ENSURING U.S. HEALTH REFORM INCLUDES PREVENTION AND TREATMENT OF MENTAL AND SUBSTANCE USE DISORDERS — A Framework for Discussion

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CORE CONSENSUS PRINCIPLES FOR REFORM FROM THE MENTAL HEALTH AND SUBSTANCE ABUSE COMMUNITY

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Originating Office
Office of the Administrator, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857

CORE CONSENSUS PRINCIPLES

The Substance Abuse and Mental Health Services Administration (SAMHSA) reached out to hundreds of stakeholder and consumer groups and dozens of Nationally and internationally recognized experts in the fields of mental health and addictions to solicit insight and recommendations on the most critical issues related to mental and substance use disorders facing the American population today, with an emphasis on identifying opportunities to ensure that imminent health reform efforts include prevention and treatment for these disorders. Their thoughtful input was used as the basis to develop the set of nine Core Consensus Principles that underpin this document.

Despite the broad range of organizations and areas of focus we surveyed, there were clear themes running through the responses we received. With consistency and solidarity, mental health and substance abuse professionals, consumers, and family members from every part of the country, every cultural and socioeconomic group, and every diagnosis and condition spoke with a single voice: *Our Nation is crying out for a health system that makes prevention and treatment for mental and substance use disorders a priority rather than an afterthought, that considers the whole person rather than physical symptoms alone, and that seeks to eliminate the stigma and fragmented systems that interfere with Americans' ability to access necessary preventive and treatment services fundamental to achieving recovery and enabling them to lead healthy and productive lives.*

Core Principle 1: Articulate a National Health and Wellness Plan for All Americans

Our Nation needs a National Health and Wellness Plan that provides for comprehensive, community-wide prevention, screening, health, and wellness services from infancy through old age. The Plan should provide for public education, prevention, early intervention, treatment, and recovery services, and must be a holistic, standardized system that emphasizes promoting wellness and resilience, preventing risky and unhealthy behaviors before they occur to avoid the onset of illness or drug use, and addressing symptoms when they first emerge rather than waiting until they become acute or chronic. The National Plan should utilize a public health model for prevention that organizes multiple community sectors to plan, implement, and evaluate appropriate strategies and programs designed to change community norms and environments to promote healthy choices and behaviors. Environmental strategies that rely on evidence-based methods have been shown to promote health while reducing costs. Universal screening tools should be used to *detect medical conditions including mental and substance use disorders* early and treat them at a low level of acuity. These approaches will slash billions of dollars from annual health care costs and dramatically improve the overall health of Americans.

Core Principle 2: Legislate Universal Coverage of Health Insurance with Full Parity

Although universal coverage is of course a necessity for health reform, it cannot be overstated that coverage does not guarantee access. In other words, simply talking about parity in private insurance coverage for mental and substance use disorders is not enough. Equal treatment for people with serious mental illness and substance use disorders must mean access to effective services and high-quality care. October 2008 saw an excellent step forward with the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, legislating parity in private insurance plans' coverage for mental health and substance abuse treatment. Children and adults with mental and substance use disorders are medically vulnerable populations. Many will not access needed primary health care or comply with medical treatment without significant support. Mechanisms developed under health reform to expand coverage for currently uninsured populations must require compliance with the new parity law. Similarly, the discriminatory IMD Exclusion under Medicaid must be modified. Achieving universal coverage will also help to promote health equity and increase access by requiring that priority attention be given to populations disproportionately affected by chronic disease. Such

populations include racial and ethnic minorities, groups with low socioeconomic status, residents of rural areas, chronically unemployed populations, women, children, older adults, persons with multiple chronic conditions, persons with disabilities, and criminal and juvenile justice–involved populations. Health reform must recognize the need for specialized mental and substance use disorders services to enable these populations to benefit from health care coverage and to promote health equity in terms of access and outcomes for those with mental and substance use conditions.

Core Principle 3: Achieve Improved Health and Long-Term Fiscal Sustainability

Successfully coordinated and integrated prevention, treatment, and recovery services would not only improve outcomes for people with mental and substance use disorders, but would also reduce costs Nationwide. There is a substantial body of evidence to demonstrate that providing adequate levels of mental and substance use disorders prevention and treatment services as well as integrating these services with primary health care can improve outcomes; cut and/or control the growth of overall health care costs; lessen the rate, duration, and intensity of disability of many illnesses; improve productivity; and control the size and growth of other social costs. By including information about preventing as well as detecting mental and substance use disorders in primary health care, institutional, and community settings, we create an environment that enables early, low-cost treatment, thereby avoiding escalation to expensive, urgent-care facilities; minimizing impact to family members, workmates, and others; and reducing the likelihood of lasting adverse effects to the consumer. Further, this cultivates a whole-health, person-centered approach that fosters not only recovery but also resilience.

Core Principle 4: Eradicate Fragmentation by Requiring Coordination and Integration of Care for Physical, Mental, and Substance Use Conditions

Complicating the challenges faced by the current treatment system for mental and substance use disorders is the frequent co-occurrence of these disorders, often together with other chronic health conditions. Our current system promotes disconnection among interrelated diseases and conditions leading to fragmentation and frustration among providers and consumers. The presence of multiple concurrent health conditions makes it increasingly difficult to engage consumers successfully in treatment and sustained recovery.

Core Principle 5: Provide for a Full Range of Prevention, Early Intervention, Treatment, and Recovery Services that Embodies a Whole-Health Approach

Medical evidence clearly demonstrates that the Nation's long-term health is best served by devoting resources to enhancing overall wellness. Addressing physical health including mental and substance use disorders through effective prevention efforts that promote healthy environments, norms, and behaviors rather than waiting for the development of full-blown acute or chronic diseases is the most cost-effective approach. It is essential that any health reform regard mental and substance use disorders as chronic diseases that are preventable, treatable, and often co-occurring with other physical illnesses. As with other chronic ailments such as asthma or diabetes, they may require lifelong management; but those who experience these disorders can achieve recovery and lead full, healthy, and productive lives in the community with the proper supports. Managing chronic disease has also been shown to be essential to long-term fiscal sustainability of any health reform plan.

Core Principle 6: Implement National Standards for Clinical and Quality Outcomes Tied to Reimbursement and Accountability

Establishing a consensus of specific and measurable criteria as to what constitutes positive outcomes is an essential element of a reformed U.S. health system. Reimbursement guidelines and benefits should be tied to need and severity regardless of payer. These guidelines must link quality improvement with

reimbursement and both encourage and reward the use of evidence-based practices without restricting coverage for those consumers who may not achieve desired outcomes with the least-costly alternative. Comparative effectiveness may be one consideration in making treatment decisions, but not be the wholesale substitute for the many factors that should be considered for coverage. Promoting health equity, especially for populations disproportionately affected by chronic disease, needs to be a key consideration if health reform is to succeed with achieving improved health outcomes. Accordingly, we must invest in research and accelerate the transfer of new science and anecdotal reports into evidence-based practices that take into account diverse populations.

Core Principle 7: Adopt and Fully Utilize Health Information Technology (HIT)

The accurate capturing of health information is critical. Our reformed health system must build on the increasing availability of health information technology (HIT) to provide a system of electronic health records (EHRs) that is universally available, affordable, and accessible to large and small providers Nationwide and is one that provides for capturing overall health information including *both* physical health and mental health and substance use. EHRs allow the sharing of information across providers and facilitate care coordination, while also enabling National and regional data collection to monitor and measure access to and cost effectiveness of care. To maximize the value of these tools, a uniform language and format are required, and consumers must retain control and ownership of their health data.

Core Principle 8: Invest in the Prevention, Treatment, and Recovery Support Workforce

The mental and substance use disorders prevention and treatment workforce is not adequate to meet the current demand for prevention, early intervention, treatment, and recovery services. Lack of adequate health care for mental and substance use conditions is a constant cycle exacerbated by a system that has failed to grow with the needs of a quickly expanding society and has not equipped its workforce with the right tools and experience to provide sorely needed care. Because there are simply too few specialists in mental and substance use disorders available, large numbers of Americans who require services for serious mental or substance abuse disorders receive them from general health care practitioners, who largely lack training in mental and substance use disorders prevention, treatment, and recovery services. It must become a National priority to increase the mental and substance use disorders workforce and provide appropriate compensation and professional support for these key members of the U.S. health system. Such incentives as loan forgiveness may attract professionals to train in the mental health and addictions fields, and increased funding for graduate medical education will expand the availability of psychiatric training programs. We must also develop a National, centralized credentialing and privileging system across all payers, and a National system for clinician licensing and the licensing and regulation of care delivery systems. This consistency will make it easier for professionals to enter and stay in the field, and for the system at large to achieve a higher level of quality.

Core Principle 9: Ensure a Safety Net for People with the Most Serious and Disabling Mental and Substance Use Disorders

Locating and dedicating the funds needed to bring about health reform will, by necessity, result in increased pressures to shift funding away from existing strategies and services and instead to repurpose these resources toward new health care reform priorities. Prevention has historically been underutilized and under-resourced in relation to its potential to cut health care costs. In addition, far too many Americans with diagnosable mental and substance use disorders already do not have access to treatments and services that are known to be effective. We can ill afford to dismantle the current safety net of block grants to states and other resources that in many states and communities are the only blockade between even higher rates of risky behaviors, illness, disability, death, health care costs, and lost productivity. Assuming expanded access to private and public insurance (Medicaid) for people with mental and substance use disorders will require a reexamination of the role of the public system at the local, state,

and Federal levels. Absent clear evidence that newly substituted health reform programs, systems, and processes are fully implemented and effective, it is imperative that our Nation's current safety net that finances health services, including school and community-based prevention programs and treatment programs for mental and substance use disorders, not be dismantled prematurely.

Ensuring U.S. Health Reform Includes Prevention and Treatment of Mental and Substance Use Disorders—A Framework for Discussion **Synopsis of Core Consensus Principles**	
Principle 1.	Articulate a National Health and Wellness Plan for all Americans.
Principle 2.	Legislate universal coverage of health insurance with full parity.
Principle 3.	Achieve improved health and long-term fiscal sustainability.
Principle 4.	Eradicate fragmentation by requiring coordination and integration of care for physical, mental, and substance use conditions.
Principle 5.	Provide for a full range of prevention, early intervention, treatment, and recovery services that embodies a whole-health approach.
Principle 6.	Implement National standards for clinical and quality outcomes tied to reimbursement and accountability.
Principle 7.	Adopt and fully utilize health information technology (HIT).
Principle 8.	Invest in the prevention, treatment, and recovery support workforce.
Principle 9.	Ensure a safety net for people with the most serious and disabling mental and substance use disorders.

EXECUTIVE SUMMARY

The United States is currently facing a rare and exciting opportunity: the chance to ensure that large-scale health reforms include an appropriate emphasis on addressing mental and substance use disorders through prevention, early intervention, treatment, and recovery-oriented systems of care. The burden of mental and substance use disorders, in terms of economic and social costs, has been well documented. Also well documented is the fact that treatment is effective and recovery is possible. **As lawmakers seek to revamp America's health care system, the prevention and treatment of mental and substance use disorders must play a foundational role in reforms and be given equal weight to medical care provisions.**

Our Nation is in the midst of one of the greatest financial crises it has ever seen, and rising health care costs are a serious concern. Simultaneously, huge numbers of our citizens are losing their employment as the economy continues to founder, and with it their health insurance. Earlier this year, President Obama stated, "Health care reform is no longer just a moral imperative; it is a fiscal imperative. If we want to create jobs, rebuild our economy, and get our Federal budget under control, then we must address the crushing cost of health care this year." During his campaign and since taking office, President Obama promised universal health care for all Americans during his first term.

We must reform health, not simply health care, by recognizing the importance of prevention; normalizing assessment, treatment, and services for mental and substance use disorders; and making these a key element of all health interactions. This requires full integration of prevention and treatment for health, including mental and substance use disorders together with physical health, in order to reduce fragmentation and the high costs and low outcomes that come with an uncoordinated system. It also requires an investment in training and development for a competent workforce. *By making prevention, early intervention, and treatment of mental and substance use disorders a health priority, we will not only reduce costs and strain on our systems, but will also create stronger families, stronger communities, and a stronger Nation.*

In the pages that follow, we outline the current health environment in the United States, the challenges facing the mental and substance use disorders field, and the recommendations we have compiled from stakeholders and other experts. **There is no health without addressing mental and substance use disorders and it is time to give Americans the comprehensive care and support they need and deserve.**

BACKGROUND

Although the preamble to the World Health Organization Constitution defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," an unfortunate but defining characteristic of the current U.S. health system is a disease model rather than a wellness model. As such, both physical health conditions and mental and substance use disorders often must reach acute or chronic levels before they are diagnosed or treated, leading to enormous cost to not only the health care system, but also the public safety, education, and criminal justice systems. Mental illness is the leading cause of disability in North America for people ages 15 to 44 years, and the burden of disease resulting from mental disorders exceeds that resulting from any other health condition. The economic impact of addictions is staggering, estimated at $500 billion annually.

According to the Substance Abuse and Mental Health Services Administration's *National Survey on Drug Use and Health*, in 2007 an estimated 22.3 million Americans (9 percent of the population age 12 years and older) were classified with substance abuse or dependence in the last year. Also in 2007, an estimated 24.3 million adults age 18 years and older experienced serious psychological distress in the last year, approximately 10.9 percent of all adults in the United States. Further, 16.5 million American adults (7.5 percent) experienced at least one major depressive episode, and nearly one in 20 had a major depressive episode with major impairment. Of the 24.3 million adults who experienced serious psychological distress, 5.4 million, or 22.2 percent of the population, also experienced alcohol or illicit drug use or dependence. Despite this high incidence, only 10.4 percent of those who needed treatment for substance abuse or dependence, 44.6 percent for serious psychological distress, and 64.5 percent for major depressive episode actually received it.

1 in 4 Americans experience mental illness, the nation's greatest cause of disability. The most serious conditions affect 10.6 million people, and twice as many Americans live with schizophrenia as with HIV/AIDS.

Especially when controlling costs is a major National priority, economic reality alone dictates that we must prevent that which is preventable. But reducing health care costs is also crucial to creating a sustainable health system, and prevention efforts play an important role in accomplishing that goal. Research from Iowa State University shows that every $1 invested in overall prevention services yields a return of almost $10. In terms of addiction, every $1 dedicated to drug and alcohol prevention saves $7-$20 in costs from crime, incarceration, emergency room care, productivity, and premature death.

According to the Director of the National Institute on Drug Abuse (NIDA), drug addiction is a developmental disorder that begins in adolescence, sometimes as early as childhood, for which prevention is critical. NIDA (2008) research finds that addiction is complex and is influenced by a number of factors, including genetics, environment, and age of first use. Adolescents who begin drinking before the age of 15 years are four times more likely to develop alcohol dependence. Each additional year of delayed drinking onset reduces the probability of alcohol dependence by 14 percent (National Institute on Alcohol Abuse and Alcoholism, 2006). Finally, according to SAMHSA (2002) data, children who first smoke marijuana younger than the age of 14 years are more than five times as likely to abuse drugs as adults than those who first use marijuana at 18 years of age. Preventing substance use by stopping it before it starts and increasing the age of first use is the least expensive and most effective way to deal with substance use disorders. Each

dollar invested in research-based substance abuse prevention achieves a savings of up to $7 in areas such as substance use disorder treatment and criminal justice costs (NIDA, 2007).

Recovery must be the common, recognized outcome of the services we support.
SAMHSA 2006 Consensus Statement on Mental Health

Thus, the treatment of substance use disorders yields both reductions in health costs and overall financial returns. A 2003 article by Parthasarathy et al. in *Medical Care* reported dramatic medical cost savings resulting from addiction treatment: fewer emergency room visits and hospital readmissions, fewer days of inpatient treatment, and a reduction in monthly per-patient medical costs from $431.12 to $200.03. Similarly, in a 2005 *Alcoholism, Clinical and Experimental Research* article, Mertens et al. stated, "On average, substance abuse treatment costs $1,583 and is associated with a monetary benefit to society of $11,487, representing a greater than 7:1 ratio of benefits to costs. These benefits were primarily because of reduced costs of crime and increased employment earnings."

In 2008, the Campaign for Mental Health Care Reform asserted that "there can be no health without mental health, that prevention of and recovery from many healthcare conditions rests on mental wellness in each individual." Addressing mental and substance use disorders through recovery-oriented systems of care is critical not only to personal health, but to creating a stronger Nation that will thrive for generations to come. Rehabilitation and employment services help promote personal and economic recovery. Individuals with mental and substance use disorders should have full access to these programs.

No longer can we wait for crisis to prevent or treat mental and substance use disorders. The United States cannot afford to spend billions of dollars on preventable health conditions, especially in the current economic climate. By eliminating fragmentation and redundancy throughout our health system, we will improve effectiveness while reducing costs when financial considerations are paramount. It is time to broaden our notion of health in the United States, and think about a person's whole health instead of just his or her diagnoses.

Beyond Those with a Diagnosis

Those personally experiencing conditions such as mental and substance use disorders are not the only ones affected by them. Their families, employers, communities, and even American taxpayers also share the burden. Yet there are few systems in place to reduce those effects. In the report "The Economic Cost of Drug Abuse in the United States: 1992-2002," the Office of National Drug Control Policy reported that illicit drug use alone costs society $181 billion each year. When adding alcohol and tobacco costs, data from numerous other sources increase the total to $500 billion as cited earlier in this document, spanning health care, criminal justice, and lost productivity.

As a result of scientific research, we know that addiction is a disease that affects both brain and behavior.

National Institute on Drug Abuse

In a stunning example, an April 2009 article in the *St. Petersburg Times* reported that nine patients in the Austin, Texas, area accounted for an astonishing 2,678 emergency room visits over six years, which carried a total cost of $3 million. That is an average of nearly 50 visits per patient per year, or almost one a week. Of the nine patients, eight had drug abuse issues, seven had diagnosed mental illnesses, and three were homeless. Nationwide, nearly 25 percent of stays in community hospitals are related to depression, bipolar disorder, schizophrenia, or other mental or substance use disorders, and addiction accounts for 2 million emergency room visits annually. Approximately 25 percent of people who are homeless have serious mental illness, many of them with not only co-occurring mental health and substance use

disorders, but also serious and substantial primary health care needs such as diabetes, hypertension, and other preventable and manageable health conditions.

Treatment of mental disorders carries the highest cost of the top 5 most costly children's conditions, totaling $8.9 billion for U.S. children ages 0 to 17. It beats infectious diseases, trauma-related disorders, and asthma.

AHRQ Medical Expenditure Panel Survey, April 2009

This raises a critical point about the cost of health care. Mental and substance use disorders are often present along with other chronic health conditions and may interfere with individuals' ability to access health insurance and affordable health care, forcing patients to access care in acute settings such as hospital emergency rooms. In large part because they lack access to regular and preventive care, adults with serious mental illness die an average of 25 years earlier than those without these illnesses, and usually as a result of unrelated health conditions (Lutterman et al, 2003). Another example of high health costs affects children of parents with mental and substance use disorders. The social, emotional, cognitive, and linguistic development of babies, children, and adolescents is strongly affected by the mental health of their caregivers, so it is significant that as many as approximately 10 percent of mothers of young children experience anxiety disorders, maternal depression, or another form of chronic depression. Children of alcoholics typically have health care costs 32 percent higher than children from non-alcoholic families, with a 24 percent higher rate of hospital admissions, hospital stays that are 29 percent longer, and in-patient drug costs that are 39 percent higher. These children, without the proper preventative interventions, are also considerably more likely to experience their own substance use or mental disorders later in life, and to experience academic and social challenges including scholastic performance and truancy.

Research shows that one in five children has a diagnosable mental disorder, and factors can predict future mental health problems in early years. Sadly, however, as many as 80 percent of children and youth in need of mental health services go untreated, leading to emotional, behavioral, and social problems as they develop and age into adulthood.

"Society's Greatest Failure"

The recent financial meltdown afflicting the United States has had devastating effects on the U.S. population. Entire communities have been rocked as the companies and industries that underpin local and regional economies close their doors. Detroit, the heart of the American auto industry, reported a 22.6 percent unemployment rate in January 2009, the highest in more than a quarter century. That number does not even account for those who have simply given up on looking for jobs or who are now underemployed. Hopelessness and despair are sweeping through many people in our society, and many are turning to drugs, alcohol, and even suicide to escape what they perceive as crushing financial and social responsibilities.

Suicide occurs somewhere along a spectrum of chronic pain — physical and/or emotional — when the balance tips too far.

Joseph A. Glazer
Mental Health Assoc. in NY

In July 2008, a 53-year-old Taunton, Massachusetts, woman shot herself to death with her husband's rifle after faxing her mortgage company a message telling them that by the time they auctioned off her foreclosed home later that afternoon she would be dead. It was already too late when the police arrived. On returning home that evening, her husband and 24-year-old son were stunned to learn of her death and said that they had no idea that the house had been foreclosed or that she was feeling desperate to the point of killing herself over their financial situation.

Even before the economic decline began in earnest in 2008, suicide has been a serious public health problem in the United States for decades. Suicide has been called society's greatest failure, and rightfully so. According to the Centers for Disease Control and Prevention, it is the Nation's eleventh leading cause of death, accounting for 33,300 deaths and a total rate of 11.1 suicide deaths per 100,000 people. By comparison, homicide is the thirteenth leading cause of death in the United States. There are an estimated eight to 25 attempted suicides for every suicide completion. Significantly, more than 60 percent of adolescents and 90 percent of adults who die by suicide have depression or another diagnosable mental or substance use disorder.

Public Safety

Untreated, mental and substance use disorders can lead not only to suicide, but also to public safety issues including crime, family and interpersonal violence, and vehicular accidents, not to mention the impact of maternal drug and alcohol abuse during pregnancy. Presence of a substance use disorder is a proven risk factor for domestic violence, and may also be an indicator of other unhealthy lifestyle behaviors. In fact, the U.S. Department of Justice (DOJ) found that 61 percent of domestic violence offenders also have experienced substance abuse. A 1994 DOJ study reported a more than 50 percent incidence of drinking by the offender in cases of murder in families. According to a survey conducted by the National Committee to Prevent Child Abuse, up to 80 percent of child abuse cases are related to abuse of alcohol or other drugs.

The Centers for Disease Control and Prevention report that the annual cost of motor vehicle crashes caused by impaired driving is $50 billion. In 2006, 32 percent of all traffic fatalities were related to alcohol impairment, and in 2007 more than 1.4 million drivers were arrested for driving under the influence of alcohol or narcotics. In a frightening statistic, 159 million U.S. adults self-report driving under the influence of alcohol each year. Marijuana, cocaine, and other illegal drugs play a role in approximately 18 percent of motor vehicle driver deaths, usually in combination with alcohol.

There is also a high incidence of illicit drug use among criminal justice populations. For instance, SAMHSA reported that for 2007, among the 5.1 million adults on probation at some time in the last year, 28.4 percent reported current illicit drug use. Of the 1.6 million adults age 18 or older on parole or other supervised release from prison during the last year, nearly a quarter (24.1 percent) were current illicit drug users, compared with only 7.7 percent among adults who were not on parole or supervised release. In addition, the criminal justice system serves as a major referral source for the publicly funded substance abuse system. A 2009 study conducted by the National Association of State Alcohol and Drug Abuse Directors reported that on average, 40 percent of admissions to publicly funded substance abuse systems came from criminal justice referrals. In all, 13 states reported that 50 to 70 percent of referrals came from the criminal justice system.

The data are clear: To transform and modernize America's health care system, mental and substance use disorders prevention and treatment services must be part of the solution. Providing people in need with the full continuum of appropriate mental and substance use disorder treatment and recovery support strategies will improve outcomes and reduces costs. Access to universal health promotion and illness prevention programs, selective prevention strategies focused on those at risk, and indicated prevention and treatment services for all will improve health and well-being and support long-term fiscal sustainability. Services for mental health and substance abuse are essential to advancing and protecting the Nation's health and vital to the success of health reform.

CHALLENGES TO A COMPLETE AND COMPREHENSIVE HEALTH SYSTEM

The United States has long been regarded as a diverse, multicultural, and multilingual Nation. But this asset has also presented some obstacles in terms of developing a health system that is effective and inclusive for our complex population. The right solution must be highly scalable to avoid the need for change in just a few short decades, and extensible enough to fit the widely varying needs while ensuring a consistent level of quality that meets the standard we demand for our citizens. Key among the challenges we face as a Nation are a lack of a coherent health and treatment strategy or defined outcome measures and accountability points, poor public awareness, and a dire shortage of health care providers.

Depression is among the top 5 chronic health care conditions driving overall health costs to employers. On average, for each $1 of medical or pharmacy cost, there is $2.3 of health-related productivity costs. Employers consistently underestimate this impact.

Journal of Occupational and Environmental Medicine

According to National Institute of Mental Health Acting Deputy Director Dr. Philip Wang, the greatest failure of our present health system is poor allocation of the significant resources that we do devote to behavioral health care. "There are three levels to focus on: individual, practice, and systems levels," says Wang. "We are not allocating well, and there are disparity issues across some social groups, especially racial and ethnic minorities. They receive less."

In short, we must overcome:

- Lack of National legislative, economic, and conceptual strategy and implementation plan surrounding health care
- A fragmented health system that fails to integrate behavioral health and physical health;
- Woefully inadequate financial and human resources to serve an increasingly diverse and growing population;
- Entrenched stigma surrounding the presence and treatment of mental and substance use disorders—societal, in communities, and in popular culture; and

Fragmentation

Mental and substance use disorders are not disorders that can be cured like a cold or an infection, yet the current U.S. health system is geared toward just such a treatment model. This disconnect leads to fragmentation and frustration among both providers and patients. Historical efforts to place mental and substance use disorders solely under the heading of disabilities rather than health issues, says Dr. Allen Daniels, "Undermines the recovery agenda and makes mental health and addictions not chronic illnesses but debilitating illnesses. Behavioral health must be part of the full spectrum of health, not an "other."

Workforce Limitations & Disproportionate Distribution

Although the United States may be largely known for its cities, nearly a quarter of its population—approximately 62 million people—live in rural areas that cover 75% of its land mass. Recent estimates suggest that 15 million of those rural residents have significant mental and/or substance use disorders. Despite similar prevalence of behavioral health conditions in rural and urban settings, suicide attempts and death rates are markedly higher in rural areas, particularly for rural elderly, whose rate is three times

that of the National average for non-rural settings. A likely factor in explanation for this startling discrepancy is the dearth of health care in general and behavioral health care specifically in non-metropolitan areas.

Only 9 to 11 percent of the Nation's physicians are practicing in rural communities, and the greater their specialization, the less likely their presence in a rural area. Psychiatry positions are disproportionately vacant in Federally funded rural community health centers. Because there are so very few mental health and addictions specialists available, large numbers of Americans who require services for serious mental or substance use disorders receive them from general health care practitioners, who largely lack training in mental and substance use disorders prevention, treatment, and recovery services.

Lack of adequate behavioral health care is a constant cycle exacerbated by a system that has failed to grow with the needs of a quickly expanding society, and has not equipped its workforce with the right tools and experience to provide sorely needed care. Aside from geographical disparities, the behavioral health field suffers mightily from limited training opportunities, chronically low salaries and poor reimbursement rates, and an increasingly diverse and complex patient population that is currently growing faster than the workforce can keep up with it. Different languages, cultural customs, and societal norms require additional competencies and specialized training, and there are not enough mental health and addictions professionals, paraprofessionals, and peer service providers to meet the demand.

Although they may recognize that their patients require treatment from someone with mental health or addictions expertise, doctors in the primary health care setting may not know what their options are in terms of making a referral. Even when these physicians are aware of possible resources in the area, often those facilities do not have the capacity to accommodate the growing need for mental health and addictions services. At times when case loads allow the acquisition of new clients, costs may be prohibitive, or consumers may lack insurance coverage, transportation, or the support system to follow through with care, and providers simply do not have the time or ability to follow up with every client.

The paucity of mental health and addictions providers throughout much of America would be less paralyzing were there stronger community care services such as in schools, faith-based organizations, and community centers. However, peer-led services such as parent-to-parent support, teen mentoring organizations, and clergy-directed counseling are also lacking due to a limited coordination, alignment, and funding.

Co-Occurrence & Comorbidity

Complicating the inadequacy of behavioral health care systems throughout our Nation is the frequent co-occurrence of mental and substance use disorders with other chronic health conditions. The presence of multiple concurrent health conditions makes it increasingly difficult to engage consumers successfully in treatment and sustained recovery. For instance, studies show that homeless individuals with both mental and substance use disorders remain homeless for substantially longer than those with one or neither disorder. As people who are homeless and have co-occurring conditions age, they may develop health conditions such as hypertension or diabetes that quickly worsen due to a lack of health care and decent housing and lack of resources, ability, or perhaps willingness to adhere to prescribed treatment regimens. Successful treatment and recovery would not only improve outcomes for this special population, but also reduce costs Nationwide.

Stigma & Social Norms

An additional and extremely debilitating factor in the fight for effective and appropriate treatment for mental and substance use disorders is the stigma surrounding behavioral health conditions. Throughout history, those with mental and substance use disorders have been marginalized, discredited, and even

subjected to violence and harsh discrimination. Often because of strong social stereotypes associated with mental and substance use disorders, those experiencing such conditions feel that they are to blame, that recovery is not an option, and that they should be ashamed of these issues and hide them rather than seeking ways to cope with their challenges and developing stronger social skills and community ties.

Such feelings of shame and worthlessness are strongly reinforced by media depictions of people with mental or substance use disorders as sources of comic relief or violent offenders. Women with mental disorders are frequently depicted as victims, and men shown as criminals or emasculated. These depictions have largely been embraced by the general public out of fear and ignorance, which creates an unfriendly and often hostile environment that does little to support community-based recovery efforts.

Special Considerations for Veterans

One group currently at the forefront, and one particularly affected by stigma, is veterans. As the war in Iraq comes to a close and troops are returning to the United States, large numbers of soldiers and their families are requiring behavioral health services to manage such conditions as posttraumatic stress disorder, substance use disorders, anxiety and panic attacks, situational or major depression, grief, domestic violence, and marriage challenges as they transition from often long-term combat conditions back into civilian life. However, many of these men and women do not live in close proximity to a VA hospital, and even those who do may fear that their taking advantage of behavioral health services will prevent them from being retained or promoted in the military in the future. If veterans and their families cannot access care, cannot afford it, or are afraid to accept it, they may end up living with treatable conditions that can lead to a lifetime of costly health repercussions. This is not a choice that any of our troops, or, for that matter, any American, should have to make; seeking help for a debilitating illness should be applauded, not viewed as evidence of weakness.

CORE CONSENSUS PRINCIPLES IN ACTION: VIABLE SOLUTIONS FOR AN INTEGRATED HEALTH SYSTEM

To create a truly successful health system, we must incorporate the insight of the Institute of Medicine report *Improving the Quality of Health Care for Mental and Substance Use Conditions 2005* that builds on the recommendations of 2001's landmark *Crossing the Quality Chasm* report. Whereas the current U.S. health system fails to appreciate and act on the inextricable link between physical and behavioral health, *Improving the Quality of Health Care* highlights the need to not only recognize but also to value this mind-body interaction. The resulting health system is person centered, holistic, and self-directed.

Core Consensus Principle 1
Articulate a National Health & Wellness Plan for All Americans

Our Nation needs a National Wellness Plan, analogous to childhood and adult vaccination schedules that outlines screening, health, and wellness services from infancy through old age that drive prevention, early intervention, and treatment in a holistic, standardized system that addresses symptoms when they first emerge rather than when they become acute or chronic. The National Plan should utilize a public health model for prevention that organizes multiple community sectors to plan, implement, and evaluate appropriate strategies and programs designed to change community norms and environments to promote healthy choices and behaviors.

At a minimum, this plan should include:

- Mental health screening and early intervention for all children in both the primary health care and educational (school nurse and classroom) settings;
- Development of consensus quality indicators for children's mental health;
- Incentives for collaboration between primary health care and mental and substance use disorders prevention and treatment;
- Integrated funding streams to improve access and coordination for children and adolescents with mental and substance use disorders;
- Increased funding to states for coordinated services within child-serving agencies;
- Mental and substance use disorders screening throughout adulthood in the primary health care setting; and
- Community-based peer and professional services that support wellness and health.

Detecting both physical health conditions and mental and substance use disorders early and treating them at a low level of acuity will slash billions of dollars from annual health costs and dramatically improve the overall health of the American public.

Core Consensus Principle 2
Legislate Universal Coverage of Health Insurance with Full Parity

Although October 2008 saw an excellent step forward with the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act legislating parity in private insurance plans for mental and substance use disorders treatment, coverage does not guarantee access, and millions of Americans still lack access to quality care for mental and substance use conditions. As discussed earlier, nearly 25 percent of the population is virtually without a mental and substance use disorders specialist in their geographical area. Large numbers of others may not realize that treatment is an option for them without screening programs or referrals from a primary care provider who may or may not be familiar with characteristics and risk factors for mental and substance use disorders. Still others may be among the 47 million Americans with no health insurance, who cannot afford routine, preventive medical care and typically access only emergency care services and generally only in the case of acute illness.

The Institutions for Mental Disease (IMD) Exclusion under Medicaid is a barrier to ensuring that every American receives appropriate and affordable treatment for mental and substance use disorders. The IMD Exclusion represents a rare policy where Federal Medicaid law prohibits Federal funding from being applied toward the cost of medically necessary care furnished by licensed care providers to enrolled program beneficiaries ages 21 to 64 years and served in institutions with fewer than 17 beds. Any exclusion that prohibits access to a viable treatment modality—particularly in light of the recent parity mandate—runs counter to the inherent right of each individual to make choices and have access to the most appropriate care based on personal circumstances and medical necessity. Because every person with a mental health or substance use disorder must be able to avail him- or herself of all appropriate levels of treatment, whether outpatient, inpatient, or residential without fear of denial of coverage, this exclusion must be modified to support such inclusive measures.

Although universal coverage is of course a necessity, **it cannot be overstated that coverage does not guarantee access**. In other words, simply talking about parity is not enough. We must make equal treatment for those with serious mental and substance use disorders a reality, not a platitude. Adults with serious mental illness are a medically vulnerable population. Many will not access needed primary health care or comply with medical treatment without significant support. *Health reform must recognize the need for*

specialized mental health, addictions and social services to enable this population to benefit from health care coverage and eliminate disparities in health outcomes for those with serious mental and substance use conditions.

"What is worrisome is the perception among legislators that we've passed parity and that there's nothing else to worry about. Parity is a piece of the answer, but it's coordination that's the real answer," says Daniels. "When in doubt, we fragment. We have to make a case for where parity fits in the overall health structure." Daniels believes the lack of coordination between general health care and mental and substance disorders prevention and treatment is a major contributing factor to the 25-year mortality disparity for those with serious mental illness.

Cross-system collaboration will go a long way toward effecting this change. In addition to aligning primary health care and mental and substance use disorders prevention and treatment, we must also create a united front with the housing, employment, child welfare, and criminal and juvenile justice systems.

Studies suggests that 10% of criminals are responsible for 90% of crime, and many who enter the system are victims of abuse, experienced lifelong exposure to mental and substance use disorders, or themselves have a one or more such disorder. Yet our approach to supporting these individuals fails to discourage or prevent recidivism in any meaningful way. We must mandate prevention, treatment, and recovery services in our jails and juvenile detention facilities, and post-release for every offender. Community supports should reinforce positive lifestyle choices and healthy behaviors, and supportive housing can ensure that each individual has a safe place to maintain recovery. Reliance upon prescription medications and other treatments and services are critical to many offenders with mental and substance use disorders, and any disruption or delay in coverage can result in relapse or directly contribute to recidivism.

An increased focus on supportive measures and behavioral health care in the child welfare system will increase early detection of risk factors and symptoms of mental and substance use disorders. These measures—spanning public education, foster care, and whole health including physical health conditions and mental and substance use disorders—will not only improve quality of life for these children, but will prevent lifelong problems, health costs, and other costs.

Both conceptual and structural reform will be drivers in the re-visioning of the U.S. health system, and multi-setting, collaborative care will continue to develop throughout this evolution. Consumers must become increasingly active participants in their care, and together with their physicians should be the primary decision makers in their treatment. No longer should payers have the final say on treatments; those judgment calls should not be made by third parties who have not had interactions with the patient who will be affected. Funding for health care cannot be restricted to only severe levels. On the contrary, payment decisions must incentivize early detection, prevention, and treatment; reward continuous quality improvement and use of evidence-based treatments and services; and facilitate long-term maintenance for chronic conditions.

Says former Magellan Healthcare CEO Henry Harbin, "Mental health folks need to protect existing mental health benefits no matter what structure emerges." The focus of attention must be on full and adequate coverage in any system. It is imperative that we legislatively mandate that payment and financing mechanism promote integration, reduce duplication, and eliminate waste and fraud—all without endangering hard-won progress thus far in the fields of mental health and addictions. Forthcoming rules and regulations to accompany the new parity legislation must continue to be developed in a patient-focused manner that reflects the broad intent of Congress—including modifying the restrictive and discriminatory IMD exclusion. Medicare managed care plans also need to incorporate parity, and we need to eliminate barriers to Medicaid enrollment for people who are homeless, those

reentering society after incarceration, young people aging out of the foster care system, and others in sub-populations with low Medicaid eligibility and enrollment despite high vulnerability to serious physical and mental and substance use conditions.

Core Consensus Principle 3
Achieve Improved Health and Long-Term Fiscal Sustainability

Successfully coordinated and integrated prevention, treatment, and recovery services would not only improve outcomes for people with mental and substance use disorders, but would also reduce costs Nationwide. There is a substantial body of evidence to demonstrate that providing adequate levels of mental and substance use disorders prevention and treatment services as well as integrating these services with primary health care can improve outcomes; cut and/or control the growth of overall health care costs; lessen the rate, duration, and intensity of disability of many illnesses; improve productivity; and control the size and growth of other social costs.

By including information about preventing as well as detecting mental and substance use disorders in primary health care, institutional, and community settings, we create an environment that enables early, low-cost treatment, thereby avoiding escalation to expensive, urgent-care facilities; minimizing impact to family members, workmates, and others; and reducing the likelihood of lasting adverse effects to the consumer. Further, this cultivates a whole-health, person-centered approach that fosters both recovery and resilience.

Core Consensus Principle 4
Eradicate Fragmentation by Requiring Coordination and Integration of Care for Physical, Mental, and Substance Use Conditions

What our Nation requires is a fundamental shift toward a recovery-oriented system of primary health care and mental and substance use disorders prevention and treatment. Prevention and early detection of mental and substance use conditions carry comparable cost savings to treatment of other chronic diseases such as cancer. Instead of the outdated model of waiting for the emergence of disease to indicate the need for costly treatment, providers at every health touch point must participate in continuous prevention efforts to promote total wellness through patient education, and regular screening to identify mental and substance use disorders before those conditions become acute. Simple questions such as, “Have you noticed any changes in your mood in the last six months?” “Have your sleeping patterns or appetite changed lately?” or “How do you feel about your level of alcohol consumption?” can provide the necessary information that may cue a primary care physician to refer a patient to a mental health or addictions specialist or recommend early intervention steps to head off potential future problems.

The Screening, Brief Intervention and Referral to Treatment (SBIRT) program initiated in 2003 by the Substance Abuse and Mental Health Services Administration demonstrates the power of screening and early intervention. SBIRT programs administered in hospital emergency rooms, community health clinics and other health care settings throughout the U.S. screen and identify patients with potential substance abuse problems. The goal is to intervene early to prevent the exacerbation of illness by referring those in need to specialty care settings. Data issued late last year shows that of the more than 745,000 people who have been screened in SBIRT programs, 23 percent needed a brief intervention, brief treatment, or referral to specialty addiction services.

Mandatory education units in mental health and addictions prevention and treatment incorporated into continuing education for physicians and other general health practitioners with equip them with the basic

knowledge to assess patients' potential need for more in-depth mental and/or substance use disorders treatment. Such training will also enable physicians to identify risk factors that may predispose their patients to certain mental or substance use disorders, and enable them to provide more attentive prevention-oriented care both through their own awareness and by educating their patients. The long-term effects of such efforts will be a lower incidence of mental or substance use conditions, and a reduced severity when they do occur.

Pediatricians and obstetricians/gynecologists can play a critical role in education and early intervention by beginning prevention efforts with the first prenatal visit and keeping parents apprised of key emotional and behavioral milestones throughout childhood. They can also remain alert to signs of caregiver depression, anxiety, or substance abuse both through parent interactions and information provided by the children. School nurses, teachers, and clergy can play a similar role, all guided by targeted professional education geared toward equipping these individuals to make informed referrals to mental health or addictions specialists. Such cross-system collaboration can also include the criminal and juvenile justice systems, which serves many of the same individuals served in community settings both before and after incarceration.

By detecting mental and substance use disorders in primary health care and community settings, we create an environment that enables early, low-cost treatment thereby avoiding escalation to expensive, urgent-care facilities; minimizing impact to family members, employers and others; and reducing the likelihood of lasting adverse effects to the consumer. Further, this cultivates a whole-health, person-centered approach that fosters not only recovery but also resilience.

Core Consensus Principle 5
Provide for a Full Range of Prevention, Early Intervention, Treatment, and Recovery Services that Embodies a Whole-Health Approach

Whether one's health conditions are from physical or mental or substance use conditions, recovery-oriented systems of care should be the gold standard. Every consumer should have a health home that comprises a strong partnership between the patient and his or her family and the full range of involved health professionals to ensure comprehensive and continuous care that takes into account the whole person rather than just physical health. To that end, ultimately, every medical practice should have a prevention specialist who focuses specifically on wellness and who is trained in mental health an addictions to support general practitioners in making appropriate referrals and coordinating care.

In cases where a mental or substance use disorder is identified, strong case management and a clear continuum of care are essential elements for success. In the United Kingdom, and now increasingly in the United States, registered nurses called "breast cancer navigators" coordinate care among primary care physicians, oncologists, surgeons, radiologists, mental health providers, and others for each patient to ensure that the consumer is informed every step of the way, knows whom to contact with any questions or concerns, and is compliant with any treatment protocols. Such provisions range from reviewing chemotherapy administration schedules and providing nutritional counseling to reminding patients to drink enough water after radiation treatments. A similar model can and should be adopted for treatment and recovery support in mental health and addictions, and may be filled by preventionists.

Trained peer counselors or certified or masters-level mental health or addictions professionals can provide follow-up services to ensure compliance with treatment regimens and encourage positive lifestyle behaviors while enabling clinicians to maintain a full patient case load. These "recovery navigators" will ensure coordination among physicians and other professionals providing services for physical health conditions and mental and substance use disorders and incorporate family members and significant others in treatment and decision making to create a supportive and recovery-oriented care

plan. Depending on each consumer's needs, recovery navigators will make available not only counseling and medication management, but also rehabilitative treatment, supporting housing, and workforce readiness training.

Additionally, long-term care must fully include family members. As evidenced by the far-reaching effects of mental and substance use disorders, spouses, children, and communities need support when coping with these conditions. Again this is essential to reducing overall health costs, not to mention costs to other systems including education, labor, public safety, and criminal justice. By demanding that a full range of stabilization supports be included in all treatment and recovery plans, we ensure that any individual diagnosed with a mental or substance use disorder not only receives appropriate treatment, but also is less likely to revert to unhealthy behaviors. This holistic approach is another essential element to effective health reform.

Core Consensus Principle 6
Implement National Standards for Clinical and Quality Outcomes Tied to Reimbursement and Accountability

To avoid creating another fragmented approach to health, we need to reach past the simple step of defining services to be provided and put them in the concept of integrated health systems. A first step to this definition is establishing a consensus definition for long-term, sustained recovery and a clear understanding of what constitutes good outcomes, as well as the specific outcomes that will be embraced by providers, communities and payers.

Each consumer will have an active role to play in defining his or her own treatment goals; however, we must also have a benchmark by which to measure our success in improving health in America. A basic tenet of any reformed health system must be that, done correctly, the reformed health system will advance health while strengthening families, communities, the economy, and the Nation as a whole. We must strive for optimum health regardless of where a patient is on the continuum, and ensure that all services are delivered in a context that is culturally competent, family and community driven, and respectful of consumers.

Establishing a consensus of specific and measurable criteria as to what constitutes positive outcomes facilitates another essential element of our reformed health system: a single set of reimbursement guidelines and a set of benefits tied to need and severity for all consumers regardless of payer. These guidelines must link quality improvement with reimbursement and both encourage and reward the use of evidence-based practice without restricting coverage for those consumers who may not achieve desired outcomes with the least-costly alternative. Comparative effectiveness should be a driver in making treatment decisions, but not be the be-all and end-all for coverage. Accordingly, we need to transfer new science and anecdotal reports into evidence-based practice.

"Other countries can teach us how to make quality and purchasing decisions more evidence-based endeavors," says NIMH's Wang. "They seem to have learned the ways to move populations toward use of proven prevention services."

Harvard economist Dr. Richard Frank echoes Wang's sentiments. "I think integration of social services with health care is especially attractive for people with severe mental and addictive disorders. This is done in the United Kingdom, France, and Holland," Frank says. "More generally, rationing is done in ways that are more sensible and certainly fairer. The emphasis on child development and child health in the Nordic countries and Holland is impressive."

Core Consensus Principle 7
Adopt and Fully Utilize Health Information Technology (HIT)

Our reformed health system must build on the increasing availability of health information technology (HIT) to provide a system of electronic health records (EHRs) that is universally available, affordable, and accessible to large and small providers Nationwide. EHRs allow the sharing of information across providers and facilitate care coordination, while also enabling National and regional data collection to monitor and measure access to and cost effectiveness of care. To maximize the value of these tools, we need to adopt a uniform language and format, and ensure that consumers retain control and ownership of their health data.

An added benefit of EHRs and HIT in general is that they can be invaluable in the context of telemedicine. Regardless of a provider's location, he or she can have real-time access to patients complete medical information including mental and substance use history, and can update records during the provision of care. This accurate capturing of health information is critical.

Core Consensus Principle 8
Invest in the Prevention, Treatment, and Recovery Support Workforce

The current mental health and addictions workforce is not adequate to meet the demand for mental and substance use disorders prevention and treatment Nationwide. It must become a National priority to increase the behavioral health workforce and provide appropriate compensation and professional support for these key members of the U.S. health system. Such incentives as loan forgiveness may attract professionals to train in the mental and substance use disorders field, and increased funding for graduate medical education will expand the availability of psychiatric training programs.

Throughout the primary and mental and substance use prevention and treatment care settings spanning community-based and institutional settings, as well as their points of intersection, cultural competence is a must. We need to take a systemic approach to promoting diversity in the mental health and addictions and medical workforce, and ensure that patient education materials are available in multiple languages. There must be funding available for linguistic interpreters when fluent clinical and other staff are not present, and physicians and other providers should be fully aware of local and telemedicine-accessible options for linguistically and culturally competent options in the event that is not possible.

Funding for research on practice-based care and culturally proven treatment methodologies is also critical. What is comfortable and effective for the American Indian community may not always be so for the Alaska Native community. The African-American and Hispanic communities have rich cultures of tradition that should not be overlooked. These long-standing practices should play a role in evidence based medicine by serving as the basis for research initiatives.

Even with increased training and incentives for entry into the mental health and addictions fields, there is still a workforce shortage that will take time to overcome, and one that is dire in rural areas. We must devote funding to telemedicine in an effort to ensure that all Americans who require services for mental and substance use disorders have access to qualified professionals and appropriate care. In areas where telemedicine is the primary delivery method for mental health and addictions services, peer counselors and trained non-clinical specialists, as well as community-based care, will be extremely valuable.

We must also develop a National, centralized credentialing and privileging system across all payers, and a National system for clinician licensing and the licensing and regulation of care delivery systems. This consistency will make it easier for professionals to enter and stay in the field, and for the system overall

maintain a high level of quality. Further, this facilitates the development of the consensus standards described earlier and provides a foundation for coordinated professional development efforts.

Core Consensus Principle 9
Ensure a Safety Net for People with the Most Serious and Debilitating Mental and Substance Use Disorders

Locating and dedicating the funds needed to bring about health reform in the U.S. will, by necessity, result in increased pressures to shift funding away from existing strategies and services and instead to repurpose these resources toward new health care reform priorities. Prevention has historically been underutilized and under-resourced in relation to its potential to cut health care costs. In addition, far too many Americans with diagnosable mental and substance use disorders already do not have access to treatments and services that are known to be effective. We can ill afford to dismantle the current safety net of block grants to states and other resources that in many states and communities are the only blockade between even higher rates of risky behaviors, illness, disability, death, health care costs, and lost productivity.

Assuming expanded access to private and public insurance (Medicaid) for people with mental and substance use disorders will require a reexamination of the role of the public system at the local, state, and Federal levels. Perhaps eventually, block grants can be used in conjunction with reformed health systems and policies to incentivize innovation in mental and substance use disorders prevention and treatment and overall wellness for individuals and communities. In the meantime, however, absent clear evidence that newly substituted health reform programs, systems, and processes are fully implemented and effective, it is imperative that our Nation's current safety net financing health services, including school and community-based prevention programs and treatment programs for mental and substance use disorders, not be dismantled prematurely.

CONCLUSIONS AND FUTURE DIRECTIONS

In driving health reform, it is critical that we not sacrifice the positives of the current system, including the all-important emerging voice of consumers and their families. Treatment must work to help people trapped by mental and substance use disorders to move toward recovery and contribute productively to society. The result will be not only lower health costs, but lower societal costs overall resulting from social inclusion, reduced crime rates, improved public safety, and increased work productivity. The prevention of tobacco use and alcohol abuse alone could save billions of dollars in medical and behavioral health costs. Alcohol is directly correlated with pancreatitis, diabetes, kidney and liver disease, and numerous other health risks, whereas tobacco plays a huge causative role in multiple cancers and such conditions as chronic obstructive pulmonary disease. Abuse of alcohol and other drugs is also associated with vehicular accidents, accidental death, and suicide.

To be truly successful in achieving these improved outcomes and decreased health costs, our Nation needs *legislative and societal changes*, and awareness is a critical element of each. When it comes to public education, doctor-to-patient interactions are an excellent start, but they merely scratch the surface of a deeply rooted problem. The stigma and stereotypes surrounding mental and substance use disorders in the United States are pervasive, and a massive public awareness effort is necessary to reverse this extremely damaging trend. Particularly in youth and adolescent culture, using alcohol or drugs is often perceived as "cool" and "sexy," but the concept of addiction is something foreign and yet deplorable to them. Many adults are desensitized to the health effects of addictions because of its ubiquity in American

society, particularly in the form of alcohol abuse and alcoholism, but they look down on those who admit to having problems with addiction.

The anti-tobacco Truth campaign, from the American Legacy Foundation, is an example of an aggressive, targeted, and highly successful campaign with a memorable message. Focusing on Americans under age 30, it seeks to highlight the dangers of tobacco use in creative and edgy ways. It includes television, print, and online content, as well as public events or demonstrations. According to the Truth campaign's website, their campaign reduced the number of young smokers by 300,000.

Similarly, the Above the Influence campaign, from the Office of National Drug Control Policy, seeks to help young people make informed decisions about substance use rather than conforming to peer pressure. Like the Truth campaign, Above the Influence includes television, print, and online content.

Although both campaigns have been individually successful in increasing awareness among young people, they lack a cohesive, targeted message geared toward reducing the stigma surrounding mental illness and addiction and disseminating accurate information about treatment for those conditions. The United States sorely needs a cross-cutting, multi-lingual campaign that addresses all facets of behavioral health, breaks down the stereotypes that prevent people from seeking treatment, and encourages a positive, wellness-focused approach to health. Although such a campaign should be centrally directed and distributed through all major media, it should also penetrate the workforce through corporate benefits and wellness programs to effectively drive a large-scale culture change in the way Americans perceive behavioral health conditions.

"[The Nation] has the opportunity to take the lead on a whole-health approach that truly embraces the coordination of mental and substance use conditions and care within the general health system," says Daniels. "This is best accomplished with a strong commitment to a robust SAMHSA that can articulate and support the needs of people with these conditions. There should be a strategic plan that outlines how this is accomplished and the long-range goal of coordination of care. This could include the framework for how the Federal government then integrates and coordinates mental health and substance abuse within the overall health infrastructure."

Health care reform is indeed a moral imperative—but it will be meaningless if it does not incorporate mental and substance use disorders prevention and treatment as central to National wellness. Screening and early intervention, access to and funding of comprehensive services, and lifelong care mean lower health costs for individuals, communities, and the Nation. We can no longer dismiss the connection between mental health, addiction, and medical health and before us now is an unprecedented opportunity to build and traverse the bridge between the two.

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