SBHAs</u> , and ensure that proper linkages exist between these services and health and behavioral health services.

<p><u>Cornerstone III</u></p> <p>Coordinate Measurement, Electronic Health Records' and Health Information Technology Initiatives as Essential Prerequisites to Improving Behavioral Health Quality in Tandem with a Stable Behavioral Health Workforce that Relies on Explicit Standards of Care and Using Best Practices to Deliver Quality Behavioral Health Care Services to Maximize Recovery for People with Behavioral Health Disorders</p>	<p>ROLE 6</p>	<p>Provide content expertise on the development of and inclusion of <u>behavioral health quality measures</u> in specifications for electronic health records, in the development of <u>health information exchanges</u>, and in public and private sector initiatives to improve the quality of behavioral healthcare.</p>
	<p>ROLE 7</p>	<p>Provide leadership to health providers, federal and state policymakers and officials, national medical societies, including primary care organizations, to ensure the <u>adequacy of providers in the behavioral health workforce</u> to deliver quality behavioral health care services.</p>
	<p>ROLE 8</p>	<p>Empower consumers to <u>maximize control of their recovery</u> through new and emerging ways to design, apply and organize existing treatments and by finding new platforms and avenues to deliver new treatments.</p>
<p><u>Cornerstone IV</u></p> <p>Work to Ensure that Public and Private Insurance Plans Operating in the State Adequately Address the Behavioral Health Interests of Eligible Enrollees Through Covered Benefits and</p>	<p>ROLE 9</p>	<p>Serve as the state authority for <u>mental health/substance abuse benefits</u> including, where possible, serving as the contractor for and payer of services on behalf of other state agencies (e.g., state Medicaid program), or by <u>developing the scope and requirements for behavioral health services</u> if contracted for or paid directly by the state Medicaid authority, as well as develop innovative payment systems that recognize and reward performance.</p>
	<p>ROLE 10</p>	<p>Provide content expertise on <u>benefits and scope and requirements for behavioral health services</u> – in partnership with state insurance authorities – <u>that are offered in public and private health insurance plans operating in the state.</u></p>

Payment Systems	ROLE 11	Actively ensure the <u>outreach and enrollment</u> of individuals with mental and substance use disorders so they may receive and maintain <u>health coverage</u> based on their eligibility and are able to easily access care.
	ROLE 12	Educate providers, insurance carriers, federal and state policymakers and officials, health care providers, consumer organizations and the general public on <u>behavioral health parity</u> within public and private insurance and monitor its implementation.

Endnotes

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² For purposes of this Consensus Statement, the term *behavioral health* refers to substance abuse and mental health. The number of combined mental health and addictions' agencies has grown over the last decade to thirty such entities. The operational location in state government of these functions has a significant impact on the degree of coordination but is not the only factor.

³ For purposes of this Consensus Statement, SBHAs are state substance abuse and mental health authorities.

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