



# BEHAVIORAL HEALTH — EVIDENCE-BASED TREATMENT AND RECOVERY PRACTICES

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# IN 2014: MILLIONS MORE AMERICANS WILL HAVE HEALTH CARE COVERAGE

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- Quality rather than quantity
- Integration rather than silo'd care – parity
- Prevention and wellness rather than illness
- Access to coverage and care rather than significant parts of America uninsured – parity
- Recovery rather than chronicity or disability
- Cost controls through better care

# BEHAVIORAL HEALTH MATTERS – IN A CHANGING HEALTH CARE ENVIRONMENT

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→ Currently, 37.9 million are uninsured <400% FPL\*

- 18 M – Medicaid expansion eligible
- 19.9 M – ACA exchange eligible\*\*
- 11.019 M (29%) – Have behavioral health condition(s)

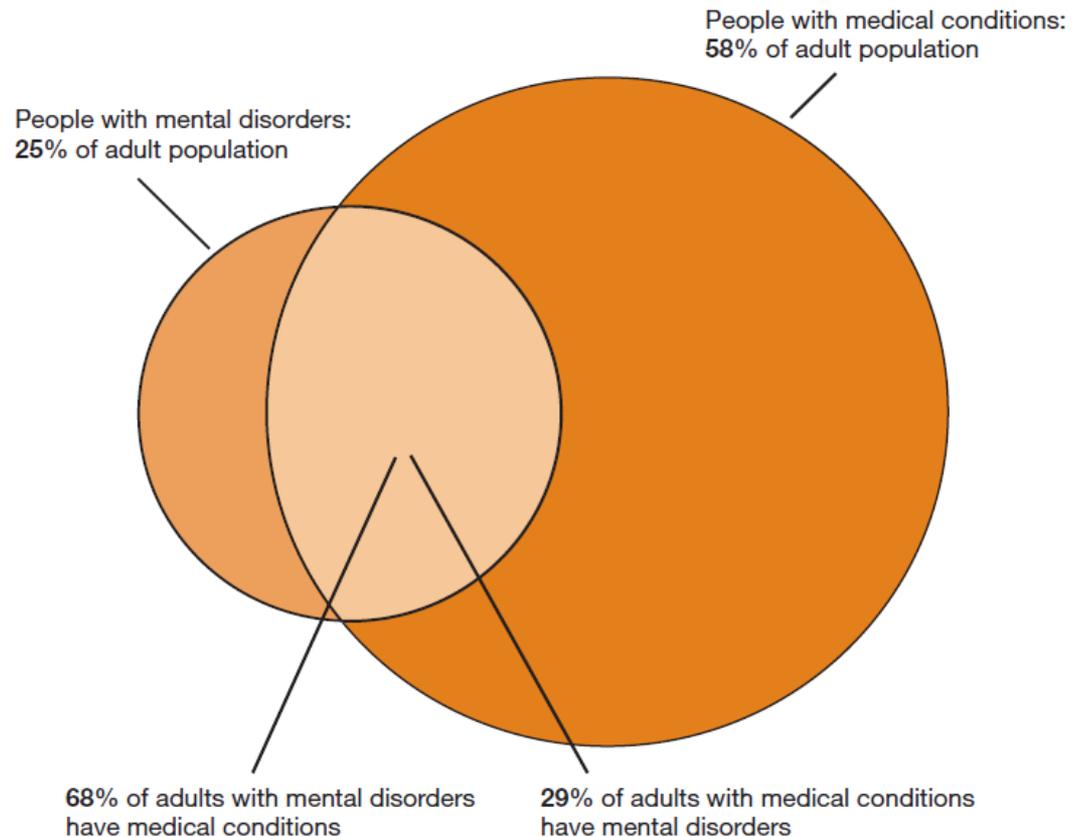
\* Source: 2010 NSDUH

\*\*Eligible for premium tax credits and not eligible for Medicaid

# BH PROBLEMS COMMON & OFTEN CO-OCCUR w/ PHYSICAL HEALTH PROBLEMS

- 1/2 of Americans will meet criteria for mental illness at some point in their lives
- 7 percent of the adult population (34 million people), have co-morbid mental and physical conditions within a given year

Figure 1: Percentages of people with mental disorders and/or medical conditions, 2001–2003

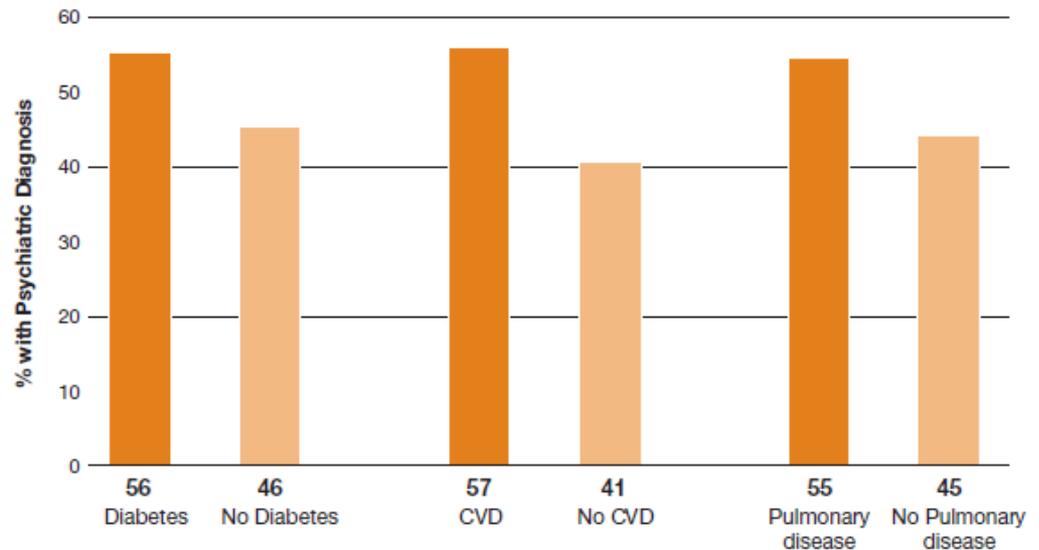


Source: Adapted from the National Comorbidity Survey Replication, 2001–2003 (3, 83)

# BH PROBLEMS ALSO COMMON IN HIGH NEED MEDICAL POPULATIONS

- Rates of cardiovascular disease, diabetes, and pulmonary disease are substantially higher among disabled individuals in Medicaid with psychiatric conditions
- 12-month prevalence of depression is ~ 5 percent among people without chronic medical conditions, 8 percent among people with one condition, 10 percent among people with two conditions, and 12 percent among people with three or more conditions
- People with asthma are 2.3 X more likely to screen positive for depression

Figure 2: Association of medical and psychiatric diagnoses among Medicaid-only beneficiaries with disabilities, 2002.



Source: Adapted from Faces of Medicaid III (93)

- 52 percent of disabled individuals with dual-eligibility for Medicare and Medicaid have a psychiatric illness
- Dual-eligibles account for 39 percent of Medicaid expenditures

# CO-MORBIDITIES

- Psychiatric disorders were among 7 of the top ten most frequent co-morbid triads in the most expensive 5 percent of Medicaid beneficiaries with disabilities
- Most common triad was co-morbid psychiatric conditions, cardiovascular disease, and central nervous system disorders
  - 9.5 percent of all beneficiaries
  - 24 percent of most expensive group

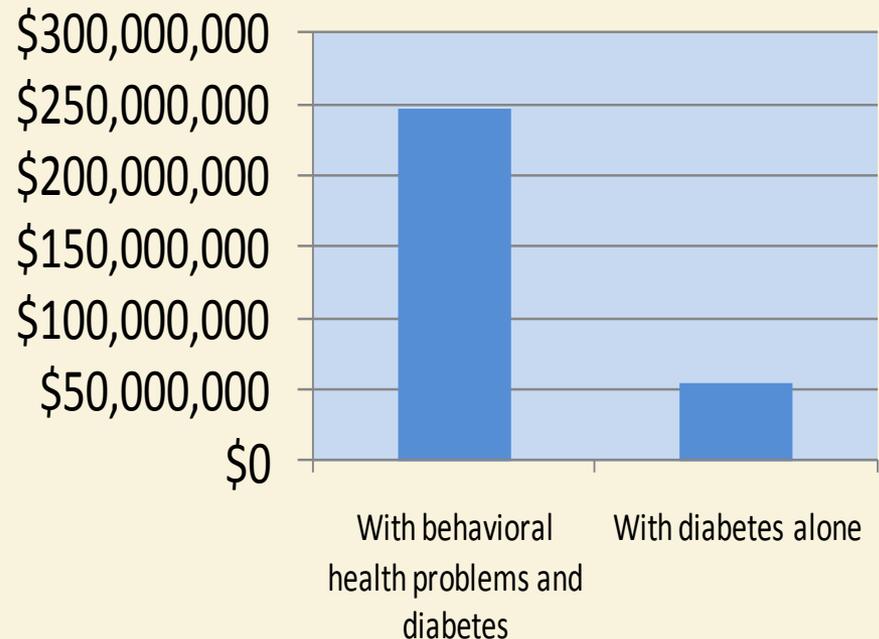
# CO-MORBIDITY CHALLENGES

- Adults who had any mental illness, serious mental illness, or major depressive episodes in the past year had increased rates of hypertension, asthma, diabetes, heart disease, and stroke (new NSDUH analysis, 2008-2009)
- Most psychiatric medications, particularly anti-psychotic medications, can cause weight gain, obesity and type 2 diabetes, all of which impact mental conditions such as major depression
- Major depression is a risk factor for developing medical conditions such as cardiovascular disease (CVD) ;
- Persons reporting CVD have 1.43 x elevated risk of lifetime anxiety disorder

# BH IMPACTS PHYSICAL HEALTH

- MH problems increase risk for physical health problems & SUDs increase risk for chronic disease, sexually transmitted diseases, HIV/AIDS, and mental illness
- Cost of treating common diseases is higher when a patient has untreated BH problems
- 24 percent of pediatric primary care office visits and ¼ of all adult stays in community hospitals involve M/SUDs
- M/SUDs rank among top 5 diagnoses associated with 30-day readmission, accounting for about one in five of all Medicaid readmissions (12.4 percent for MD and 9.3 percent for SUD)

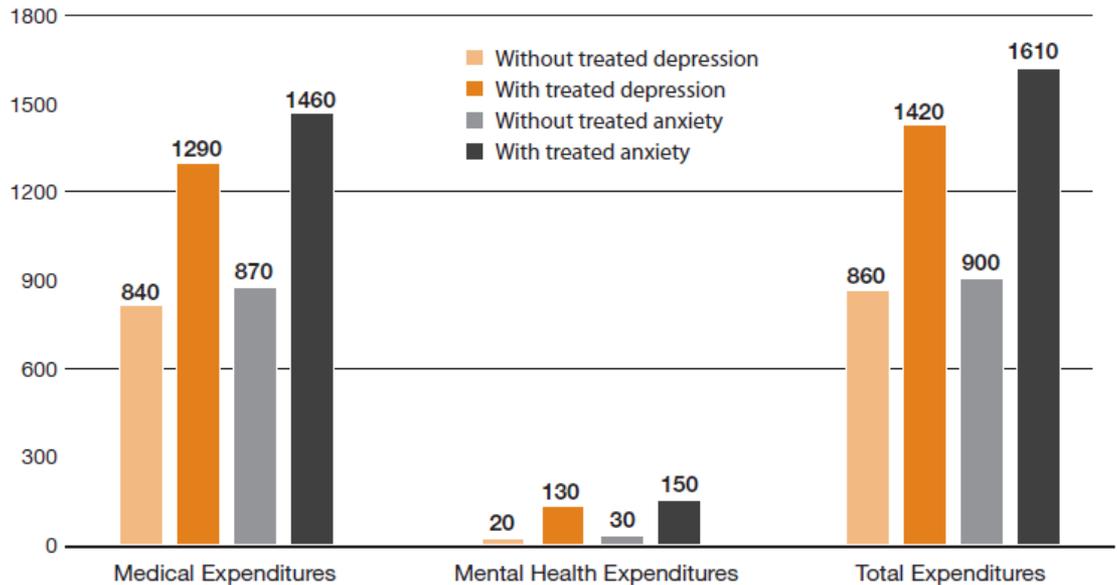
Individual Costs of Diabetes Treatment for Patients Per Year



# BH PROBLEMS = HIGHER MEDICAL COSTS

- Co-morbid depression or anxiety increase physical and mental health care expenditures
- > 80 percent of this increase occurs in physical health expenditures
- Average monthly expenditure for a person with a chronic disease and depression is \$560 dollars more than for a person without depression
- Discrepancy for people with and without co-morbid anxiety is \$710

Figure 5. Comparison of monthly health care expenditures for chronic conditions and comorbid depression or anxiety, 2005



Source: Melek and Norris (107)

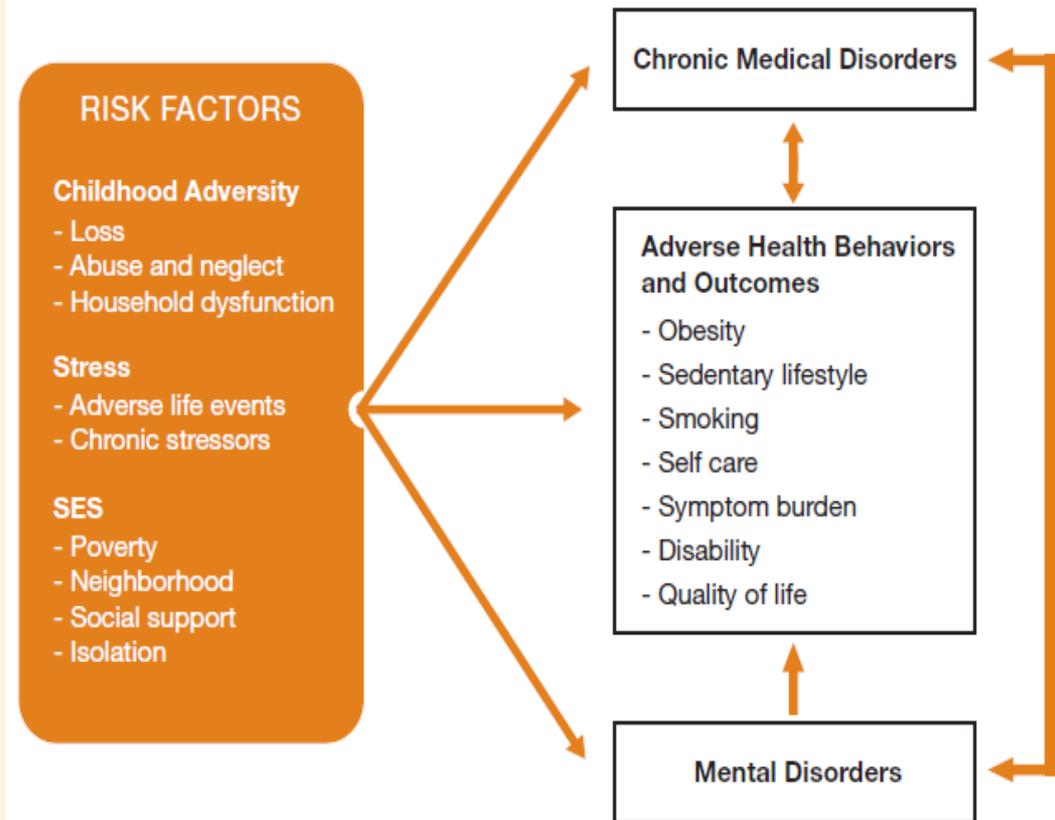
- A HMO claims analysis found that general medical costs were 40 percent higher for people treated with bipolar disorder than those without it

# WHY WORSE PHYSICAL HEALTH FOR PERSONS WITH BH CONDITIONS?

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- BH problems are associated w/ increased rates of *smoking* and deficits in *diet & exercise*
- People with M/SUD are less likely to receive *preventive services* (immunizations, cancer screenings, smoking cessation counseling) & receive *worse quality of care* across a range of services

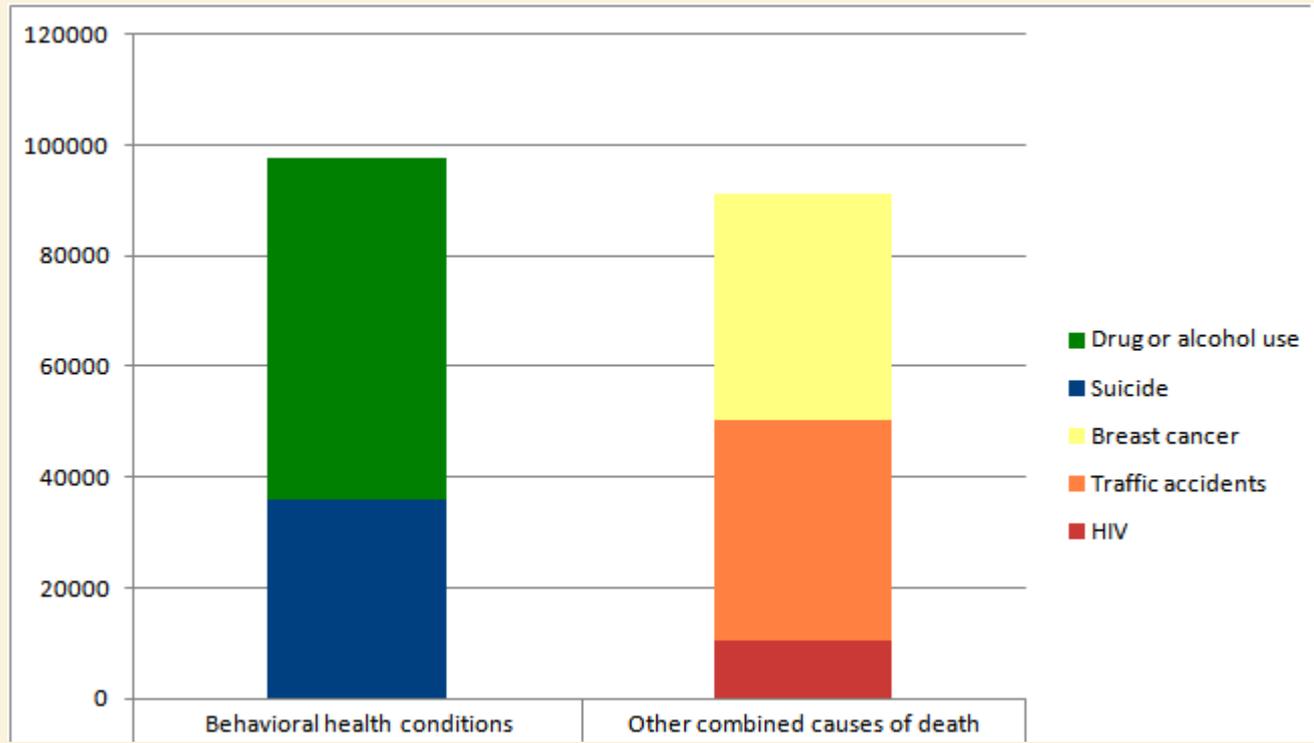
Figure 3: Model of the interaction between mental disorders and medical illness



Source: Modified from Katon (80)

# PREMATURE DEATH AND DISABILITY

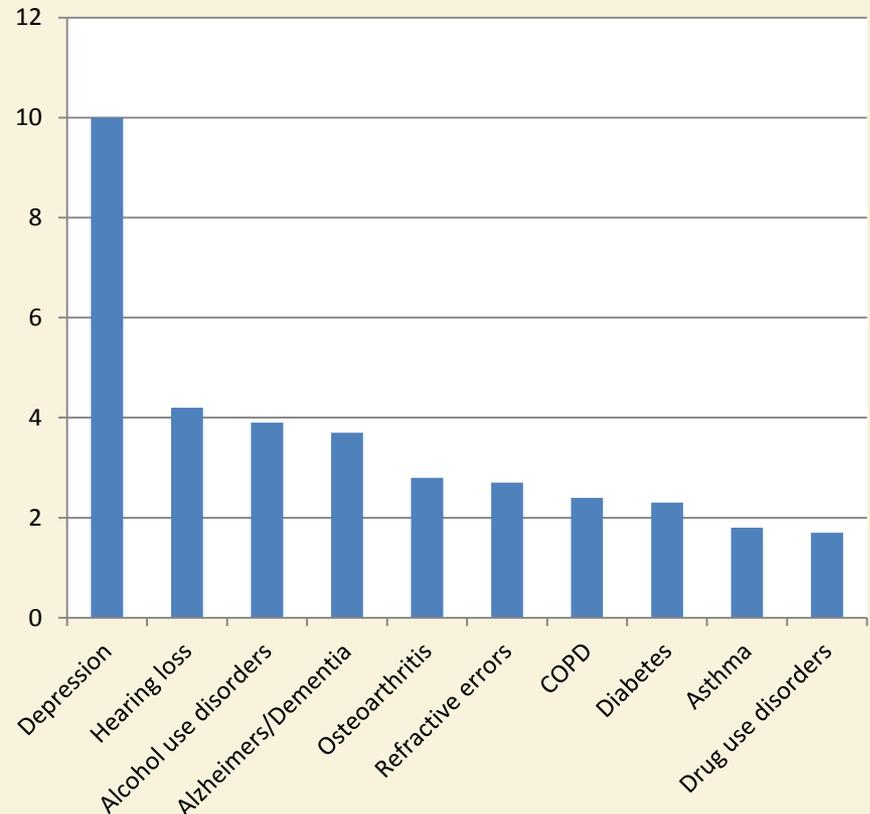
- People with M/SUDs are nearly 2x as likely as general population to die prematurely, (8.2 years younger) often of preventable or treatable causes (95.4 percent medical causes)
- BH conditions lead to **more deaths** than HIV, traffic accidents + breast cancer combined



- More deaths from suicide than from HIV or homicides
- Half the deaths from tobacco use are among persons with M/SUDs

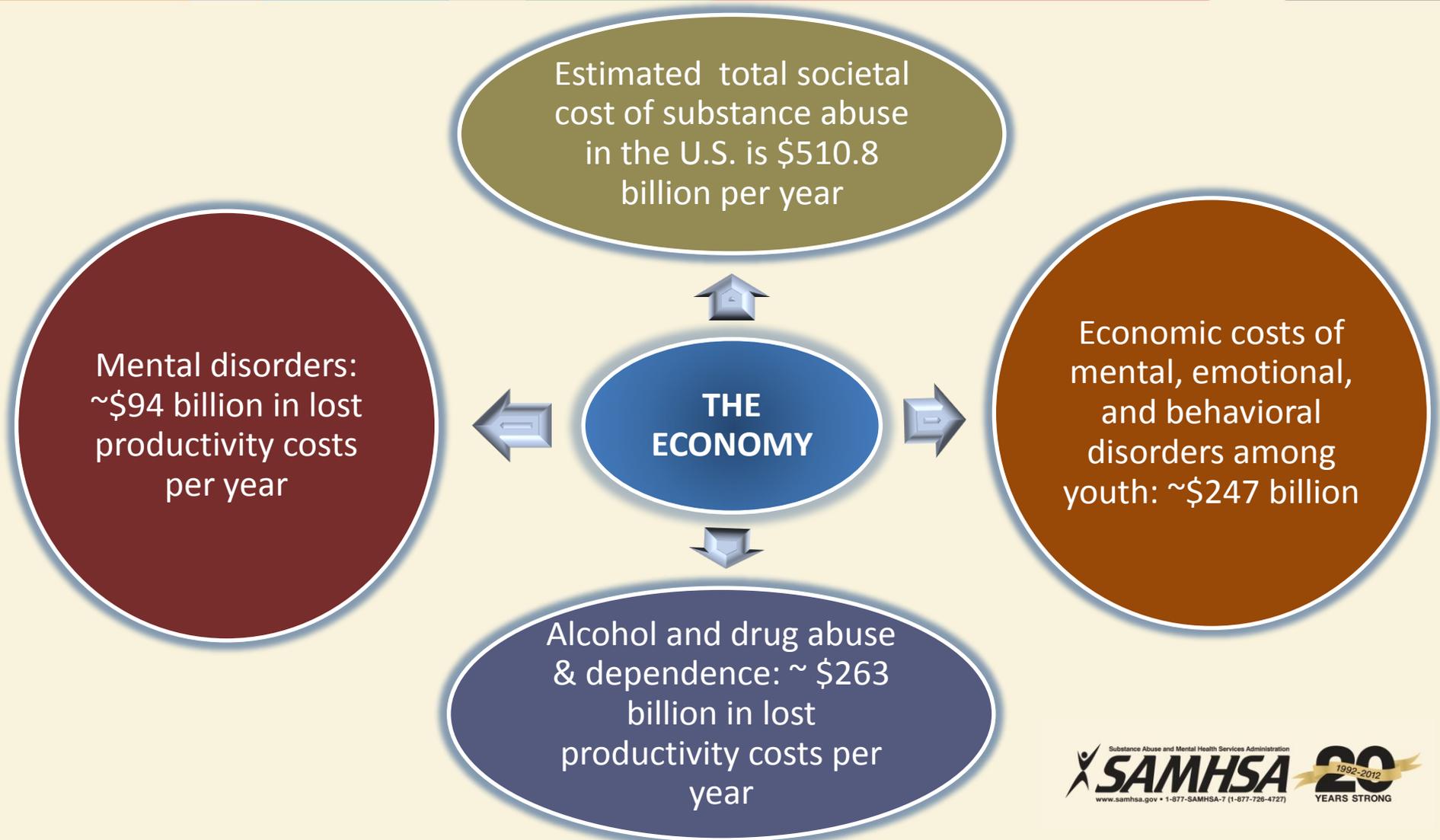
# BH-RELATED DISABILITY

- According to the CDC, more than 2 million Americans report mental/emotional disorders as the primary cause of their disability
- Depression is the most disabling health condition worldwide; & SA is # 10



Years Lost Due to Disability in Millions (High-Income Countries – World Health Organization Data)

# STEEP HUMAN AND ECONOMIC COSTS



# PUBLIC PERCEPTION OF VALUE

- Public is less willing to pay to avoid mental illnesses compared to paying for treatment of medical conditions, even when mental illnesses (including SUDs) are recognized as burdensome (NICHD, 2011)
  - Public willing to pay 40 percent less than what they would pay to avoid medical illnesses
- Mental illnesses account for 15.4 percent of total burden of disease (WHO), yet mental health expenditures in U.S. account for only 6.2 percent

# BEHAVIORAL HEALTH AFFECTS EVERYONE

- ~Half of Americans will meet criteria for mental illness at some point
- > Half of Americans know someone in recovery from substance use problem
- Positive emotional health helps maintain physical health; engage productively w/ families, employers, friends; & respond to adversity w/ resilience and hope



66 percent believe treatment and support can help people with mental illness lead normal lives



20 percent feel people with mental illness are dangerous to others



Two-thirds believe addiction can be prevented



75 percent believe recovery from addiction is possible



20 percent would think less of a friend/relative in recovery from an addiction



30 percent would think less of a person with a current addiction

# TREATMENT WORKS, BUT INACCESSIBLE FOR MANY

- Like many other illnesses, most people recover from M/SUDs
- 88 percent of individuals diagnosed with depression recover within 5 years

Any MI:  
45.1 million

37.8 %  
receiving  
treatment

SUD: 22.1  
million

11.2 %  
receiving  
treatment

Diabetes: 25.8  
million

84 %  
receiving  
treatment

Heart Disease:  
81.1 million

74.6 %  
receiving  
screenings

Hypertension:  
74.5 million

70.4%  
receiving  
treatment

# BH IS COMMUNITY HEALTH

- Adults with mental disorders experience high rates of unemployment and disability
  - Unemployment rates are 3 to 5 times higher for people with mental disorders
- 44 percent of children in special education w/ emotional disturbances drop out of school – highest of any category of disability
- Substance use reduces ability to parent and work; increases chances of involvement in criminal justice system
  - 1/2 of all incarcerated people have MH problems; 60 percent have substance use problems; 1/3 have both

# MENTAL & SUBSTANCE USE DISORDERS CAN BE PREVENTED

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- Product of biological, environmental and social factors
- Experiences trigger or exacerbate BH problems
  - Trauma, adverse childhood experiences, disasters and their aftermath, poverty, domestic violence, involvement with the criminal justice or child welfare systems, neighborhood disorganization and family conflict
- Addressing risk factors is effective in reducing likelihood of M/suds
  - Individual, family and community risk and protective factors
- Brain impacts – chronic acute stress in early childhood can lead to:
  - Future health problems (including depression and other BH problems)
  - Damage to hippocampus
  - Smaller physical size of developing brain

# EARLY INTERVENTION REDUCES IMPACT

- 1/2 of all lifetime cases of mental illness begin by age 14; 3/4 by age 24
- On average, > 6 years from onset of symptoms of M/SUDs to treatment
- Effective multi-sectoral interventions & treatments exist
- Need treatment & support earlier
  - Screening
  - Brief interventions
  - Coordinated referrals

# BEHAVIORAL HEALTH AS SOCIAL PROBLEM

- ➔ Public dialogue about behavioral health is in a social problem context rather than a public health context
  - Homelessness
  - Crime/jails
  - Child welfare problems
  - School performance or youth behavior problems
  - Provider/system/institutional/government failures
  - Public tragedies
  
- ➔ Public (and public officials) often misunderstand, blame, discriminate, make moral judgments, exclude
  - Ambivalence about worth of individuals affected and about the investment in prevention/treatment/recovery
  - Ambivalence about ability to impact “problems”

# LEADING TO INSUFFICIENT RESPONSES

Increased  
Security &  
Police  
Protection

Tightened  
Background  
Checks &  
Access to  
Weapons

Legal  
Control of  
Perpetrators  
& Their  
Treatment

More Jail  
Cells,  
Shelters,  
Juvenile  
Justice  
Facilities

Institutional  
System  
Provider  
Oversight

# BEHAVIORAL HEALTH FIELD'S MESSAGES

## → Multiple and inconsistent messages

- Disease; disability; chronic medical condition; social reaction to difference; brain/genetic or environmental; treat the same as physical conditions; treat with a different psychosocial approach
- Substance abuse and mental illness stem from the same causes and often co-exist; or they are completely different fields and different diseases/conditions
- Behavioral health is and should be extraordinary; or should be the same as any other health condition

# WHAT AMERICANS KNOW

## → Most Know or Are Taught:

- Basic First Aid and CPR for physical health crisis
- Universal sign for choking; facial expressions of physical pain; and basic terminology to recognize blood and other physical symptoms of illness and injury
- Basic nutrition and physical health care requirements
- Where to go or who to call in an emergency

# WHAT AMERICANS DON'T KNOW

→ Most Do Not Know and Are Not Taught:

- Signs of suicide, addiction or mental illness or what to do about them or how to find help for self or others
- Relationship of behavioral health to individual or community health or to health care costs
- Relationship of early childhood trauma to adult physical & mental/substance use disorders

# FOCUS: SAMHSA'S STRATEGIC INITIATIVES

*AIM: Improving the Nation's Behavioral Health (1-4)*

*AIM: Strengthening Health Care in America (5-6)*

*AIM: Achieving Excellence in Operations (7-8)*

1. Prevention

2. Trauma and Justice

3. Military Families

4. Recovery Support

5. Health Reform

6. Health Information Technology

7. Data, Outcomes & Quality

8. Public Awareness & Support

# STRATEGIC INITIATIVE

## 1.Prevention

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- Prevent substance abuse (including tobacco) and mental illness and build emotional health
- **Prevent suicide – mortality & thoughts/attempts**
- Underage drinking/alcohol polices
- Prescription drug abuse

# 10 Leading Causes of Death, United States 2008, All Races, Both Sexes

RANK	ALL AGES
1.	Heart Disease: 616,828
2.	Malignant Neoplasms: 565,469
3.	Chronic Low Respiratory Disease: 141,090
4.	Cerebro-vascular : 134,148
5.	Unintentional Injury: 121,902
6.	Alzheimer's Disease: 82,435
7.	Diabetes Mellitus: 70,553
8.	Influenza & Pneumonia: 56,284
9.	Nephritis: 48,237
10.	Suicide: 36,035



# SUICIDE: TOUGH REALITIES

	AGE 14-18	AGE 18 AND ↑
HAD SERIOUS THOUGHTS OF SUICIDE	2.9 million, 13.8%	8.4 million, 3.7%
MADE A PLAN	2.3 million, 10.9%	2.2 million, 1%
ATTEMPTED SUICIDED	1.3 million, 6.3%	1.1 million, .05%
DIED BY SUICIDE	>1,000	~37,000

# TOUGH REALITIES

50 percent of those who die by suicide were afflicted with major depression...the suicide rate of people with major depression is 8 times that of the general population

90 percent of individuals who die by suicide had a mental disorder

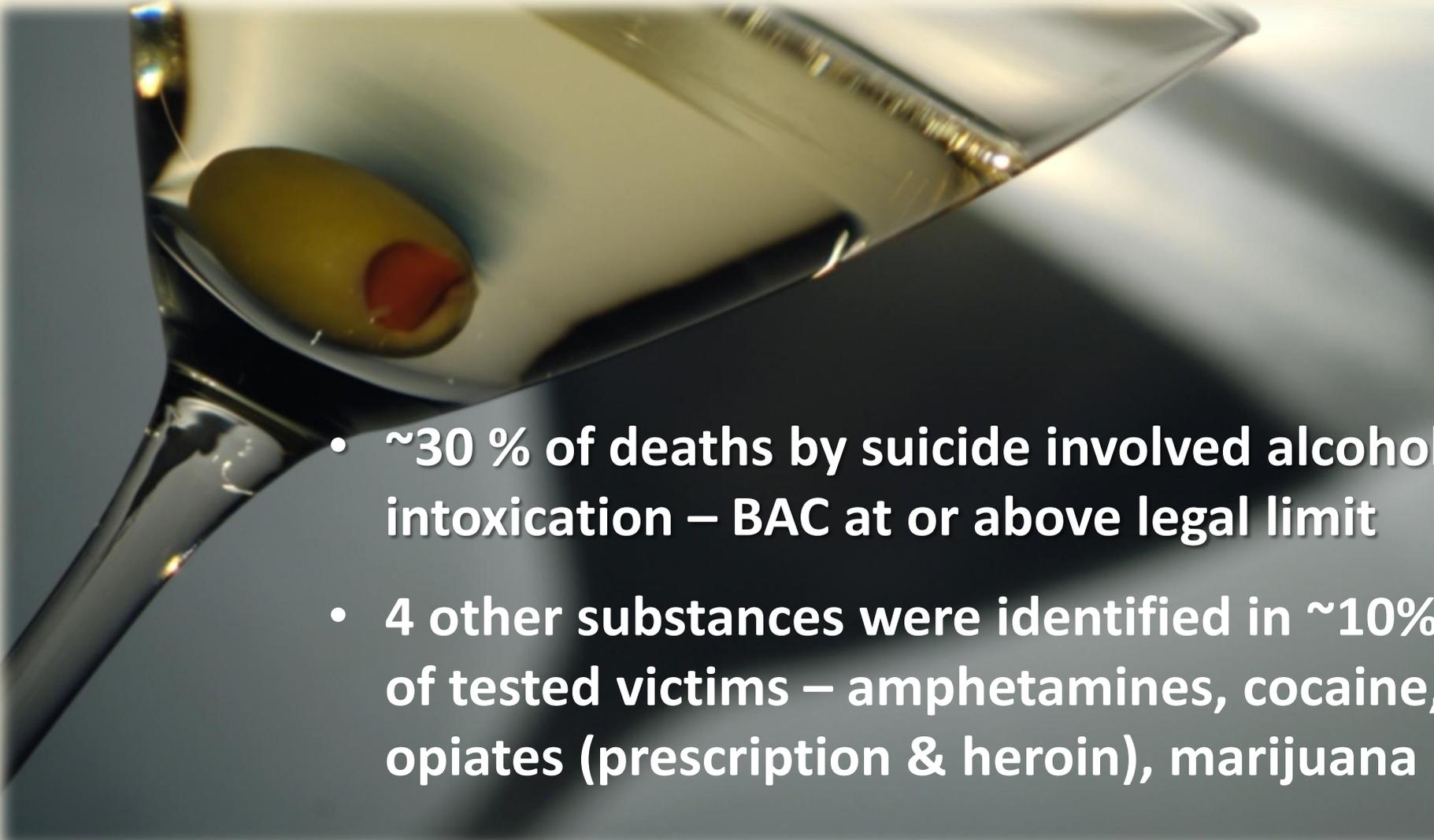
# MISSED OPPORTUNITIES = LIVES LOST

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→ Individuals discharged from an inpatient



# TOUGH REALITIES Cont.

- 
- ~30 % of deaths by suicide involved alcohol intoxication – BAC at or above legal limit
  - 4 other substances were identified in ~10% of tested victims – amphetamines, cocaine, opiates (prescription & heroin), marijuana

# MISSED OPPORTUNITIES = LIVES LOST Cont.

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77 percent of individuals who die by suicide had visited their primary care doctor w/in the year

45 percent had visited their primary care doctor w/in the month

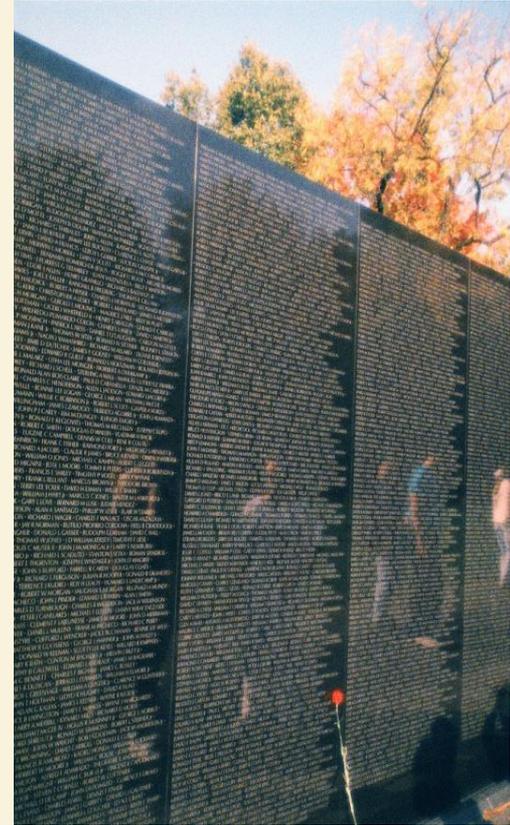
18 percent of elderly patients visited their primary care doctor on same day as their suicide



**THE QUESTION OF SUICIDE WAS SELDOM RAISED . . .**

# LIFELINE – A SPECIAL CONFIDENTIAL SERVICE

- ➔ Free, 24-hour hotline for anyone in suicidal crisis or emotional distress – 1-800-273-TALK (1-800-273-8255 )
- ➔ A confidential service for veterans, active military, and their families. By pressing “1” at the prompt after dialing the Lifeline toll-free number,) individuals are connected to trained VA counselors



# STRATEGIC INITIATIVE

## 7. Data, Outcomes & Quality

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### → **National Behavioral Health Quality Framework (NBHQF)**

- Part of National Quality Strategy (NQS) to improve health care in America

### → **NREPP** measures, metrics and evidence

### → **Use of SAMHSA Tools to Improve Practices**

- Models (e.g., SPF, coalitions, SBIRT, SOCs, suicide prevention)
- Emerging science (e.g., oral fluids testing)
- Technical assistance capacity (e.g., trauma)
- Partnerships (e.g., HIT meaningful use; Medicaid/Medicare)
- Services research as appropriate

# NBHQF – GOALS & MEASURES

	SAMHSA	Program/ Practitioner	Population
Effective			
Person/Family Centered			
Coordinated			
Evidence- Based/Best Practices			
Safe			
Affordable/High			

# NATIONAL REGISTRY OF EVIDENCE-BASED PROGRAMS AND PRACTICES (NREPP)

- Searchable online registry of mental health and substance abuse interventions, reviewed and rated by independent reviewers – [National Registry of Evidence-Based Programs and Practices website at URL http://www.nrepp.samhsa.gov/](http://www.nrepp.samhsa.gov/)
- Purpose: to reduce the lag time between the creation of scientific knowledge and its practical application in the field
- Use: to assist practitioners, providers, and the public in identifying scientifically-based interventions and approaches to preventing and treating mental/substance use disorders that can be readily disseminated to communities and to the field

# NATIONAL REGISTRY OF EVIDENCE-BASED PROGRAMS AND PRACTICES (NREPP) CONT.

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- Using data to show people recover
  - Metrics show treatment is effective
- ➔ NREPP is a searchable database that includes multiple dimensions of evidence that to consider and integrate by the user in a decision support context
- ➔ NREPP rates the quality of research supporting intervention outcomes and the quality and availability of training and implementation materials

# NREPP AS OF MAY 2012

- **234** interventions have been reviewed and posted on the NREPP Web site
- **90** additional interventions in the review queue
- **3–7** new summaries are posted per month
- More than **13,500** visitors/month to the site

# REACH OF NREPP

Leading national resource for contemporary and reliable information on scientific basis and practicality of selected interventions to prevent and/or treat mental illness and/or substance abuse

- Implemented in **50** states and **7** territories
- > **110** countries
- > **119,000,000** clients
- > **318,000** sites

# NREPP TOPIC AREAS

- Mental health promotion: **95**
- Mental health treatment: **60**
- Substance abuse prevention: **96**
- Substance abuse treatment: **60**

# EXAMPLE: TRAUMA FOCUSED COPING (Multimodality trauma treatment – August 2011)

- Trauma Focused Coping (TFC)  
– a school-based group intervention for children and adolescents in grades 4-12 who have been exposed to a traumatic stressor (e.g., disaster, violence, murder, suicide, fire, accident)
- Targets posttraumatic stress disorder (PTSD) symptoms and other trauma-related symptoms, including depression, anxiety, anger, and external locus of control.



# EXAMPLE: MINDFULNESS-BASED COGNITIVE THERAPY (MBCT) – March, 2012

- For adults with recurrent major depressive disorder
- Integration of components from Mindfulness-Based Stress Reduction and CBT
- Mindfulness = a mental state whereby one attends to and purposefully manages one's awareness of what is happening in the moment
- Meditation and cognitive skills to prevent depression relapse – involving family and refocusing habitual negative thoughts
- Also been used for children and adults to help prevent substance abuse and SA relapse

# EXAMPLE: BRIEF STRATEGIC FAMILY THERAPY (Created at University of MIAMI)

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- Prevent, reduce, treat adolescent behavior problems (drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers)
- Improve pro-social behaviors, e.g., school attendance/ performance
- Improve family functioning, effective parental leadership & mgmt, positive parenting, & involvement w/ child, peers, school
- # and frequency of BSFT sessions depends on severity of communication and management problems within family and are conducted at locations convenient to family, including the home

# INCREASING KNOWLEDGE AND IMPROVING SKILLS THROUGH EVIDENCE-BASED TREATMENT/RECOVERY PRACTICES

➔ Two SAMHSA grants to University of Miami Medical School

➔ 2008 – Brief Strategic Family Therapy (BSFT)

➔ 2011 – Campus Suicide Prevention

2011	\$101,966
2012	\$96,456
2013	\$97,231



# Applause to University of Miami Miller School of Medicine, Department of Epidemiology and Public Health



Family Therapy Training Institute of Miami

UM Unites



# Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover