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August 18, 2014

Ms. Pamela S. Hyde, J.D.
Administrator
Substance Abuse and Mental Health Hygiene Administration
1 Choke Cherry Road
Rockville, MD 20857

**RE: NASMHPD Comments on the Draft 2015-2018 Strategic Plan**

Dear Ms. Hyde:

The National Association of State Mental Health Program Directors (NASMHPD) has reviewed the draft of SAMHSA's 2015-2018 Strategic Plan, "Leading Change 2.0," and appreciates SAMHSA's leadership in providing a strategic vision for changes in behavioral health. This correspondence offers suggestions for inclusion in the Strategic Plan which we hope you will consider. Some of our recommendations are higher-level, such as the need for SAMHSA to continue to enhance its leadership role among Federal agencies on behavioral health issues. Other recommendations are more at the detail level, such as the need to address the shortage of behavioral health practitioners who treat older persons under Strategic Initiative 6.

As you know, NASMHPD is the member organization representing the state executives responsible for the $37 billion public mental health service delivery systems serving 7.2 million people annually in 50 states, 4 territories, and the District of Columbia.

**SAMHSA's Theory of Change**

First, we believe that the "Theory of Change" graphic contained within the "Roadmap to Leading Change" has omitted two important elements of what we know to be SAMHSA's leadership approach—soliciting stakeholder feedback and partnerships and ensuring continuous quality improvement in evidence-based practices. It is the stakeholder feedback which you so consistently seek—as illustrated by this very comment solicitation—which ensures transparency in the development of policy initiatives and provides the on-the-ground perspective critical to understanding whether a proposed SAMHSA policy initiative will work and, subsequently, whether it is producing the outcomes intended. This feedback loop also helps to ensure that improvements to and/or reservations about published evidence-based practices are identified early and disseminated expeditiously to those who may have adopted those practices or are considering their adoption.

**The Six SAMHSA Key Strategic Initiatives**

NASMHPD is fully supportive of the six key strategic initiatives identified, but would encourage you to include as a critical element of each of these initiatives—or consider adding as a seventh key strategic initiative—the role of providing leadership, coordination, and subject matter expertise on all behavioral health issues for and across all Federal agencies. SAMHSA has been filling this role for years, and should gain greater recognition for its accomplishments in this area. A public acknowledgement of this crucial responsibility would help SAMHSA to achieve additional inter-agency cooperation on behavioral health issues in the future. If this is not to be added to the list of Key Strategic Initiatives, SAMHSA should at least add an acknowledgment of its leadership role on page 9, under the subtitle "Program and Operational Synergy—The Roadmap to Leading Change."

On the other hand, we also believe that SAMHSA's reduction in the number of Key Strategic Initiatives, from eight to six, should help it to provide additional focus to the initiatives that remain. At the same time, SAMHSA might want to consider adding a more detailed explanation of how these Initiatives interrelate to create an integrated and holistic approach to achieving a common, comprehensive goal. Absent that explanation, the list could seem disconnected to the uninitiated.

**Consistency in Terminology**

We recognize the Strategic Plan is the joint product of many SAMHSA program leaders, but it appears that the result is that there is a lack of consistency in the use of terminology, specifically with regard to the terms "mental illness" and "mental disorder," "substance use disorder" and "substance abuse," and "behavioral health disorder." Given that the use of the terms "mental illness" and "substance abuse" are increasingly problematic, and that many state agencies have combined their mental health and substance use agencies into a single behavioral health agency, we'd recommend the use throughout the Strategic Plan, where appropriate, of the term "behavioral health."

**Strategic Initiative 1 – Prevention of Substance Abuse and Mental Illness**

We recommend that the first Key Strategic Initiative be retitled "Promoting Positive Behavioral Health" rather than the current "Prevention of Substance Abuse and Mental Illness." We suggest this both because of the need for consistency in terminology, as mentioned previously, but also for purposes of agency outcomes measurement. It would likely facilitate reporting to provide more meaningful evidence of the positive outcome of promoting positive behavioral health rather than proving attainment of the goal of "preventing" mental illness and substance abuse, especially when the Plan's proposed metrics measure a reduction in incidence rather than total prevention. We also wonder whether there might be a more precise metric for "preventing mental illness" under **Goal 1.1** than reducing major depression episodes in the past year.

NASMHPD applauds SAMHSA for promoting suicide prevention among populations at high risk under **Goal 1.3,** but in identifying the population groups listed, SAMHSA has neglected to include—surely an unintended oversight given SAMHSA's primary mission—individuals with mental illness and substance use disorders. A 2010 study by King's Health Partners[i] found that people with serious mental illness were 12 times more likely to die by suicide in the first year following diagnosis, and their rate remains 4 times higher than the general population a decade after

their diagnosis. Furthermore, males 75 years and older have the highest suicide rates among any age group (rate 36 per 100,000).

We strongly encourage SAMHSA to align its list of the population groups at high-risk for suicide with the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, a report from the U.S. Surgeon General and the National Action Alliance for Suicide Prevention,[ii] which identified the following groups as being at a higher risk for suicidal behaviors than the general population:

- American Indians/Alaska Natives;
- Individuals bereaved by suicide*;
- Individuals in justice and child welfare settings*;
- Individuals who engage in non-suicidal self-injury (NSSI)*;
- Individuals who attempted suicide;
- Individuals with medical conditions*;
- Individuals with mental and/or substance use disorders*;
- Lesbians, gay, bisexual, and transgender (LGBT) populations;
- Members of the Armed Forces and veterans;
- Men in midlife; and
- Older men*.

We are fully supportive of **Goal 1.4,** Prevent[ing] and Reduc[ing] Prescription Drug and Illicit Opioid Misuse and Abuse, as written.

On page 12, we believe the metric contains a typographic error, and should be revised to read "Reduce the percentage of youth ages 12-17 and young adults."

**Strategic Initiative 2 – Health Care and Health Systems Integration**

NASMHPD's members are in full agreement that **Goal 2.4**, Finaliz[ing] and Implement[ing] Mental Health Parity and disseminating information about parity, should be a high priority for SAMHSA. But we also recommend a specific mention of a partnership with the Centers for Medicare and Medicaid Services (CMS), beyond the general mention of working with "federal partners and other stakeholders" to evaluate the impact of parity on access, coverage and costs. In addition, given the apparent reluctance of some state insurance agencies to undertake enforcement action on the issue, SAMHSA might want to consider adding as a **new Objective 2.4.4** Partnering with CMS in Monitoring State Insurance Agency Enforcement Activities Relating to Parity.

**Goal 2.5,** Foster[ing] Implementation of Quality Indicators to Advance Behavioral Health Outcomes, is an important element of the Strategic Plan, and we are very supportive. However, we question the mention of "harmonization" of the GPRA measures with measures adopted for SAMHSA-funded programs. Given NQF's major role in developing behavioral health measures for CMS' Medicaid and Medicare programs, we believe it is far more important that those efforts be highlighted here and that the objectives under **Goal 2.5** should include efforts to align SAMHSA behavioral health measures with the NQF-endorsed measures adopted by CMS over the next four years.

**Strategic Initiative 3 – Trauma and Justice**

It is important that the goals and objectives throughout this section avoid stigmatizing mental health through an association with violence and criminal behavior. In fact, this stigmatizing association is a public policy area where SAMHSA should be taking the lead among its fellow Federal agencies in driving efforts to disassociate mental illness from the prevalence of public violence, and we recommend that as a **new Goal 3.4**.

We'd also recommend a second look generally at how this Key Strategic Initiative section is constructed. It appears to be attempting to combine too many disparate policy areas, resulting in a distorted focus. For instance, how does **Goal 3.2,** Creat[ing] Capacity and System Change in the Behavioral Health and Justice Systems, and its metric of reducing recidivism rates among individuals served by SAMHSA grantees, relate to the nominal focus of the Strategic Initiative, the inter-relationship between trauma and justice? Should the metric instead be focused on diversion programs that keep individuals from initial incarceration?

**Strategic Initiative 4 – Recovery Support**

We are supportive of this Initiative as fundamental to your work and ours.

**Strategic Initiative 5 – Health Information Technology**

Again, this is an important area for SAMHSA to take leadership. We are extremely pleased to see that the goals under this Strategic Incentive include both changes to 42 CFR Part 2 and support for inclusion of substance abuse and mental health treatment and prevention service providers in health information exchanges (HIEs). But we also very strongly urge the addition of a **new Objective 5.1.4,** Supporting Legislative and Regulatory Changes as Necessary to Achieve Provider Access to Electronic Health Record Incentive Payments under the Medicare and Medicaid Programs. Unless those incentive payments can be authorized for behavioral health providers, alleviating in part the capital and training costs of health information technology (HIT) adoption, the metrics listed under Strategic Incentive 5 are far less likely to be achievable.

We would also caution, however, that there are members of NASMHPD who believe the pervasive use of HIT can interfere with patient-provider interaction, particularly during the learning and adoption phase. Technology should not be permitted to inhibit the patient-provider relationship—particularly in the behavioral health field where personal interaction is so important. For this reason, we recommend that the technical assistance referenced under **Objective 5.2.1** include training in provider utilization that goes beyond the mechanics of how the hardware works.

**Strategic Initiative 6 – Workforce Development**

This Strategic Initiative is among the more important elements of the Strategic Plan. While this section seems fairly comprehensive, it lacks a very important element: attention to the shortage of behavioral health practitioners who specialize in geriatrics.

Recently, the American Psychiatric Association polled its members and found that only 4.2 percent identified older adults as a priority population for them. A 2012 Institute of Medicine of the National Academies (IOM) report, *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?*, brought national attention to the issue that the current

behavioral health workforce for older Americans is inadequately meeting their needs due to the chronic workforce shortage. The report cited that nearly one in five older Americans (an estimated 5.6 to 8 million) have one or more mental health and substance use disorder conditions.

Given that this number will nearly double to 14 million in two decades, we feel that it is essential that the metrics for **Goal 6.1**, Develop[ing] and Disseminat[ing] Workforce Training and Education Tools and Core Competencies to Address Behavioral Health Issues specifically target the geriatric behavioral health workforce. In addition, **Goal 6.3**, Develop[ing] Consistent Data Collection Methods to Identify and Track Behavioral Health Workforce, should track behavioral health worker specialties, such as geriatrics, to gain a better understanding of the workforce shortage.

Further, SAMHSA should consider incorporating IOM's three recommendations for SAMHSA to address the workforce shortage in its strategic plan:[iii]

i. *The SAMHSA Administrator should ensure that the agency devotes sufficient attention to the capacity of the behavioral health workforce to provide both geriatric mental health and geriatric substance use services.*

ii. *The SAMHSA Administrator should ensure that the agency restores funding of the Older Adult Mental Health Targeted Capacity Expansion Grant program.*

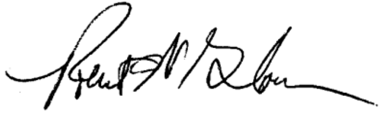
iii. *The SAMHSA Administrator should require states that receive MH/SU block grants to document and to report how the funds are used to support local capacity to serve older adults.*

The silver tsunami of retiring baby boomers is rapidly approaching and we must ensure that we have the infrastructure to support the behavioral health needs of older Americans. We strongly encourage SAMHSA to take the lead among Federal agencies, working especially with the National Institutes of Mental Health and the National Institute on Drug Abuse, in addressing the behavior health needs of aging adults as part of Strategic Initiative 6.

With regard to substance use providers, we also strongly urge attention to expanding the availability of Addiction Technology Transfer Centers. And finally, under **Goal 6.1,** Develop[ing] and Disseminat[ing] Workforce Training and Education Tools and Core Competencies, we recommend that SAMHSA take leadership on training and educational efforts on Medication-Assisted Treatments, particularly in medical schools and among other health professionals.

Thank you for your attention to our comments on this very important strategic document. If you have additional questions regarding the issues raised in this correspondence, please feel free to contact me at bob.glover@nasmhpd.org or 703-739-9333 or NASMHPD's Director of Policy and Health Care Reform, Stuart Gordon, at stuart.gordon@nasmhpd.org or 703-682-7552.

Sincerely,



Robert W. Glover, PhD.
Executive Director
National Association of State Mental Health Program Directors

*Groups not identified as at "high-risk" by SAMHSA in the 2015-18 Strategic Plan.

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[i] Dutta, R; Murray, RM; Hotopf, M.; Allardyce, J; Jones, PB; Boydell, J., "Reassessing the long-term risk of suicide after a first episode of psychosis," *Archives of General Psychiatry* 67(12):1230-7 (December 6, 2010).
[ii] 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. A report of the U.S. Surgeon General, National Action Alliance for Suicide Prevention, Washington, DC, US Department of Health & Human Services, p.101 (September 2012).
[iii] Institute of Medicine, *The Mental Health and Substance Use Workforce for Older Adults: in Whose Hands?* National Academies Press, Washington, DC (2012).