

# **COMMUNICATING SAMHSA'S ROLE IN HEALTH CARE REFORM AND FINANCING SUBSTANCE ABUSE/MENTAL HEALTH SERVICES**

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**Substance Abuse & Mental Health Services Administration  
Office of Communications**

## **Overview**

The Substance Abuse and Mental Health Services Administration (SAMHSA) must work to assure that services for the prevention and treatment of mental and substance use disorders are included in health care reform legislation, and that the maximum benefit is received by people in need through implementation of that legislation. Obviously, the challenges and opportunities of financing these services are a critical aspect of any such effort, so SAMHSA has created a *Financing Initiative* - both to build the agency's internal capacity to wrestle with these complex issues, and to promote a wider dialogue with other stakeholders. This Initiative includes mobilizing SAMHSA staff expertise, creating a Financing Center of Excellence, and developing a network of learning and dialogue opportunities for field leadership.

SAMHSA's leadership efforts on health care reform, as well as results from the Financing Initiative's activities, need to be communicated effectively. Communication activities are required both inside SAMHSA and with the substance abuse and mental health (SA/MH) fields, plus to other Federal agencies, Federal and state policymakers, and the public. SAMHSA's Office of Communications is developing a strategic communications plan for that purpose, which this study is intended to inform. These activities will help SAMHSA achieve its mission of improving quality and increasing availability of services for the prevention and treatment of mental and substance use disorders - through support to the States, communities and providers, and through support of the Obama Administration's overall policy directions on health care reform.

## **Study Method**

Unstructured conversations were conducted by telephone to obtain input from 26 thought leaders and key stakeholders on how SAMHSA can best communicate about financing of SA/MH services, and inclusion of these services in health care reform (especially the integration of these services into the full spectrum of primary care, public health and prevention). A draft of the report was shared with interviewees to obtain their input on its accuracy and completeness. A list of interviewees is in the Appendix.

Activities of the SAMHSA Financing Center of Excellence (supported by a contract with Deloitte) were examined for this analysis, e.g., a recent review paper on health care transformation. Also reviewed was input from two listening sessions coordinated by the SAMHSA Centers, from brainstorming sessions with SAMHSA staff, and from other Financing Initiative activities.

## **Results**

Eight recommendations emerged from this study (see Summary Chart) that SAMHSA can consider as it develops a strategic communications plan for health care reform and services financing. Some are focused directly on communications methods, some on how SAMHSA is viewed by other stakeholders, and some on actions SAMHSA needs to take that go considerably beyond communications, but have implications for communications strategy.

## *Summary Chart*

### **RECOMMENDATIONS: COMMUNICATING SAMHSA'S ROLE IN HEALTH CARE REFORM AND FINANCING SUBSTANCE ABUSE/MENTAL HEALTH SERVICES**

#### ***1 - Develop a communications strategy about SAMHSA's role in health care reform and services financial that is simple and consistent***

- a. Prepare and share widely a one-page summary of SAMHSA's activities related to health care reform and services financing
- b. Prepare and share widely a one-page summary of costs of substance abuse/mental health care, and cost savings possible through enhanced services and coordination with the broader health care system
- c. Use consistent language to discuss substance abuse and mental health financing and health care reform
- d. Include the experiences of implementing the Parity law in communicating about SAMHSA's role in health care reform and services financing
- e. Include discussion about possible re-organization of SAMHSA as part of the response to health care reform

#### ***2 - Align communications about substance abuse and mental health services with health care reform***

- a. Align SAMHSA's discussions about substance abuse/mental health services with the larger frame of health care reform, as presented by the Obama Administration
- b. Provide information that helps constituency groups communicate their views about substance abuse/mental health services with attention to cost containment - values count but must be put in the context of cost

#### ***3 - Actively engage SAMHSA's leadership in the national dialogue about health care reform***

- a. Broaden the dialogue about health care reform by bringing SAMHSA's Administrator together with key government and public leaders
- b. Recruit a "point person" on health care reform for SAMHSA, who has credibility in the larger realm of medicine and health care

#### ***4 - Promote outreach to key constituencies that are involved in health care reform***

- a. Look for appropriate public figures to communicate information about substance abuse/mental health services and health care reform
- b. Develop mass media strategies to provide public information on substance abuse/mental health services as part of health care reform
- c. Look at ways in which the business community can be an active partner in bringing substance abuse/mental health services into health care reform

#### ***5 - Explore how substance abuse/mental health services workforce development can contribute to effective health care reform***

#### ***6 - Explore how evidence-based practices (EBPs) can play a more vital role in substance abuse/mental health services in the era of health care reform***

#### ***7 - Explore how to better integrate prevention in substance abuse/mental health services and health care reform***

#### ***8 - Look for ways in which the stigma of mental and substance use disorders can be reduced as part of health care reform***

***Recommendation 1 - Develop a communications strategy about SAMHSA's role in health care reform and services financial that is simple and consistent***

**a. Prepare and share widely a one-page summary of SAMHSA's activities related to health care reform and services financing**

SAMHSA is addressing health care reform and services financing on a number of fronts, such as the Financing Center of Excellence it created. Several interviewees emphasized the need to provide a brief overview of all that SAMHSA is doing in this area. Presented in a one-page chart format (perhaps organized like a Venn diagram), this document can be distributed both in person at individual or group meetings, and electronically (e.g., through inclusion on SAMHSA's website) to all who are involved in these activities. Interviewees often said they had heard about or been involved in some of these activities, but some reported they did not have the "big picture" context.

Components to be included in this one-page chart document include:

- \* Two review meetings were held to provide the SA/MH fields opportunities to provide input to SAMHSA; written summaries of these meetings were prepared.
- \* Input was sought from SAMHSA's Advisory Councils.
- \* Input also was sought from SAMHSA staff through an all-hands meeting and through brainstorming sessions with SAMHSA's Executive Leadership Team.
- \* The SA/MH services field was provided an opportunity to offer input in writing, and more than 100 papers have been received to date.
- \* Results from these four sources were synthesized into nine core consensus principles for how to integrate SA/MH services into health care reform, presented in a May 2009 brief, *Ensuring U.S. Health Reform Includes Prevention and Treatment of Mental and Substance Use Disorders - A Framework for Discussion*.
- \* A review paper, *Health Care Transformation in the US: Perspectives on Mental Illness and Substance Use Conditions*, was prepared by the SAMHSA Financing Center of Excellence (this is now undergoing final review, and six core functions identified by SAMHSA leadership in response to the eight Obama Administration principles for health care reform will be added).
- \* Other efforts are being developed by the Center of Excellence, such as a website, webinar series (e.g., on how insurance companies work, on defining medical underwriting) and related learning events, plus additional review papers (some of these are called "landscape reviews," e.g., on what the field knows about financing and its role in health care reform).
- \* SAMHSA's Office of Communications is creating a strategic communications plan for all these activities, to which this study report can contribute.

**b. Prepare and share widely a one-page summary of costs of substance abuse/mental health care, and cost savings possible through enhanced services and coordination with the broader health care system**

This also should be presented in a one-page format, as well as a lengthier but still short summary report. Both can be used for brief dialogues with Congressional staff, business executives, etc. The summary can be aligned (or combined) with a piece now being written that will attach cost-savings figures to the nine principles in the above-cited May 2009 brief.

At present, said one interviewee, “few people outside the public sector look to SAMHSA for information about financing or the organization of care.” There is a huge hole that SAMHSA could fill, using data from the National Treatment Expenditure Studies and other routinely gathered data from SAMHSA research. Another interviewee broadened the scope of this point somewhat: “This is the logic model: substance abuse and mental health disorders are expensive, but we have tools that work to treat them. They are costly but it costs more if we don’t treat.”

Just to give a few examples of studies that might be included in the summary and report:

\* A study by Petterson and colleagues at the Robert Graham Center found that costs of medical expenditures for adults with chronic health problems nearly double when the patient also has a mental disorder.

\* According to the SAMHSA Financing COE, mental and substance use disorder-related emergency department visits increased markedly over the last decade, driving costs higher, especially in Medicaid.

\* A study by McFadden and colleagues found that depression is a significant risk factor for coronary disease and that high alcohol consumption has the same impact on hypertension as salt intake, thus increasing costs for both health conditions.

More research currently is being done to learn about these inter-relationships. For instance, one interviewee reported that NASADAD is doing a study about Massachusetts, Vermont and Maine, about whether coverage for substance abuse by private insurance, Medicaid and other public sector coverage has in fact improved access to care (SAMHSA is supporting this study).

There is a great deal of research showing cost offsets related to prevention and treatment of mental and substance use disorders, said one interviewee, “but we don’t put it into formats that are accessible to most people.” This is primarily a communications problem, and the research brief in short, accessible format advocated here would be a partial solution to this problem. This brief could be used with the media as well (see separate recommendation below).

### **c. Use consistent language to discuss substance abuse and mental health financing and health care reform issues**

In the current set of written materials generated by SAMHSA on this topic, a number of different languaging choices have been made. None of them are inherently right or wrong, but it is important to have consistent language across this field of products. For instance:

\* Both “health reform” and “health care reform” are used (and both terms also have been used by the Obama Administration, the media, etc.) - several interviewees advised picking one term and using it consistently in all of SAMHSA’s communications on this topic.

\* In referring to the services central to SAMHSA’s work, various terms are used: “substance abuse and mental health” (SA/MH), “mental and substance use disorders,” “substance use” (which some prefer because it may reduce the stigma of referring to “abuse”), “substance/mental illness (S/MI)” etc. Again, the advice was to pick one term and use it consistently. For this report, the term substance abuse and mental health (abbreviated SA/MH) will be used throughout to refer to services and the fields from which they come; “mental and substance use disorders” will be used throughout to refer to the life problems for which services are needed.

\* In some cases these have also been subsumed into the larger term “behavioral health,” which is liked by some because it is a term widely used in the business world, in the insurance industry, and somewhat in medicine. The term is disliked by others since it can imply that substance use or even mental disorders are behavioral “choices.” Nonetheless, this term needs to be acknowledged in SAMHSA’s communications, even if it is not the preferred language.

\* Language used in this field has always been that of the “carve out” - people and programs in substance abuse and mental health have tended for decades to say “we’re different,” “we should not be included in the larger frame of health services.” This now has some unfortunate consequences, as it becomes clearer that including SA/MH services in health care reform requires integration, not separateness. There now needs to be an emphasis, said a number of interviewees, that mental and substance use disorders are health problems, and that services for them are health services.

\* The language of history also is important - that is, the need to refer to key historical documents that have helped shape current thinking about SA/MH services - for instance, the Institute of Medicine report on substance abuse, and the New Freedom report on mental health. Part of SAMHSA’s communications strategy is to agree on what are the key documents, again so that the references to them can be consistent.

These language choices, once made, can be applied to all documents and materials SAMHSA prepares, to establish a greater consistency in the knowledge base SAMHSA is creating. All language choices will need to be aligned with Obama Administration terminology as well.

#### **d. Use the experiences of implementing the Parity law in communicating about SAMHSA’s role in health care reform and services financing**

The Mental Health Parity and Substance Abuse Equity Act of 2008 is now law, and implementing regulations are currently being written. Interviewees noted that the Parity law in some ways is seen as a “warm-up” act for health care reform. Its implementation will be carried out through writing regulations. SAMHSA is at the table for this and needs to take advantage of that opportunity on behalf of people with mental and substance use disorders.

There is a caution here - several interviewees said they thought that Congress believes that now that there is a Parity act, the game is over and they don’t have to do anything further. In fact, said several interviewees, the language of the Act itself and the regulations now being drafted will leave many loopholes. These will need to be addressed by SAMHSA as a part of getting SA/MH service to the table in discussions about health care reform.

#### **e. Include discussion about possible re-organization of SAMHSA as part of the response to health care reform**

Several interviewees said that no external communication effort about health care reform and SA/MH services will succeed without internal changes first occurring at SAMHSA. These interviewees emphasized that such a change process must begin with re-examining how SAMHSA presents its overall objectives. For example, several reported they think the Matrix has seen its time, and is a distraction in the way SAMHSA needs to be presented now. The “One SAMHSA” philosophy has many advantages, but loses some who are committed to substance abuse or mental health services as single issues (and, said several interviewees, has also tended to reduce the emphasis on prevention).

Also, mental health promotion is not substance abuse prevention - they really are different, and have different aspects relevant to health care reform. At the same time, several interviewees said that the silos in which SAMHSA operates interferes with its ability to play in the larger arena

of health care reform and health care financing. So prevention (or treatment) distinctions must be balanced with attention to integration of these services, especially where co-occurring disorders are concerned.

Repurposing of SAMHSA block grants was mentioned by several interviewees as the most important re-organization of the agency that could take place. Said one: "the substance abuse block grants are irresponsible as currently administered - a number of states make no corresponding contribution of their own, and there are no standardized measures of impact."

Real leadership would mean incentivizing both greater lengths of care (for which there is empirical evidence of value) and screening and brief interventions (which also have evidence of efficacy). Leadership also would need to involve getting states to turn on Medicaid codes that would promote its wider use.

It is possible to make block grants more accountable than they are now, said several interviewees. SAMHSA is in fact a major player in financing of SA/MH services - about 70% of the third party marketplace for prevention and treatment of substance use disorders, and a large amount for mental disorders. One way to increase accountability would be to offer block grant funding in tiers such as the following:

- \* 70% of total block grant funding left unrestricted for state-decided allocation
- \* 10% conditional on the state undertaking performance measurement on a quarterly basis
- \* 10% conditional on the state finding a 10% match for block grant funding from some other source
- \* 10% conditional on the state getting its Medicaid director to "turn on switches for getting services paid" for people with SA/MH problems

SAMHSA is a purchaser of services for a disenfranchised population, said one interviewee, and needs to use every means of provoking improved quality of service for them. This kind of tiered, incentive-oriented funding strategy for the block grant is one way to do it.

At the more fundamental level of re-organization, several interviewees argued for "doing away with the three centers altogether." SAMHSA would then be reconstituted as a single "Center for Behavioral Health," as one interviewee suggested, so that it could address SA/MH service needs in a much more integrated way.

Several interviewees called for the absorption of SAMHSA into another Federal agency such as HRSA. Others, however, felt strongly that this would be a "bad move." They felt that there is not enough unification or standardization in the SA/MH services field to present the kind of front that would be needed to become successfully integrated.

All of the preceding suggestions were made only by one or a few interviewees. Many others appeared to be satisfied with SAMHSA's organizational structure as it is. However, the frequency with which some type of significant re-structuring was advocated suggests that SAMHSA may find it of value to include information about these alternatives in its communications plan, highlighting how they align with Obama Administration priorities.

***Recommendation 2 - Align communications about substance abuse and mental health services with health care reform***

**a. Align SAMHSA's discussions about substance abuse/mental health services with the larger frame of health care reform, as presented by the Obama Administration**

The most direct path to alignment is to put SAMHSA's recommendations and actions in the context of the Obama Administration's eight principles for health care reform:

- \* Protect Families' Financial Health
- \* Make Health Coverage Affordable
- \* Aim for Universality
- \* Provide Portability of Coverage
- \* Guarantee Choice
- \* Invest in Prevention and Wellness
- \* Improve Patient Safety and Quality Care
- \* Maintain Long-Term Fiscal Sustainability

One interviewee suggested that SAMHSA develop one brief, scientifically-based paper summarizing the needed actions and values statements of the SA/MH field for each of the eight principles. These documents could in themselves help to get SAMHSA to the table in discussions of health care reform.

For example, data SAMHSA already has available on the financial costs (and impact on families) of schizophrenia and depression could be summarized in a paper on the first principle. The data (discussed above) on cost containment possible in both SA/MH services and related health care services from earlier and/or more effective treatment for people with mental or substance use disorders also can be presented persuasively.

A paper on universality can include a discussion of the new Parity law (see Recommendation 1d). This law will lead the country in the direction of universal coverage, but leave a number of gaps. Similar approaches can be taken for each of the other five principles.

The first step is to commission an overview paper about how SA/MH services relate to health services, and making it publicly available on the SAMHSA website. As long as these services are seen as separate from health, it will be hard for them to be integrated into the larger health care system, as they must be if they are to be covered under health care reform. There has been some effort by the SA/MH field not to get included, because there is a perception, probably accurate, that they will lose some control if they do so. But these services also will be increasingly marginalized, said our interviewees.

A second concept with which SA/MH services need to be aligned is that of the "medical home," or "health home" as it is now more comprehensively being called. As one interviewee put it, "there must be room in the home for substance abuse and mental health services." Moreover, there needs to be increased attention to integrating a larger health care perspective into the services offered for people with substance abuse and mental health problems.

The medical home model is at odds with some of the traditional interests of specialty care in medicine - how are these being dealt with? Such an analysis may provide clues for how to best integrate SA/MH care - another specialized type of health service - into the medical home.

Integration of SA/MH services and the organizations offering them also can happen with regard to public funding provided through the American Recovery and Relief Act. While SAMHSA didn't get direct funding under ARRA, there are many ways in which the agency can have impact on SA/MH services through activities that are supported by ARRA. For example, as one interviewee pointed out, \$1/2 billion of funding is coming to HRSA for development of the health workforce. SAMHSA could explore partnerships with HRSA to get its own workforce development materials included in these educational efforts. Similarly, \$1 billion is being given to improve community health centers, and SAMHSA's \$7 million initiative to integrate SA/MH services with CHCs could be a prime resource here.

In a related private effort, the Whole Health Campaign is creating a series of papers on SA/MH services in the era of health care reform. They cover finance, coverage, payment reform, access, integration of care, workforce, public health and health promotion and leadership. SAMHSA can contribute to these papers and to their dissemination to key stakeholder audiences.

And while it may be time for the "carve out" mentality of the SA/MH services field to end, there is still a need to keep these life problems of people, and the services to help with them, in sharp focus. There is a tendency in health care reform to want to flatten or merge everything in the name of efficiency - this isn't desirable, said several interviewees. This isn't just a SA/MH services problem - it needs to be seen in this larger context.

SAMHSA also needs to be looking internally at technical issues associated with health care reform: cost-containment strategies used in the larger health field, electronic health records, e-prescribing, claims billing (some substance use treatment facilities get all their payments through government not through insurance companies so haven't updated their billing procedures). There is much learning possible from the examination of these practices in the larger health care field, and there may also be opportunities for partnerships.

Just as one example, how is SAMHSA relating to Health Level 7? This project is developing common industry standards for electronic health records, so that software vendors will know what standards to meet and how to deal with privacy and confidentiality issues. SAMHSA can provide input specific to SA/MH services concerns, in the context of stigma.

**b. Provide information that helps constituency groups communicate their views about substance abuse/mental health services with attention to cost containment - values count but must be put in the context of cost**

As one interviewee said, "no doubt everyone believes that mental health and substance abuse coverage is important in any health care reform package ... but then we have exhausted the consensus!" Who should be covered, who should make the decisions about coverage, should there be unlimited benefits or at parity with coverage for other conditions, does treatment work - there is no consensus here. And this in fact is true for other areas of health care also.

Some people believe that substance use and even mental disorders to some extent are "choice driven" - that is, there is a fundamental belief about how the mind works and about what choices are voluntary. Those who think that substance use is a choice, for instance, may not be in favor of spending public funds for treatment, and it is hard to move people off these beliefs.

Such people regard many cost-benefit studies as biased, because they start with the assumption that these problems are not primarily based on voluntary choices. Messages that are one-sided and don't acknowledge this point of view, even when challenging it, are not likely to be effective.

Once these values issues are dealt with however, the underlying reality is that treatment and prevention activities reduce costs. Even those who believe there is personal responsibility and choice at play, especially with respect to substance use, can be moved by arguments that interventions will reduce costs. The problem, as several interviewees said, is that "we haven't made a good business case that we can reduce costs through treatment." The kinds of research briefs and media and professional education activities suggested here can help with this.

Another factor at play: SAMHSA is regarded by some as an agency that is too eager to advocate for SA/MH services. It is seen as a partner of advocacy organizations in these fields - so oriented to values-based action ("it is the right thing to do") rather than cost-based decisions ("this is the most cost-effective service") that cost considerations are seen as irrelevant ... in the view of some who assess SAMHSA's statements and actions.

Interviewees said that the essential issue is one of balance. Health care reform itself has a values component - about the need to get services for people who don't now have them, if nothing else. But this is set in a larger frame of cost and quality, as well as access.

A number of interviewees, both within SAMHSA and in the field, say that the agency really doesn't understand how to make their point within the context of financing services. SAMHSA sometimes has been seen as more of an advocate rather as a knowledge and solution resource. Said one interviewee: "They don't understand a payer's reality, that payers can't always cover everything." Moreover, said several of those interviews, with public programs the definition of what can be covered is made by Congress.

Thus, SAMHSA needs to walk a fine line in its communications - providing information and suggesting strategies for mental illness and substance abuse services, but not advocating so that they are seen by other Federal agencies as "shills" for the advocacy community, making what some view as extreme arguments. SAMHSA needs to avoid statements that seem to say "we must do this independent of cost," when in reality *everything* is done in the context of cost.

In the end, this means that SAMHSA needs to provide information about "what's the worst thing that could happen if people with mental health and substance abuse problems don't get covered in health care reform, and thus don't get services?" This depiction can include both cost figures and depictions of individual, family and community consequences.

At the same time, information also is needed about "what's the worst that could happen if they *are* covered?" There is a lot of pent-up demand, and with expanded availability of services financing there could be a good deal of mission creep (e.g., a patient says she is sad, but the doctor can get reimbursed if the diagnosis is depression). How can the line be drawn so that mental health and substance abuse services are affordable, without depriving people of needed services? What is the minimum standard or basic benefit that needs to be available - what's a desirable level without going for what is the maximum potential?

Adopting a more balanced point of view, interviewees said, is really the only way to be taken seriously in the larger health care reform debate. They emphasized that this is how medical services for cancer, heart disease and so forth are also being discussed.

***Recommendation 3 - Actively engage SAMHSA's leadership in the national dialogue about health care reform***

**a. Broaden the dialogue about health care reform by bringing SAMHSA's new Administrator together with key government and public leaders**

A good opportunity is on the horizon, now that HHS Secretary Sebelius is on board and a new permanent SAMHSA Administrator will be selected. Several interviewees felt that one of the best paths towards greater involvement for the agency in health care reform would be to initiate a personal dialogue between the Administrator and key leaders such as:

\* *Karen Davis, CEO of the Commonwealth Fund*, one of the most influential foundations in the realm of health policy. For instance, according to one interviewee, Commonwealth has advocated giving primary care physicians control over all the money allocated for individual patient care, so that they become the health funding gatekeeper. An open dialogue about how information from SAMHSA's Financing Initiative and its input on health care reform could help to shape such an initiative could be productive. And Karen Davis might have useful ideas about how SA/MH services could be brought more fully to the table in the debate about health care reform.

\* *Nancy-Ann DePaule, Director of the White House Office of Health Reform*, is an obvious choice for a personal dialogue, both about her Office's activities and about other efforts going on throughout the Federal government (DePaule also used to run the Health Care Financing Administration).

\* *Charlene Frizzera, Administrator of the Centers for Medicare and Medicaid Services*, is another obvious choice, to look more broadly at CMS and how their programs, philosophy and data could relate more broadly to SAMHSA and to SA/MH services.

\* *Mary Wakefield, Administrator of the Health Resources and Services Administration*, also is a straightforward choice. Several interviewees admonished SAMHSA to "stop the infighting with HRSA" and to partner on topics of mutual interest, since many of the same poor, disenfranchised people are the stakeholders of both agencies. One interviewee noted that in the Clinton administration efforts were made to absorb both HRSA and SAMHSA into CMS - so there also is a reason of mutual survival for having a dialogue.

\* *Eric Holder, Secretary of the Department of Justice*, is a priority choice because after CMS, the highest public expenditures for SA/MH services are in the criminal justice system. These services need to be better-integrated and otherwise improved. There are some pioneering SAMHSA efforts in this realm, but they need to be coordinated with larger health care reform efforts and new policy directions. The Administrator could use contacts available through organizations in which SAMHSA already has made an investment. One topic of particular interest would be how to organize a potent set of messages in the corrections field to justify diversion programs from a financial standpoint (DOJ and SAMHSA already are co-funding a project in this area).

\* *Peter Orszag, Director of the Office of Management and Budget*, is a good choice because OMB can help SAMHSA look at performance measures and how to better show the impact of SA/MH services. In the larger context of what other agencies are doing, SAMHSA doesn't always fare very well because it has tended to answer questions in terms of programs, not services, according to one interviewee. Several others noted SAMHSA's tendency, shared by the entire SA/MH field, to support the "carve out" of SA/MH services because they are too idiosyncratic to be funded using the same procedures as for other efforts. It is accordingly difficult for these services to be seen as part of the larger public health arena.

\* *Kathleen Sebelius, Secretary of the Department of Health and Human Services*, herself would be a critical candidate for inclusion in this series of conversations, said several interviewees.

Interactions with the national leaders of other groups vitally interested in health care reform may also be in order:

- \* labor unions
- \* community pharmacies
- \* hospital industry
- \* nursing home and long-term care industry
- \* foundations

One particularly critical person who could be interviewed in the foundation world is Steve Gunderson, CEO of Council on Foundations and a former Member of Congress with deep knowledge about Federal financing of health services. All of these connections need to be aligned with the priorities of the Obama Administration.

**b. Recruit a “point person” on health care reform for SAMHSA, who has credibility in the larger realm of medicine and health care**

SAMHSA needs to have a point person in the Administrator’s office who is knowledgeable about health care reform, and who is a well-known and recognized expert - whether there in an employee or consulting capacity. At present, said several interviewees, “when you think of SAMHSA you don’t think of any one individual who is knowledgeable about health care reform and who is known outside the agency.”

There is no substitute for someone with “street cred” in the health care reform arena, interviewees said. This specifically means a physician who knows health care financing. Said one interviewee, at present there is only one physician on the staff of SAMHSA. Partly for this reason (and the interviewee acknowledged this may be unfair), “many people would find SAMHSA irrelevant to financing and health care reform in the larger picture.”

Moreover, SAMHSA is not an operational organization that purchases services, as CMS is. It is a grantmaking and analytic organization one level removed from the playing field - so it needs to invest extra effort in maintaining credibility. Having the SAMHSA Center of Excellence in existence helps, and so does having health care savvy staffers like Sarah Wattenberg in the front office, said several interviewees. It also helps to have people at the Center staff level who are knowledgeable about health care and the financing, such as CMHS’s Bill Hudock and CSAT’s Rita Vandivort. But the need is clear for the kind of person described above, who can represent SAMHSA, along with the Administrator.

***Recommendation 4 - Promote outreach to key constituencies that are involved in health care reform***

**a. Look for appropriate public figures to communicate information about substance abuse/mental health services and health care reform**

Said one interviewee: “Rosalynn Carter and Tipper Gore brought people together around mental health services in the last round of discussion about health care reform in the early 1990s.” What public leaders are available now to serve in this high-profile advocacy role for improving

SA/MH services? Especially with the retirement of Senator Pete Domenici, there are few elected officials who have a primary focus on either substance abuse or mental health, said several interviewees. Getting the support on message of anyone who is knowledgeable about both subjects, such as Congressman Patrick Kennedy, is important to increasing the impact of basic messages about including SA/MH services in health care reform.

Public figures from sports, entertainment and public life also can help. Athlete Greg Louganis, and bipolar illness expert Dr. Kay Jamison, are just two of the nominees mentioned by the interviewees as examples. They are what one interviewee called "wounded warriors" - people of public renown and charisma, who can talk persuasively about their own fights with these life problems and the progress they've made.

**b. Develop mass media strategies to provide public information on substance abuse/mental health services as part of health care reform**

The Kaiser Family Foundation's journalism program, Kaiser Health News, now commissions articles to be placed in major newspapers like *The Washington Post*, written by health journalists hired by Kaiser from their former newspapers. Since people get health information from the news media more than from doctors, organizations or any other source (especially online news), this could be a powerful force for getting the challenges of SA/MH services and their inclusion at the table for health care reform out as an issue for the general public to consider. Media partnerships could be developed here, e.g., with the Kaiser Family Foundation, the University of Southern California Lear Center and its Hollywood Health and Society Program, the Entertainment Industries Council, and others.

In these media discussions, traditionally the case has been made in human and compassionate terms, but this will only go so far. It is also necessary to look at SA/MH services as an investment in the future long-term. That is, funding these services can provide help for people who are ill, and save money by reducing health care costs and people are more productive members of society in the long run. People need to see this as an investment not just dealing more effectively short-term with a cost center. As one interviewee put it, "we need to put together summaries of the pay now or pay later type," making a case for investment now!

There also is increasing importance not just of the traditional media such as television, radio and newspapers, but also of alternate media. Interviewees said social media are becoming increasingly important. What is the role for SAMHSA on Facebook or Twitter?

Agenda setting is not controlled the way it once was - self-selected niche communications like those mentioned have changed the landscape. But a few public figures, especially President Obama at the present time, can still set the agenda, and this is a subject for careful discussion with those in the SA/MH field who are close to the current Administration. One reference by the President on national television could make a real difference, said one interviewee.

Also in the realm of conventional media, several interviewees suggested that articles in the *New Yorker*, *Atlantic Monthly* and other elite print publications are important, because that's where arguments can be laid out for examination by thought leaders and policymakers. To do so, a champion is needed - a writer who would take on this task.

CDC's Health Communication, Media & Marketing Conference in August 2009 will be a platform for discussing these and other issues related to creating and implementing a strategic communications plan for SAMHSA's role in health care reform and SA/MH services financing. In particular, a mini-plenary session has been organized in which Kaiser Family Foundation Vice-President Matt James, former ONDCP Director General Barry McCaffrey and SAMHSA Office of Communications' Mark Weber will be the speakers.

There also is a need to add new elements to SAMHSA's public dissemination activities about health care reform and services financing:

\* *Creation of a section on the SAMHSA website devoted to financing and health care reform - adding to the section that already exists inviting papers on this subject.* This could be linked to the Financing COE website (or could be that website, perhaps re-g geared to make it accessible to a broader audience). One of the interviewees suggested that such a website section should include a searchable database that could be used by journalists, as well as advocacy organizations, policymakers and other interested parties.

\* *Creation of weekly online "pulse checks," consisting of brief summaries of news items by states - so that people at the state level can understand more fully what the key issues are (this could be hosted on the Financing COE website, with a link to the SAMHSA website).*

\* *Broadening the target audiences for SAMHSA's eBlasts on health care reform and services financing - to include advocates, public and private leaders, researchers and others from beyond the SA/MH fields, so that SAMHSA's messages get a wider reaction.*

\* *Creation of a SAMHSA website page for the media, targeted to presenting updated information on how the SA/MH fields are addressing health care reform and services financing, and including dramatic human stories of challenge and success.*

In developing these electronic media activities, it is important to be mindful that professional associations, trade associations and advocacy groups are all out there in the field doing some of the same work. SAMHSA needs to coordinate with these other efforts, and in particular to partner on message development and dissemination wherever possible.

There is room for improvement at SAMHSA in this regard. Other Federal agencies have simply been more effective in getting media attention for their issues and points of view. As one interviewee put it, "if there was a problem on the moon CDC would figure out how to get involved." SAMHSA doesn't operate this way, and could certainly benefit from improving its strategies. Careful examination of approaches used by CDC, CMS, HRSA and other Federal agencies could help to identify possible options.

### **c. Look at ways in which the business community can be an active partner in bringing substance abuse/mental health services into health care reform**

The management of disability is a huge issue for American employers, public and private. A great deal of short term disabilities are for mental health reasons, especially for depression. As one interviewee noted, 20% of all medications prescribed are psychotropics - but too often people are not getting a diagnosis or any kind of treatment other than the drugs! For non-manufacturing employers, disability attributed to mental disorders ranks in the top three sources in all studies - and often produce lengthy, high-cost events.

But business people talk about emotional wellness, not mental disorders - they talk about people who are stressed and using substances to self-medicate for stress, not about substance abuse. There is a focus on productivity, stress reduction, and health status - but it must be very broad to get the business community interested (that is, not just focused on serious mental illnesses and addiction).

SAMHSA's recently has created a new website section designed to provide help for people who are experiencing stress related to the economic and lifestyle consequences of the recession. Interviewees mentioned that this effort has been well-received by those in the business community who are aware of it. However, interviewees also said they believed many in the

business sector do not know about this relatively new program, and that efforts to alert them would be useful because it would increase interest generally in SA/MH services as well as to the specifics of dealing with the impact of the recession.

Visibility for SA/MH services and SAMHSA's role in them is a problem in itself. If one asks the Vice Presidents of Human Resources or Benefits for Fortune 500 companies, they know CDC and AHRQ, but they don't know SAMHSA, according to one interviewee. This needs to be changed!

A major change advocated by several interviewees is to reach out to business groups in both trade associations and academic institutions, to be sure that SA/MH problems and the best evidence-based interventions for dealing with them are included in the knowledge products developed for the business world. For example, the National Business Group on Health in 2005 published an employer's guide to behavioral health services (with SAMHSA funding). In this guide, EBPs were mentioned, but it was difficult to present them effectively because (as already mentioned) most SA/MH EBPs have never been translated into benefits language and codes so they can be reimbursed.

In general, employers are not much aware of what EBPs are and what they can do. As one interviewee noted, if Assertive Community Therapy (ACT) is mentioned in a business meeting, most employers would not know what it is. There also is little understanding of what CMHCs offer that is not available in the private market, and how employers could access them.

It would be useful to develop an EBP on disability management, said one interviewee. This would be a good investment for SAMHSA and a way of tying into the employer community.

NBGH also recently published a comprehensive guide on prevention services and how they apply in the workplace. This guide already has had 350,000 downloads - and it is a 514-page document! Unfortunately, noted one interviewee, the guide only has two pages on mental health. More efforts to reach out to groups like NBGH could increase the opportunities for appropriate coverage of SA/MH services in documents like this.

As one interviewee said, "SAMHSA needs to find ways to make themselves valuable to employers." Doing so would require more regularly including business people at the table in SAMHSA's discussions and conferences. "We tend to do too much talking to ourselves," said one interviewee. In addition to employers, school superintendents, governors and mayors are all stakeholders who aren't usually at the table in SAMHSA convenings

The argument is an old one. Advocates think social justice and rights - employers think competitiveness and having workers healthy and productive. It is hard to find a balance between the two. But there are bridges - Obama's call for productivity and national competitiveness as a product of health care reform is one of them. As more people become disabled and sick the less competitive the nation is - regardless of the source.

Today EAPs are seeing a 30-50% increase in people seeking services for problems of anxiety and depression as a result of the recession, said one interviewee. Such statistics could help to make a convincing business case for including SA/MH services in health care reform.

It also would make sense to develop educational interventions for the major benefits consultancies like Hewitt, Mercer and Watson Wyatt. These would provide them with information about SA/MH services and SAMHSA's role in health care reform. The interventions would make the argument that including coverage for prevention and treatment of mental and substance use disorders in benefits packages is cost-effective. If the benefits consultancies accept this argument, they will promote it to their employer clients.

The National Business Group on Health has regional counterparts in the Midwest, Kansas, New York - coalitions of local employers. They will listen to CDC, AMA about needed changes in health care services and financing, and then go to their vendors and put on pressure to change coverage. SAMHSA can advance its arguments with the same groups.

***Recommendation 5 - Explore how substance abuse/mental health services workforce development can contribute to effective health care reform***

SAMHSA staff, according to several interviewees, need to have more training than they've received to date about the basics of services financing and health care reform. The SA/MH services workforce also needs such continuing education. In-person or electronic seminars on these topics could be developed by the Financing COE. Offerings of these educational experiences to the field could be done through SAMHSA projects such as the CAPTs, ATTCs and CMHS technical assistance centers.

***Recommendation 6 - Explore how evidence-based practices (EBPs) can play a more vital role in substance abuse/mental health services in the era of health care reform***

SAMHSA needs to focus on "the science of mental health and substance abuse care," said one interviewee. In practice, this interviewee went on to say, there has been an overemphasis by SAMHSA on the role of the consumer in managing and designing care - so much so that some of the EBP science gets lost in the process. "You wouldn't ask patients to design their own care if it were heart disease." However, SAMHSA may need to make the counter-argument here that including the consumer and family point of view also can improve quality of care. Moreover, such inclusion is now much more common in other fields of health care, and that SAMHSA not only can learn from that, but also can contribute to good practice with what has been learned in the SA/MH services field about consumer and family involvement.

Moreover, SAMHSA has focused largely on social support interventions and housing, said several internal and external interviewees. In doing so, said one interviewee, the agency has lost focus on treatment EBPs. In an era of performance-based medicine and outcome management, this puts SA/MH services at odds with the rest of the health care field.

Yet there is also an argument to be made for social supports or housing as reducers of symptoms and rehospitalizations for mental disorders, and as reducers of relapses in substance use disorders. As one example, the EBP Multifamily Group approach to family involvement in mental health services shows approximately the same effect size in regards to rehospitalization rates as modern era antipsychotic medications, at a fraction of the cost and almost zero side effects. When such evidence is available, convincing arguments can be made to include these types of interventions in the health care reform discussion.

More study by SAMHSA is needed in this area, and also work to continue developing the National Outcome Measures as a part of the evidence base for SA/MH services. The context in which specific practices expressed as EBPs can be placed will come partly out of this research.

Some good work also is being done at the state level. But too often state contributions get ignored - if it is not a Federal accountability standard it is not useful, said one interviewee.

Identifying and promoting effective strategies for financing the wider use of EBPs in SA/MH services can be the center of SAMHSA's efforts, according to a number of those interviewed. No other entity is likely to take on this challenge. As it is, the NREPP project can't be used with third party payers, because it is not organized to encourage payment for users of these EBPs. Similarly, while SAMHSA has made a major investment in the Toolkits to promote wider adoption of EBPs, there is no easy way to get these information resources aligned with payment

codes - this needs to happen. As such efforts increase, part of the communication strategy is to inform providers, payers and policymakers of their existence.

***Recommendation 7 - Explore how to better integrate prevention in substance abuse/mental health services and health care reform***

Several interviewees emphasized that when professionals, policy makers and the public start thinking of mental and substance use disorders as chronic conditions, then as with diabetes, prevention starts to make a lot of sense. It gives these services a better position in the overall arena of health care financing during discussions of health care reform.

Ultimately, a continuum approach is needed, according to several of those interviewed. Prevention is just one piece of the puzzle - risk and protective factors need to be addressed along with treatment interventions for those who need them. One interviewee said, "prevention and treatment need to stop fighting with each other internally over priorities and resources - the truth is that both are needed."

A continuum of care is essential, although a major shift to prevention funding is unlikely. Funding of prevention for mental and substance use disorders is more difficult than for heart disease and diabetes because these other conditions don't have the stigma issues so prominent in the SA/MH fields.

Also, prevention in the SA/MH field does not do a good job of translating science into simple principles. Said one interviewee, "prevention researchers are not secure in their own science and this has a big effect."

Prevention is carrying a lot of interest in the broader context of health care reform, and is included as one of the Obama Administration's eight principles. There is a more positive larger context now, several interviewees asserted. SAMHSA needs to put together effective messages about how mental and substance use disorder prevention activities create cost-offsets - not just reducing the costs of SA/MH services but also that these disorders, untreated, increase costs for dealing with other medical conditions. This could be part of an overview paper about the Obama principle on prevention.

***Recommendation 8 - Look for ways in which the stigma of substance abuse and mental illness can be reduced as part of health care reform***

There are many opportunities for reducing stigma that go along with health care reform and changes in the financing system for SA/MH services. It actually reduces stigma to integrate these services and payment for them into the larger health care system - "carve out" services are more likely to create conditions of stigma. At each step along the way, those involved in integrating SA/MH services into health care reform need to ask penetrating questions about whether a particular set of experiences or viewpoints contributes.

**Conclusion**

In many of the interviews conducted for this study, there was a sense of urgency. Repeatedly, people used expressions like "the train has already left the station," and "I don't see SAMHSA at the table at all."

As one interviewee said, "we need a six-month agenda" for action, aligned with what the Administration will be doing in the same time frame. Much of the change may be in mindset, language and coordination rather than in actual treatment and prevention services. For instance, SAMHSA can encourage SA/MH service providers to speak of themselves as health

care providers - this includes them in the larger health care community. SA/MH providers need to find out about health insurance status and physical health status of clients, even if they are not in an environment that makes immediate use of this information.

The most important voice has to be the patient - what are their needs and how can they best be met? This means SAMHSA has to encourage providers to stand together with advocacy groups across the board, and with others involved in the health care reform debate, asking for improvements in the services provided to vulnerable people that also will reduce the costs of their health care. A system wide coalition advocating for the patient is needed, with its focus on patients and outcomes for them, rather than on funding infrastructure.

It will be important also to have advocates who have nothing directly at stake included - academics who have studied the whole system, or providers who are not in SA/MH services settings (e.g., hospitals, criminal justice systems or nursing homes). All must be voicing support for the patient, and they have to be armed with the facts. The lack of clarity now on SA/MH services economic data is a big problem, as pointed out in these interviews.

There need to be motivators that move policy. This needs to be a blend of *compassion* - "it is the right thing to do" (this is why the patient has to be at the center) and *economics* - the financial realities that impact health system reform. There needs to be an explicit argument for why investing in SA/MH services is just as important as investing in services for diabetes or heart disease. Important questions will have to be answered, like "What would it take to motivate people with no one in their family with SA/MH problems to support funding for them?" and "Is it a better society where people take care of those with SA/MH service needs - like taking care of your babies?"

Once these basics are in line, then it is time to build a coalition. This is where pushing comes in - "if you don't push you don't get" in the words of one interviewee. Once at the table, however, there will be fighting and there will be coalitions to fight together. The result will be not only funding, but also a place on the policy agenda. The overall results have to engage corporate America - the health system of the future will have to be designed to involve corporations (and work organizations of all sorts). But it also has to be a grassroots movement.

Financing and reform should not have lives of their own. In the end, money is intended to purchase things. We are purchasing health care. Reform is intended to make services better. "Too often the tail wags the dog," said one interviewee. This is a final point to consider in developing a useful communications strategic plan for SAMHSA on health care reform and services financing.

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report prepared by **Thomas E. Backer, PhD, Human Interaction Research Institute**

## **Appendix INTERVIEWEES**

John Agwunobi, Walmart  
John Carnevale, John Carnevale & Associates  
Keith Cherry, Deloitte  
Westley Clark, SAMHSA/CSAT  
Daniel Conti, JP Morgan Chase  
Mary Jane England, Regis College  
Ron Finch, National Business Group on Health  
Eric Gopelrud, George Washington University  
Bob Glover, NASMHPD  
Henry Harbin, Consultant  
Frances Harding, SAMHSA/CSAP  
Ric Harwood, NASADAD  
Kevin Hennessey, SAMHSA/OPPB  
Bill Hudock, SAMHSA/CMHS  
Matt James, Kaiser Family Foundation  
Daryl Kade, SAMHSA/OPPB  
Ann Kohler, National Association of State Medicaid Directors  
Philip R. Lee, Palo Alto Clinic  
Noel Mazade, NASMHPD Research Institute  
Tom McLellan, Tresearch  
Michael McMullan, Deloitte  
Rob Morrison, NASADAD  
Kathryn Power, SAMHSA/CMHS  
Sue Thau, CADCA  
Rita Vandivort, SAMHSA/CSAT  
Sarah Wattenberg, SAMHSA/OPPB