



June 2012

## **Fact Sheet on Forming and Implementing Public Policy: the SBHA Role (1)**

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Due to its significant position and resource knowledge management base, essentially all state behavioral health policy and related matters should be discussed with the SBHA. This consultative responsibility and management role pertains to all regulations developed in another state/federal agency that involves behavioral health issues. In states that opt not to have all funding related to behavioral health managed by the SBHA, all funding decisions administered by other agencies should be discussed 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, integrity, 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 small group in our society having aberrant emotional and behavioral health conditions, which increase the complex policymaking and service delivery systems surrounding this ecosystem. But the number 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 well-being of people serious behavioral health conditions. A host of services and social, medical and economic supports should be made available to people with severe

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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 and capacities of the individual, this spectrum of assistance might encompass income support, housing aid, health care services, employment training and placing, education programs, transportation, and recreational activities. The complexity of the SBHAs role is to assure that behavioral health services are delivered appropriately by working with other agencies in a coordinating role such as Medicaid, housing, education, children's agencies, criminal and juvenile justice and corrections, schools, 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 2009-2011 period which has required SBHAs to cut or staff, reduce administrative costs, reduce services, 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 to make sure that all funds are used efficiently.

### *General Service integration*

#### *Fact Sheet on Ensuring Public Safety and Public Welfare: The SBHA Role(1)*

SBHAs are often responsible for managing psychiatric emergency screening services and other public safety functions to ensure the safety and security of people with behavioral health issues 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.

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 difficulties as well as mental health liaisons to adult and juvenile justice court personnel.

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

SBHAs also are regularly involved in responding to large and small scale natural disasters (e.g., tornados) 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.

SBHAs play a pivotal role in the state disaster relief operations. Successful disaster response activities require comprehensive knowledge of the State's administrative infrastructure and emergency operations plan. The behavioral health emergency operations plan of SBHAs, identify the necessary administrative and clinical activities and resources that can be mobilized rapidly in the face of a disaster. Emphasis is placed on establishing formal and informal communication networks between the various State agencies and providers who will be involved in disaster response activities.

Disaster recovery training is provided by SBHAs to therapists, case managers, and care coordinators to (1) provide disaster counseling services to people with mental illness, and (2) assist staff in distinguishing normal disaster responses in people with preexisting illness and exacerbations of their mental illness. Disaster recovery training is provided by SBHAs to others who give support to clients such as family members, board-and-care home operators, single-room-occupancy hotel managers, consumers who run programs, staff of satellite housing programs; and to consumers regarding preparation for what to do during impact, response, recovery, and peer counseling and support.

<sup>1</sup> For purposes of this Consensus Statement, SBHAs are state substance abuse and mental health authorities, and the term *behavioral health* refers to substance abuse and mental health.

June 2012



### *General Service Integration*

#### *Fact Sheet on Providing Direct Services: The SBHA Role (1)*

Many SBHAs directly provide care using state employees in state-operated community behavioral health centers, psychiatric hospitals and forensic centers. Through state hospital systems, homeless prevention and related services, the 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 shed the costs of health insurance and pensions associated with civil service, states may likely contract out for services. It will be critical for SBHAs to shape these transitions, 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 in nature versus traditional civil commitments.

The direct service responsibilities of the SBHAs are part of a diverse portfolio of systems, services and programs that are managed by the agencies that focus on responding to and serving, persons with behavioral health needs; provider organizations; consumers; families; planning and advisory councils, and systems of higher learning. Through state hospital systems and related services, SBHAs serve as safety-net providers for vulnerable populations.

This assistance covers a variety of administrative, policy, financial, clinical, and program areas.

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Examples include: the planning and implementation of evidence-based practices; promoting an understanding of the impact of trauma and the need for trauma-informed care; clinical protocols and program design that support recovery and enhance resilience for individuals across the lifespan; financing strategies; workforce development; cross-system collaboration; consumer empowerment, including the use of consumer-directed care and the expansion of meaningful roles for consumers in all stages of program/service planning, delivery, and evaluation.

SBHAs ensure that mental health delivery safety-net systems meet a core set of competencies in order to continue being an important part of the health care delivery system that includes:

1. A full array of specialty behavioral health services
2. A well-defined assessment process and level of care system
3. A solid approach to prevention, early intervention, and recovery
4. The ability to practice as a team to coordinate care
5. Demonstrated use of clinical guidelines
6. Measurement systems and tools that measure consumer improvement
7. A robust EHR that includes patient registries
8. Quality improvement processes and supporting data systems
9. Financial systems to manage case rate payments
10. Ability to market services in response to increased competition

Under the best case scenario, about 22 million Americans will be uninsured in 2019 despite coverage expansions under health care reform. SBHAs will play a critical role in assuring that people with uninsured individuals with behavioral health problem receive timely care in the right settings.

In order to identify gaps in the continuum of services, SBHAs determine what specific behavioral health services they like to cover in addition to what is being covered by insurers. They create crosswalks, to identify gaps in both insurance coverage or in specific behavioral services, by population group. In the context of this changing regulatory environment, SBHAs review their health insurance mandates; in some cases, they may be strengthened, in others relaxed. SBHAs collaborate to determine which supplemental services to purchase, and for whom, to fill the behavioral service gaps. This can be done either through a Medicaid state plan amendment or be using federal and state appropriations, such as block grants.

June 2012

General Service integration

### *Ensuring Human and Civil Rights: The SBHA Role (1)*

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 the mental health of populations.

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. 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.

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

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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 must continue 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.

June 2012



## **GENERAL INTEGRATION SERVICE**

### *Fact Sheet on Monitoring and Overseeing the Regulatory Process: The SBHA Role (1)*

SBHAs have key regulatory and monitoring responsibilities in order to ensure the provision of safe, high quality services to consumers through evidence-based, minimum performance standards.

SBHAs have statutory and regulatory authority over providers of behavioral health services to consumers. Separate standards apply depending on the type and level of service provided. The type and level of service is usually organized in the following manner: Inpatient Psychiatric Service Providers, Community Mental Health Agencies, 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 three types of Residential Facility License which ODMH can issue.

SBHA regulatory activities include on-site surveys, inspections and reviews to determine compliance with the applicable administrative rules. 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 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.

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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 is to: 1) foster the establishment of State-administered controlled substance monitoring systems in order to ensure that health care 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 State 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.

June 2012

### **CHILDREN'S SERVICES**



*Fact Sheet on Coordinating Children's and Youth Behavioral Health Services:*

*The SBHA Role(1)*

Children's mental health is clearly a public health issue. 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 other 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 fourteen (14).

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 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 policies, programs, and practices aimed at eliminating risks and increasing strengths, have helped reduce the number of new cases of behavioral health disorders and significantly improve the lives of young people.

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One example is the promotion -- through public education initiatives – of smoking cessation programs.

SBHAs 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 and youth 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;
- Reductions in suicide-related behaviors;
- Decreases in utilization of inpatient care and reduced costs due to fewer days in inpatient care;
- Significant reductions in contacts with law enforcement agencies.

A hallmark of this program is that youth and families partner with providers and SBHA policy makers in service delivery and system reform planning and decision-making. Children and youth with serious behavioral health conditions and their families need supports and services from many different child- and family-serving agencies and organizations. Often, these agencies and organizations are serving the same children, youth, and families. By creating partnerships among these groups, Systems of Care -- through SBHAs -- are able to coordinate services and supports that meet the ever-changing needs of each child, youth, and family.

June 2012

**UNDER PUBLIC PRIVATE FINANCING AND PLACE GRAPHIC WITH ONE FROM THE ROLES DOC ON FUNDING STREAMS**

### *Fact Sheet on Harmonizing Funding Streams: The SBHA Role(1)*

Public behavioral health systems are comprised of multiple funding streams, including direct state appropriations, Medicaid, federal block grants, county, third party insurance, corrections/parole,

public benefits and entitlements, housing, vocational rehabilitation and other funds. Often, the SBHA is the agency that brings together separate entities in order to coordinate these complex funding streams into programs that work for people with behavioral health disorders.

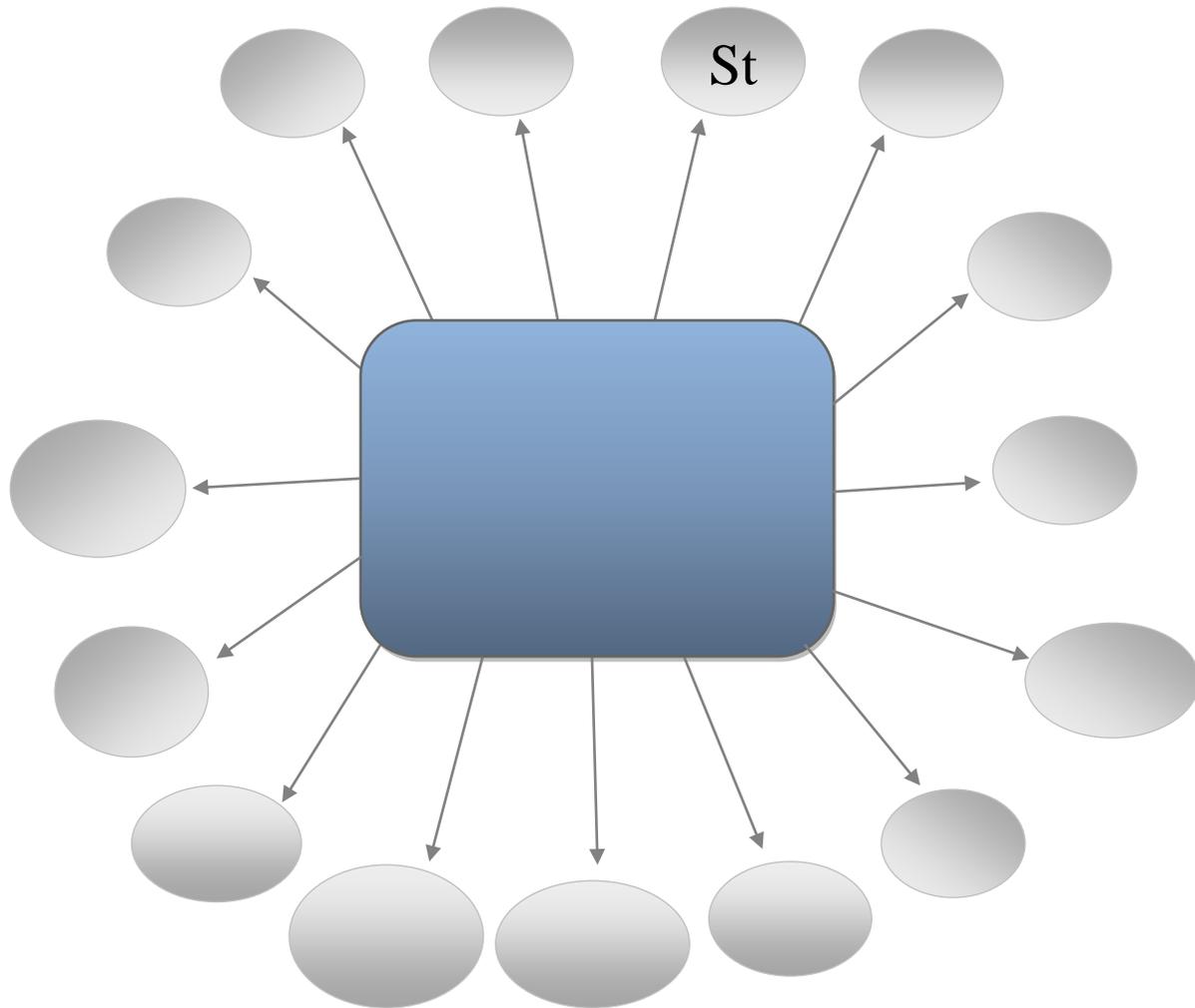
The financing system for behavioral health services differs from that for general medical services. Most notably, public sources play a larger role in financing behavioral health care (representing 61 percent of expenditures) than they do in overall health services (representing 46 percent of expenditures).

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.

As Medicaid becomes a larger payer for both 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 several states, the SBHA directly manages Medicaid and other funding in order to align payments with multiple programs, services, and practices to the extent possible.

SBHAs try to align several funding sources to address the needs of individuals with behavioral health conditions including:

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Many disabled Medicare beneficiaries qualify for coverage on the basis of a mental illness, but other beneficiaries have behavioral health needs as well. Beneficiaries who are dually eligible for Medicare and Medicaid report the highest rates of behavioral health conditions (59 and 20 percent of disabled and aged, respectively).

Medicare’s behavioral health benefits were initially modeled after private coverage and included many coverage limitations. Some limits on Medicare coverage of behavioral health services have been eased over time, but the program’s behavioral health benefits still retain some of their historical limits on psychosocial and support services, inpatient psychiatric hospital care, and certain providers. A large number of other federal, state, and local public programs finance services to support individuals with behavioral health needs. Many of these programs are not targeted to individuals with behavioral health problems, yet they provide key ancillary support

services such as housing, income support, and vocational training.

The largest federal program dedicated to financing behavioral health services is 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. Stemming from a long history of financing and delivering behavioral health services, other state and local funds finance a range of services and account for nearly a quarter of financing for behavioral health services in the nation.

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.

Though 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.

SBHAs directly contract with private local community-based behavioral health providers. SBHAs may also 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. Pooled financing of Medicaid, state general funds, block grants, and other categorical funds can 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. Such an assessment will help SBHAs target their funding and programs to fill gaps in care.

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 pathway, 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.

June 2012



Place under Parity

*Fact Sheet on Implementing Mental Health Parity: The SBHA Role(1)*

The Mental Health Parity and Addictions Equity Act (MHPAEA) requires most health plans to increase coverage and eliminate discriminatory rules and payments, making benefits for mental

health and addictions treatment comparable to the coverage provided for all other health conditions. While the implementation of parity presents challenges, the parity law improves access to services for many individuals living with behavioral health conditions.

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 extend 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 have a role in ensuring that qualified health plans provide benefits in compliance with parity, and should advocate that state Health Insurance Exchange advisory boards under health care reform, 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 can promote education of and compliance with parity requirements, monitor results, facilitate handling of consumer complaints, enhance transparency and accountability, and expand consumer protections.

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SBHAs should 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.

June 2012



**PLACE UNDER BEHAVIORAL HEALTH AND PRIMARY SUBCATEGORY**

*Fact Sheet on Accelerating on Integration of Primary Care, Behavioral  
Health and Prevention: The SBHA Role (1)*

SBHAs are addressing new challenges as to how individuals with chronic diseases of persistent mental illness and other behavioral health conditions can best receive primary care, preventative and behavioral health services.

Why is integration of primary care and behavioral health important?

- Over 12 million visits to emergency departments are individuals with behavioral health disorders.
- 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.
- Nearly half of all cigarette consumption is by individuals with behavioral health disorders.
- Nearly three in four individuals with significant behavioral health disorders had at least one chronic health condition, nearly half had 2 chronic diseases and almost one-third had 3 or more conditions. Most of the individuals who have three or more physicians do not talk with another or share information.
- Individuals with with severe addiction and co-occurring mental illness, a significant percentage of those with substance use or mental health problems, die prematurely--on average, 37 years sooner than Americans without severe addiction and mental health problems. A recent study found that people with serious mental illness die 25 years sooner than the general population from common medical conditions such as cancer and heart disease.
- Health care expenditures of Americans with SMI are 2 to 3 times higher than other patients.

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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 to the community level, and aligning fragmented prevention programs into one cohesive whole, that are realizing significant cost savings and reducing the emergence of chronic and debilitating disorders.

SBHAs have become champions and 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. SBHAs in many states have supplied primary care physicians with materials already developed for behavior health consumer education and self-management, as well as for staff training and professional development. 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.

June 2012



**PLACE UNDER QUALITY AND HIT**

***Fact Sheet on Measuring and Encouraging Improved Behavioral Health***

***Performance and Outcomes: The SBHA Role(1)***

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 clients. 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 "realizing an integrated data strategy and a 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."

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 streamline the many behavioral health metrics into a single streamlined measure set.

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.

The Agency for Healthcare Research and Quality (AHRQ) is identifying areas in which 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.

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As states 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 about self-help services, education, and supports to consumers and family members;
- Information about identifying behavioral health conditions;
- Information about behavioral health care treatments;
- Information about EBPs;
- Information about outcomes of SBHA providers;
- Information about specific recovery initiatives by SBHAs; and
- Performance measures on SBHA providers.

June 2012

*Place under quality and HIT*



*Place under Quality and HIT*

*Fact Sheet on Designing and Implementing Evidence-based Practices (EBPs):*

*The SBHA Role(1)*

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.

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.

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.

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.

<sup>1</sup> SBHAs are state substance abuse and mental health authorities, and the term *behavioral health* refers to substance abuse and mental health.

Place under workforce

### *Fact Sheet on Promoting Peer Support Services: the SBHA Role(1)*

As part of pursuing a recovery-based system, SBHAs have supported the coverage of peer support as a specific type of service and/or provider in the Medicaid program. Peer support – services from staff who have experienced a serious behavioral health disorder and who relate to participants based on their experience in the recovery process – can play an important role in recovery. Peer providers teach social and coping skills essential to increasing resiliency and provide a model of 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 promote peer support and recovery work as cost-effective with good outcomes. SBHAs spread the word about peer support via journal articles and workshops as well as continue the development of evaluation instruments, competency assessments, and provider recovery skills.

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June 2012



**PLACE UNDER BH AND PC INTEGRATION**

*Fact Sheet on Reducing the Behavioral Health Impact of Trauma:*

*The SBHA Role(1)*

Individuals with histories of violence, abuse, and neglect from childhood onward make up 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 actually experienced multiple experiences of trauma.
- 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% 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, increased risk of suicide, obesity, heart disease, and early death.

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 focus on the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.

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 about how to respond in a trauma-sensitive manner in times of disaster.

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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 9/11, 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 to society will continue.



Place under Quality and HIT

*Fact Sheet on Empowering Consumers to maximize Control of  
their Recovery: The SBHA Role(1)*

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. 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 health care 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.

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.

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- Align relevant Federal programs to improve access and accountability for behavioral health services.
- 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," (NFC, 2003, p. 35).

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 health care system. It should, they said, be "safe, effective, patient-centered, timely, efficient, and equitable." The report, focused primarily on the physical health care system, and identified several dimensions of patient-centered care including (IOM, 2001, pp. 49-50):

- Respect for patients' values, preferences, and expressed needs;
- Coordination and integration of care;
- Information, communication, and education; and
- 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 health care consumers and families access – user-friendly information on the effectiveness of available services in order that they may truly make informed health care decisions.

Under Veteran's

*Place under Veterans services*

***\*\*Fact Sheet on Strengthening Behavioral Health Services for Military Service Members, Veterans, and Their Families: The SBHA Role(1)***

*\*\*This document includes sections from SAMHSA's Strategic Initiatives report*

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, depression, TBI, and substance abuse (particularly alcohol and prescription drug abuse); too many die from suicide. A growing body of research exists on the impact of deployment and trauma-related stress on military families, particularly wives 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. National Guard and Reserve troops who have served in Iraq and Afghanistan (approximately 40 percent of the total) are eligible for behavioral health care 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.

SBHAs have focused on improving the behavioral health of military service members, veterans, and their families, including relatives, caregivers, and significant others.

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

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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 is complicated by the reality 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.



Place under BH and prevention

*Fact Sheet on Initiating Suicide Prevention Programs: The SBHA Role (1)*

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. 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. 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 by working 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 SMI.

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.

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