

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



BEHAVIORAL HEALTH – WHY IT MATTERS AND HOW SAMHSA CAN HELP

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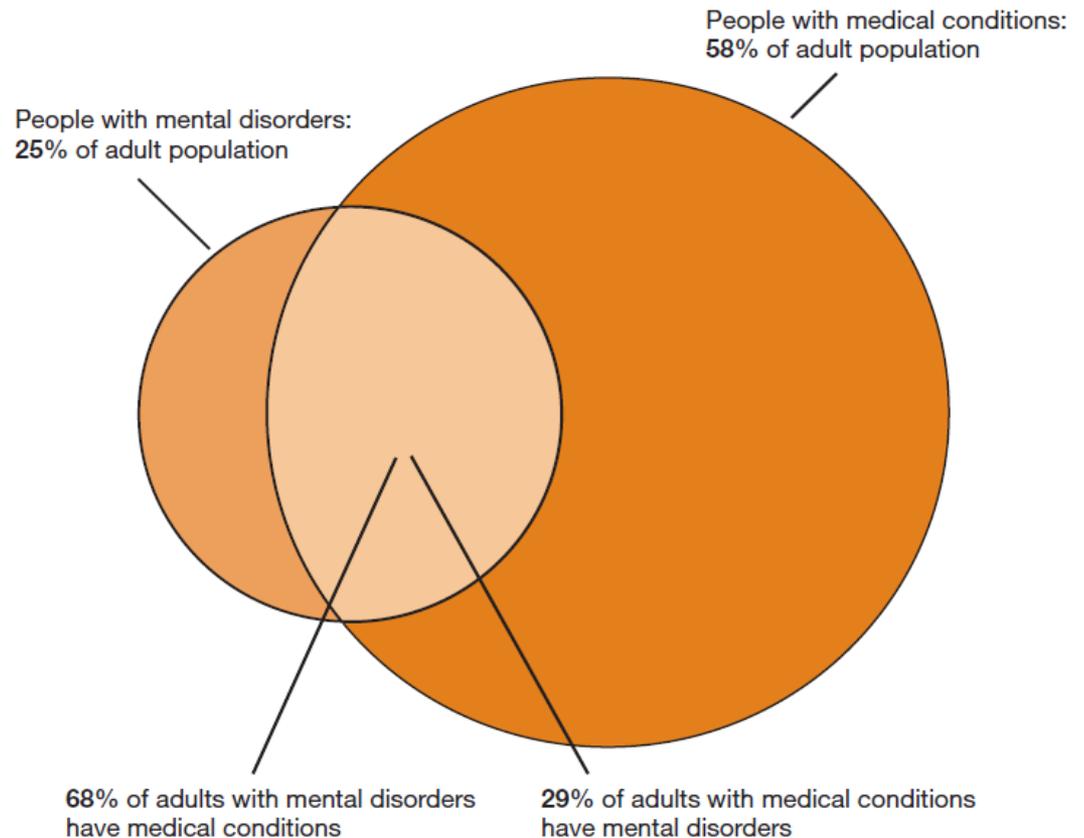
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BH PROBLEMS COMMON & OFTEN CO-OCCUR w/ PHYSICAL HEALTH PROBLEMS

- 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

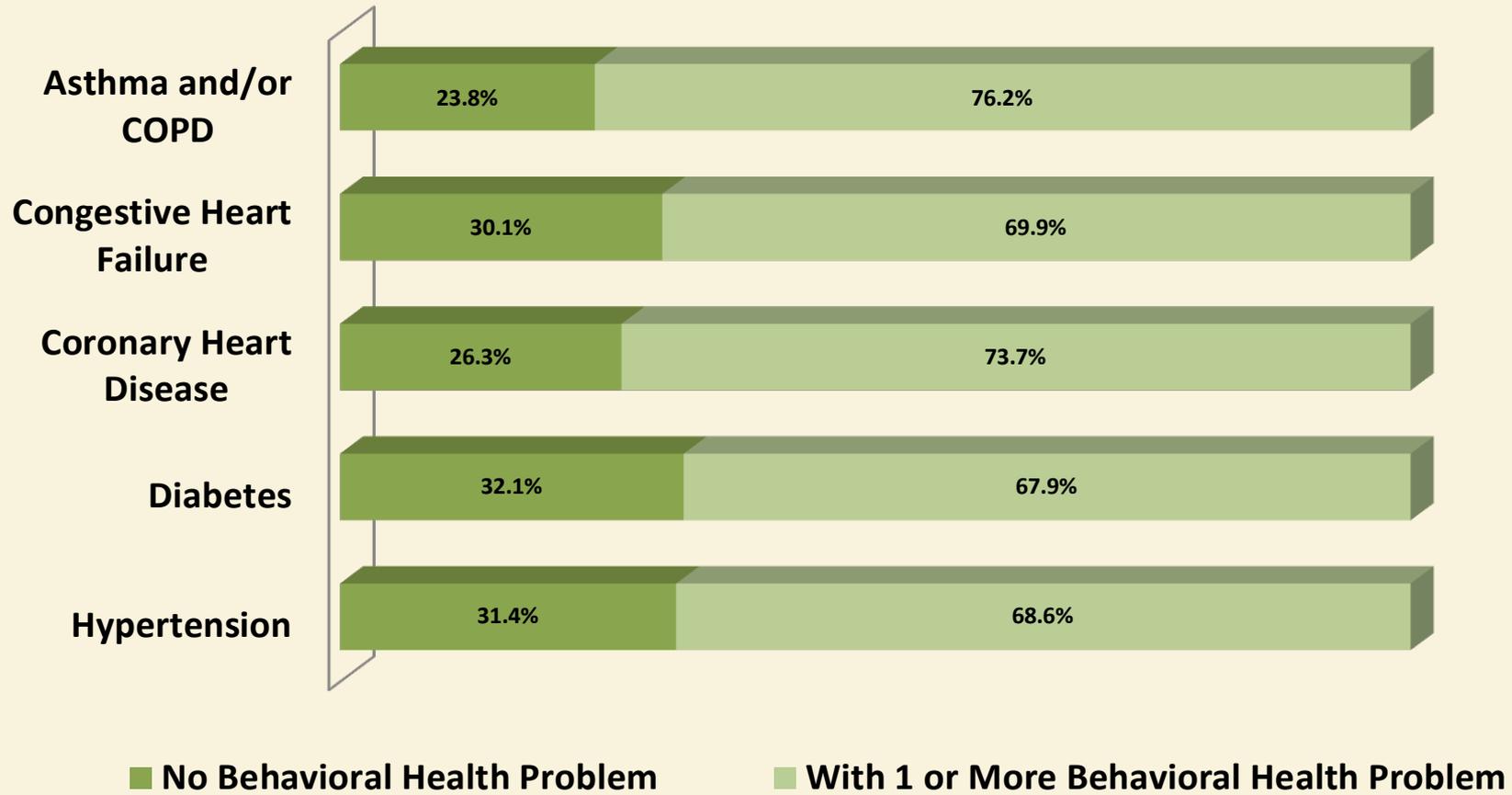
Figure 1: Percentages of people with mental disorders and/or medical conditions, 2001–2003



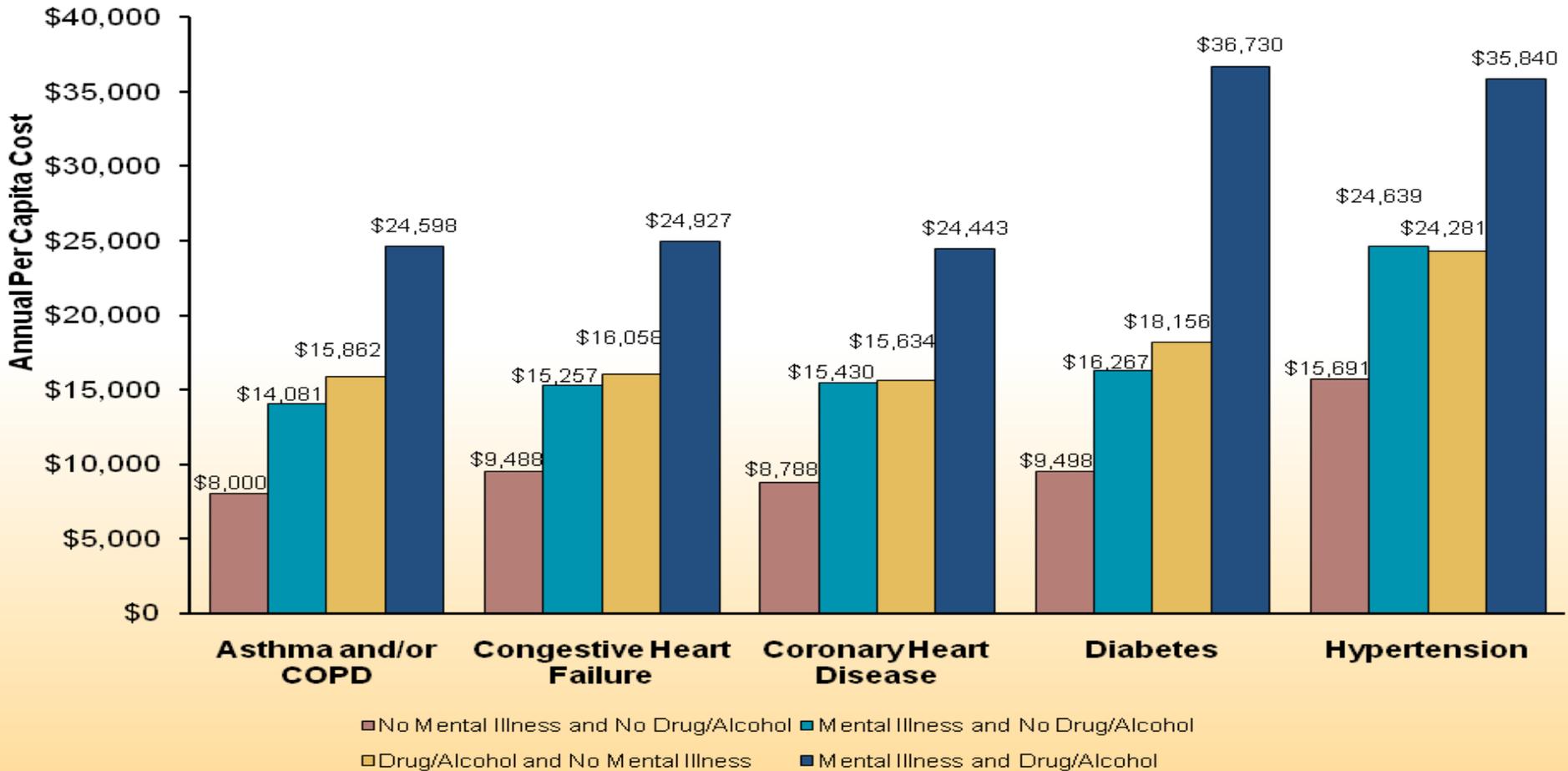
Source: Adapted from the National Comorbidity Survey Replication, 2001–2003 (3, 83)

BH CO-MORBIDITIES W/ PHYSICAL HEALTH

(MEDICAID-ONLY BENEFICIARIES W/DISABILITIES)



IMPACT OF BH CO-MORBIDITIES ON PER CAPITA COSTS (MEDICAID-ONLY BENEFICIARIES W/DISABILITIES)

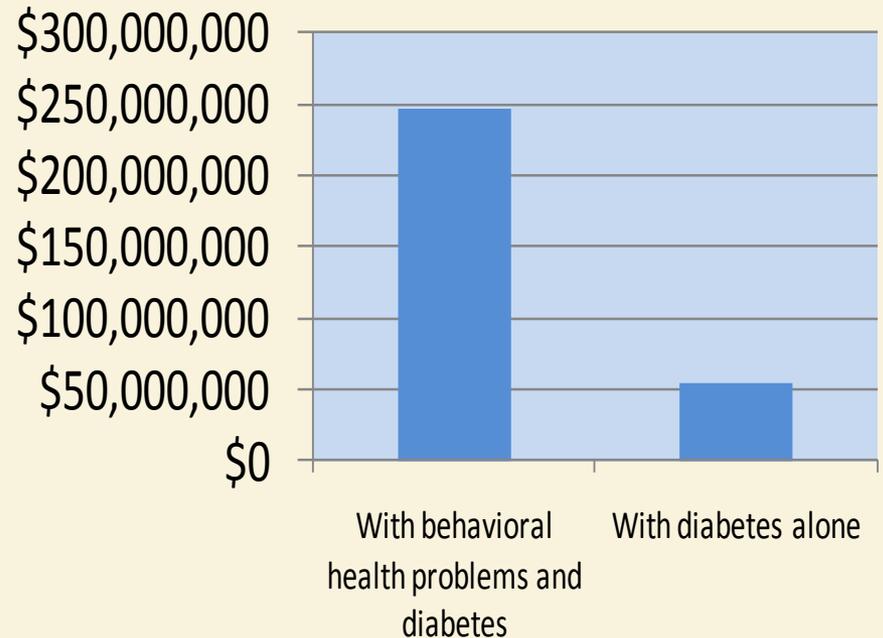


Boyd, C., Clark, R., Leff, B., Richards, T., Weiss, C., Wolff, J. (2011, August). Clarifying Multimorbidity for Medicaid Programs to Improve Targeting and Delivering Clinical Services. Presented to SAMHSA, Rockville, MD.

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)

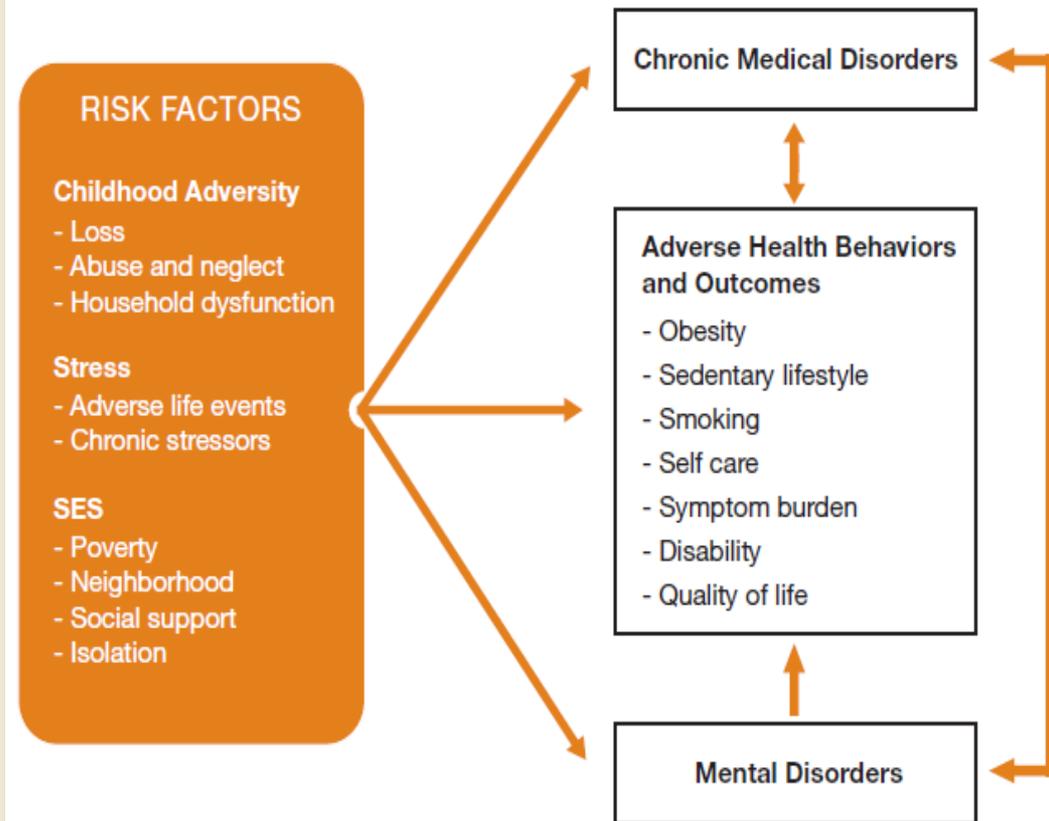
Individual Costs of Diabetes Treatment for Patients Per Year



WHY WORSE PHYSICAL HEALTH FOR PERSONS WITH BH CONDITIONS?

- ➔ BH problems are associated w/ increased rates of *smoking* and deficits in *diet & exercise*
- ➔ Up to 83 percent of people w/SMI are overweight or obese
- ➔ 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

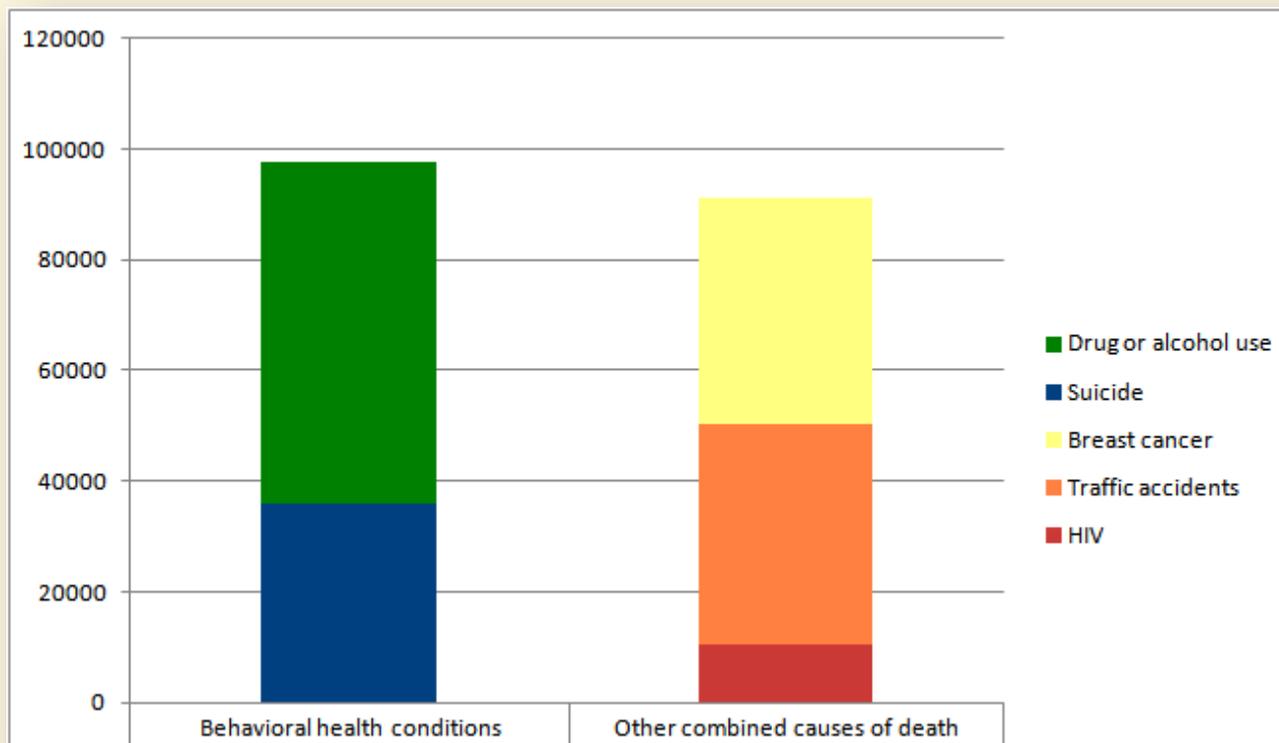
Figure 3: Model of the interaction between mental disorders and medical illness



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

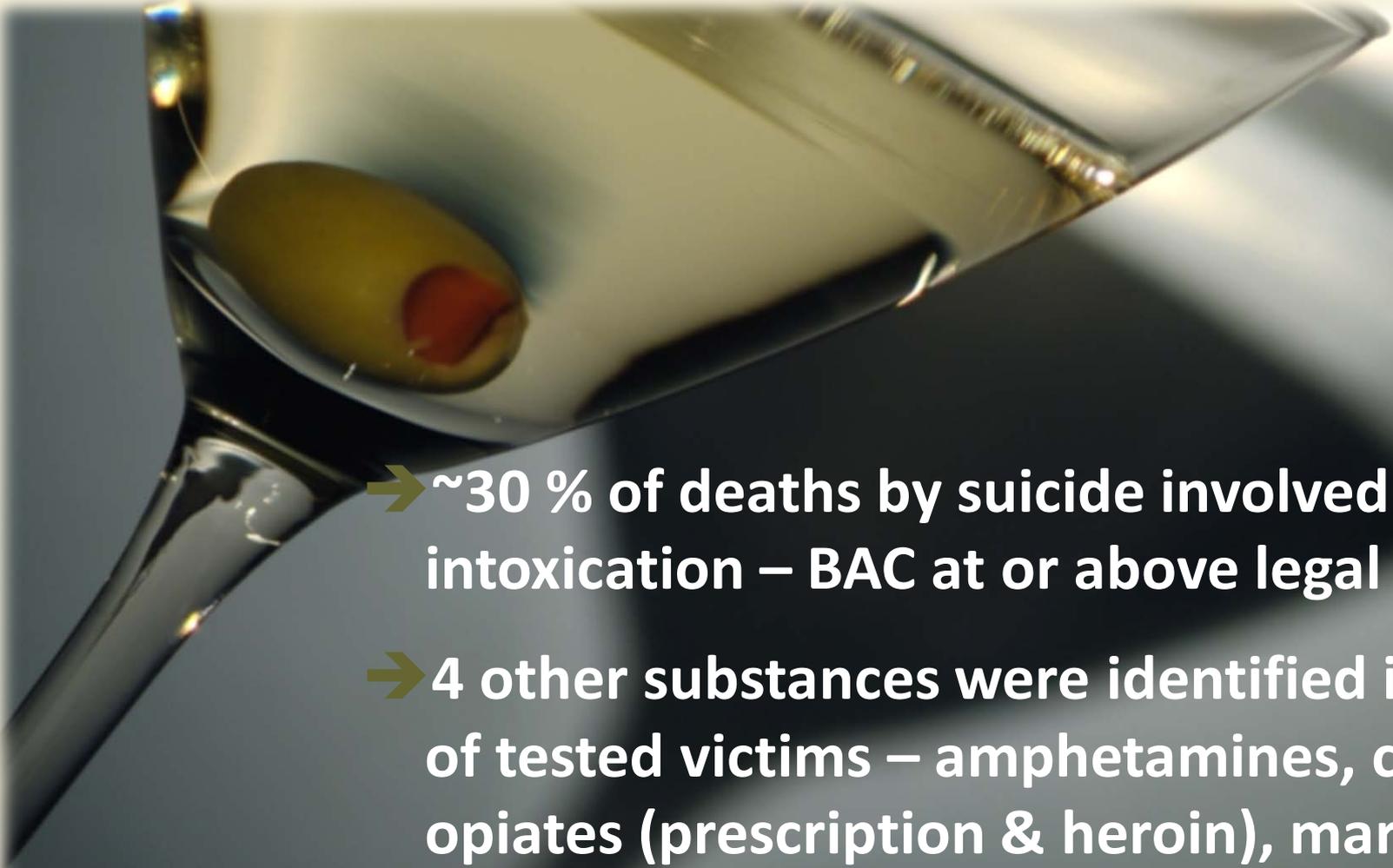
10 LEADING CAUSES OF DEATH, U.S. 2009, ALL RACES, BOTH SEXES

RANK	ALL AGES
1.	Heart Disease: 599,413
2.	Malignant Neoplasms: 567,628
3.	Chronic Low Respiratory Disease: 137,353
4.	Cerebro-vascular : 128,842
5.	Unintentional Injury: 118,021
6.	Alzheimer's Disease: 79,003
7.	Diabetes Mellitus: 68,705
8.	Influenza & Pneumonia: 53,692
9.	Nephritis: 48,935
10.	Suicide: 36,909

TOUGH REALITIES

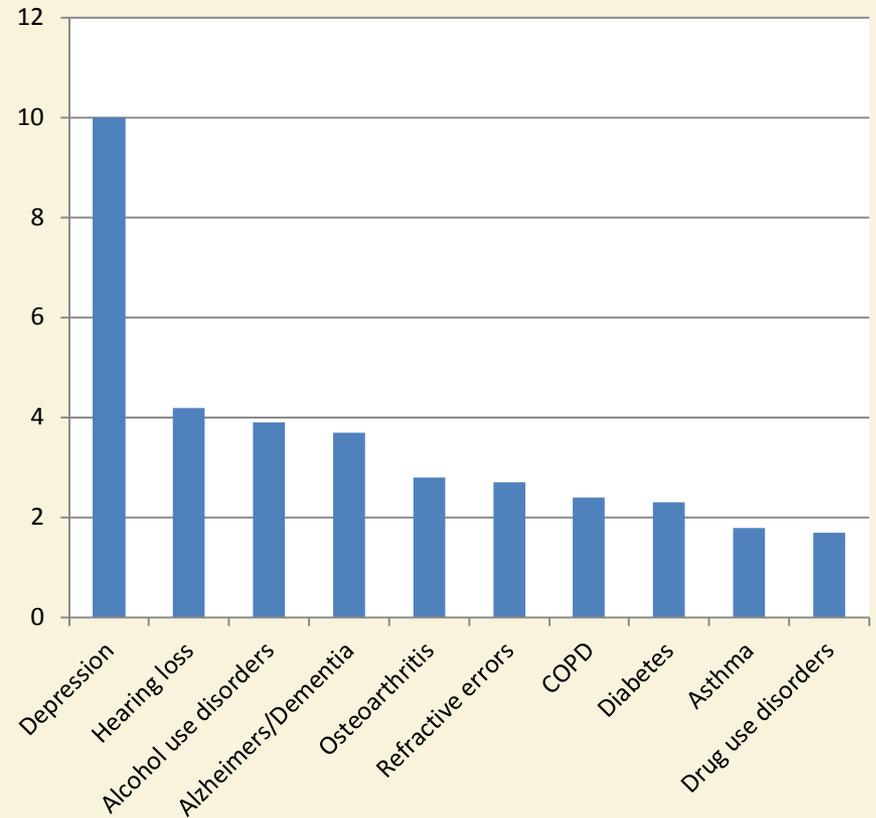
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- ~30 % of deaths by suicide involved alcohol intoxication – BAC at or above legal limit
 - 4 other substances were identified in ~10% of tested victims – amphetamines, cocaine, opiates (prescription & heroin), marijuana

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
- ➔ Mental disorders: ~ \$94 billion in lost U.S. productivity costs per year



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

BH CONDITIONS ARE PREVENTABLE

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- ¼ of adult mental disorders start by age 14; ½ by age 25
- Adverse Childhood Experiences (ACEs) potentially explain 32.4 percent of M/SUDs in adulthood
 - Six million children (9 percent) live with at least one parent who abuses alcohol or other drugs
 - > 6 in 10 U.S. youth have been exposed to violence within the past year; nearly 1 in 10 injured
- Symptoms start ~ 6 years before diagnosis or treatment
 - Universal screening (SBIRT) exists and works
- Multi-sector approaches to individual and environmental strategies exist and work (IOM 2009)

TOUGH REALITIES – YOUNG PEOPLE DIE

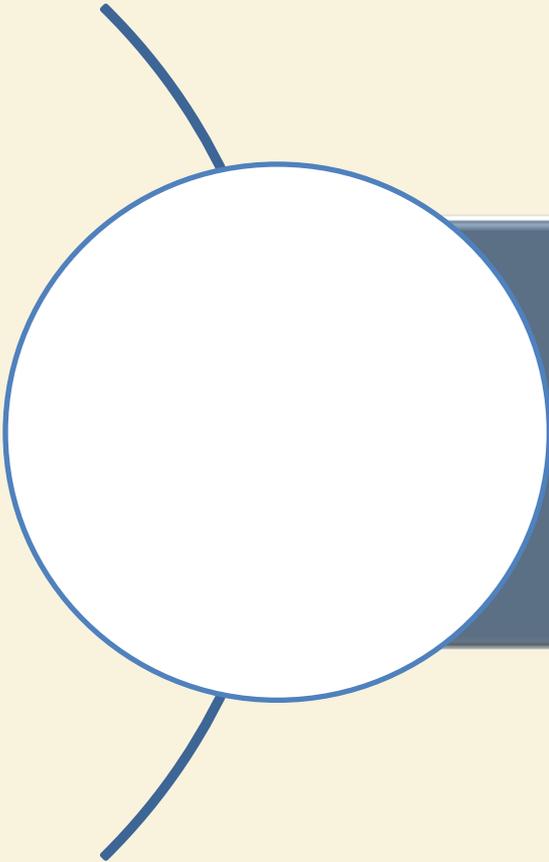


Prevalence of serious MH conditions among 18 to 25 year olds is almost double that of general population

Suicide is 3rd leading cause of death among all youth 15-24 years old

Adults who begin drinking alcohol before age 21 more likely to have alcohol dependence or abuse than those who had their first drink after age 21

Young people have lowest rate of help-seeking behaviors



SAMHSA – DATA, QUALITY, AND OUTCOMES

SAMHSA COLLECTS AND REPORTS PUBLIC HEALTH DATA RE BEHAVIORAL HEALTH

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→ General population data

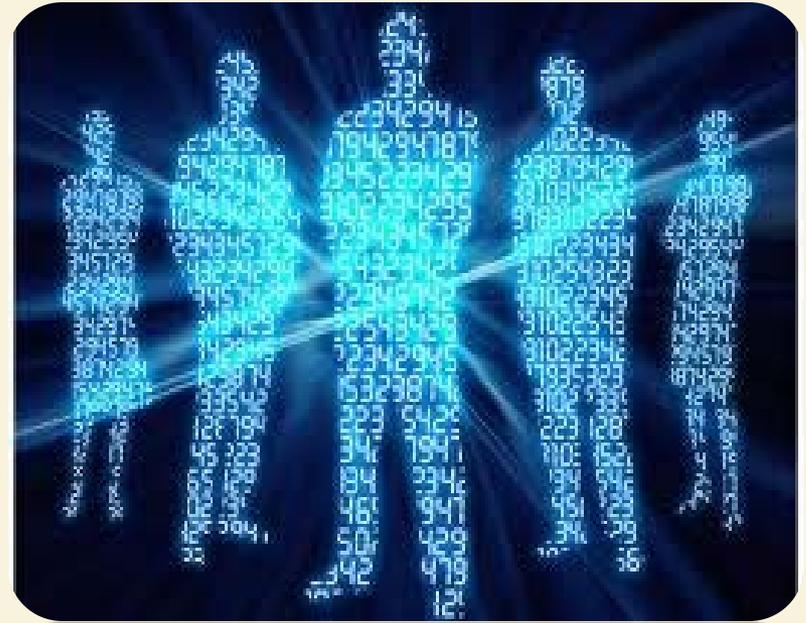
→ State level data

→ Community level data

→ Program level data

→ Treatment services data

→ Emergency departments and mortality data



SAMHSA'S SURVEYS AND DATA COLLECTION SYSTEMS

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- National Survey on Drug Use and Health (NSDUH)
- Drug Abuse Warning Network (DAWN)
- Drug and Alcohol Services Information System (DASIS)
- Treatment Episode Data Set (TEDS)
- National Survey of Substance Abuse Treatment Services (N-SSATS)
- Alcohol and Drug Services Study (ADSS)
- Drug Services Research Survey (DSRS)
- CSAT Substance Abuse Information System (SAIS)
- CMHS TRACS and CSAP Prevention Data System

DATA, QUALITY, AND OUTCOMES – A SAMHSA STRATEGIC INITIATIVE

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- ➔ Integrated approach – single SAMHSA data platform
- ➔ Common data requirements for states to improve quality and outcomes
 - Trauma and military families
 - Prevention billing codes
 - Recovery measures
- ➔ Common evaluation and service system research framework
 - For SAMHSA programs
 - Working with researchers to move findings to practice
 - Improvement of National Registry of Evidence-Based Programs & Practices (NREPP) as registry for EBPs

NATIONAL BEHAVIORAL HEALTH QUALITY FRAMEWORK (NBHQF)

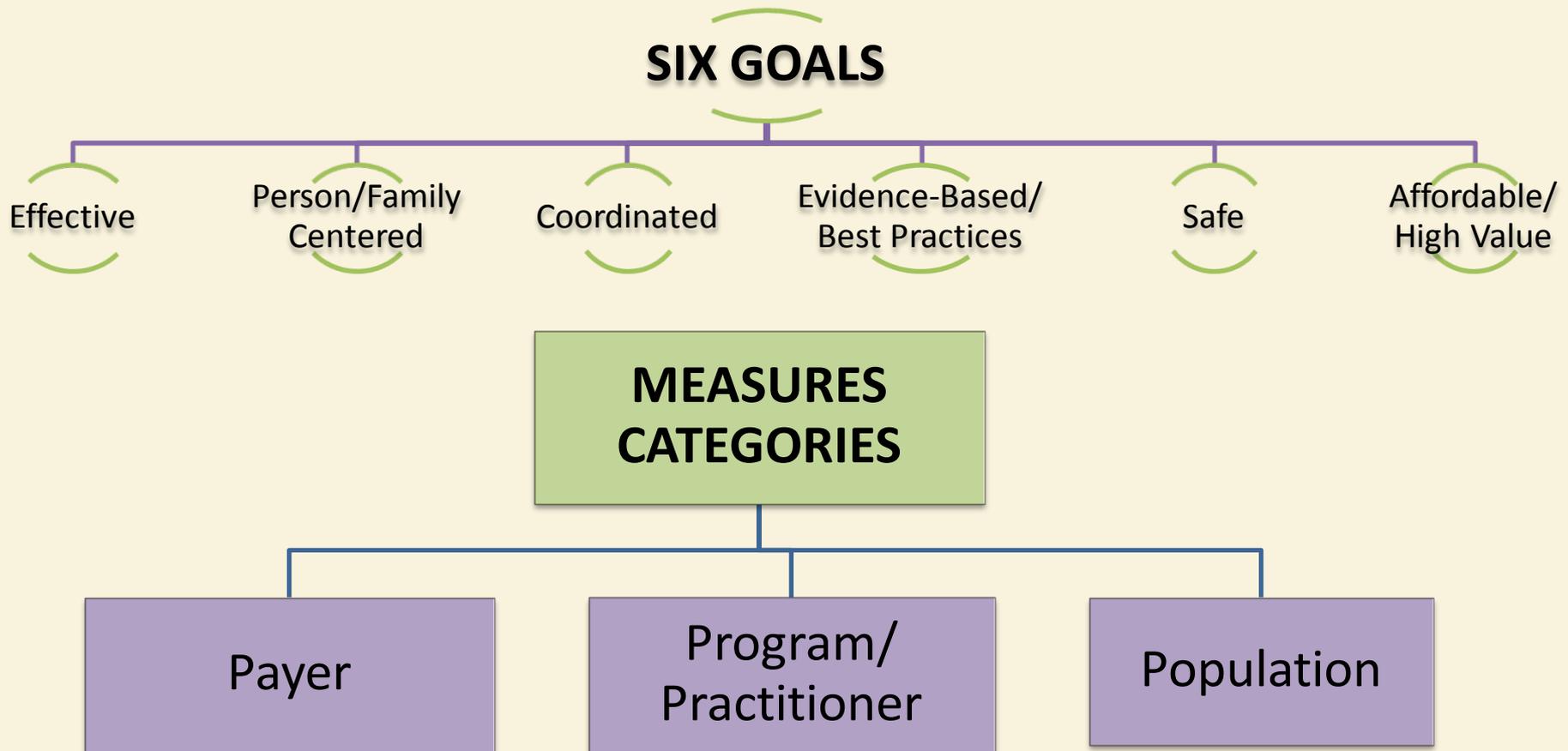
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→ Builds on Affordable Care Act's National Quality Strategy

→ Aims:

- **Better Care:** Improve overall quality by making behavioral health care more person-, family-, and community-centered; and reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve U.S. behavioral health by supporting (***and disseminating, added by SAMHSA**) interventions to address behavioral, social, environmental determinants of positive behavioral health; and delivering higher quality behavioral health care.
- **Affordable Care*:** Increase the value of behavioral health care for individuals, families, employers, and government. ***Accessible care for SAMHSA**

NBHQF: GOALS & MEASURES



SAMHSA's BEHAVIORAL HEALTH *BAROMETER*

- ➔ Annual snapshot of the state of BH nationally (regionally), and within states:
- Highlights key indicators from population and treatment facility-based data sets
 - Provides point-in-time and trend data reflecting status and progress in improving key BH indicators

SAMHSA'S VISION

- A nation that acts on the knowledge that:
- Behavioral health is essential to health
 - Prevention works
 - Treatment is effective
 - People recover

A nation/community free of substance abuse and mental illness and fully capable of addressing behavioral health issues that arise from events or physical conditions



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