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Assessment #6

The Role State Mental Health Authorities Can Play in Delivery of Integrated Primary and Behavioral Health Care for People with Serious Mental Illness, including those with Co-Occurring Substance Use Disorders

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*Seventh in a Series of Ten Briefs Addressing: **What Is the Inpatient Bed
Need if You Have a Best Practice Continuum of Care?***

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The Role State Mental Health Authorities Can Plan in Delivery of Integrated Primary and Behavioral Health Care for People with Serious Mental Illness, including those with Co-Occurring Substance Use Disorders

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Executive Summary

It is well-established that individuals with serious mental illness (SMI), including persons with a co-occurring substance use disorder, die on average younger than individuals who do not suffer from SMI. A seminal 2006 study commissioned by the National Association of State Mental Health Program Directors (NASMHPD) found that the rates of mortality and morbidity among people with SMI are alarmingly high in comparison to the rest of the population, resulting in a lifespan reduction of 25 years.¹ A more recent study determined that this trend is worsening: Individuals with SMI are now estimated to be losing 28.5 years of life.²

Both studies attribute the elevated morbidity and mortality in large part to treatable medical conditions: 85 percent of premature deaths among individuals with SMI are due to preventable conditions such as high blood pressure, high cholesterol, diabetes, and heart disease.³ All these conditions are frequently caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care.

Yet in spite of this research base, there appears to be insufficient change in practice to improve the health of individuals with SMI/co-occurring disorders (COD). In recognition of the impacts of traumatic experiences and behavioral health conditions on health and wellness, and the impact of physical health conditions on behavioral health, State Mental Health Authorities (SMHAs) must assist in determining the behavioral health system's role(s) in identifying and responding to physical health conditions among individuals with behavioral health disorders. Once identified, fulfilling this role(s) will likely require changes in planning, financing, and evaluating service delivery, and the development of policies and procedures that facilitate physical and behavioral health care integration.

Comorbid Medical Conditions are Common in Individuals with Mental Illness

Serious mental illness rarely occurs in isolation. In a study sponsored by the Robert Wood Johnson Foundation, more than 68 percent of adults with a mental health disorder reported having at least one general medical disorder.⁴

Comorbidities often begin well before adulthood. Adverse childhood experiences (ACEs), such as abuse, neglect, the household presence of mental health problems, domestic violence, substance use, divorce, or incarceration of relatives can increase the risk for adopting maladaptive behaviors (*e.g.*, substance use) and developing chronic

¹ Parks J., Svendsen D., Singer P. & Foti M.E., *Morbidity and Mortality in People with Serious Mental Illness*. National Association of State Mental Health Program Directors, Medical Directors Council (2006).

² Olfson M., Gerhard T., Huang C., Crystal S. & Stroup T.S., Premature Mortality among Adults with Schizophrenia in the United States, *JAMA Psychiatry* 72(12):1172-81(2015).

³ *Ibid.*

⁴ Goodell S., Druss B.G. & Walker E.R., *Mental Disorders and Medical Comorbidity*, Robert Wood Johnson Foundation Synthesis Report No. 21 (2011).

health and behavioral health conditions in adulthood.⁵ Those chronic, co-morbid conditions can last into late life. For example, late-life depression is an important public health problem, associated with increased risk of morbidity, self-neglect, and suicide, as well as decreased physical, cognitive, and social functioning.⁶ Older adults receiving antipsychotic medications are at elevated risk for strokes, fractures, kidney injury, and mortality.⁷

Conversely, people with physical health conditions, such as asthma and diabetes, report higher rates of substance use disorders (SUDs) and serious psychological distress. There are a range of medical illnesses that present with symptoms of anxiety and/or depression. According to the Centers for Disease Control and Prevention (CDC), many chronic illnesses are associated with mental illnesses, and it has been shown that treatment of mental illnesses associated with chronic diseases can reduce the effects of both and support better outcomes.⁸ Mental health practitioners could be treating individuals for anxiety or depression that is actually the result of an underlying medical condition without knowledge of that underlying condition. Absent a thorough medical exam, behavioral health treatment and the funds that support it would be used ineffectively in such cases.⁹

Not only do co-occurring medical conditions result in premature loss of life, they have a tremendous impact on the costs of health care. Individuals with co-occurring physical and behavioral health conditions are more likely to use costly inpatient and emergency department (ED) treatment. In a 2011 study of Medicaid expenditures commissioned by the Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid enrollees in every age and eligibility group who had a behavioral health diagnosis had expenditures nearly four times higher than did enrollees with no behavioral health diagnosis.¹⁰ Yet, in spite of these higher costs, this population generally experiences significantly poorer health outcomes.

Co-Morbid Medical Conditions are Often Caused by Modifiable Risk Factors

Increased morbidity and mortality for individuals with SMI is due in large part to treatable medical conditions, which in turn are frequently caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care.

⁵ Felitti V.J., Anda R.F., Nordenberg D., Williamson D.F., Spitz A.M., Edwards V., Koss M.P. & Marks J.S., The relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults, *American Journal of Preventive Medicine* 14(4): 245–258 (1998).

⁶ Blazer D.G., Depression in Late Life: Review and Commentary, *The Journals of Gerontology, Series A: Biological Sciences and Medical Sciences* 58:249–65 (2003).

⁷ Olfson M., King M., & Schoenbaum M., Antipsychotic Treatment of Adults in the United States, *Journal of Clinical Psychiatry* (in press).

⁸ CDC Fact Sheet: Mental Illness Surveillance among Adults in the United States, https://www.cdc.gov/mentalhealthsurveillance/fact_sheet.html.

⁹ Dong Y. M.D., Ph.D., Noorani F. M.D., Vyas R., M.D., Balgobin C., D.O., Torres-Llenza V. M.D. & Crone C., M.D., Managing Anxiety in the Mentally Ill, *Psychiatric Times* (January 30, 2015) http://www.psychiatrictimes.com/special-reports/managing-anxiety-medically-ill/page/0/1?mbid=synd_aolhealth.

¹⁰ Medicaid and CHIP Payment and Access Commission, Chapter 4: Behavioral Health in the Medicaid Program—People, Use, and Expenditures, *MACPAC Report to Congress on Medicaid and CHIP, June 2015* pp.89-122 (2015).

The following facts are illustrative:

- Individuals with depression, bipolar disorder, and schizophrenia are 1.2 to 3.5 times more likely than the general public to be obese.¹¹ Research suggests that obesity increases the risk for chronic health conditions such as diabetes, heart disease, stroke, and specific cancers across the life span.¹²
- People with behavioral health conditions also have higher rates of smoking than the general public. Mental Health America has determined that 44 percent of all cigarettes smoked in the U.S. are consumed by people with a mental illness, who represent less than 18 percent of the population.¹³ Cigarette smoking is the leading preventable cause of death in the United States; each year, smoking causes about one out of every five deaths.¹⁴ Smokers are more likely than non-smokers to develop heart disease, stroke, and lung cancer. Smoking harms nearly every organ of the body and affects a person's overall health.¹⁵
- Individuals with SMI have high rates of co-occurring SUDs. All mental illnesses, including mood, anxiety, personality, and schizophrenia-spectrum disorders, are associated with a greater incidence of SUDs compared to the general population.¹⁶ Furthermore, individuals with the most severe psychiatric disorders tend to have the highest rates of co-occurring SUDs.¹⁷ These comorbidities lead to poor outcomes: people with bipolar disorder who also abuse drugs or alcohol benefit less from any treatment they are receiving, recover more slowly from violent mood swings, and are more likely to die by suicide.¹⁸ Similarly, individuals with psychotic disorders who abuse drugs or alcohol spend more days hospitalized and have higher rates of HIV infection, relapse, re-hospitalization, depression, and suicide.¹⁹

Individuals with SMI are less likely to have access to adequate health care.²⁰ The Clinical Antipsychotic Trials of Intervention Effectiveness study of adults with schizophrenia found that 88 percent of those with dyslipidemia, 62 percent of those with hypertension, and 30 percent of those with diabetes were not receiving treatment for these serious health conditions.²¹ The lack of adequate health care can result in lack of a primary care

¹¹ *Statement 16: Health and Wellness for People with Serious Mental Illnesses*, Mental Health America (2012), <http://www.mentalhealthamerica.net/positions/wellness>.

¹² Harvard School of Public Health, Obesity Prevention Source web page,

<https://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/health-effects/>.

¹³ Mental Health America Statement 16.

¹⁴ Centers for Disease Control and Prevention, *Fact Sheet – Smoking and Tobacco Use* (updated 2017) https://www.cdc.gov/tobacco/data_statistics/fact_sheets/index.htm.

¹⁵ *Ibid.*

¹⁶ Drake R.E., Mueser K.T. and Brunette M.F., Management of persons with co-occurring severe mental illness and substance use disorder: Program implications, *World Psychiatry* 6(3): 131–136 (2007).

¹⁷ *Ibid.*

¹⁸ Substance Abuse and Mental Health Services Administration (2005). *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) Series, No. 42. HHS Publication No. 13-3992. Rockville, MD: SAMHSA.

¹⁹ *Ibid.*

²⁰ Mental Health America Statement 16.

²¹ Nasrallah H.A., Meyer J.M., Goff D.C., McEvoy J.P., Davis S.M., Stroup T.S. & Lieberman, J.A., Low Rates of Treatment for Hypertension, Dyslipidemia and Diabetes in Schizophrenia: Data from the CATIE Schizophrenia Trial Sample at Baseline. *Schizophrenia Research* 86(1-3):15-22 (2006),

relationship, overuse of emergency and medical acute inpatient care and lower rates of routine testing to identify health conditions.²² Access to a primary care medical home that is accountable for providing and coordinating comprehensive medical care is critical to the provision of preventive and continuous medical care.

Why State Mental Health Authorities Should Promote Integrated Care

Given the increased demands made on state behavioral health systems without commensurate increased resources, State Mental Health Authorities (SMHAs) may be reluctant to take on the additional responsibility of integrating service delivery with primary care. However, there are several reasons why SMHAs should assume a role in care integration.

The reality is that SMHAs are already dealing with the impact of a lack of access to primary care by the individuals they serve. This lack of access results in a revolving door through inpatient beds and ED visits or visits to crisis services and between general medical and behavioral health systems. A study recently published by the Agency for Healthcare and Research Quality (AHRQ) reported that the utilization of ED services resulting from behavioral health conditions increased sharply across the country from 2006 to 2013.²³ A 52-percent increase in ED utilization was found for people experiencing a serious mental illness, and a 56-percent increase was found for other behavioral health conditions, such as anxiety, depression, and stress reactions. These additional behavioral health-related ED visits were frequently covered by Medicaid, increasing costs to the Medicaid program.

Although high Medicaid costs may seem more relevant to State Medicaid Directors, SMHAs should also share this concern. The state Medicaid match comes from the same state revenues as state mental health funding; the more dollars spent on the Medicaid match, the fewer dollars available to be allocated to state mental health programs. Creating solutions that reduce costs can help to alleviate pressure on the behavioral health system and result in better outcomes for individuals with behavioral health conditions.

Early Intervention as an Element of Integrated Care

Earlier detection and treatment of behavioral health disorders, especially in children and young adults, can deter progression to chronic conditions. Young adults with emerging SMI who fail to engage with treatment that meets their needs are at risk for:²⁴

- Developing a chronic mental disorder;
- Becoming incarcerated, homeless and/or addicted to illicit drugs and/or alcohol;

²² <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>.

²³ Stanton M.W. & Rutherford M.K., *The High Concentration of U.S. Health Care Expenditures: Research in Action Issue 19*. Agency for Healthcare Research and Quality (2006), http://meps.ahrq.gov/mepsweb/data_files/publications/ra19/ra19.pdf.

²⁴ Serious Mental Health Challenges among Older Adolescents and Young Adults. (May 6, 2014). SAMHSA, Center for Behavioral Health Statistics and Quality Report. Retrieved June 6, 2016 from <http://archive.samhsa.gov/data/2k14/CBHSQ173/sr173-mh-challenges-young-adults-2014.pdf>

- Re-experiencing severe psychiatric crisis; and
- Academic underachievement, unemployment, and the loss of social supports.

Pediatricians and primary care professionals (PCPs) are likely to be the first to treat most children and young adults, and to need education and support to identify emerging behavioral health disorders. The Recovery After an Initial Schizophrenic Episode (RAISE) project funded by the National Institute of Mental Health has found that reducing the amount of time between the identification of first episode psychosis, which usually occurs in the teen or early adult years, and the delivery of appropriate treatment results in better outcomes.²⁵ Defined pathways between primary care and behavioral health professionals could facilitate earlier referral to treatment.

PCPs are also likely to be the first to treat individuals with depression, especially people contemplating suicide. People who die by suicide are more than twice as likely to have visited a primary care physician as a mental health clinician in the preceding year.²⁶ A review of studies analyzing this clinical scenario estimates that 45 percent of individuals who die by suicide have seen their primary care physician in the preceding month, while only 20 percent have seen a mental health professional in the same period.²⁷ By encouraging behavioral health professionals to provide support to pediatricians and PCPs, SMHAs can help to promote earlier identification of potential suicidality and referral to the behavioral health system to save lives.

Finally, as noted above, individuals with chronic medical conditions who experience poor health also experience a greater incidence of behavioral health conditions, such as depression, anxiety and substance abuse. Left untreated, these conditions can progress to serious and chronic behavioral health disorders that eventually require more intensive and costly treatment through the behavioral health system. Providing behavioral health education, training, and clinical consultation to PCPs is an effective approach to early identification of, and intervention in, behavioral health conditions, preventing further progression and debilitation.

The formal public behavioral health system does not have the workforce or financial resources to treat everyone with a behavioral health condition. Nor does everyone with a behavioral health condition want to be involved with the formal behavioral health system, and there is a research base that recognizes the impact of meeting individuals' preferences on treatment adherence.²⁸ SMHAs should embrace primary care as a partner in preventive care and meeting the needs of individuals with emerging or less serious conditions. SMHAs can promote and recognize these partners, as well as support arrangements whereby PCPs have access to psychiatric consultation as needed.

²⁵ *RAISE Questions and Answers*, National Institute of Mental Health,

<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/raise-questions-and-answers.shtml#19>.

²⁶ Luoma J.B., Martin C.E. & Pearson J.L., Contact with Mental Health and Primary Care Providers before Suicide: A Review of the Evidence, *American Journal of Psychiatry* 159(6):909-16 (2002).

²⁷ Ibid.

²⁸ Siminoff L.A., Incorporating Patient and Family Preferences into Evidence-Based Medicine, *BMC Medical Informatics and Decision Making* 13 (Suppl 3) (2013).

Value-Based Purchasing as an Element of Integrated Care

Finally, there is a growing recognition that treating an individual's health and behavioral health needs successfully also requires addressing their "social needs," such as housing, employment, and transportation.²⁹ Funding sources, including Federal block grants, Medicaid and Medicare, and state governments, are increasing the adoption of value-based purchasing. Payers are shifting focus from delivering service units to achieving better results from dollars spent. The significance of this shift for SMHAs is that, in many states, they fund and administer behavioral health safety net services. SMHAs can assist in achieving better value and outcomes by endorsing and providing evidence-based practices such as permanent supportive housing, supported employment/education, and peer/recovery support. As payers recognize the value in providing integrated care coordinated with services that address social determinants of health, demand for these services are likely to increase and SMHAs should be planning and preparing to respond to this demand.

How State Mental Health Authorities Should Promote Integrated Care

Recognizing the importance of integrated care is a critical first step to improving wellness for individuals with SMI and CODs. SMHAs can play a key role in facilitating care integration. There is no single recommended approach; rather, each SMHA's strategy must be based on an environmental scan of the health care needs and resources available within the state.

Promoting Strategies that Address Modifiable Risk Factors

SMHAs must promote an agenda for addressing the modifiable risk factors known to contribute to morbidity and mortality among individuals with SMI, including smoking, obesity, and substance use. Minimally, contracted providers should be required to routinely screen for, and report data on, these factors. Individuals identified as struggling with these issues should be provided with evidence-based approaches, such as smoking cessation tools or integrated COD treatment. SMHAs can require contracted providers to promote wellness, educating consumers about health risks, and conducting routine health screens such as monitoring weight/body mass index and blood pressure. SMHAs can make tools available to providers that address unhealthy behaviors, such as the CDC's *I'm Ready to Quit*³⁰ on-line tips or NASMHPD's Tobacco-Free Living in Psychiatric Settings toolkit.³¹

SMHAs must address the deleterious practices of providers, including state psychiatric hospitals, which allow tobacco to be used for behavior modification. Behavioral health providers have been successful in eliminating use of tobacco in various types of program

²⁹ SAMHSA Topics: Health Care and Health Systems Integration, <https://www.samhsa.gov/health-care-health-systems-integration>.

³⁰ <https://www.cdc.gov/tobacco/campaign/tips/quit-smoking/index.html>.

³¹ https://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/Downloads/Toolkits/nasmhpd_toolkit_updated_april_2011.pdf.

settings.³² For example, ten behavioral health organizations from across Maine were recently recognized for achievements in advancing their campus' smoke- and tobacco-free policies, as well as for promoting tobacco-free lifestyles.³³

In spite of a significant evidence base for integrated mental health and substance use disorder treatment, siloed treatment is still the norm in many states. A 2015 study identified three specific issues within the mental health system that hinder the delivery of effective co-occurring disorder services: organizational failure to sustain integrated care, limited support for co-occurring disorder treatment training, and diagnostic and billing restrictions.³⁴ SMHAs must continue to advocate for and facilitate the delivery of COD treatment by addressing these issues. SAMHSA's Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices KIT (Knowledge Informing Transformation) provides helpful information on how SMHAs can be involved in addressing COD program development and implementation.³⁵ In addition, while Medicaid is likely the predominant payer for COD treatment, SMHAs can and should advocate for changes to service delivery and payment rules that impede the provision of Medicaid reimbursement for COD treatment.

Increasing Access to Primary Care

NASMHPD has long been a champion of addressing concerns related to comorbidities and inadequate health care for individuals with SMI/CODs. The NASMHPD Medical Directors Council's 11th Technical Report, *Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities*, issued in 2005, identified three principles for framing thinking about the relationship between behavioral health and general health:³⁶

1. Increased integration of behavioral health and health care services is a priority at the national, state, local, and individual levels. Good public policy will work to sustain, support, and require integration of services between the two “safety net” systems of community health centers and State Mental Health Authority providers, ranging from coordination of care to full integration of medical and behavioral services.

³² *Policy Change in Behavioral Healthcare and Addiction Treatment Facilities*, Indiana State Department of Health Tobacco Prevention and Cessation Commission, https://www.in.gov/isdh/tpc/files/Behavioral_Health_Policy_Change_Oct_2012.pdf.

³³ Maine Behavioral Health Organizations Recognized for Addressing Tobacco, *MaineHealth* website, <https://mainehealth.org/news/2017/06/maine-behavioral-health-organizations-recognized-for-addressing-tobacco>.

³⁴ Padwa H. Ph.D., Guerrero E.G. Ph.D., Braslow J.T. M.D. Ph.D. & Fenwick K.M. L.C.S.W., Barriers to Serving Clients With Co-occurring Disorders in a Transformed Mental Health System, *Psychiatric Services* 2015 May 1; 66(5): 547–550, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4417038/> (May 1, 2015).

³⁵ Substance Abuse and Mental Health Services Administration. Integrated Treatment for Co-Occurring Disorders: Evidence-Based Practices KIT – 2010, <https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367> (January 2010).

³⁶ Parks J. M.D., Pollock D. M.D., Bartels S. M.D., Mauer B. M.S.W. C.M.C., *Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities*, National Association of State Mental Health Program Directors (2005).

2. Physical health care is a core component of basic services to persons with serious mental illness. Ensuring access to preventive health care and ongoing integration and management of medical care are primary responsibilities and missions of mental health authorities.
3. Behavioral health care is a core component of essential services to persons seeking primary health care. Ensuring access to preventive, ongoing, and appropriate behavioral health services is a primary responsibility and mission of general health care providers.

There are multiple ways in which SMHAs can increase access to integrated care and thereby increase the health and well-being of individuals with SMI and CODs.

Data Sharing and Evaluation

Assessing the need for and impact of integrated care requires data analysis, typically across payers, service systems, and service providers. This analysis is one of most frequently named barriers to planning and evaluation. States throughout the country struggle to develop shared information systems across agencies and systems. Federal and state confidentiality regulations are often cited as preventing the sharing of patient information related to mental health and SUD treatment.

While there are legitimate reasons to protect individuals' confidentiality and health information, states are finding ways to maintain these protections while improving service delivery.³⁷

- In Louisiana, managed care organizations and the State Mental Health Agency partnered to share data to measure the quality of HIV treatment and improve outcomes through linkage to care coordination services.
- Connecticut has facilitated Homeless Management Information System (HMIS) data- and Medicaid data-matching to identify homeless high utilizers for outreach, housing, and evaluation.
- Kentucky has developed a process to match HMIS and Medicaid data, targeting individuals with SMI/CODs who are high utilizers of healthcare services.
- Washington State developed and maintains an “integrated client database.” The database has the capacity to produce policy-driven analyses of government-funded social and health services in the state, providing the data necessary to assess need, cost, and outcomes for Department of Social and Health Services (DSHS) social and health services that include economic assistance, food assistance, child support services, long-term care, child protective services, foster care, adoptions support, mental health treatment, drug and alcohol treatment, child care, supports for persons with disabilities, refugee services, vocational rehabilitation services, and institutional and community services for juvenile offenders. The integrated client database enables in-depth analysis of clients who

³⁷ Medicaid Innovations Accelerator Program, State Medicaid Housing Agency Partnerships Data Matching Webinar, Centers for Medicare and Medicaid Services (September 22, 2016).

use services from multiple DSHS programs. De-identified data is made available to local, state, and Federal agency managers, the Governor's office, state legislators, and the general public.³⁸

SMHAs should be key in identifying appropriate information for data collection and evaluation. It is critical to develop carefully articulated outcome and performance measures that assess and incentivize the provision of integrated care by behavioral health providers.

Devising data-sharing solutions is a state-specific task. SMHAs can help by determining existing capacities for matching data to identify individuals with physical/behavioral health conditions, including those with co-occurring disorders. SMHAs should identify available means of compiling service utilization and the cost impact of siloed care. In addition, SMHAs can work across systems to help access data-matching opportunities to fill existing gaps.

SMHAs can be content experts in helping to craft language identifying appropriate performance and outcome measures to assess the adequacy and quality of services for individuals with SMI/CODs. As a system-level strategy to promote integrated care, several states merged into single contracts managed care organization responsibilities for the administration and oversight of physical and behavioral health care. However, when the approach realized mixed results with regard to care integration, a number of those states revised their managed care contracts to stipulate well-articulated requirements and/or performance measures with payment incentives.

Recommendations: Partnerships: Policy, Planning and Advocacy

The growing recognition of the importance of behavioral health care in achieving population health is revitalizing the call for responsive and accessible behavioral health services. SMHAs should use this opportunity to create new partnerships and energize existing ones that can facilitate integrated care through policy development, strategic planning, and advocacy.

Policy

SMHAs should lead the way in engaging sister state agencies in identifying the roles and responsibilities of physical and behavioral health care systems within their states. SMHAs can assist in developing policies and procedures that facilitate bi-directional referral when appropriate. Once these policies and procedures are established, the behavioral health system must serve as a responsive partner. While the formal behavioral health system may not be the primary treatment source for all individuals, it should be a resource for referral and consultation when called.

SMHAs can provide leadership in promoting the expectation for screening and referral to treatment across both physical and behavioral health systems. Routine screening for

³⁸ Kitzmiller E.M., *Washington State's Integrated Client Data Base and Analytic Capacity*, Actionable Intelligence for Social Policy, University of Pennsylvania (April 2014), http://www.aisp.upenn.edu/wp-content/uploads/2015/08/WAState_CaseStudy.pdf.

common medical conditions among children and adolescents, adults, and older adults with behavioral health conditions is critical. Establishing a policy encouraging or requiring behavioral health providers to conduct routine medical screenings can help them identify physical health conditions when they first appear, and prevent or mitigate their progression.

SMHAs must also work with stakeholders to identify and eliminate policies and regulations that deter integrated physical/behavioral health treatment. This is likely to require strategies for financing or reimbursement for services. For example, SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) program awards grants of up to \$500,000 annually to community mental health centers and other community-based behavioral health settings to provide integrated health care for individuals with SMI. But PCBHI grantees continue to struggle with planning for the financial sustainability of integrated primary care services beyond the grant period.³⁹

Planning

Integrated care will not simply occur; thoughtful, systemic planning is necessary to ensure that the capacity, processes, and structures to support this approach are in place. SMHAs should first conduct an assessment of the health care needs and preferences of people served by the behavioral health system. SMHAs should also engage representatives of the physical health care system to identify the behavioral health needs of the people they serve. Each system can then plan for and develop shared strategies with points of accountability for delivering integrated care. Planning for sufficient service capacity will help to establish a responsive behavioral health system.

For example, Delaware has developed a crisis intervention services model to prevent unnecessary and inappropriate hospitalizations of people experiencing mental health symptoms or substance use disorders. The state contracts with teams of nurses and a variety of behavioral health professionals to provide screening, assessment, treatment, and referral for people in crisis. In addition, crisis staff work with every police department in the state to provide training for police academies and evaluation assistance for people with criminal charges. Crisis centers have seen diversion rates from emergency departments as high as 80 percent.⁴⁰

Education/Advocacy

Primary care practices are often overextended just trying to meet their patients' health care needs. They may not know, or have the time to learn, what they can and should expect from the behavioral health system. SMHAs can assist in promoting positive relationships with primary care by providing education on the role of the formal

³⁹ Scharf D.M., Eberhart N.K., Hackbarth N.S., Horvitz-Lennon M., Beckman R, Han B. & Burnam M.A., *Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program: Final Report (Task 13)*, RAND Corporation, Santa Monica, CA (2014), http://www.rand.org/pubs/research_reports/RR546.html.

⁴⁰ *New Report Shows Increase in ED Utilizations for Behavioral Health – What States Can Do*, Bluestein J. & Purington K., National Academy for State Health Policy (January 13, 2017).

behavioral health system in providing patient engagement, treatment, consultation, and support services in the continuum of care.

SMHAs must advocate for the delivery of evidence-based practices, regardless of the care setting. Primary care practices are partners in the identification and treatment of behavioral health disorders; SMHAs can assist them in this role by providing training and education on the use of evidence-based screening instruments and treatment protocols. The behavioral health system can also help to identify errant primary care practices, such as the inappropriate prescription of psychotropic medications. Likewise, SMHAs can ensure that behavioral health care providers utilize established medical screening protocols, with referral to health care providers when indicated, for individuals across the lifespan.

SMHAs can also influence the delivery of integrated care by setting an expectation for sharing health care information between physical and behavioral health providers. SMHAs can serve as a valuable resource for training on the requirements of behavioral health information sharing, with focused attention on additional considerations under 42 Code of Federal Regulations Part 2 when patient-identifying substance use disorder information.

Finally, SMHAs should promote access to stable housing, employment, and social connectedness as key contributors to effective health and behavioral health care. High-quality, well-integrated treatment will have limited impact on the well-being of individuals who are unstably housed, unemployed, living in poverty, or socially isolated. This recognition requires SMHAs to assess their capacity to provide permanent supportive housing, supported employment, and peer support services for individuals within the behavioral health system.

Conclusion

State Mental Health Authorities are tasked with administering funding for, and overseeing the delivery of, mental health (and, in some cases, substance use disorder) services. SMHAs are responsible for improving treatment outcomes and the quality of life for those who need these services. Adopting strategies that address high risk factors and promoting integrated physical and behavioral health care are important roles for SMHAs to undertake in meeting the needs of individuals with behavioral health conditions.