Substance Abuse and Mental Health Services Administration
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Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

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Executive Summary

The Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division within the U.S. Department of Health and Human Services (HHS), is charged with reducing the impact of substance abuse and mental illness on America's communities. SAMHSA pursues this mission at a time of significant change. Health reform has been enacted, bringing sweeping improvements in how the United States delivers, pays for, and monitors health care. The evidence base behind behavioral health[i] prevention, treatment, and recovery services continues to grow and promises better outcomes for people with and at risk for mental and substance use disorders.[ii] All of this change is happening at a time when State budgets are shrinking and fiscal restraint is a top priority.

Recognizing the need to balance these opportunities and challenges, SAMHSA has identified eight Strategic Initiatives to focus its limited resources on areas of urgency and opportunity. The Initiatives will enable SAMHSA to respond to national, State, Territorial,[iii] Tribal, and local trends and support implementation of the Affordable Care Act and the Mental Health Parity and Addictions Equity Act. People are at the core of SAMHSA's mission, and these Initiatives will guide SAMHSA's work through 2014 to help people with mental and substance use disorders and their families build strong and supportive communities, prevent costly and painful behavioral health problems, and promote better health for all Americans.

Each Initiative has an overarching purpose, specific goals, action steps, and measures for determining success. In addition, three issues cut across all of the Initiatives: behavioral health disparities, health reform, and workforce development. This strategic plan will guide SAMHSA as it:

- Sets budget and policy priorities;
- Manages grants, contracts, technical assistance, agency staff, and interagency efforts;
- Engages partners at every level; and
- Measures and communicates progress.

[i] The term "behavioral health" in this document refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illnesses and substance use disorders, which are often chronic in nature but that people can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use, and related problems, treatments and services for mental and substance use disorders, and recovery support.

[ii] "Mental and substance use disorders" are referred to throughout this document. This phrase is meant to be inclusive of mental disorders, substance use disorders, and co-occurring mental and substance use disorders.

[iii] In this paper, the term "Territories" includes United States Associated Jurisdictions.

The Initiatives are data driven and grounded in a public health foundation as they respond to the toll that substance abuse, poor emotional health, and mental illnesses take. Like physical illnesses, mental and substance use disorders cost money and lives if they are not prevented, are left untreated, or are poorly managed. Their presence exacerbates the cost of treating co-morbid physical diseases[1] and results in some of the highest disability burdens in the world for individuals, families, businesses, and governments.[2]

The impact on America's children, adults, and communities is enormous:

- The annual total estimated societal cost of substance abuse in the United States is $510.8 billion.[3]
- By 2020, behavioral health disorders will surpass all physical diseases as a major cause of disability worldwide.[4]
- In 2008, an estimated 9.8 million adults aged 18 and older in the United States had a serious mental illness. Two million youth aged 12 to 17 had a major depressive episode during the past year.[5]
- In 2009, an estimated 23.5 million Americans aged 12 and older needed treatment for substance use.[6]
- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.[7]

In 2011 and beyond, SAMHSA will work to improve understanding about mental and substance use disorders, promote emotional health and the prevention of substance abuse and mental illness, increase access to effective treatment, and support recovery. SAMHSA's Strategic Initiatives will address trauma; support military families; improve access to culturally competent, high-quality care; develop community, peer, and family support; build information systems; and promote important messages about behavioral health while adjusting to changing conditions. By working across health, justice, social services, education, and other systems and with State, Territorial, Tribal, and other partners, SAMHSA will lead the way to improving the Nation's behavioral health.

The Strategic Initiatives

The following eight Initiatives will guide SAMHSA's work from 2011 through 2014:

1. **Prevention of Substance Abuse and Mental Illness**—Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families.

2. **Trauma and Justice**—Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.

3. **Military Families**—Supporting America's service men and women—active duty, National Guard, Reserve, and veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.

4. **Recovery Support**—Partnering with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.

5. **Health Reform**—Increasing access to appropriate high quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and other co-occurring health conditions such as HIV/AIDS.

6. **Health Information Technology**—Ensuring that the behavioral health system, including States, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of health information technology (HIT) and interoperable electronic health records (EHRs).

7. **Data, Outcomes, and Quality**—Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.

8. **Public Awareness and Support**—Increasing the understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

Introduction

This paper details eight Strategic Initiatives that will provide a framework to support the vision and mission of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS).

Vision

SAMHSA provides leadership and devotes its resources—programs, policies, information and data, contracts and grants—toward helping the Nation act on the knowledge that:

- Behavioral health is essential for health;
- Prevention works;
- Treatment is effective; and
- People recover from mental and substance use disorders.

Mission

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. By providing leadership, voice, funding, and standards, SAMHSA has the expertise and facilitates the collaboration needed to achieve its vision. SAMHSA accomplishes this mission through partnerships, policies, and programs that build resilience and facilitate recovery for people with or at risk for mental or substance use disorders. SAMHSA-funded services help individuals pursue recovery, avoid the abuse of drugs or alcohol, and reduce the impact of mental illnesses.

This document first presents a brief overview of SAMHSA's plan for leading change, including SAMHSA's focus on people and recovery, SAMHSA's roles, and some background about the eight Initiatives. The individual chapters present key facts and each Initiative's overall purpose, followed by background information; a discussion of the Initiative in the context of disparities, health reform, and the behavioral health workforce; an overview of the components of the Initiative; and specific goals and action steps.

Finally, each chapter provides measures for determining progress. Each Initiative has at least two measures: one population based and one SAMHSA specific. The population-based measures are aspirational and will require broad change in partnership with other systems, levels of government, private organizations, and the American people. The SAMHSA-specific measures are closely tied to SAMHSA-funded programs and provide more immediate targets for the work described in these Initiatives.

Above All, SAMHSA Seeks To Improve the Lives of People

Individuals and families cannot be healthy without positive mental health and freedom from addictions and abuse of substances. Prevention, treatment, and recovery support services for behavioral health are important parts of health service systems and communitywide strategies that work to improve health status and lower costs for individuals, families, businesses, and governments.

Substance abuse, addictions, poor emotional health, and mental illnesses take a toll on individuals, families, and communities. They cost money, and they cost lives, as do physical illnesses that are not prevented, are left untreated, or are poorly managed. Their presence exacerbates the cost of treating co-morbid physical diseases and results in some of the highest disability burdens in the world, compared with other causes of disability.[8] SAMHSA has a unique responsibility to focus the Nation's health and social agendas on these preventable and treatable problems stemming from disease, trauma, inadequate access to appropriate care, and insufficient community and family supports.

SAMHSA's goal is a high-quality, self-directed, satisfying life integrated in a community for all Americans. This life includes:

- **Health**—Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;
- **Home**—A stable and safe place to live that supports recovery;
- **Purpose**—Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society; and
- **Community**—Relationships and social networks that provide support, friendship, love, and hope.

A person's health, home, purpose, and community are compromised when emotional resources are inadequate to contend with adverse events, a mental disorder is left untreated, drugs and alcohol are abused or lead to addictive disorders, families or communities experience trauma, health care is unavailable, or basic needs go unmet. In these circumstances, security and hope are lost. SAMHSA will work to restore hope for individuals, families, and communities by helping service delivery systems prevent and improve these conditions.

SAMHSA's Roles

In order to achieve its mission and vision and improve the lives of people, SAMHSA has many roles:

Providing **Leadership and Voice** by developing policies; convening stakeholders; collaborating with people in recovery and their families, providers, localities, Tribes, Territories, and States; collecting best practices and developing expertise around behavioral health services; advocating for the needs of persons with mental and substance use disorders; and emphasizing the importance of behavioral health in partnership with other agencies, systems, and the public.

Promoting change through **Funding and Service Capacity Development**. Supporting States, Territories, and Tribes to build and improve basic and proven practices and system capacity; helping local governments, providers, communities, coalitions, schools, universities, and peer-run and other organizations to innovate and address emerging issues; building capacity across grantees; and strengthening States', Territories', Tribes', and communities' emergency response to disasters.

Supporting the field with **Information/Communications** by conducting and sharing information from national surveys and surveillance (e.g., National Survey on Drug Use and Health [NSDUH], Drug Abuse Warning Network [DAWN], Drug and Alcohol Service Information System [DASIS]); vetting and sharing information about evidence-based practices (e.g., National Registry of Evidence-based Programs and Practices [NREPP]); using the Web, print, social media, public appearances, and the press to reach the public, providers (e.g., primary, specialty, guilds, peers), and other stakeholders; and listening to and reflecting the voices of people in recovery and their families.

Protecting and promoting behavioral health through **Regulation and Standard Setting** by preventing tobacco sales to minors (Synar Program); administering Federal drug-free workplace and drug-testing programs; overseeing opioid treatment programs and accreditation bodies; informing physicians' office-based opioid treatment prescribing practices; and partnering with other HHS agencies in regulation development and review.

Improving Practice (i.e., community-based, primary care, and specialty care) by holding State, Territorial, and Tribal policy academies; providing technical assistance to States, Territories, Tribes, communities, grantees, providers, practitioners, and stakeholders; convening conferences to disseminate practice information and facilitate communication; providing guidance to the field; developing and disseminating evidence-based practices and successful frameworks for service provision; supporting innovation in evaluation and services research; moving innovations and evidence-based approaches to scale; and cooperating with international partners to identify promising approaches to supporting behavioral health.

Meeting the Needs of a Diverse Nation

SAMHSA will be proactive in targeting its limited resources, setting priorities, and engaging private and public partners at the national, State, Territorial, Tribal, local, and community levels.

SAMHSA acknowledges that American Indian and Alaska Native Tribal governments are sovereign governmental entities that have a unique historical and legal relationship with the Federal Government. SAMHSA will honor that relationship and embrace a government-to-government approach, to the extent allowed by law, in working with Tribal governments. SAMHSA's Tribal activities will be based on early and meaningful consultation, trust, mutual respect, and shared responsibility. SAMHSA will seek guidance from Tribal governments about the Initiatives included in this strategic plan as well as other activities affecting Tribes.

As needed, SAMHSA also will provide Tribal governments and providers with assistance to address issues stemming from entrenched poverty, historical trauma, small or sparse populations, remote locations, lack of capacity, and differing requirements across Federal programs.

Accountability will be maintained while SAMHSA looks for ways to accommodate the unique needs and strengths of American Indians and Alaska Natives. Tribes or Tribal issues are specific foci of several parts of this plan, and broad Tribal participation throughout SAMHSA's programs is expected and encouraged.

As SAMHSA moves forward with these Initiatives, it will address the disparities in access, quality, and outcomes of care for vulnerable populations that historically have been underserved or inappropriately served by the behavioral health system. These groups include racial and ethnic minorities; lesbian, gay, bisexual, transgender, and questioning (LGBTQ[iv]) individuals; women; children; people with disabilities; and persons who face economic hardship or live in health care workforce shortage areas. Across its Initiatives, SAMHSA will encourage behavioral health services and systems to incorporate respect for, and understanding of, the histories, traditions, beliefs, language, sociopolitical contexts, and cultures of diverse racial and ethnic populations. This work will be guided by the leadership of the newly established Office of Behavioral Health Equity within SAMHSA.

A Framework for Managing Change

The Strategic Initiatives have been chosen for a number of reasons. For each Initiative, there are documented concerns, gaps, or problems; identified opportunities for Federal leadership; and available resources and actions to support this leadership. This section outlines three overarching aims that connect the Initiatives with the HHS Strategic Plan: (1) improving the Nation's behavioral health, (2) transforming health care in America, and (3) achieving excellence in operations.

AIM: Improving the Nation's Behavioral Health

In a time of constrained resources, focusing on critical areas of need is more important than ever. Because behavioral health conditions, taken together, are the leading causes of disability burden in North America, efforts to improve their prevention and treatment will benefit society as a whole. To achieve nationwide improvements in health, SAMHSA will lead efforts to reduce the impact of mental and substance use disorders on America's communities. Four Strategic Initiatives address this aim.

Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

The promotion of positive mental health and the prevention of substance abuse and mental illness have been key parts of SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. The evidence base in this area continues to grow and was recently summarized by the 2009 Institute of Medicine (IOM) report, *Preventing Mental*,

[iv] This paper uses two abbreviations: LGBTQ (lesbian, gay, bisexual, transgender, and questioning) and LGBT (lesbian, gay, bisexual, and transgender). LGBTQ refers to broad populations that may include individuals who are questioning their sexual or gender identities. LGBT refers to communities and stakeholder groups that are known to exist. Cohesive questioning communities typically do not exist. Many stakeholder groups do not explicitly include or represent persons questioning their sexual or gender identities.

Emotional, and Behavioral Disorders among Young People. The Affordable Care Act is also putting a heavy focus on prevention and promotion activities at the community, State, Territorial, and Tribal levels. Unfortunately, much of the strong evidence in this area has not been moved into practice, and our Nation lacks a consistent infrastructure for the prevention of substance abuse and mental illness. Through this Initiative, SAMHSA will work to take advantage of the opportunities presented by the Affordable Care Act and the growing evidence base behind prevention.

Goal 1.1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.

Goal 1.2: Prevent or reduce consequences of underage drinking and adult problem drinking.

Goal 1.3: Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives.

Goal 1.4: Reduce prescription drug misuse and abuse.

Strategic Initiative #2: Trauma and Justice

Trauma can occur from a variety of causes, including maltreatment, separation, abuse, criminal victimization, physical and sexual abuse, natural and manmade disasters, war, and sickness. Although some individuals who experience trauma move on with few symptoms, many, especially those who experience repeated or multiple traumas, suffer a variety of negative physical and psychological effects. Trauma exposure has been linked to later substance abuse, mental illness, increased risk of suicide, obesity, heart disease, and early death.

This Initiative has a dual focus. First, it seeks to address the behavioral health impact of trauma by developing a public health approach to trauma that strengthens surveillance, prevention, screening, and treatment and supports trauma-informed systems that better respond to people who have experienced trauma and are less likely to cause trauma through their interventions. Second, the Initiative focuses on the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.

Goal 2.1: Develop a comprehensive public health approach to trauma.

Goal 2.2: Make screening for trauma and early intervention and treatment common practice.

Goal 2.3: Reduce the impact of trauma and violence on children, youth, and families.

Goal 2.4: Address the needs of people with mental disorders, substance use disorders, co-occurring disorders, or a history of trauma in the criminal and juvenile justice systems.

Goal 2.5: Reduce the impact of disasters on the behavioral health of individuals, families, and communities.

Strategic Initiative #3: Military Families

Military families (i.e., active duty, National Guard, Reserve, and veteran) are feeling the strain of frequent deployments; separation; exposure to combat and other dangers, such as military sexual trauma; and health and behavioral health needs. Too frequently, community providers are not equipped or trained to meet the needs of these families. Gaps exist in the care available in communities for military families. Increased coordination is needed between military health care systems and the behavioral health care system. SAMHSA will work with the U.S. Departments of Defense (DoD) and Veterans Affairs, States, Territories, Tribes, and communities to reduce barriers and increase military families' access to culturally competent, trauma-informed services, regardless of where they choose to seek care.

Goal 3.1: Improve military families' access to community-based behavioral health care through coordination among SAMHSA, TRICARE®, DoD, and Veterans Health Administration services.

Goal 3.2: Improve the quality of behavioral health-focused prevention, treatment, and recovery support services by helping providers respond to the needs within the military family culture.

Goal 3.3: Promote the behavioral health of military families with programs and evidence-based practices that support their resilience and emotional health and prevent suicide.

Goal 3.4: Develop an effective and seamless behavioral health service system for military families through coordination of policies and resources across Federal, national, State, Territorial, Tribal, and local organizations.

Strategic Initiative #4: Recovery Support

While coverage expansions under the Affordable Care Act and the Mental Health Parity and Addiction Equality Act will ensure broader coverage and access to traditional behavioral health care, many recovery supports are not covered within the traditional medical framework. A broad range of services and supports beyond traditional treatments for mental and substance use disorders can help people manage their recovery from mental and substance use disorders. Behavioral health care and support should also be more responsive to the needs and direction of people in recovery and their families. The elements of *health, home, purpose,* and *community* are the pillars of person-centered, evidence-based, quality-driven systems and services that support recovery from mental and substance use disorders.

Goal 4.1: (Health) Promote health and recovery-oriented service systems for individuals with or in recovery from mental and substance use disorders.

Goal 4.2: (Home) Ensure that permanent housing and supportive services are available for individuals with or in recovery from mental and substance use disorders.

Goal 4.3: **(Purpose)** Increase gainful employment and educational opportunities for individuals with or in recovery from mental and substance use disorders.

Goal 4.4: (Community) Promote peer support and the social inclusion of individuals with or in recovery from mental and substance use disorders in the community.

AIM: Transforming Health Care in America

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (Affordable Care Act) (P.L. 111–148) into law, transforming and modernizing the Nation's health care system. The Affordable Care Act makes health insurance coverage more secure and reliable for Americans who have it, brings about more affordable coverage, and reduces health care costs. HHS will improve patient outcomes, promote efficiency and accountability, support patient safety, encourage shared responsibility, and work toward a high-value health care system. SAMHSA will ensure that behavioral health is embedded throughout the transformed health care paradigm. Three Initiatives encompass this aim.

Strategic Initiative #5: Health Reform

Health reform will have a dramatic impact on the Nation's behavioral health system. It will increase access to health care, including behavioral health care; grow the country's health and behavioral health workforce; reduce physical and behavioral health disparities experienced by low-income Americans, racial and ethnic minorities, and other underserved populations; and implement programs that draw on the science of behavioral health promotion and of prevention, treatment, and recovery support services. States, Territories, Tribes, primary care and behavioral health providers, and individuals and families will need assistance to understand and participate actively in local health reform efforts. SAMHSA will address this need by providing technical assistance and training to help these groups understand and participate actively in health reform efforts and to move toward the integration of primary and behavioral health care. As part of its integration activities, SAMHSA will address the behavioral health needs of persons with or at risk for HIV/AIDS by implementing recommendations from the President's National HIV/AIDS Strategy.

Goal 5.1: Ensure that behavioral health is included in all aspects of health reform.

Goal 5.2: Support Federal, State, Territorial, and Tribal efforts to develop and implement new provisions under Medicaid and Medicare.

Goal 5.3: Finalize and implement the parity provisions in the Mental Health Parity and Addiction Equity Act and the Affordable Care Act.

Goal 5.4: Develop changes in SAMHSA Block Grants to support recovery and resilience.

Goal 5.5: Foster the integration of primary and behavioral health care.

Strategic Initiative #6: Health Information Technology

Both the American Recovery and Reinvestment Act and the Affordable Care Act are driving health systems toward the use of information technology for service delivery, quality improvement, cost containment, and increased patient control of personal health care and related information. State, Territorial, Tribal, county, and city governments as well as providers and service recipients will need support through this fundamental change in the way that health care is delivered. In the past, the specialty behavioral health system has often operated independently from the broader health system and has differed in the type and scope of information technology used. Through this Initiative, SAMHSA will work to increase access to HIT so that Americans with behavioral health conditions can benefit from these innovations. In partnership with the

Office of the National Coordinator for Health Information Technology (ONC), SAMHSA will drive innovation and the adoption of HIT and EHRs to support the transition of specialty behavioral health to interoperate with primary care by 2014.

Goal 6.1: Develop the infrastructure for interoperable EHRs, including privacy, confidentiality, and data standards.

Goal 6.2: Provide incentives and create tools to facilitate the adoption of HIT and EHRs with behavioral health functionality in general and specialty health care settings.

Goal 6.3: Deliver technical assistance to State HIT leaders, behavioral health and health providers, patients and consumers, and others to increase adoption of EHRs and HIT with behavioral health functionality.

Goal 6.4: Enhance capacity for the exchange and analysis of EHR data to assess quality of care and improve patient outcomes.

AIM: Achieving Excellence in Operations

In addition to internal efforts to invest in its workforce, SAMHSA will build a world-class organization, realign grants and contracts around Strategic Initiatives, improve program integrity, enhance policy development and implementation processes, and increase its presence throughout the United States by moving staff to each of the 10 HHS regional offices. SAMHSA will achieve excellence in operations through the following two Strategic Initiatives:

Strategic Initiative #7: Data, Outcomes, and Quality

Given the resource constraints faced at all levels of government, the need is great to track outcomes, improve the quality of services, and ensure that resources are directed to effective approaches. Both outside and inside of government, there is a demand for increased data. For example, the GPRA Modernization Act of 2010, which amends the Government Performance and Results Act (GPRA) of 1993, requires SAMHSA to report information to HHS on a quarterly basis. In addition, better coordination is needed around data collection and evaluation at multiple levels. Through this Initiative, SAMHSA will track results, improve quality and outcomes for the people it serves, and increase transparency.

Goal 7.1: Implement an integrated approach for SAMHSA's collection, analysis, and use of data.

Goal 7.2: Create common standards for quality of care, outcomes measurement, and data collection to better meet stakeholder needs.

Goal 7.3: Improve the quality of SAMHSA's program evaluations and services research.

Goal 7.4: Improve the quality and accessibility of surveillance, outcome and performance, and evaluation information for staff, stakeholders, funders, and policymakers.

Strategic Initiative #8: Public Awareness and Support

Although acceptance of the importance of behavioral health is greater now than at any time in the past, a great need exists for public awareness around mental and substance use disorders.

Serious gaps exist between the number of people who need treatment for mental and substance use disorders and those who seek that treatment. Attitudes and discrimination toward people with mental and substance use disorders impede their recovery and create barriers to their ability to lead full lives integrated within their communities.

Goal 8.1: Increase public understanding about mental and substance use disorders, the reality that people recover, and how to access treatment and recovery supports for behavioral health conditions.

Goal 8.2: Create a cohesive SAMHSA identity and media presence.

Goal 8.3: Advance SAMHSA's Strategic Initiatives and HHS priorities through strategic communications efforts.

Goal 8.4: Provide information for the behavioral health workforce.

Goal 8.5: Increase social inclusion and reduce discrimination.

2011 and Beyond

This is a living document, and SAMHSA will continue to work with its partners to update and implement these Initiatives as conditions change over time. Undoubtedly, action steps and goals will shift, but the purpose will remain the same. These Strategic Initiatives will provide direction for SAMHSA and the field and ensure that resources are focused where greatest need meets greatest opportunity. Through this dialogue and these actions, SAMHSA will continue to improve the Nation's behavioral health, transform health care in America, and achieve excellence in operations.

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Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

Lead: Fran Harding, Director, Center for Substance Abuse Prevention

Key Facts

- By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.[9]
- Each year, approximately 5,000 youth under the age of 21 die as a result of underage drinking.[10]
- Annually, tobacco use results in more deaths (443,000 per year) than AIDS, unintentional injuries, suicide, homicide, and alcohol and drug abuse combined. Almost half of these deaths occur among people with mental and substance use disorders.[11]
- In 2008, an estimated 2.9 million persons aged 12 and older used an illicit drug for the first time within the past 12 months, an average of 8,000 initiates per day.[12]
- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.[13]
- Adults who began drinking alcohol before age 21 are more likely to be later classified with alcohol dependence or abuse than those who had their first drink at or after age 21.[14]
- More than 34,000 Americans die every year as a result of suicide, approximately one every 15 minutes.[15]
- One estimate puts the total economic costs of mental, emotional, and behavioral disorders among youth in the United States at approximately $247 billion.[16]
- The annual total estimated societal cost of substance abuse in the Unites States is $510.8 billion.[17]
- In 2008, an estimated 9.8 million adults aged 18 and older in the United States had a serious mental illness; 2 million youth aged 12 to 17 had a major depressive episode during the past year.[18]
- In 2009, an estimated 23.5 million Americans aged 12 and older needed treatment for substance use.[19]
- Among persons aged 12 and older who used prescription pain relievers nonmedically in the past 12 months, 55.9 percent got them from a friend or relative for free.[20]
- A range of studies indicate that lesbian, gay, and bisexual adults and youth are much more likely to be smokers than their heterosexual counterparts. [21]
- In 2009, the percentage of female youth aged 12 to 17 (14.3 percent) who were current drinkers was similar to the rate for male youth aged 12 to 17 (15.1 percent).[22]
- In 2009, transition age youth aged 18 to 25 had the highest rates of binge drinking (41.7 percent) and heavy alcohol use (13.7 percent) of any age group.[23]

Overview

Mental and substance use disorders have a powerful effect on the health of individuals and on the Nation's social, economic, and health-related problems. Mental and substance use disorders are among the top conditions for disability, burden of disease, and cost to families, employers, and publicly funded health systems. Excessive alcohol use and illicit drug use are linked directly to increased burden from chronic disease, diabetes, and cardiovascular problems.[24]

Purpose of Initiative #1

Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families.

The Institute of Medicine's (IOM's) 2009 report *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*[25] describes evidence-based services and interventions that build emotional health by addressing risk factors and supporting protective factors and resilience to prevent many mental and substance use disorders in children and young adults. The report documents that behavior and symptoms signaling the likelihood of future behavioral disorders—such as substance abuse, adolescent depression, and conduct disorders—often manifest 2 to 4 years before a disorder is actually present. If communities and families can intervene earlier—before mental and substance use disorders are typically diagnosed, future disorders can be prevented or the symptoms mitigated. Doing so requires multiple and consistent interventions by all systems touching these children and youth (e.g., schools, health systems, faith-based organizations, families, and community programs). Most adult mental and substance use disorders manifest before age 25, and many of the same risk and protective factors affect physical health. The focus on preventing mental health and substance use disorders and related problems among children, adolescents, and young adults is critical to the Nation's behavioral and physical health now and in the future.

The promotion of positive mental health and prevention of mental and substance use disorders are key parts of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission to reduce the impact of substance abuse and mental illnesses on America's communities. The World Health Organization defines health as a "state of complete physical, mental, social well-being, and not merely absence of disease or infirmity." Mental, emotional, and behavioral health refers to the overall psychological well-being of individuals and includes the presence of positive characteristics, such as the ability to manage stress, demonstrate flexibility under changing conditions, and bounce back from adverse situations. SAMHSA plans to promote health by placing a national priority on healthy mental, emotional, and behavioral development, especially in children, youth, and young adults.

Disparities

Significant behavioral health disparities persist in diverse communities across the United States, including racial and ethnic groups; lesbian, gay, bisexual, transgender, and questioning (LGBTQ) individuals; people with disabilities; and girls and transition-age youth. For example, the American Indian/Alaskan Native (AI/AN) communities face elevated levels of substance use

disorders and experience higher suicide rates than the general population. They also have higher rates of certain risk factors for mental, emotional, and behavioral problems, including poverty, domestic violence, childhood and historical trauma, as well as involvement in the foster care and criminal justice systems. Native Hawaiian and Pacific Islander youth have among the highest rates of illicit drug use and underage drinking. African Americans have among the highest unmet needs for treatment of depression and other mental health disorders. The LGBT population has elevated rates of tobacco use. Latina youth are exhibiting the highest rates of suicide attempts[26] and adolescent youth in general are showing an increase in binge drinking. SAMHSA is committed to addressing these disparities by improving prevention programs that serve members of AI/AN communities and other groups. SAMHSA will work with Tribes and other organizations serving these populations to develop culturally focused, universal, selective, and indicated prevention programs.

Health Reform

The passage of the Affordable Care Act has brought increasing commitment to prevention across government and in States, Territories, Tribes, and communities. This commitment means fostering physical and behavioral health and well-being in addition to ensuring access to affordable and effective health care through public- and employer-sponsored health coverage. Now is a perfect opportunity to engage stakeholders and partners—including AI/AN Tribes—to embrace prevention as the top strategic initiative in the behavioral health field.

Behavioral Health Workforce

There is a growing need to develop a behavioral health workforce focused on the prevention of substance abuse and mental illness and the promotion of health and wellness. Identified problems include worker shortages; inadequately and inconsistently trained workers; education and training programs that do not reflect the current research base; inadequate compensation; and high levels of turnover, poorly defined career pathways, and difficulties recruiting people to the field, especially from minority communities. Expanding the role and capacity of the workforce to prevent substance abuse and mental illness and to promote health and wellness is critical to this Strategic Initiative. Through this Initiative, SAMHSA will build capacity for system and service improvements in support of prevention; develop and implement trainings to strengthen the prevention-oriented workforce; educate the field about successful interventions, such as screening, brief intervention, and referral to treatment (SBIRT); and develop and implement training around suicide prevention and prescription drug abuse.

Components of Initiative

SAMHSA's efforts will include programs to assist States, Territories, Tribal governments, and communities to adopt evidence-based practices; deliver health education related to prevention; and establish effective policies, programs, and infrastructure to build resilience and prevent mental and substance use disorders and related problems. By building capacity within States, Territories, and Tribes and supporting the development of Prevention Prepared Communities (PPCs), SAMHSA will promote the emotional health of children and youth, and provide them with skills to overcome risks experienced in adolescence and young adulthood.

SAMHSA will work with States, Territories, and Tribes to support PPCs in using a comprehensive mix of evidence-supported environmental, universal, selective, and indicated prevention strategies to build greater social connectedness and stronger community cohesion, strengthen families in which future generations will live and grow, and develop a healthier and more effective workforce for the future. These approaches will include environmental efforts, such as policy changes to reduce access or change unhealthy social norms, in addition to population-based and individual approaches that bring interventions to individuals according to levels of risk in their environment or individual situation.

SAMHSA also will work to enhance the ability of health systems, schools, families, and other entities to intervene early and consistently in ways that meet the cultural and linguistic needs of diverse populations. In doing so, SAMHSA will build on scientific evidence to create understanding of what works to help young people exhibiting risk factors for mental and substance use disorders and related problems before these conditions become disabling. SAMHSA will restructure multiple prevention programs and activities to focus these resources, enhance collaboration, identify strategic problems, and develop plans for addressing the health and well-being of whole communities.

Public awareness and health education will be an essential part of the overall Prevention Strategic Initiative. Parents, schools, and communities have an intense need for information to help keep their children safe and healthy. For example, problem drinking, including underage drinking, is a serious health and safety issue, but many Americans tolerate and even support it. Some adults, including some parents, mistakenly think that underage drinking is part of growing up and a harmless rite of passage. Problem drinking is not just an issue for young people. Many adults are concerned about their own, their partner's, or their aging parents' use of alcohol. Educating the public about problem drinking and delaying the onset of underage alcohol use can result in better health outcomes for all ages.

The field of prevention science, well known for advancing the health of people at risk for illnesses, such as cancer, diabetes, HIV/AIDS, and heart disease, also has produced effective strategies for behavioral health. Properly implemented, prevention and wellness promotion efforts result in safer communities, better health outcomes, and increased productivity. Preventing and delaying initiation of substance abuse or the onset of mental illness can reduce the potential need for treatment later in life.

SAMHSA's prevention efforts will also address the unique needs of people living with substance abuse and mental illness. People with mental and substance use disorders are two to three times more likely to smoke cigarettes than the general population.[27] This harmful behavior must be prevented. Research shows that ongoing, community-based, comprehensive approaches to preventing specific problems or risk behaviors can achieve these goals.

Goals

Goal 1.1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.

Goal 1.2: Prevent or reduce consequences of underage drinking and adult problem drinking.

Goal 1.3: Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives.

Goal 1.4: Reduce prescription drug misuse and abuse.

Specific Goals, Objectives, and Action Steps

Goal 1.1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.

Objective 1.1.1: Build and develop PPCs.

Action Steps

1. Collaborate with the Office of National Drug Control Policy (ONDCP), U.S. Department of Education (ED), U.S. Department of Justice (DOJ), National Institute on Drug Abuse (NIDA), and National Institute on Alcohol Abuse and Alcoholism (NIAAA) to create and implement PPCs in conjunction with States, Territories, Tribes, and local communities.
2. Promote a data-driven strategic prevention framework for States, Territories, and Tribes and within PPCs that comprises representatives from multiple community sectors, including education, business, justice, housing, health care, and other relevant fields.
3. Work with PPCs to enhance workforce capacity to deliver specialized prevention services and with the broader human services workforce to support prevention and the promotion of social and emotional health.

Objective 1.1.2: Prevent substance abuse and improve well-being in States, Territories, Tribes, and communities across the Nation.

Action Steps

1. Use SAMHSA Block Grant and discretionary funds in conjunction with other Federal prevention programs to build emotional health from early childhood to young adulthood and to implement universal, selective, and indicated prevention activities for mental and substance use disorders among the most vulnerable and impoverished in States, Territories, and Tribes and communities.

2. Work with States, Territories, and Tribes to promote positive behavioral health for children by using age appropriate evidence-based programs as found in the IOM report, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.[28]
3. Provide technical assistance to States, Territories, Tribes, and communities to develop and implement strategic plans to prevent substance abuse and improve mental, emotional, and behavioral health.
4. Develop and implement a workforce development training strategy to strengthen the prevention-oriented workforce, with an emphasis on meeting the needs of diverse communities.
5. Coordinate SAMHSA prevention and promotion efforts with the President's National Prevention, Health Promotion, and Public Health Council.
6. Collaborate with other U.S. Department of Health and Human Services (HHS) agencies, including the Centers for Disease Control and Prevention (CDC), and other Federal partners to prevent fetal alcohol spectrum disorders and their negative consequences.
7. Engage local government leadership and the National Congress of American Indians on how to use behavioral health data in their communities.
8. Support best practice guidelines for health and behavioral health providers to prevent and reduce family rejection of LGBTQ youth problems associated with rejection, such as homelessness, behavioral health disorders, risky sexual behavior, and suicide.
9. Ensure a focus on communities and populations facing behavioral health disparities, especially racial and ethnic minorities, Tribes, and LGBTQ youth.
10. Build on SAMHSA's surveillance resources and work with NIDA to identify the prevalence of current and emerging drugs and develop strategies to prevent their use.

Objective 1.1.3: Eliminate tobacco use among youth and reduce tobacco use among persons with mental and substance use disorders.

Action Steps

1. Promote tobacco cessation efforts among individuals with mental and substance use disorders through formula and Block Grant requirements to States and Territories and grants to targeted provider agencies.
2. Promote integration of State and Territorial Synar efforts with the State enforcement contracts funded by the Food and Drug Administration (FDA).
3. Promote tobacco-free initiatives in mental health, substance abuse treatment, and community-based prevention efforts through SAMHSA's 100 Pioneers for Smoking Cessation Virtual Leadership Academy.
4. Promote tobacco cessation among individuals with mental and substance use disorders and co-existing disabilities through the HHS Tobacco Prevention and Control Working Group (a collaboration with CDC, FDA, National Institutes of Health including the

National Cancer Institute, Centers for Medicare and Medicaid Services [CMS], Indian Health Service [IHS], Administration for Children and Families [ACF), Administration on Aging [AoA], Health Resources and Services Administration [HRSA], and offices within HHS).

5. Create expectation that all SAMHSA grantees maintain a tobacco-free space.
6. Enhance and increase tobacco cessation efforts for LGBTQ individuals with mental and substance use disorders.

Goal 1.2: Prevent or reduce consequences of underage drinking and adult problem drinking.

Objective 1.2.1: Establish the prevention of underage drinking as a priority issue for States, Territories, Tribal entities, colleges and universities, and communities.

Action Steps

1. In collaboration with the Interagency Coordinating Committee on the Prevention of Underage Drinking, develop and implement a strategy to prevent underage drinking, with added emphasis on girls and transition-aged youth.
2. Collaborate with HHS and other Federal partners, including ED, to develop and adopt the HHS Secretary's core underage drinking prevention messages.
3. Through the Sober Truth on Preventing Underage Drinking Act components, enhance intergovernmental cooperation and coordination on the issue of alcohol use among youth and provide communities with timely information about state-of-the-art practices that have proven to be effective.
4. Collaborate with NIAAA and ED to prevent underage drinking and its related negative consequences among college students.
5. Collaborate with NIAAA to provide technical assistance and increase use of screening and brief intervention and improve pathways to treatment and recovery services particularly for girls, Native Hawaiian and Pacific Islander youth, and other groups that have documented high or increasing rates of underage drinking.

Objective 1.2.2: Establish the prevention of excessive drinking by adults as a priority issue for States, Territories, Tribal entities, and communities.

Action Steps

1. In conjunction with CDC and NIAAA, develop and implement a national awareness campaign focused on excessive drinking by adults, with a special focus on populations at higher risk, and coordinate with related efforts like the U.S. Department of Agriculture (USDA) dietary guidelines.

2. Educate physicians, nurses, medical students, social workers, rehabilitation agency staff, peers, peer specialists, and other health care professionals about adult problem drinking and appropriate screening, brief intervention, and referral to treatment interventions.
3. Implement policy academies to assist States, Territories, Tribes, communities, and colleges and universities to implement proven policies and test new policies to reduce excessive drinking by adults.

Goal 1.3: Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives.

Objective 1.3.1: Improve mental, emotional, and behavioral health and well-being among military families, youth, American Indians and Alaska Natives, ethnic minorities including Latina girls, LGBTQ youth, people aged 45 to 65, and people with disabilities.

Action Steps:

1. Educate primary care and behavioral health practitioners, communities, schools, and the public about the risk and protective factors that contribute to emotional health and the ability to manage adverse life events.
2. Tailor educational materials to address the perspectives of military audiences.
3. Collaborate with the U.S. Department of Veterans Affairs (VA), U.S. Department of Defense (DoD), and other Federal agencies around this objective.
4. Develop and encourage culturally specific programs that promote strong sense of self and appropriate help-seeking among African American, American Indian and Alaska Native, Asian American, Native Hawaiian and Other Pacific Islander, Hispanic, and LGBTQ youth.
5. Support suicide prevention programming for high-risk populations through SAMHSA formula and Block Grant funds and other prevention programs and engage States, Territories, and Tribes in developing suicide prevention plans.

Objective 1.3.2: Increase public knowledge of the warning signs for suicide and actions to take in response.

Action Steps:

1. Convene the National Action Alliance for Suicide Prevention together with SAMHSA's Federal Partners for Suicide Prevention to update and implement the National Strategy To Prevent Suicide.

2. Ensure the National Suicide Prevention Lifeline program is adequately resourced and increase the visibility and accessibility of suicide prevention services in partnership with States, Territories, Tribal entities, communities, rehabilitation agencies, private and public health care providers, representatives of secondary and higher education, and military, faith-based, and LGBT organizations.
3. Increase access to suicide prevention resources by collaborating with behavioral health, educational, faith-based, military, and LGBT organizations.
4. Implement and develop a strategic plan to educate parents, health practitioners, school officials, community leaders, youth, State, Territorial, and Tribal leaders, first responders, employers, faith-based organizations, LGBT organizations, and the public about suicide warning signs that are specific to different cultures and communities, and preventive actions they can take to help someone contemplating a suicide.
5. Develop and implement a workforce development training strategy to familiarize providers, educators, clergy, and others with the varying warning signs and methods of suicide specific to different communities and cultures.
6. Increase awareness of suicide prevention and the suicide hotline among populations at higher risk for suicide identified by the National Action Alliance for Suicide Prevention, including LGBTQ youth, American Indians and Alaska Natives (AIs/ANs), and military veterans.

Objective 1.3.3: Increase the use and effectiveness of the Veterans Suicide Prevention Hotline/Lifeline.

Action Steps:

1. Collaborate with States, Territories, and Tribal entities, VA, and DoD—including collaboration with the VA National Suicide Prevention Coordinator, VA Center of Excellence for Suicide Prevention, and DoD Center for Excellence on Psychological Health—to improve access to and quality of suicide prevention resources for former and current members of the military and their families.
2. Educate and conduct outreach activities to military families to increase awareness and use of the Suicide Prevention Hotline/Lifeline through an interagency agreement and partnership with VA.
3. Given the disproportionate number of racial minorities and AIs/ANs in the military, ensure access and culturally appropriate outreach to these communities about the Veterans Suicide Prevention Hotline.

Goal 1.4: Reduce prescription drug misuse and abuse.

Objective 1.4.1: Educate current and future prescribers regarding appropriate prescribing practices for pain and other medications subject to abuse and misuse.

Action Steps:

1. Collaborate with NIAAA, NIDA, NIMH, Agency for Healthcare Research and Quality (AHRQ), VA, DoD, FDA, and the HHS Behavioral Health Coordinating Council as well as intermediary professional organizations to build upon and develop resources for prescribers specific to pain and other medications subject to abuse and misuse.
2. Collaborate with the NIDA, ED, VA, DoD, FDA, Bureau of Justice Affairs, other Federal agencies, and the HHS Behavioral Health Coordinating Council, as well as intermediary professional organizations to incorporate information about warning signs and consequences of prescription drug abuse, strategies for patient referral, and the critical need for appropriate prescribing practices into curricula for medical professionals.

Objective 1.4.2: Educate the public about the appropriate use of opioid pain medications, and encourage the safe and consistent collection and disposal of unused prescription drugs.

Action Steps:

1. In collaboration with NIDA, CMS, FDA, CDC, HRSA, and other Federal agencies as appropriate, build upon SAMHSA's national prescription drug abuse public education campaign, targeting consumers about proper disposal of unused prescription drugs and how to keep prescription drugs securely out of reach from unintended users.
2. In collaboration with FDA, ONDCP, Drug Enforcement Administration, and other Federal, State, Territorial, Tribal, and local partners, support planning and implementation of "turn in your drugs" campaigns and the national and local levels.

Objective 1.4.3: Support the establishment of State/Territory-administered controlled substance monitoring systems and develop a set of best practices to guide the establishment of new State and Territorial programs and the improvement of existing programs.

Action Steps

1. Build on the SAMHSA National All Schedules Prescription Electronic Reporting Act Program Grants and other Prescription Drug Monitoring systems to incorporate key elements into community, medical, and behavioral health services provider systems to identify and prevent prescription drugs, especially opioids, from being inappropriately prescribed to individuals who may be "doctor shopping" or with a known risk for suicide.

2. Collaborate with FDA and other Federal agencies as appropriate to expand the utility of prescription drug monitoring programs, allowing more States and Territories to share information internally and regionally with neighboring States and Territories.
3. Collaborate with FDA and other Federal agencies as appropriate to develop a set of best practices for States and Territories as they establish or enhance their prescription drug monitoring programs**.**
4. Collaborate with DOJ and other Federal agencies to foster development and adoption of common technology standards for the interstate sharing of prescription monitoring data as well as coordinate complementary grant-funding programs for State prescription monitoring programs.
5. Promote safer, healthier, and more productive workplaces through the Federal Drug-Free Workplace Program, the National Laboratory Certification Program, and other comprehensive drug-free and health and wellness workplace programs.

Strategic Initiative #1 Measures

Population-Based

- Reduce the percentage of children and youth aged 12 to 20 reporting past 30-day substance use (including improper use of prescription drugs).
- Decrease the percentage of children and youth aged 12 to 17 reporting a major depressive episode in the past year.

SAMHSA Specific

- Reduce the percentage of children and youth aged 12 to 20 receiving services through SAMHSA grants reporting past 30-day substance use (including improper use of prescription drugs).
- Increase the number of individuals calling the Suicide Hotline who report receiving followup services within 30 days.

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Strategic Initiative #2: Trauma and Justice

Lead: Larke Huang, Director, Office of Behavioral Health Equity

Key Facts

- Trauma is strongly associated with mental and substance use disorders.[29, 30]
- More than 6 in 10 U.S. youth have been exposed to violence within the past year, including witnessing a violent act, assault with a weapon, sexual victimization, child maltreatment, and dating violence. Nearly 1 in 10 was injured.[31]
- An estimated 772,000 children were victims of maltreatment in 2008.[32]
- Adverse childhood experiences (e.g., physical, emotional, and sexual abuse; and family dysfunction) are associated with mental illness, suicidality, and substance abuse.[33]
- A lifetime history of sexual abuse among women in childhood or adulthood ranges from 15 to 25 percent. The prevalence of domestic violence among women in the United States ranges from 9 to 44 percent, depending on definitions.[34]
- The cost of intimate partner violence, which disproportionately affects women and girls, was estimated to be $8.3 billion in 2003. This total includes the costs of medical care, mental health services, and lost productivity.[35]
- In a 2008 study by RAND, 18.5 percent of returning veterans reported symptoms consistent with post traumatic stress disorder (PTSD) or depression.[36]
- More than half of all prison and jail inmates (people in State and Federal prisons and local jails) meet criteria for having mental health problems, 6 in 10 meet criteria for a substance use problem, and more than a third meet criteria for having both a substance abuse and mental health problem.[37]
- The use of seclusion and restraint on persons with mental and substance use disorders has resulted in deaths and serious physical injury and psychological trauma. In 1998, the Harvard Center for Risk Analysis estimated deaths due to such practices at 150 per year across the Nation.[38]
- Racial incidents can be traumatic and have been linked to PTSD symptoms among people of color.[39]
- Evidence suggests that some communities of color have higher rates of PTSD than the general population.[40,41]
- LGBT individuals experience violence and PTSD at higher rates than the general population.[42]
- 18.9 percent of men and 15.2 percent of women in the United States reported a lifetime experience of a natural disaster.[43]
- In 2008, an estimated 4.8 percent of American males under the age of 18 experienced sexual victimization in the past year, and an estimated 7.5 percent experienced sexual victimization in their lifetime.[44]

Overview

Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people receiving treatment for mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

Purpose of Initiative #2

Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.

The effects of trauma place a heavy burden on individuals, families, and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationship among traumatic events, impaired neurodevelopmental and immune system responses, and subsequent health risk behaviors resulting in chronic physical and behavioral disorders. In fact, the chronic stress that often accompanies repeated or unresolved trauma has even been linked to physically observable negative changes in brain development, including a reduction in the size of the hippocampus,[45] the portion of the brain associated with long-term memory and spatial reasoning. With appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders, chronic physical diseases, and early death.[46]

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Preventing exposure to traumatic events and responding with early interventions and treatment for those experiencing traumatic stress may improve outcomes for these individuals and prevent prolonged involvement with the justice and child welfare systems.

High-Risk Groups and Disparities

Although much of the focus on trauma is on individuals, some communities experience historical trauma that is transmitted from one generation to the next. For example, African Americans and American Indians and Alaska Natives have suffered historical losses of land and identity and assaults on their culture and way of life that result in intergenerational trauma. The connection between historical trauma and the undermining of the economic and social fabric of the community with associated behavioral health problems and high-risk behaviors is well documented.[47]

Another growing community exposed to trauma is military service members, veterans, and their families. Dealing with the losses, fears, and injuries associated with two ongoing wars, military families with trauma-associated symptoms and disorders are increasingly coming to the attention of behavioral health providers. Repeated deployments, relocations, military sexual trauma, and serious injuries exert an emotional toll on military personnel, their families, and their communities.

In recent years, manmade and natural disasters—such as terrorist attacks, hurricanes, floods, oil spills, and mass shootings—have received national attention as causes of death, physical injury, environmental damage, economic hardship, and emotional trauma. Research indicates that these disasters and their aftermath are likely to have an impact on the exposed population's behavioral health, resulting in an increase in mental and substance use disorders, along with a decline in perceived quality of life. With appropriate and early behavioral health services, trauma experienced by survivors of disasters can be mitigated and deleterious effects prevented.

Pertinent to the justice component of this Strategic Initiative, significant disparities exist in pathways to the criminal and juvenile justice system with disproportionate representation among communities of color. Among youth and adults, African Americans, Latinos, and American Indians are more likely to have involvement with the justice systems and often when presenting with mental or addiction disorders end up in the justice system rather than the behavioral health care system.

Health Reform

Coverage expansions included in the Affordable Care Act will mean that individuals reentering communities from jails and prisons, who generally have not had health coverage in the past, will soon have that coverage. Given that members of this population experience comparatively high rates of mental and substance use disorders, an opportunity exists to coordinate new health coverage with other efforts to facilitate a successful transition back into the community. Addressing their behavioral health needs can reduce their chances of recidivism: improving the safety of America's communities, reducing expenditures in the criminal justice system, and improving outcomes and lives for reentering individuals. SAMHSA will collaborate with partners in the Office of Justice Programs within the U.S. Department of Justice (DOJ) to develop standards and improve coordination around these coverage expansions.

The Affordable Care Act also presents opportunities to improve outcomes related to trauma. New home visiting funding will support a range of programs that have been proven effective in reducing traumatic events such as child maltreatment. In addition, coverage expansions through health reform will mean that more individuals have access to treatment for psychological trauma. Through this Initiative, SAMHSA will work with Federal, State, Territorial, Tribal, and local partners to improve practices around the prevention and treatment of trauma.

Behavioral Health Workforce

The current behavioral health workforce will require training on the role of trauma in people's lives, the centrality of trauma to behavioral health disorders, trauma-specific interventions, and strategies to build trauma-informed systems. Practitioners and systems will need to have a better

understanding of how their policies, practices, and behaviors can promote healing and recovery or be secondarily traumatizing to people who are in their care. The action steps in this Strategic Initiative are built around technical assistance and training strategies to develop practitioners skilled in trauma and trauma-related work and systems that have the capacity to prevent, identify, intervene and effectively treat people in a trauma-informed approach.

Significant workforce needs are related to behavioral health in the criminal justice system. Police and other first responders need training to respond appropriately and safely to people with mental and substance use disorders in crisis. Judges and other court officials need education and support to develop successful specialty court and diversion programs for people with mental and substance use disorders. This Initiative will support education and program development in these areas.

Strategic Public Health Approach

Addressing individual, family, and community trauma requires a comprehensive, multiprong public health approach. This approach includes:

- Increasing awareness of the harmful short- and long-term effects of trauma experiences in children and adults;
- Developing and implementing effective preventive, treatment, and recovery and resiliency support services that reflect the needs of diverse populations;
- Building strong partnerships and networks to facilitate knowledge exchange and systems development;
- Providing training and tools to help systems identify trauma and intervene early; and
- Informing public policy that supports and guides these efforts.

SAMHSA is one of the leading agencies addressing the impact of trauma on individuals, families, and communities. SAMHSA has made contributions in key areas through a series of significant initiatives over the past decade. These contributions include the development and promotion of trauma-specific interventions, the expansion of trauma-informed care, and the consideration of trauma and its behavioral health effects across health and social service delivery systems.

SAMHSA provides consultation and education to develop trauma-informed environments in publicly funded programs. Trauma-informed, developmentally appropriate, gender-specific care represents a new paradigm of service delivery. It recognizes that every aspect of the service system—organization, management, and staff—must have a basic understanding of how trauma and gender affect a person needing treatment for a mental or substance use disorder. Trauma-informed, gender-specific services are based on an understanding of the vulnerabilities and triggers of trauma survivors, which may differ for women and men and may be exacerbated in traditional behavioral health care, leading to retraumatization.

SAMHSA's work on preventing and reducing the use of seclusion and restraint in treatment settings also has led to major changes in the cultures of treatment environments. As a result of

the Alternatives to Restraint and Seclusion State grants, mental health facilities successfully eliminated or reduced the use of coercive and retraumatizing practices; improved the safety and morale of clients and staff; and facilitated resilience, recovery, and consumer self-directed care.

These changes are not limited to behavioral health care. Jails, forensic treatment settings, and courts have implemented trauma-informed care and, in some cases, have seen reductions in recidivism, fewer staff injuries, and improved adherence to treatment and involvement in care. Child welfare systems may also benefit from a trauma-informed approach.

Components of Initiative

A better understanding of the needs of trauma survivors has emerged over the past decade. Behavioral health providers have implemented trauma-specific services to directly address the impact of trauma on people's lives. They have also created service settings that are trauma informed—an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

The mission of this Initiative has two related parts: (1) to create trauma-informed systems to implement prevention and treatment interventions to reduce the incidence of trauma and its impact on the behavioral health of individuals and communities and (2) to better address the needs of persons with mental and substance use disorders in the criminal justice system.

Goals

Goal 2.1: Develop a comprehensive public health approach to trauma.

Goal 2.2: Make screening for trauma and early intervention and treatment common practice.

Goal 2.3: Reduce the impact of trauma and violence on children, youth, and families.

Goal 2.4: Address the needs of people with mental disorders, substance use disorders, co-occurring disorders, or a history of trauma in the criminal and juvenile justice systems.

Goal 2.5: Reduce the impact of disasters on the behavioral health of individuals, families, and communities.

Goal 2.1: Develop a comprehensive public health approach to trauma.

Objective 2.1.1: Create a surveillance strategy for trauma and its association with mental and substance use disorders.

Action Steps:

1. Develop a standard definition and culturally competent measures of individual and community trauma to be included in individual assessments and community and national surveillance systems through a partnership with national organizations, and trauma research experts and providers.

2. Incorporate these trauma measures (including exposure and symptoms) into surveillance systems, treatment and facility surveys, and performance measures for SAMHSA grant programs.
3. Coordinate with SAMHSA's State, Territorial, and community epidemiologic work groups to include culturally appropriate trauma measures.
4. Develop criteria and measures for trauma-informed care that can be used with a range of health and human service programs and collaborate with the Centers for Disease Control and Prevention (CDC) and other Federal agencies to incorporate them into surveillance systems.

Objective 2.1.2: Build the public's awareness of the impact of trauma on health and behavioral health.

Action Steps:

1. Develop an easy-to-understand list of the warning signs of early trauma and how to take action.
2. Develop and implement a national campaign on trauma and its association with health and behavioral health. Include targeted work with Tribes, Asian Americans and Pacific Islanders, African Americans, Hispanic, and immigrant and refugee communities.
3. Collaborate with other U.S. Department of Health and Human Services (HHS) Operating Divisions and other Federal partners to adopt trauma prevention and awareness messages and coordinate communications related to trauma.
4. Collaborate with the Indian Health Service and Tribal communities to develop a specific information and awareness campaign on trauma and its sequelae (e.g., suicide) for American Indians and Alaska Natives.
5. Collaborate with the National Network to Eliminate Disparities in Behavioral Health to develop and disseminate culturally relevant trauma information and materials to the diverse racial, ethnic, and LGBT communities in this Network.
6. Work with the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care to integrate trauma assessment and information into primary care.

Objective 2.1.3: Build a trauma-informed behavioral health system.

Action Steps:

1. Coordinate the work of the National Child Traumatic Stress Network (NCTSN), National Center for Trauma-Informed Care (NCTIC), and Disaster Technical Assistance Center (DTAC) to provide training and technical assistance on trauma and trauma-informed care and focus on population groups vulnerable to health disparities and with poor access to trauma-informed care.

2. Engage trauma survivors; service providers; researchers; SAMHSA grantees and technical assistance providers; Federal, State, Territorial, and Tribal partners; related service areas, such as domestic violence services; and stakeholders from the behavioral health field to develop and implement a culturally competent national strategy for trauma-informed care.
3. Create core competencies for direct service professionals for screening, assessing, and treating trauma among diverse populations. Create core competencies for administrators and managers for creating trauma-informed therapeutic environments. Highlight the relationship between violence, trauma, and behavioral health issues.
4. Conduct trainings on trauma-informed care and alternatives to seclusion and restraint for behavioral health facilities in collaboration with HHS regional areas and SAMHSA regional staff, Addiction Technology Transfer Centers (ATTCs), the Center for the Application of Prevention Technologies (CAPT), and other technical assistance centers.
5. Create a comprehensive training strategy to develop a workforce trained in trauma care that is representative of diverse populations, using existing SAMHSA mechanisms, such as the ATTCs, CAPT, NCTSN, DTAC, National Center on Substance Abuse and Child Welfare, and the National Network to Eliminate Disparities in Behavioral Health.
6. Provide culturally informed training on trauma and trauma-informed care to SAMHSA staff and grantees.

Goal 2.2: Make screening for trauma and early intervention and treatment common practice.

Objective 2.2.1: Identify effective screening tools for trauma based on developmental age, nature of trauma exposure, culture, and service context.

Action Steps:

1. Develop an annotated compendium of screening tools for trauma, a statement of principles, and guidance and standard protocols for trauma screening in various settings that are relevant for different cultural contexts.
2. Develop a service research project to incorporate trauma screening tools into standard practice in diverse settings (e.g., health centers, emergency departments, behavioral health, child welfare, criminal and juvenile justice, behavioral health, and military) for diverse populations.
3. Ensure that trauma prevention, screening, and treatment are addressed in block grant training and programs.

Objective 2.2.2: Develop a continuum of interventions that are appropriate to the severity of trauma and that are included in benefits and services addressed in health reform.

Action Steps:

1. Convene a technical expert work group that includes trauma survivors, providers, researchers, and intervention developers to identify gaps in the continuum of trauma interventions (e.g., early identification, brief interventions, and ethnic and gender-specific interventions), and develop a strategy to fill these gaps.
2. Develop service definitions and identify payment strategies aligned with the Affordable Care Act's implementation and other funding streams to increase public awareness about trauma community wide, provide screening and early intervention in multiple settings, and implement evidence-based trauma interventions. Collaborate with the Centers for Medicare and Medicare Services (CMS) and other insurers to identify which professionals and screening tools will be reimbursable.

Goal 2.3: Reduce the impact of trauma and violence on children, youth, and families.

Objective 2.3.1: Increase the use of programs and interventions that have been shown to prevent the behavioral health impacts (including trauma) of maltreatment and interpersonal and community violence in child-serving settings.

Action Steps:

1. Reduce exposure to violence and risk factors for trauma through SAMHSA prevention programs for child-serving settings and their communities (e.g., Project LAUNCH, Safe Schools/Healthy Students, suicide prevention programs, SAMHSA formula and Block Grants, and Drug Free Communities).
2. Seek input from culturally diverse and vulnerable youth populations in the development, implementation, and dissemination of all prevention efforts related to trauma.
3. Partner with the Administration for Children and Families (ACF), CDC, and State, Territorial, Tribal, and local child welfare agencies to increase the reach of trauma prevention and treatment programs for child welfare, and foster care settings through a shared funding opportunity to implement trauma treatments and trauma-informed systems work.
4. In the above action steps, ensure a focus on children of color who are disproportionately represented in out-of-home care in the child welfare system.

5. Create a topline multidepartment collaborative stopbullying.gov Web site that integrates multiagency content from HRSA's StopBullyingNow and SAMHSA's BullyingSolutions (BETA) sites with the information on bullyinginfo.org/ findyouthinfo.gov with a focus on particularly vulnerable populations such as LGBTQ youth.

Objective 2.3.2: Support programs to address trauma experienced in childhood and its subsequent impact across the life span.

Action Steps:

1. Develop a dissemination, training, and technical assistance strategy using the SAMHSA trauma centers to move established trauma-focused interventions beyond specific grantees and more broadly into child-serving systems. Through this strategy, identify and address barriers to access for trauma-specific treatments. Ensure that this strategy is inclusive of diverse racial, ethnic, socioeconomic, and LGBT communities.
2. Continue to improve behavioral health care for children and families in child welfare by testing specialized and culturally appropriate trauma treatments (including early intervention) in child welfare settings, and coordination with the Administration on Children, Youth and Families (ACYF) programs to support learning collaboratives focused on trauma in child welfare.
3. Collaborate with the HHS/Assistant Secretary for Planning and Evaluation-led Interagency Work Group on Youth Programs that includes Office of National Drug Control Policy (ONDCP), HHS agencies (ACF, CDC, HRSA, Indian Health Service [IHS], and SAMHSA), and the U.S. Departments of Education (ED), Defense (DoD), Agriculture (USDA), Interior (DOI), Justice (DOJ), Labor (DOL), Housing and Urban Development (HUD), and Transportation to develop informational materials for the shared FindYouthInfo Web site that can be used by these agencies to promote understanding of the impact of trauma and the importance of intervening early and increasing access to trauma interventions and trauma-informed care in child serving settings, such as pediatric care, home visiting, early childhood systems (Early Head Start and Head Start), schools, and in child welfare, juvenile justice, and public housing programs.
4. Collaborate with ED to create and disseminate behavioral health materials related to bullying and its traumatic effects on school-age youth and sense of safety in schools.
5. Work with the DOJ Office of Justice Programs (OJP) Children Exposed to Violence Initiative by linking these OJP grantees with evidence-based interventions, informational toolkits and materials, and experts and potential training opportunities from the National Child Traumatic Stress Network.
6. Engage the Office of the Assistant Secretary for Planning and Evaluation and the ACYF related to trauma interventions for children of incarcerated parents.

Objective 2.3.3: Improve policies to address the impact of trauma on children.

Action Steps:

1. Ensure that SAMHSA-funded programs (discretionary and Block Grant) address trauma prevention and treatment for children, youth, and families.
2. Collaborate with other programs and child-serving systems, such as Home Visiting Programs at HRSA and Child Abuse Prevention and Child Welfare programs at ACF, to strengthen policy directives and program goals to include a trauma-informed approach.
3. Develop financing models to support trauma efforts that include family-centered, multigenerational interventions and prevention efforts.
4. Ensure that SAMHSA-funded programs address the culture-specific trauma prevention, treatment, and recovery for children in low-resourced, racial, and ethnic minority communities.

Goal 2.4: Address the needs of people with mental disorders, substance use disorders, co-occurring disorders, or a history of trauma in the criminal and juvenile justice systems.

Objective 2.4.1: Expand alternative responses and diversion for people with behavioral health problems and trauma histories within the criminal and juvenile justice system.

Action Steps:

1. Work with the DOJ Bureau of Justice Affairs (BJA), Office of Juvenile Justice and Delinquency Prevention, and OJP as well as constituency groups to develop new approaches to address mental and substance use disorders through courts and diversion initiatives that maximize flexibility for communities and serve more individuals with mental illnesses and substance use disorders that come into contact with the criminal or juvenile justice systems.
2. Support State, Territorial, and Tribal planning efforts so that substance abuse, mental health, and criminal justice planning is coordinated, including involvement of State, Territorial, and Tribal behavioral health agencies in justice-related grant solicitations.
3. Work with the OJP to provide training and tools for adult and juvenile court officials about behavioral health and related community and population specific issues in partnership with OJP, National Institute on Drug Abuse (NIDA), National Institute of Mental Health (NIMH), and the National Judicial College.
4. Support training for State and local rehabilitation counselors, HUD housing authority staff, and parent foster care support agencies about behavioral health, trauma, and the community context of crime to inform early intervention and improved outcomes for transition age youth with mental and substance use disorders.

5. Work with BJA/OJP, expert consultants, mental health court judges and key stakeholders to establish broad parameters for mental health courts and/or behavioral health courts and court collaboratives.

Objective 2.4.2: Improve the ability of first responders to respond appropriately to people with mental and substance use problems and histories of trauma.

Action Steps:

1. Partner with criminal justice, law enforcement, and related groups (e.g., International Association of Chiefs of Police, Associations of Sheriffs, OJP, and the National Association of Drug Court Professionals) to expand the use of culturally appropriate crisis intervention training and pre booking diversion for people with behavioral health problems and histories of trauma.
2. Provide culturally appropriate technical assistance and training tools, such as Web-based training, toolkits, and training of trainers, to improve first-responder preparedness for intervening with people with behavioral health crises and histories of trauma.

Objective 2.4.3: Improve the availability of trauma-informed care, screening, and treatment in criminal and juvenile justice systems.

Action Steps:

1. Provide culturally appropriate training and technical assistance on trauma-informed care and trauma specific interventions through partnerships with criminal and juvenile justice organizations, associations, and agencies, with a focus on returning veterans.
2. Incorporate trauma-informed and culturally appropriate principles and practices, such as multiple-point screening starting with entry into the justice system, into all criminal justice-based SAMHSA grants.
3. Collaborate with the Racial and Ethnic Disparities Issue Team of the Coordinating Council on Juvenile Justice and Delinquency Prevention to identify areas in which behavioral health issues contribute to disproportionate minority contact (especially among Hispanic/Latino, African American, and LGBTQ youth) and use SAMHSA's current grant portfolio to support services to reduce disproportionate minority involvement in the justice system.

Objective 2.4.4: Improve coordination of behavioral health services for persons reentering the community from jail or prison.

Action Steps:

1. In collaboration with BJA and the Council for State Governments Justice Center, convene the American State Corrections Association, National Association of State Alcohol and Drug Abuse Directors (NASADAD) and National Association of State

Mental Health Program Directors (NASMHPD) to jointly develop and provide training on standards of care for reentry.

2. Adapt and implement the models to facilitate enrollment in health insurance and other benefits for individuals with, at risk for or in recovery from, mental and substance use disorders who are transitioning out of jails and prisons, with a focus on preparing for the coverage expansions coming under the affordable care act.
3. Convene a reentry policy academy for States to develop policies that improve outcomes for individuals transitioning to the community from jails or prisons.

Goal 2.5: Reduce the impact of disasters on the behavioral health of individuals, families, and communities.

Objective 2.5.1: Ensure that behavioral health is a core element of Federal, State, Territorial, Tribal, and local disaster response policies and practices.

Action Steps:

1. Examine the recommendations of the National Biodefense Science Board Disaster Mental Health Subcommittee to identify areas requiring development in research, policies, and practice across the three phases of disaster (preparedness, response, and recovery).
2. Develop a white paper that addresses the role of behavioral health in effective disaster response and recovery.
3. Develop a strategy to ensure that behavioral health surveillance systems are in place before, immediately after, and in the recovery phase following a disaster.
4. Engage the State and Territorial Disaster Mental Health Coordinators, disaster response organizations, and agencies to share training materials and resources with local disaster response personnel to prevent secondary trauma.
5. Ensure that disaster plans address how to maintain continuity of behavioral health care for persons with mental and substance use disorders who are displaced by disasters, including those most vulnerable to disrupted services, such as diverse racial, ethnic, and linguistic populations.

Objective 2.5.2: Build public awareness to ensure an appropriate behavioral health response in communities that experience disasters.

Action Steps:

1. Emphasize stress management and resilience-building communications that make the link between traumatic events and health and behavioral health in public awareness materials.
2. Ensure that lessons learned from the Federal Emergency Management Agency/SAMHSA Crisis Counseling Program are shared broadly.

3. Take an affirmative role in response to disasters to provide leadership and information about related behavioral health issues.

Objective 2.5.3: Enhance the approach to disasters across the three phases (preparedness, response, and recovery).

Action Steps:

1. Following a disaster, connect communities to the national disaster behavioral health hotline after they experience disasters through DTAC, the Crisis Counseling Program (CCP), and SAMHSA communications efforts.
2. Move lessons learned from the Institute of Medicine committee white paper prepared for the Institute of Medicine Forum on Medical and Public Health Preparedness for Catastrophic Events into appropriate SAMHSA programs, such as CCP, and address the distinct needs of individuals from diverse racial and ethnic communities.

Strategic Initiative #2 Measures

Population-Based

- Decrease the percentage of individuals with mental and substance use disorders involved in the criminal justice system.
- Increase the percentage of substance abuse and mental health treatment facilities reporting that they screen for trauma and stress.

SAMHSA Specific

- Improve behavioral health outcomes for individuals engaged in SAMHSA-supported service programs who are in contact with the criminal and juvenile justice systems.
- Increase the percentage of individuals served through the National Child Traumatic Stress Network who show improved outcomes.

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Strategic Initiative #3: Military Families

Lead: Kathryn Power, Director, Center for Mental Health Services

Key Facts

- Approximately 18.5 percent of service members returning from Iraq or Afghanistan have post traumatic stress disorder (PTSD) or depression, and 19.5 percent report experiencing a traumatic brain injury (TBI) during deployment.[48]
- Approximately 50 percent of returning service members who need treatment for mental health conditions seek it, but only slightly more than half who receive treatment receive adequate care.[49]
- The Army suicide rate reached an all-time high in June 2010.[50]
- In the 5 years from 2005 to 2009, more than 1,100 members of the Armed Forces took their own lives, an average of 1 suicide every 36 hours.[51]
- In 2010, the Army's suicide rate among active-duty soldiers dropped slightly (162 in 2009; 156 in 2010), but the number of suicides in the National Guard and Reserve increased by 55 percent (80 in 2009; 145 in 2010).[52]
- More than half of the Army National Guard members who killed themselves in 2010 had never deployed.[53]
- In 2007, 8 percent of soldiers in Afghanistan reported using alcohol during deployment, and 1.4 percent reported using illegal drugs/substances.[54]
- Between 2004 and 2006, 7.1 percent of U.S. veterans met the criteria for a substance use disorder.[55]
- Mental and substance use disorders caused more hospitalizations among U.S. troops in 2009 than any other cause.[56]
- According to an assessment by the Departments of Housing and Urban Development (HUD) and Veterans Affairs (VA), nearly 76,000 veterans were homeless on a given night in 2009. Some 136,000 veterans spent at least one night in a shelter during that year.[57]
- Cumulative lengths of deployments are associated with more emotional difficulties among military children and more mental health diagnoses among U.S. Army wives.[58, 59]
- Children of deployed military personnel have more school-, family-, and peer-related emotional difficulties, compared with national samples.[60]

Overview

There are an estimated 23.4 million veterans in the United States[61] as well as approximately 2.2 million military service members (including National Guard and Reserve)[62] and 3.1 million immediate family members.[v] Since September 11, more than 2 million U.S. troops have been deployed to Iraq and Afghanistan.[63] A significant proportion of returning service men and women suffer from PTSD, depression, TBI, and substance abuse (particularly alcohol and prescription drug abuse); too many die from suicide. A growing body of research exists on the impact of deployment and trauma-related stress on military families, particularly wives and children. Military service is likely to affect other family members as well, including parents of service members and others who may provide supports such as child care during deployments and other service-related disruptions. Although active duty troops and their families are eligible for care from the U.S. Department of Defense (DoD), a significant number choose not to access those services due to fear of discrimination or the harm receiving treatment for behavioral health issues may have on their military career or that of their spouse. National Guard and Reserve troops who have served in Iraq and Afghanistan (approximately 40 percent of the total) are eligible for behavioral health care services from the VA, but many are unable or unwilling to access those services. National Guard, Reserve, veterans, and active duty service members as well as their families do seek care in communities across this country, particularly from State, Territorial, Tribal, local, and private behavioral health care systems, often with employer-sponsored coverage.

Purpose of Initiative #3

Supporting America's service men and women—Active Duty, National Guard, Reserve, and Veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.

This Initiative focuses on improving the behavioral health of the Nation's military service members, veterans, and their families, including relatives, caregivers, and significant others. As the Federal Agency with the mission to reduce the impact of mental illnesses and substance abuse on America's communities, the Substance Abuse and Mental Health Services Administration (SAMHSA) will provide support and leadership through a collaborative and comprehensive approach to increase access to appropriate services, prevent suicide, promote emotional health, and reduce homelessness. SAMHSA will facilitate innovative community-based solutions that foster access to evidence-based prevention, treatment, and recovery support services for military service members, veterans, and their families at risk for or experiencing mental and substance use disorders through the provision of state-of-the-art technical assistance, consultation, and training.

The President has identified military families as a key priority for the Nation. In May 2010, First Lady Michelle Obama, along with Dr. Jill Biden, rolled out a national Call to Action for military families to focus on three broad areas: (1) addressing the unique challenges facing military families, (2) building stronger civilian-military community ties, and (3) engaging and

[v] This number includes spouses, children, and adult dependents, but not other groups, such as parents or siblings, that can also considered part of a military family.

highlighting the service and sacrifice of military families. SAMHSA is well positioned to support all three and will work with States, Territories, Tribes, and communities to ensure that needed behavioral health services are accessible to America's service men and women and their families and that outcomes are successful.

Disparities

Minority populations are heavily represented in the military and in the enlisted ranks of the military services. Meeting the behavioral health needs of these populations within the military will require service providers that are attuned not only to the culture of the military context but to the cultures of these individuals who have also dedicated service to the military and their country. This reality is complicated by the reality that minority populations have been historically underserved by the behavioral health field.[64] Efforts to address the needs of returning veterans and their families from a variety of backgrounds will have to meet their unique needs, while contending with the existing workforce shortage.

State and community service systems will be challenged and need to be flexible in understanding the complexities of serving military families in a cultural and societal context. For example, the proposed military buildup in Guam is expected to increase the island's population by 80,000 within the next 3 years, representing a 50 percent increase in Guam's total population. This increase in population may strain the current health care, education, and public safety service systems, and present unique issues with behavioral health consequences. Understanding and addressing the impact of this change on Guam's cultural and capacity issues will be important to meeting the behavioral health needs of members of the military, their families and the people of Guam.

Health Reform

Although the Affordable Care Act does not target the population of military families for special attention, it contains several provisions that especially are important to them. This Initiative will support and collaborate with Centers for Medicare and Medicaid Services (CMS), DoD, VA, National Guard, and Reserves on issues important to military families, including the expansion of Medicaid eligibility as well as subsidies for purchase of insurance through State Health Exchanges and the elimination of preexisting condition limitations (especially PTSD) for those military service members and their families seeking care through private employer or individual insurance.

Behavioral Health Workforce

The essential workforce issue for this Strategic Initiative is the development of a public health-informed model of psychological health service systems staffed by a full range of behavioral health practitioners who are well trained in the culture of the military and the military family and the special risks and needs that impact this population, such as PTSD and TBI. The role of peer counselors within this model will also be important to its success.

Programs adequately staffed appear to have a positive impact on the potential to improve the overall system of care for this population, but coordination is lacking and some redundancy

exists across these staff resources. Behavioral health service providers may also not have an understanding of military culture and the unique issues faced by military families. Lack of access to well trained staff using current evidence-based practices is a particular problem for those 60 percent of active duty military members living out in the civilian community, and especially for National Guard and Reserve families that have different needs and usually less access to services and supports due to distance.

Among the workforce efforts planned under the Military Families Strategic Initiative are exploration of funding to support expansion of the returning service members, veterans, and their families' Policy Academies; development and distribution of training curricula and resources for clinicians on needs of returning veterans; development of partnerships with professional organizations and academic institutions to ensure military culture is included in core curricula and published standards, as demonstrated by the American Psychological Association and the Council on Social Work Education; and continuing coordination with TRICARE®, VA, and DoD to ensure improved quality in care.

Components of Initiative

Several fundamental expectations underlie the work plan for this Strategic Initiative:

- When appropriate, military families should have access to well-prepared civilian behavioral health care delivery systems;
- Civilian, military, and veteran service systems should be coordinated;
- Suicide prevention for military families must be implemented across systems;
- Emotional health promotion for military families is important to reducing mental and substance use disorders and to weathering increased exposure to adverse events; and
- Military families want and need stable housing.

Goals

Goal 3.1: Improve military families' access to community-based behavioral health care through coordination among SAMHSA, TRICARE, DoD, and Veterans Health Administration services.

Goal 3.2: Improve the quality of behavioral health-focused prevention, treatment, and recovery support services by helping providers respond to the needs within the military family culture.

Goal 3.3: Promote the behavioral health of military families with programs and evidence-based practices that support their resilience and emotional health.

Goal 3.4: Develop an effective and seamless behavioral health service system for military families through coordination of policies and resources across Federal, national, State, Territorial, Tribal, and local organizations.

Specific Goals, Objectives, and Action Steps

Goal 3.1: Improve military families' access to community-based behavioral health care through coordination among SAMHSA, TRICARE, DoD, and Veterans Health Administration services.

Objective 3.1.1: Encourage and support community-based behavioral health care providers' participation in the TRICARE network.

Action Steps:

1. Sponsor TRICARE/behavioral health care provider organizations forums for national and regional representatives and an ongoing dialogue to provide a mechanism for sharing information (e.g., credentialing, reimbursable services, and filing claims).
2. Enhance communications, facilitate answers to questions, and identify system issues that need attention at senior management levels by acting as a liaison between the behavioral health field and TRICARE.

Objective 3.1.2: Increase credentialing under TRICARE for behavioral health providers.

Action Steps:

1. Implement a pilot to assess the value of onsite TRICARE technical assistance credentialing teams in providing consultation and support to selected community behavioral health care centers interested in credentialing of staff for the TRICARE network.
2. Increase the credentialing of culturally competent minority and minority-serving providers eligible for participation in TRICARE.

Objective 3.1.3: Educate and assist behavioral health care providers about the appropriate referral process to the Veterans Health Administration and DoD military treatment facilities.

Action Steps

1. Work with DoD, VA, Vet Centers, and the Health Resources and Services Administration to identify available resources and develop a user-friendly resource package to guide providers in the use of available referral sources for members of the military, veterans, and their families. Specify procedures for referral and ensure that the referral sources and materials include culturally appropriate providers and information. Recognizing the reluctance to seek behavioral health services, provide training on facilitated referrals to improve the linkage to needed services, including nonmilitary providers.

2. Through a memorandum of understanding, distribute package to provider networks participating in two National Guard/SAMHSA pilot States; Solicit feedback from providers, including minority and minority-serving providers, on the usefulness of the resource package; and assess possible expansion of use of this resource to other States and Territories.

Goal 3.2: Improve the quality of behavioral health focused prevention, treatment, and recovery support services by helping providers respond to the needs and culture of military families.

Objective 3.2.1: Optimize SAMHSA grantees' provision of prevention, treatment, and recovery support services to military families.

Action Steps:

1. Work with State and Territorial mental health and substance abuse authorities to focus attention on needs of service members, veterans, and their families.
2. Collect military families' data in all SAMHSA data sets to identify military service members, veterans, and their families to track outcomes for this population.
3. In collaboration with other U.S. Department of Health and Human Services (HHS) agencies, develop standard definitions around military/veteran status to be included in HHS data sets and surveys.
4. Engage behavioral health providers and require grantees to collect military/veteran status of service recipients.

Objective 3.2.2: Strengthen community-based behavioral health care providers' understanding of military culture and their ability to provide effective prevention and treatment services for returning combat veterans, military service members, veterans, and their families.

Action Steps:

1. Develop and conduct a Webinar on behavioral health for military families that explores the potential collaboration across the behavioral health field, VA, and SAMHSA programs.
2. Explore the lessons learned from Operation Immersion and assess its potential as a model and its applicability to improving recovery for the diverse ethnic; racial; and lesbian, gay, bisexual, transgender, and questioning (LGBTQ) people within the military.
3. Establish a national technical assistance behavioral health resource for behavioral health care providers, military members, veterans, and their families.

4. Collaborating with the National Center for PTSD, VA Medical Center, National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), DoD, etc. to collect a list of evidence-based practices that have shown to be effective with military members/veterans. Once identified, collaborate with federally funded regional centers, academic institutions, professional organizations, and other primary care providers to develop a training plan in evidence-based techniques and best practices leveraging the training resources of various Federal, State, Territorial, and Tribal agencies.
5. Collaborate with the Defense Center of Excellence to develop a white paper about TBI and the role of the behavioral health system in addressing TBI.

Goal 3.3: Promote the behavioral health of military families with programs and evidence-based practices that support their resilience and emotional health.

Objective 3.3.1: Identify and develop activities at SAMHSA that support a public health model for psychological health services that emphasizes prevention, resilience, and delivery of high-quality recovery-oriented and specialized behavioral health care.

Action Steps:

1. Provide leadership as appropriate in the implementation of the proposed recommendations included in the report of the Sub-Interagency Policy Council (IPC) Group on Psychological Health.
2. Review current inventory of existing SAMHSA toolkits and ensure awareness of and use of these toolkits by VA and DoD provider services.
3. Develop a behavioral health guide for racial and ethnic minorities and the LGBTQ population about the challenges and the strategies for coping with their realities in the military.
4. Explore possibility of using SAMHSA technical assistance centers for training and technical assistance to support resilience and promote emotional health for the diverse racial, ethnic, and LGBTQ populations in the military.

Goal 3.4: Develop an effective and seamless behavioral health service system for military families through coordination of policies and resources across Federal, national, State, Territorial, Tribal, and community organizations.

Objective 3.4.1: Continue and facilitate ongoing partnerships with appropriate Federal, national, State, Territorial, and Tribal agencies and organizations to develop a full-spectrum behavioral health service system for military families.

Action Steps

1. Work closely with the National Security Council and HHS to disseminate and support the Presidential Study Directive 9 on Military Families.
2. Work through Sub-IPC to finalize the report from the Psychological Health Team.
3. Convene the Federal Partners Reintegration Work Group.
4. Create a SAMHSA/National Guard memorandum of understanding (MOU).
5. Engage DoD Suicide Prevention Task Force and include a focus on diverse populations.
6. Develop the proposed MOU with the Defense Center of Excellence.
7. Work with SAMHSA Tribal representatives to explore possible initiatives for military families within existing Tribal structures.
8. Work with employers to design and implement initiatives that support this objective.
9. Support policy academies to establish of statewide plans to comprehensively address the behavioral health needs of service members, veterans, and their families.

Strategic Initiative #3 Measures

Population-Based

- Reduce rates of untreated mental and substance use disorders among veterans and/or family members.

SAMHSA Specific

- Improve behavioral health outcomes for veterans and their families who are served through SAMHSA supported programs.

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Strategic Initiative #4: Recovery Support

Lead: Kathryn Power, Director, Center for Mental Health Services

Key Facts

- For those with substance use disorders, a comprehensive array of services assists recovery from substance use disorders,[65] and social supports improve recovery outcomes.[66]
- A study has shown that at 24 months' followup, individuals entering Oxford House (supported housing) after substance use disorders treatment had significantly lower substance use, significantly higher monthly income, and significantly lower incarceration rates than did those entering usual care.[67]
- One-third of individuals with severe mental illnesses who receive community mental health services after lengthy stays in a State hospital achieve full recovery in psychiatric status and social function and another third improve significantly in both areas.[68]
- Of the more than 6 million people served by State mental health authorities across the Nation, only 21 percent are employed. Despite this exceptionally low rate, only 2.1 percent of people served receive evidence-based supported employment services.[69]
- A qualitative study found that 33 percent of those who reported having dropped out of treatment indicated they might have stayed longer in substance abuse treatment if they had received practical assistance, help with areas of life functioning, and better individualized services.[70]
- Supported employment programs that help people with the most serious mental illnesses place more than 50 percent of their clients into paid employment.[71]
- In 2009, more than half of the 4.3 million persons aged 12 and older who received treatment for alcohol or illicit drug use in the past year received that treatment at a self-help group.[72]
- A recent 10-year study suggests that supported employment initiatives for people who are high users of mental health services can reduce their need for such services, saving public funding over time.[73]
- In 2006, 13 percent of admissions to substance abuse treatment were homeless.[74]
- Sixty-four percent of persons who are homeless have an alcohol or substance use disorder.[75]
- One-third (32.7 percent) of individuals aged 12 and older who attended a self-help group for substance abuse in the past year also received specialty treatment for substance use during that same period.[76]
- Conversely, 66 percent of persons aged 12 and older who received any alcohol or illicit drug use specialty treatment in the past year also attended a self-help group during the same time frame.[77]

- Research indicates that a combination of long-term housing, treatment, and life affirming services leads to improved residential stability and reductions in substance use and psychiatric symptoms.[78]
- In one research study, providing housing for individuals with mental illness who are homeless reduced criminal justice involvement by 38 percent and prison days by 84 percent.[79]
- More than half of adolescents in the United States who fail to complete high school have a diagnosable psychiatric disorder. The proportion of failure to complete school that is attributable to psychiatric disorder is estimated to be 46 percent.[80]

Overview

Behavioral health problems are more common in the United States than is generally realized. According to estimates from the 2009 National Survey on Drug Use and Health, approximately 20 percent of persons aged 18 and older reported having a diagnosable mental illness in the previous year, 9 percent of persons aged 12 and older reported using an illicit drug in the past month, and 24 percent reported binge alcohol use (i.e., drinking five or more drinks on the same occasion) at least once in the past month.[81] Mental and substance use disorders often occur together as well as with general medical conditions, such as diabetes or heart disease. In fact, those admitted to treatment reporting psychiatric problems in addition to substance abuse problems more than doubled between 1992 and 2006.[82]

Purpose of Initiative #4

Partnering with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.

Recovery is a unique journey for each individual, and each person in recovery must choose the range of services and supports ranging from clinical treatment to peer services. To facilitate resilience, recovery, and social inclusion, persons with mental and substance use disorders will also likely need to receive treatment for their co-occurring health problems. Access to services must be paired with shared decisionmaking process between people in recovery and providers to determine how best to select, structure, and deliver services. Like other aspects of health care and unless adjudicated by courts of law, people have the right to choose and determine what services and treatments best meet their needs and preferences. Self-determination is the foundation of person-centered and consumer-driven recovery supports and systems, including such approaches as person-centered planning, shared decisionmaking, and peer-operated services. People in recovery should be meaningfully involved in all aspects of behavioral health services, including planning, policy development, training, delivery, administration, and research.

The goal of recovery is exemplified through a life that includes:

- **Health**—Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;

- **Home**—A stable and safe place to live that supports recovery;
- **Purpose**—Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society; and
- **Community**—Relationships and social networks that provide support, friendship, love, and hope.

These elements—*health, home, purpose, and community*—are central to recovery from mental and substance use disorders. An individual's ability to have a successful, satisfying, and healthy life integrated in a community is fostered through the availability of and appropriate use of prevention, health, clinical treatment (including residential treatment if needed), and recovery support services that are culturally appropriate, and directed by persons in recovery (and family members as appropriate). Recovery is also supported by getting and maintaining, as needed, accessible, affordable housing with supportive services; mainstream jobs that pay a living wage; and accessible educational opportunities. Finally, to support recovery, communities should welcome everyone, regardless of condition or disabilities, as full, participating members in every facet of American life.

To recover, people need good health. Research reveals the startling fact that individuals with the most serious mental illnesses and co-occurring disorders die at age 53, on average.[83] They die from treatable medical conditions caused by modifiable risk factors, including smoking, obesity, high blood pressure, and substance use. Unfortunately, these deaths often stem from inadequate access to overall medical care. There is increasing recognition that most serious behavioral health disorders can be long-term conditions and that they frequently co-occur with, and may exacerbate, other medical conditions. However, individuals who have serious behavioral health conditions and lack financial resources are often unable to access quality care, either for their behavioral health conditions or for other health problems. Properly addressing behavioral health conditions is necessary because untreated mental and substance use disorders not only negatively impact a person's behavioral health but also lead to worse outcomes for co-occurring physical health problems. Good behavioral health is associated with better physical health outcomes, improved educational attainment, increased economic participation, and meaningful social relationships.[84] In fact, good health is not possible without good behavioral health.

To recover, people need a safe, stable place to live. The number of people experiencing homelessness on any given night in the United States is estimated at more than 643,000. Due to the current economic downturn, this number may increase. Approximately 63 percent are individuals, and 37 percent are adults with children. Although Federal, State, and Territorial policies have been successful in beginning to reduce the number of individuals and veterans who are chronically homeless, the number of families that are homeless at any time during a year has increased about 30 percent since 2007.[85] Permanent supportive housing has emerged as a model in which individuals who have mental and substance use disorders can secure stable housing and receive the range of supports they need to manage mental illnesses or other disabilities. Research and practice reveal that supportive housing decreases symptoms, increases housing stability, and is cost effective. For many in recovery from substance use disorders short term drug-free housing may be essential to achieving long-term recovery. A recent study found that residents in a Sober

Housing program linked to outpatient substance abuse treatment showed decreases in the number of months using substances and maximum number of days of substance use per month, reduced arrests, and increased rates of employment. Seventy-six percent of the residents in the study remained in the house at least 5 months, and 39 percent reported being employed at some point during the past 30 days.[86] Such "recovery housing" can be provided through a variety of models ranging from peer–run, self-supported, drug-free homes to community-based housing that includes a range of supportive services.

To recover, people need meaningful work and the ability to enhance their skills through education. Employment by its very nature helps integrate individuals in society and acknowledges their ability to contribute. In 2009, unemployed adults were classified with substance dependence or abuse at a higher rate (16.6 percent) than were full- or part-time employed adults (9.6 percent and 11.2 percent, respectively).[87] The income employment produces enables people to improve their living situation, reducing exposure to violence and other stressors that may adversely affect behavioral health. Conversely, being unemployed is associated with increased rates of mental disorders, especially among men,[88] and with relapse to substance use.[89,90,91,92] Employment is recognized as a factor in preventing and ending homelessness among people with disabilities; for many individuals, it helps develop motivation and hope for the future. Nevertheless, individuals with mental disabilities have the lowest earning level and household income of any disability group.[93] People who are unemployed show higher rates of substance dependence or abuse than those who are employed full or part time.

Education is closely linked to opportunities for work, yet individuals with mental and substance use disorders have the lowest educational attainment level of any disability group. Mental illnesses often begin when young adults are completing high school and looking at future opportunities and career plans. The same holds true for those with substance dependence or abuse. In 2009, college or university graduates had a lower rate of dependence or abuse (7.5 percent) than those who graduated from high school (8.9 percent), those who did not graduate from high school (11.6 percent), and those with some college (9.9 percent).[94] Supported education is a promising practice that allows individuals with behavioral health problems to enroll and remain in an educational program.

To recover, individuals need to be full, participating members of their communities. Individuals with behavioral health conditions do not recover in isolation—they recover in families and community. However, living *in* the community is necessary but not sufficient for individuals with behavioral health disorders to be included fully in society. Even if they live in neighborhoods alongside people without disabilities, individuals with substance use and mental conditions may lack socially valued activity, adequate income, personal relationships, recognition and respect from others, and a political voice. They remain, in a very real sense, socially excluded.[95] The exclusion comes from society's attitudes and fears about persons with mental and substance use disorders as much or more than from any disability associated with these disorders.

As observers have noted, insufficient natural structures exist in the community to involve persons with mental and substance use disorder in shared social activities, either with peers or with members of the community at large.[96] Mutual support groups play a critical role for many,

but there is still an unmet need. A person with a behavioral health condition is as capable of living a full life integrated in a community as anyone else. Successful recovery from mental and substance use disorders is an important societal goal, especially attainment of levels of recovery that enhance economic security and reduce reliance on government-funded disability income support programs. Innovative programs promoting economic resiliency (and reducing poverty-related behavioral health risks) can be used effectively, in combination with other programs of rehabilitation and support, to increase and accelerate the likelihood of recovery for those with behavioral health illnesses. The role of the Substance Abuse and Mental Health Services (SAMHSA)—in collaboration with partners at the Federal, State, Territorial, Tribal, and local level—is to help remove attitudinal barriers and establish appropriate supports to make this possible. The goal is for people with behavioral health conditions to *flourish*, not merely function, in their communities.

Health Reform

The passage of the Affordable Care Act recognizes that an individual's health and behavioral health care are interwoven and that both must be appropriately addressed to achieve successful health outcomes. Several provisions of the Affordable Care Act support an integrated approach to care, and SAMHSA will work to ensure that this integrated approach supports recovery from mental and substance use disorders. The challenge in achieving the promise of integrated physical and behavioral health care is that it requires structural, policy, practice, and cultural and financial changes to our health care systems as well as to our social service systems. Recognizing the size and complexity of this undertaking, SAMHSA is using this Strategic Initiative and action plan as the foundation to support transformational change. SAMHSA will engage stakeholders and partners within and outside of the behavioral health field to understand and embrace recovery and all of its dimensions as the appropriate course to follow. SAMHSA will also work through this Initiative to ensure that coverage expansions under the Affordable Care Act are met with recovery supports.

Behavioral Health Workforce

Workforce development issues have an impact on almost every aspect of prevention and treatment across all sectors of the diverse behavioral health field. The majority of the U.S. behavioral workforce will need support and training in understanding and providing behavioral health promotion and prevention activities to supplement their current training in treatment. This Initiative supports the future development of the behavioral health workforce and builds an understanding of recovery-oriented practices, including incorporating peers into the current workforce to support peer-run services. It also emphasizes collaborative relationships with children, youth, and families that involve shared decisionmaking service options. This Initiative will leverage public and private relationships, provide technical assistance, and facilitate systems and services to demonstrate that recovery with behavioral health conditions is possible. Through the action steps outlined below, SAMHSA will support the development of a capable, recovery-oriented workforce in partnership with grantees, States, Territories, Tribes, communities, families, and individuals.

Disparities

Many racial and ethnic groups face elevated levels of substance use disorders and experience higher suicide rates than the general population. They also have higher rates of certain risk factors for mental, emotional, and behavioral problems, including poverty, domestic violence, and childhood and historical trauma as well as involvement in the foster care and criminal justice systems. Behavioral health disparities are also present for American Indian and Alaska Native communities and Tribes; people with disabilities; lesbian, gay, bisexual, transgender, and questioning (LGBTQ) individuals; girls; and transition-aged youth. SAMHSA is committed to addressing these disparities by improving prevention, treatment, and recovery support programs that serve members of these groups. In particular, SAMHSA will work with Tribes to develop culturally focused and person-centered health and wellness initiatives and housing supports that are also person driven whenever and to the greatest extent possible.

Components of Initiative

No single program, either within the U.S. Department of Health and Human Services (HHS) or anywhere else in the Federal Government, can solve the problems of homelessness, joblessness, educational challenges, and community cohesion for people with mental and substance disorders. Coordination of programs and the piecing together of the various resources offered throughout the Federal Government are necessary to provide the full range of recovery support and behavioral health service options needed at the State, Territorial, and community level to effectively serve persons and families to thrive in their communities. This Strategic Initiative aligns with current Administration efforts to expand opportunities for individuals with disabilities to live in integrated, community settings. Through this Initiative, SAMHSA can serve as the lead Federal agency for promoting and increasing practices for individuals to recover and for their communities to support and welcome them.

Goals

Goal 4.1: (Health) Promote health and recovery-oriented service systems for individuals with or in recovery from mental and substance use disorders.

Goal 4.2: (Home) Ensure that permanent housing and supportive services are available for individuals with or in recovery from mental and substance use disorders.

Goal 4.3: (**Purpose)** Increase gainful employment and educational opportunities for individuals with or in recovery from mental and substance use disorders.

Goal 4.4: (Community) Promote peer support and the social inclusion of individuals with or in recovery from mental and substance use disorders in the community.

Specific Goals, Objectives, and Action Steps

Goal 4.1: (Health) Promote health, recovery-oriented service systems and peer support for individuals with or in recovery from mental and substance use disorders.

Objective 4.1.1: Promote health, wellness, and resiliency.

Action Steps:

1. Initiate and sustain a national campaign to promote health and wellness among individuals with mental and substance use disorders and/or in recovery. The campaign should build on the updated Recovery Month campaign that now applies to recovery from both mental and substance use disorders and conditions, as well as the 10 By 10 Campaign.

Objective 4.1.2: Promote recovery-oriented service systems.

Action Steps:

1. Finalize and disseminate a consensus statement on recovery from mental and substance use disorders.
2. Develop and disseminate recovery-oriented service protocols for behavioral health providers.
3. Develop and disseminate facility and organizational standards for recovery-oriented behavioral health care in behavioral health settings.
4. Provide training and technical assistance on recovery and recovery-oriented systems, services, and supports to State, Territorial, Tribal, and local officials (e.g., Commissioners of Behavioral Health, Commissioners of Mental Health Services, Single State Authorities for Substance Abuse Services, National Prevention Network members, Public Health Commissioners, Superintendents of Education, Correctional Commissioners, County Commissioners, and State Judges) on how to develop and implement and/or update strategic plans that include specific efforts to move systems and services toward a recovery orientation through the new Recovery Support TA Center.
5. Provide training and technical assistance on recovery and recovery-oriented systems, services, and supports to program administrators, policymakers, clinical supervisors, frontline providers in behavioral health agencies, primary care associations, and other relevant community support systems (e.g., places of worship, centers of aging, and fraternal organizations), and ethnic and racial-specific community providers and organizations.
6. In collaboration with individuals in recovery, peers, and family members, develop online curricula, Webinars, training tools, strategic planning guides, and other resources to assist States, Territories, Tribes, communities, and organizations adopt a recovery orientation

and/or further enhance their efforts to implement culturally competent recovery-oriented services and supports.

7. Promote individual recovery through safe and effective pharmacological/medication-assisted treatment for people recovering from substance use disorders when appropriate.

Objective 4.1.3: Engage individuals in recovery and their families in self-directed care, shared decisionmaking, and person-centered planning.

Action Steps:

1. Participate in HHS activities to develop cross-agency policies on participant-directed care.
2. Foster individual and family choice by supporting approaches in which service recipients choose behavioral health services and providers, such as voucher-based systems.
3. Develop and disseminate guides on person-centered planning for individuals, families, peers, providers, and administrators.
4. Provide information and assistance to States, Territories, Tribes, grantees, and provider organizations to design and implement self-directed care approaches and models, including targeted outreach to provider organizations serving diverse, underserved populations.
5. Work with the Centers for Medicaid and Medicare Services (CMS) and other Federal partners to develop and disseminate information and fact sheets on a range of recovery supports, including mutual aid associations and self-help groups, the faith community, transportation resources, dental care, housing and employment supports, education about self-care, the role of spirituality, the use of creative arts approaches, accessing recreational and other natural supports and social support opportunities available within communities, healthy and appropriate sexuality and relationships, the use of personal health records, and financial literacy for individuals with mental and substance use disorders.
6. Collaborate with policymakers and providers at State, Territorial, Tribal, and local levels in expanding programs that implement shared decisionmaking in behavioral health care.

Objective 4.1.4: Promote self-care and alternatives to traditional care.

Action Steps:

1. Collaborate with the National Institutes of Health (NIH) National Center for Complementary and Alternative Medicine in developing and disseminating information on complementary and alternative treatments and supports for individuals with mental and substance use disorders.
2. Publish and disseminate a guide for States, Territories, and Tribal nations on self-care approaches for individuals in recovery with mental and substance use disorders.

3. Work with the HHS initiative on multiple chronic conditions by having individuals in recovery with mental and substance use disorders delineate those self-care approaches that have been associated with decreased illness and death and enhanced wellness.

Goal 4.2: Home: Ensure that permanent housing and supportive services are available for individuals with or in recovery from mental and substance use disorders.

Objective 4.2.1: Improve access to mainstream benefits, housing assistance programs, and supportive services for people with mental and substance use disorders.

Action Steps:

1. Work with Federal partners to improve access to mainstream benefit programs and services (e.g., Medicaid, SSI/SSDI, Temporary Assistance for Needy Families, Special Needs Assistance Programs by using demonstrated programs, including evidence-based enrollment strategies for Social Security Disability Insurance (SSDI); the Social Security Administration's Homeless Outreach Projects and Evaluation; U.S. Department of Housing and Urban Development (HUD) Housing Opportunities for People with AIDS, and online application software.
2. Work with Federal partners to develop policy guidance and directives that support recovery-oriented systems of care, provide integrated primary and behavioral health services, increase access to mainstream housing programs, and enhance the Nation's housing capacity for low-income individuals with behavioral health problems.
3. Distribute SAMHSA's Permanent Supportive Housing, Supportive Education, and Supportive Employment Toolkits, and related Treatment Improvement Protocols to Federal, State, Territorial, Tribal, and local partners; relevant professional and community-based organizations; and health care providers, especially those affiliated with behavioral health.
4. Disseminate information to behavioral health providers on effective financing strategies for creating and providing linkages to permanent housing and supportive behavioral health services using onsite and Web-based technical assistance as well as partnering with qualified Medicaid services providers, including Health Care for the Homeless organizations and federally qualified health centers (FQHCs).
5. Promote the use of evidence-based permanent housing and supportive services models in existing SAMHSA grant programs (e.g., Primary and Behavioral Health Care Integration, Access to Recovery, Pregnant and Post-partum Women, and Minority HIV/AIDS).
6. For those in recovery from substance use disorders, promote the use of evidence-based transitional drug-free housing, (such as peer–run, self-supported, drug-free homes, or community-based housing that includes a range of supportive services).

Objective 4.2.2: Build leadership, promote collaborations, and support the use of evidence-based practices related to permanent supportive housing for individuals and families who are homeless or at risk of homelessness and have mental and substance use disorders.

Action Steps:

1. Work in concert with the USICH (United States Interagency Council on Homelessness) and other Federal partners in implementing the Federal Strategic Plan to Prevent and End Homelessness, including a focus on populations especially vulnerable to homelessness (e.g., minorities, LGBTQ youth, and veterans).
2. Partner with HUD, the HHS Office of the Assistant Secretary for Planning and Evaluation, USICH, and other Federal partners to improve access to mainstream (e.g., housing choice vouchers) and targeted housing assistance programs (e.g., Veterans Affairs Supportive Housing) for individuals and families who are homeless and are experiencing behavioral health problems.
3. Work together with the Administration for Children and Families (ACF), CMS, Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), Indian Health Service (IHS), and HHS Office of the Secretary to streamline and coordinate technical assistance approaches aimed at preventing and ending homelessness, including a focus on diverse racial and sexual minority populations.
4. Improve health outcomes and access to care for people living with HIV/AIDS through stable housing and supportive behavioral health services.
5. Join forces with the Department of Veterans Affairs (VA) effort to end homelessness for the Nation's veterans through a memorandum of understanding and shared practices.
6. Collaborate with IHS to ensure that the specific needs of American Indians and Alaska Natives with behavioral health disorders are included in Administration efforts to prevent and end homelessness.
7. Collaborate with stakeholders (e.g., advocacy groups, nonprofits, foundations, businesses, and national minority and LGBT organizations) in efforts to increase recovery support services and housing opportunities for people who are homeless or at risk of being homeless upon leaving institutional settings, such as prisons, mental health facilities, and nursing homes.
8. Engage national experts to identify best practices related to permanent housing and recovery services for people with mental and substance use disorders, and to disseminate the findings to the field and inform the development of SAMHSA programs.

Objective 4.2.3: Increase the knowledge of the behavioral health field and SAMHSA grantees about housing and homelessness among people with mental and substance use disorders.

Action Steps:

1. Collaborate with Federal partners and other stakeholders to develop and disseminate a paper on a comprehensive housing and supportive services package based on evidence-based models and practices, including options for transition age youth.
2. Identify and take steps to address Federal, State, Territorial, Tribal, and local barriers to provide housing to individuals with substance use disorders and criminal records.
3. Use SAMHSA training, technical assistance, and Web technology resources and develop online curricula and other training materials focused on creating partnerships in local communities to prevent and end homelessness among individuals with mental and substance use disorders and educate the behavioral health workforce in identifying those at risk of homelessness as well as the supports and services that exist for individuals and families who are currently homeless.
4. Construct topic-specific community sites using SAMHSA's existing Web 2.0 technology to increase awareness of recovery-oriented systems of care, peer supports, and prevention of homelessness among behavioral health providers.
5. Increase knowledge among States, Territories, Tribes, provider organizations, and SAMHSA grantees about evidence-based interventions and recovery-oriented service systems aimed at preventing and ending homelessness for individuals with mental and/or substance use disorders.

Goal 4.3: Purpose: Increase gainful employment and educational opportunities, while decreasing legal and policy barriers, for individuals in recovery with mental and substance use disorders.

Objective 4.3.1. Increase the proportion of individuals with mental and/or substance use disorders who are gainfully employed and/or participating in self-directed educational endeavors.

Action Steps:

1. Convene stakeholders to develop a national strategic plan for identifying and addressing employment disparities among individuals with mental and/or substance use disorders.
2. Establish meaningful participation on SAMHSA's advisory councils by individuals in recovery from mental and/or substance use disorders and family members. When appropriate, convene subcommittees to address policy barriers to employment, especially for those with criminal justice histories.

3. Work with the Social Security Administration (SSA) in assisting individuals in recovery with mental and/or substance use disorders to use the Ticket to Work program.
4. Partner with the U.S. Department of Labor (DOL) to provide training and technical assistance to individuals in recovery from mental and/or substance use disorders by having a Toolkit to One-Stops, using the community recovery and resilience approach.

Objective 4.3.2. Develop employer strategies to address national employment and education disparities among people with and without identified behavioral health problems.

Action Steps:

1. Collaborate with Federal partners and other stakeholders in writing and disseminating a paper on a "Good and Modern Behavioral Health Employment Support System."
2. Conduct a behavioral health awareness campaign focused on decreasing discrimination and improving employment outcomes for individuals with mental and substance use disorders.
3. Work with the National Business Group on Health to develop an employer's guide to emotional wellness and drug-free workplaces.
4. Establish a SAMSHA workgroup to evaluate and provide guidance on best practices and strategies for including individuals in recovery in the workplace.

Objective 4.3.3. Improve the employment and educational outcomes among individuals with mental and/or substance use disorders served by SAMHSA grantees.

Action Steps:

1. Increase the use of funding that is or can be used by SAMHSA grantees or subrecipients to enhance supported employment, employment readiness and other vocational/employment supports, and education by individuals with identified behavioral health problems. Examples of SAMHSA grants include Mental Health Transformation Grants focused on supported employment, supported education, permanent supportive housing, and peer supports; Access to Recovery (ATR); Recovery Community Services Program; Targeted Capacity Expansion/Local Recovery-Oriented Systems of Care to continue providing employment-related services and supports, including peer-to-peer services, for people with behavioral health conditions and disorders; and Family-Centered Substance Use Treatment Grants for Adolescents and their Families.
2. Provide training and technical assistance on supported employment, permanent supportive housing, recovery housing, supported education, and recovery supports to relevant SAMHSA grantees or subrecipients.

3. Conduct Webinar seminar series in collaboration with SAMHSA's Office of Behavioral Health Equity to raise awareness of issues associated with employment and educational outcomes for diverse communities.

Objective 4.3.4. Implement evidence-based practices related to employment and education for individuals with mental and/or substance use disorders throughout all service systems.

Action Steps:

1. Work with Federal partners and the Mental Health Transformation Employment Work Group (FPEWG) to develop and disseminate a matrix for financing supported employment through Federal funding sources.
2. Work with the FPEWG and the Interagency Committee on Disability Research Subcommittee on Employment to market and disseminate supported employment and supported education toolkits to stakeholders providing employment supports to people with disabilities, including State offices of Vocational Rehabilitation, vocational rehabilitation service providers, DOL One-Stop Career Centers, SSA Employment Networks, independent living centers, U.S. Department of Veterans Affairs (VA) employment service providers, U.S. Department of Justice (DOJ) employment service providers, and educational and youth disability service organizations.
3. Develop and disseminate resources on peer-to-peer recovery support services related to job readiness, job skills training, vocational assessment, job preparation, and related skills for entering and remaining gainfully employed.

Goal 4.4: Community: Promote peer-support/mutual support and the social inclusion of individuals with or in recovery from mental and substance use disorders and their families.

Objective 4.4.1. Increase the number and quality of consumer/peer recovery support specialists and consumer-operated/peer-run recovery support service provider organizations.

Action Steps:

1. Work with CMS, other Federal and private sector partners to analyze frequency and service quality of claims data and information of the States, Territories, and Tribes to identify those that have used the option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system in an effort to provide informed technical assistance and encourage expansion.
2. Develop and disseminate online tools and resources to assist peer-run and consumer-operated recovery support services organizations in assessing their readiness and enhancing their capacity to provide recovery support services for individuals with mental

and substance use disorders, including meeting relevant certification, licensure, and accreditation requirements. Expand the peer and consumer organizations to include those from diverse ethnic, racial, and sexual minority populations.

3. Convene stakeholder groups to develop a set of core competencies or standards for behavioral health peer-run/consumer-operated recovery support specialists and disseminate core competencies to appropriate agencies and policymakers, taking into consideration specific cultural competencies for diverse populations.
4. Provide training and technical assistance to States, Territories, Tribes, and localities on best practices for operating consumer-operated/peer-run recovery support services with consumer/peer/recovery organizations.
5. Leveraging the Statewide Family and Consumer Networks, provide training and technical assistance to grassroots peer-run and consumer-operated recovery support services organizations in areas including, but not limited to, organizational development, nonprofit management, community development, business practices, financing of services, respite programs, sustainability, leadership development, and recovery programming.
6. Collaborate with States, Territories, and Tribes to expand peer/recovery specialist approaches in criminal justice, homelessness, primary care, military families, HIV/AIDS, and other settings.

Objective 4.4.2: Promote the social inclusion of people with substance use and mental disorders.

Action Steps:

1. Protect the rights of individuals with mental and substance use disorders by providing assistance to State-designated protection and advocacy agencies.
2. Work with the HHS Community Living Initiative to foster the community integration of individuals with disabilities, including those with mental and substance use disorders.
3. Collaborate with DOJ and other relevant partners around compliance with and issues surrounding the Olmstead case.
4. Develop and disseminate training materials and provide other assistance to reduce the use of seclusion and restraint in all settings, including hospitals, correctional facilities, and educational institutions.
5. Provide information and assistance to States, Territories, Tribes, counties, organizations, and individuals on strategies that foster the social inclusion of people with mental and substance use disorders while acknowledging the social determinants of behavioral health problems, as described in *Healthy People 2020*.

Strategic Initiative #4 Measures

Population-Based

- Improve the health status of individuals with co-occurring physical and behavioral health conditions.

SAMHSA Specific

- Increase the percentage of individuals served by SAMHSA programs who have a positive perception of social connectedness to and support from others in the community, such as family, friends, coworkers, and classmates.
- Increase the number of States with reimbursement policies for services provided by certified peer support specialists to enhance the recovery and resiliency of others with severe emotional disorders, severe mental illness, and/or chronic substance abuse.

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Strategic Initiative #5: Health Reform

Lead: John O'Brien, Senior Advisor for Behavioral Health Financing

Key Facts

- In 2014, 32 million more Americans will be covered by health insurance because of changes under the Affordable Care Act. Between 20 to 30 percent of these people (6 to 10 million) will have a mental or substance use disorder.[97, 98]
- The Affordable Care Act will increase the number of people who are insured. Currently, individuals with a mental disorder are twice as likely to be uninsured than those without a mental disorder.[99]
- Among the currently uninsured aged 22 to 64 with family income of less than 150 percent of the Federal poverty level (FPL), 32.4 percent had illicit drug or alcohol dependence/abuse or mental illness.[100]
- As of 2005, Medicaid paid for 28 percent of all spending on mental health services and 21 percent of substance abuse treatment in the United States.[101]
- As of 2005, Medicare paid for 8 percent of all spending on mental health services and 7 percent of substance abuse treatment in the United States.[102]
- Medicaid is a primary source of support for mental health services at the State level—44 percent of mental health funding managed by State Mental Health Authorities comes from Medicaid.[103]
- In 2006, nearly 7.5 million individuals were dually eligible for both Medicare and Medicaid at a cost of approximately $200 billion.[104, 105] Fifty-two percent of these people have a psychiatric illness.[106]
- Many individuals with mental and substance use disorders will no longer pay significant out-of-pocket expenses for medication due to the closing of the "doughnut hole" in Medicare Part D.[107]
- States spend as much as 75 percent of their Medicaid mental health funds for children on residential treatment and inpatient hospital services.[108]
- The Mental Health Parity and Addiction Equity Act (MHPAEA) affects 140 million individuals participating in group health plans.[109]
- Lesbian, gay, bisexual, transgender, and questioning (LGBTQ); racial; and ethnic populations are disproportionately represented in the ranks of the uninsured. In 2008, 22 percent of gay and lesbians reported having no health insurance,[110] and in 2009, 34 percent of Hispanics, 28 percent of American Indians and Alaska Natives, 23 percent of African Americans, and 18 percent of Asian Americans, compared with 14 percent of white Americans, were uninsured.[111]

Overview

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (together referred to as the Affordable Care Act) that make health insurance coverage more affordable for individuals, families, and the owners of small businesses. The Affordable Care Act is one aspect of a broader movement toward a reformed behavioral health system. For the behavioral health field, "health reform" includes MHPAEA, Olmstead[vi] and early periodic screening, diagnosis, and treatment (EPSDT)[vii] issues, integration with the broader health system, and increased use of health information technology (HIT). More specific efforts are also important to the reform of the behavioral health system, such as the National HIV/AIDS Strategy, the Tribal Law and Order Act, and the National Action Alliance for Suicide Prevention. These developments present SAMHSA with the challenge of managing and responding in an environment of rapid, dramatic change. Health reform also presents opportunities to make a positive impact on health and behavioral health systems, services, and payer sources. Through this Strategic Initiative, SAMHSA will work to include persons in need of services for mental and substance use disorders; their family members; and the practitioners and providers who serve them in all aspects of health reform.

Purpose of Initiative #5

Increasing access to appropriate high quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and co-occurring health conditions, such as HIV/AIDS.

The Affordable Care Act reforms insurance markets to make them more competitive. It protects consumers' rights by prohibiting such practices as excluding people from coverage due to preexisting conditions, placing annual or lifetime caps on coverage, banning rescission of coverage, and establishing basic minimum benefit packages. The Affordable Care Act addresses the reality that racial and ethnic minority populations are disproportionately uninsured, face systemic barriers to health care services, and experience worse health outcomes. The Affordable Care Act also includes prevention, early intervention, and treatment of mental and substance use disorders as an integral part of improving and maintaining overall health. When fully implemented, the Affordable Care Act will provide access to coverage for an estimated 32 million Americans who are now uninsured. It will ensure that mental health and substance use services for newly covered individuals are provided at parity, consistent with the MHPAEA passed in 2008.

SAMHSA has a prominent role in several key Affordable Care Act provisions, including a requirement for States and Territories to consult with SAMHSA in developing medical homes for individuals with mental and substance use disorders. If funds are appropriated by congress,

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[vi] In 1999, the U.S. Supreme Court issued the landmark Olmstead decision applying the Americans with Disabilities Act to the right of individuals with disabilities to receive health care in a community-based setting.

[vii] This child health component of Medicaid is required in every State.

SAMHSA will also be responsible for developing Centers of Excellence for Depression and Post Partum Depression. In addition, SAMHSA is taking a lead role in shaping policies on home- and community-based services for individuals with mental and substance use disorders. Parity between mental health and addiction services and medical and health services is a SAMHSA priority. SAMHSA will work to ensure that behavioral health services covered by the Affordable Care Act and MHPAEA are at parity and that these services are managed no differently than medical and other health benefits offered by Medicaid and private insurance.

The Affordable Care Act will have an impact on SAMHSA's Block Grants and the alignment of public and private sectors. The new opportunities under the law will significantly expand mental health and substance use treatment and support services under Medicaid and insurance products offered to working-class families. Some changes are already in effect while others are not yet implemented, including a major expansion in Medicaid enrollment in 2014. Because of this anticipated increase in funding for treatment and services, SAMHSA Block Grants will soon be able to purchase other needed services that support individuals and families toward their recovery and resiliency goals. Many of these services may not be covered by Medicaid or private insurance; therefore, Block Grant services will likely be necessary to complete the benefit package for people with insurance coverage and deliver the full range of services to others who still do not have or move in and out of coverage.

CMS currently funds more than a third of mental health services and substance abuse treatment[112] in the United States. Under the Affordable Care Act, the Medicaid program will play an increasing role in the financing and delivery of mental health and substance use services. The Affordable Care Act enables States and Territories to use current and new provisions of the Medicaid program to offer services to current and newly eligible enrollees, such as expanding eligibility to individuals without dependent children and whose incomes are below 133 percent of the FPL. It provides a significant focus on expanding and improving home- and community-based services for individuals with disabilities, including those with mental and substance use disorders. In addition, the Medicaid program will cover some prevention services, including screening for depression and alcohol misuse or abuse. CMS will enhance efforts to develop strategies for individuals who are dually eligible for Medicare and Medicaid services—a significant number of these individuals need mental health and substance use services.

For certain populations, people with disabilities, children from low- to moderate-income families, and older Americans, services funded and regulated by CMS are the primary form of care received. In 2014, low-income adults without dependent children will also begin to receive coverage from Medicaid. Because of the prevalence of mental and substance use disorders among these populations and the access issues they face, their needs have long been a priority for SAMHSA. SAMHSA recognizes the unique role that CMS plays in funding and regulating the health services critical to their behavioral health and will actively partner with CMS to ensure that they receive the best possible care and support. In addition to working with CMS, SAMHSA will maintain a focus on reforming all services and systems regardless of payer. This focus includes other publicly funded services through the Health Resources and Services Administration (HRSA), Administration for Children and Families (ACF), and other U.S. Department of Health and Human Services (HHS) Operating Divisions; programs funded at the State, county, city, and community levels; and services covered by the private insurance sector.

The Affordable Care Act seeks to enhance the availability of primary care services, especially for low-income individuals with complex health needs. Many provisions seek to identify and coordinate primary care and specialty services for these individuals through medical homes. In use for many years, the term "medical home" means the specific designation of a health care professional, practice, or clinic to be accountable for identifying and coordinating a wide range of services for a particular individual or group. Specific provisions of the Affordable Care Act will increase access to medical homes for individuals with serious mental illness and individuals with co-occurring addiction and other chronic health and mental health conditions. Better coordination will help reign in unsustainable costs for families, government, and the private sector, making care more accessible, affordable, and effective. HIV/AIDS is an example of a co-occurring health concern that SAMHSA remains committed to addressing. Behavioral health problems put individuals at greater risk for HIV infection and can hinder access to treatment and maintenance in care for those with HIV/AIDS. Through this initiative, SAMSHA will support coordinated mental health and addictions treatment services for people with HIV/AIDS, HIV risk assessment, pre-test counseling, HIV testing, post-test counseling, referrals for treatment, and testing for other infectious diseases (such as hepatitis C).

SAMHSA will promote the planning and development of integrated primary and behavioral health care for individuals with mental and substance use disorders. This bidirectional integration of primary and behavioral health care will better meet the needs of individuals with mental and/or substance use disorders who seek care in primary care settings to address their health needs. As a result, SAMHSA will focus on enhancing access to (health and behavioral health) services and effective referral arrangements for those living with mental and/or substance use disorders across all health care settings—whether specialty behavioral health or primary care providers. SAMHSA addresses health from a "multiple chronic conditions approach" which recognizes that individuals with a mental and/or substance use disorder are at a heightened risk for or are often diagnosed with a concurrent chronic health condition. SAMHSA also uses a "whole person" philosophy—caring not just for an individual's health condition but providing linkages to long-term community care services and supports, social services, and family services.

Disparities

Low-income minority populations are less likely to have coverage or access to a health home today. When dealing with behavioral health problems, they also confront significant individual, family, linguistic, cultural, and systemic barriers to care. As a result, these populations tend to use more costly services, such as emergency departments, and are not reached by preventive care or early intervention services. They are doubly jeopardized by their minority and behavioral health status, resulting in preventable, costly, and at times, inappropriate care and poorer behavioral health outcomes.

The Affordable Care Act provides an opportunity to improve access and care for racial, ethnic, LGBTQ, and other populations. It includes the expansion of initiatives to increase racial and ethnic diversity in health care professions. It also strengthens requirements for language and outreach services to improve communications between providers and consumers. The Affordable Care Act underscores the importance of outreach to racial and ethnic minority groups that may meet expanded eligibility criteria for Medicaid but fail to enroll. In addition, as a step to improve

services to diverse linguistic populations, CMS released a letter on July 1, 2010, that outlines access to enhanced Federal match for linguistic services[113] (in reference to the State Children's Health Insurance Program), demonstrating a commitment to this issue.

The Affordable Care Act also includes many provisions applying specifically to Tribes. Because American Indians and Alaska Natives experience numerous health disparities, they will benefit importantly from health reform. The complexity of these issues and the scope of the changes require implementation efforts that incorporate Tribal consultation.

Behavioral Health Workforce

Increasing the pool of health care providers is a key component in reforming the behavioral health system. The Affordable Care Act, MHPAEA, and other efforts contribute to a comprehensive strategy to achieve this goal by improving the resources and training pipeline. SAMHSA is working with partners and stakeholders to develop a new generation of providers, promote innovation of service delivery through primary care and behavioral health care integration, and increase quality and reduce health care costs through health insurance exchanges and the essential and benchmark benefit plans.

SAMHSA is collaborating with HRSA and CMS workforce projects that include the promoting and awarding grants for behavioral health workforce development, increasing access to providers in underserved areas, and integrating behavioral health and primary care. Specifically, SAMHSA and HRSA are jointly funding a national resource center that will provide training and technical assistance to community behavioral health programs, community health centers, and other primary care organizations. The resource center will also help develop models of integrated care across behavioral health and primary care.

Components of the Initiative

Reform of the health care system will be complex, challenging, and laden with competing priorities. Work accomplished over next 3 years will be the foundation for the newly reconfigured health care system for many years to come. SAMHSA must focus on ensuring that mental health and addiction services are an integral part of many health reform efforts. In addition, SAMHSA must support States, Territories, Tribes, primary care and behavioral health providers, and individuals and families to understand and participate actively in designing and implementing State, Territorial, Tribal, and local health reform efforts.

SAMHSA and CMS must work closely in designing services to meet the needs of individuals with a wide range of mental and substance use conditions. SAMHSA will provide the content expertise to CMS in planning, designing, reimbursing, and overseeing services. Indeed, several provisions require the two Operating Divisions to provide technical assistance and guidance for States, Territories, Tribes, and providers on critical policies and programs.

Although the details of what services will be available to individuals under Medicaid and private insurance are pending, SAMHSA anticipates that more recovery- and resiliency-oriented services will be purchased with Block Grant funds. SAMHSA will work closely with States, Territories, Tribes, and other stakeholders to discuss and design changes to the Block Grant

program before 2014 when 32 million more Americans will be covered by private and public health insurance.

SAMHSA will build upon its Primary and Behavioral Health Care Integration (PBHCI) program to implement new opportunities under The Affordable Care Act, MHPAEA, and other initiatives. SAMHSA will collaborate in planning the next generation of PBHCI with CMS, Indian Health Service, HRSA, and relevant Federal Offices of Minority Health created by the Affordable Care Act. These efforts will include developing new or expanding current models that support integration of services for mental and substance use disorders with physical health in both directions (primary care in behavioral health care and behavioral health in primary care). SAMHSA will collaborate with HRSA in a technical assistance effort for States, Territories, Tribes, and providers to spread and sustain integration efforts. SAMHSA will also engage the field around Olmstead and EPSDT issues and focus on improving practice around specific issues of concern, such as HIV/AIDS. By working across systems, SAMHSA will build the best possible prevention, treatment, and recovery support services whether needs first become apparent (or first present) in the primary care office, in behavioral health providers and clinics, or in other settings such as schools, jails/prisons, or child welfare.

Goals

Goal 5.1: Ensure behavioral health is included in all aspects of health reform.

Goal 5.2: Support Federal, State, Territorial, and Tribal efforts to develop and implement new provisions under Medicaid and Medicare.

Goal 5.3: Finalize and implement the parity provisions in MHPAEA and the Affordable Care Act.

Goal 5.4: Develop changes in SAMHSA Block Grants to support recovery and resilience and increase accountability.

Goal 5.5: Foster the integration of primary and behavioral health care.

Goal 5.1: Ensure behavioral health is included in all aspects of health reform.

Objective 5.1.1: Implement strategies that address critical provisions in the Affordable Care Act.

Action Steps:

1. Develop and implement work plans for major provisions of the Affordable Care Act that are SAMHSA's responsibility and ensure all work plans incorporate the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards, as developed by the HHS Office of Minority Health). Major areas of focus will be the development of integrated health homes that include mental health and addiction services, prevention, primary care behavioral health integration initiatives, home visiting programs (with HRSA and ACF), mental health and behavioral health

education and training grants (with HRSA), Centers of Excellence for Depression (if funded), and pilots for post-partum depression (if funded).

2. Co-lead an HHS workgroup to develop policies for home- and community-based services offered by Federal and State agencies.
3. Leverage changes under The Affordable Care Act, such as coverage expansions affecting parents; provisions related to home visiting, health homes, required preventative services, and preexisting conditions; and new parity requirements to better meet the needs of children and youth affected by mental and substance use disorders.
4. Develop recommendations about the mental health and addiction services that should be available for individuals who receive services through essential and benchmark plans.

Objective 5.1.2: Support States, Territories, and Tribes in their efforts to understand, design, and implement State, Territory, and Tribe-specific health reform strategies and to reduce health disparities.

Action Steps:

1. Develop strategies for States, Territories, and Tribes to implement health reform, including identifying model policies and lessons learned from States, Territories, and Tribes that have expanded eligibility, especially in underserved communities.
2. With the expanded eligibility provisions in the Affordable Care Act, develop strategies to increase the enrollment of diverse racial, ethnic, and LGBT groups.
3. Develop, coordinate, and evaluate a technical assistance strategy for States, Territories, and Tribes on health reform, including outreach, enrollment, access, parity, prevention, and quality improvement strategies targeted to underserved diverse populations.
4. Support Tribes in their efforts to understand, design, and implement health reform strategies through tailored technical assistance and information resources, including identifying model policies and lessons learned from States and Territories that have expanded eligibility.
5. Work with the National Association of Insurance Commissioners about behavioral health issues within State insurance exchanges.

Objective 5.1.3: Support providers in their efforts to understand, design, and implement State-, Territory-, and Tribe-specific health reform strategies.

Action Steps:

1. Assist provider organizations to identify their programmatic and operational needs under health reform—including provisions to reduce health disparities—and tools to support transition.
2. Develop a strategy for addressing providers' infrastructure needs for health reform (billing, electronic health records [EHRs], compliance, access, and retention).

3. Support SAMHSA and other HHS agencies' demonstration and targeted grant programs that encourage community providers to integrate behavioral health and primary health care activities consistent with CLAS Standards.
4. Establish a national training and technical assistance center on the bidirectional integration of primary and behavioral health care and related workforce development, including increasing the diversity in behavioral health care professions.

Objective 5.1.4: Ensure adults and children with mental and substance use disorders and their families understand and take advantage of all opportunities across health reform.

Action Steps:

1. Identify immediate health reform issues and concerns by developing and conducting an environmental scan, including issues for diverse populations and geographic areas and develop educational and other communications materials on aspects of health reform based in accordance with CLAS Standards.
2. Identify enrollment issues and effective enrollment strategies from States, Territories, and Tribes that have implemented expanded eligibility, including specific strategies to reach ethnic and racial minority populations.
3. Provide information and technical assistance for States, Territories, and Tribes on effective enrollment strategies.
4. Develop processes to track and assess State-, Territory-, and Tribe-specific educational and enrollment activities.
5. Target technical assistance for populations with behavioral health needs that may be harder to enroll.

Objective 5.1.5: Effectively communicate with States, Territories, Tribes, providers, consumers, and other stakeholders about health reform opportunities.

Action Steps:

1. Develop outreach materials for consumers and providers, including materials specifically geared to diverse racial, ethnic, and LGBT groups.
2. Coordinate initial Webinars on high-risk pools, exchanges, and health homes.
3. Update SAMHSA Web site with new health reform section and launch SAMHSA Health Reform Blog.
4. Hold regular meetings with groups representing a broad and diverse range of behavioral health stakeholders, including people in recovery, racial and ethnic minorities, Tribes, the LGBT health organizations, and others.
5. Provide input to Healthreform.gov and other Federal communications efforts related to health reform.

Goal 5.2: Support Federal, State, Territorial, and Tribal efforts to develop and implement new provisions under Medicaid and Medicare.

Objective 5.2.1: Increase SAMHSA staff's understanding of current Medicaid program coverage and the potential impact of health reform on States, Territories, and Tribes.

Action Steps:

1. Develop and implement a training strategy for SAMHSA staff members who work closely with States, Territories, and Tribes on Medicaid, Medicare, and health reform.
2. Develop and implement an information and training strategy with SAMHSA staff and other HHS agencies that focuses on disparities in behavioral health care access, quality, and outcomes for ethnic, racial, and LGBTQ individuals.
3. Work with the Center for Health Care Strategies and the Association of Health Insurance Plans to identify best practices to incentivize reduction of health disparities for diverse minority populations.
4. Work with CMS to identify current coverage under Medicaid for mental and substance use disorders by State and Territory.
5. Identify current Medicaid services coverage issues that will remain after implementation of health reform, including parity.
6. Identify opportunities for work with Medicare to enhance behavioral health focused prevention, treatment, and recovery support for Medicare recipients.

Objective 5.2.2: Provide technical assistance for States and Territories regarding current and new opportunities under the Medicaid program.

Action Steps:

1. Identify critical Medicaid strategies under the different aspects of health reform.
2. Develop initial informational strategies for States and Territories to take advantage of opportunities, including provisions for workforce development to improve quality of care and access to prevention, treatment, and recovery support in underserved communities.
3. Meet with CMS to discuss information dissemination and technical assistance plans and identify internal and external technical assistance resources to support these plans.
4. Provide technical assistance for State and Territorial single State agency directors and mental health commissioners about collaboration opportunities with State and Territorial Medicaid directors.

Objective 5.2.3: Work with CMS to develop policies and programs that expand access to behavioral health services.

Action Steps:

1. Review and comment on draft regulations and State and Territorial Medicaid directors' letters prior to formal clearance.
2. Chair or participate on interagency workgroups on Medicaid and such issues as long-term care, health homes, dual-eligibility, behavioral health, and technology.
3. Develop a joint CMS/SAMHSA technical assistance effort for Olmstead and EPSDT issues.
4. Develop a joint data-driven CMS/SAMHSA technical assistance effort targeting behavioral health care disparities for diverse racial, ethnic, and LGBT groups.

Goal 5.3: Finalize and implement the parity provisions in MHAPEA and the Affordable Care Act.

Objective 5.3.1: Develop additional policies that clarify parity in health reform.

Action Steps:

1. Work with CMS and the Assistant Secretary for Planning and Evaluation (ASPE) to develop Medicaid-managed care guidance and/or regulations.
2. Work with ASPE to review interim final rule (IFR) comments and propose changes to the IFR.
3. Facilitate information dissemination about parity laws and regulations and their implications for behavioral health.

Objective 5.3.2: Track consumer and employer complaints regarding implementation of parity.

Action Steps:

1. Identify State, Territorial, and Federal touch points for consumer complaints about coverage and develop a comprehensive communications effort to educate the public about parity in multiple languages and ensure outreach to diverse populations.
2. Work with CMS, U.S. Department of Labor, and ASPE to collect and analyze information on complaints.
3. Work with Federal partners and stakeholders to develop effective oversight and enforcement strategies.

Goal 5.4: Develop changes in SAMHSA Block Grants to support recovery and resilience and increase accountability.

Objective 5.4.1: Develop a spending baseline for current Block Grants.

Action Steps:

1. Collect and analyze current spending information for Block Grants.
2. Identify information gaps, develop strategies to obtain additional information, including data on racial and ethnic minorities and LGBTQ populations participating in the behavioral health system, and collect and analyze the information to address these gaps.
3. Develop a report that provides baseline spending under the Block Grants and annual reports in the future to track changes in spending patterns.

Objective 5.4.2: Develop recommendations for spending changes.

Action Steps:

1. Based on the analysis under objective 5.4.1, identify capacity and service gaps, including gaps specific to access and services across racially and ethnically diverse populations and communities.
2. Project services that will be covered under third-party reimbursement.
3. Identify service specific categories for use of Block Grant funds.
4. Identify use of Block Grant funds for nonservice-specific activities.

Objective 5.4.3: Incorporate service definitions into Block Grants.

Action Steps:

1. Identify services workgroups (especially prevention, Tribal services, recovery, children and family support services, and residential).
2. Develop standard service definitions and service models, including culturally specific and practiced-based services.
3. Meet with stakeholders, including representatives from racial and ethnic minority, and LGBT stakeholder groups, to review service models.
4. Amend Block Grant application to include new service definitions or models.

Objective 5.4.4: Develop changes in application and reporting under Block Grants.

Action Steps:

1. Identify and implement programmatic changes for the Block Grant application in 2011 in preparation for FY 2012–14.
2. Develop communications and planning strategies with State associations and include provisions for the participation of State and Territorial child and adolescent directors, women's services coordinators, and State and Territorial offices and directors of minority and multicultural health.
3. Work with States, other stakeholders, and Federal partners to identify services and infrastructure activities to be purchased with Block Grant funds in FY 2014.
4. Work with States, other stakeholders, and Federal partners to develop and standardize strategies for reporting service utilization and outcomes for diverse racial and ethnic populations served with Block Grant funds.
5. Determine whether SAMHSA reauthorization related to the block grants is feasible and if so, when and how.

Objective 5.4.5: Assist States and Territories to make the best use of Block Grant funds as changes to the Block Grants are implemented.

Action Steps:

1. Analyze and disseminate Block Grant Addendum information provided by States and Territories.
2. Train and organize SAMSHA staff to provide targeted technical assistance for States and Territories with Block Grant plans and related transitions resulting from changes to the Block Grants.
3. Convene State and Territorial representatives related to shared Block Grant issues, including transitions resulting from changes to the Block Grants, services, implementation, and/or reporting.

Goal 5.5: Foster the integration of primary and behavioral health care.

Objective 5.5.1: Increase State, Territorial, Tribal, and local efforts to integrate primary and behavioral health care.

Action Steps:

1. Implement a National Training and Technical Assistance Center (NTTAC) on the bidirectional integration of primary and behavioral health care and related workforce development.
2. Through NTTAC, develop recovery-oriented training and technical assistance resources for diverse providers, including medical/primary care, specialty behavioral health, and peer/family specialists. Materials will include best practices for integrated services, outreach, and engagement for racial and ethnic minorities, Tribes, and LGBTQ populations.
3. Increase the number and diversity of programs providing integrated primary care and behavioral health services.
4. In cooperation with HRSA and Agency for Healthcare Research and Quality (ARHQ), provide technical assistance for federally qualified health centers (FQHCs) and community health centers (CHCs) to address the service needs of individuals with mental and substance use disorders.
5. Develop and implement a strategy to provide technical assistance for States and Territories that seek to amend their Medicaid Plan to include health homes for persons with a mental illness or substance use disorder and to ensure that health homes screen for mental illnesses and substance abuse.

Objective 5.5.2: Expand screening, brief intervention, and referral to treatment (SBIRT) across primary care settings.

Action Steps:

1. Develop a workforce development plan for FQHCs, CHCs, and larger primary care practices to adopt effective SBIRT approaches, including guidance in billing Medicaid for screening in primary care settings, in collaboration with HRSA and CMS.
2. Increase efforts by Federal Agencies to promote the coverage of SBIRT in reimbursement and grant activities.
3. Increase third-party coverage of SBIRT for depression, alcohol, and other conditions.
4. Finalize white paper describing the state of evidence for SBIRT-like models for alcohol, illicit drugs, tobacco, trauma, and mental illnesses.
5. Develop and pilot screening, brief intervention, and referral models for trauma to be implemented in conjunction with SBIRT for alcohol and drugs.

Objective 5.5.3: Collaborate with the Office of National AIDS Policy and Federal partners to implement the National HIV/AIDS Strategy.

Action Steps:

1. Work with HHS partners to focus minority HIV/AIDS resources on the 12 cities with the highest rates of HIV/AIDS to improve coordination of behavioral health resources and services for persons with or at risk for HIV/AIDS.
2. Increase access to rapid testing for HIV in SAMHSA-supported programs.
3. Provide guidance to the field on the use of SAMHSA funds for syringe services programs to engage individuals in substance abuse treatment, reduce drug use, and prevent the transmission of HIV/AIDS and hepatitis.
4. Work with the Office of the Assistance Secretary for Health and the White House to make mental health and addictions treatment available for persons with HIV/AIDS.

Strategic Initiative #5 Measures

Population-Based

- Increase rates of insurance coverage among people with mental and substance use disorders.

SAMHSA Specific

- Increase the proportion of SAMHSA Block Grant funding going to community and recovery supports.

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Strategic Initiative #6: Health Information Technology

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Key Facts

- Of 175 substance abuse treatment programs surveyed, 20 percent had no information systems, e-mail, or even voicemail.[114]
- On average, information technology (IT) spending in behavioral health care and human services organizations represents 1.8 percent of total operating budgets—compared with 3.5 percent of the total operating budgets for general health care services.[115]
- Fewer than half of behavioral health and human services providers possess fully implemented clinical electronic record systems.[116]
- State and Territorial laws vary on the extent that providers can share medically sensitive information, such as HIV status and treatment for psychiatric conditions.
- A study of 56 mental health clinicians in an academic medical center revealed that their concerns about privacy and data security were significant and may contribute to the reluctance to adopt electronic records.[117]

Overview

Both the American Recovery and Reinvestment Act and the Affordable Care Act are driving health systems toward the use of information technology for service delivery, quality improvement, cost containment, and increased patient control of personal health care and related information. In 2014, Medicaid will expand its role as the single largest payer for behavioral health services. This expansion and other requirements under the Affordable Care Act mean that the behavioral health system must integrate with the primary care system. State, Territorial, Tribal, county, and city governments as well as providers and service recipients will need support through this fundamental change in the delivery of health care.

In the past, the specialty behavioral health system has often operated independently from the broader health system and differed in the type and scope of information technology used. Through this Initiative, SAMHSA will work to increase access to health information technology (HIT) so that Americans with behavioral health conditions can benefit from these innovations. SAMHSA will support the use of interoperable electronic health records (EHRs) by the behavioral health system, focus on integrating information systems with the broader health systems, and work through its programs to drive innovation and the adoption of HIT and EHRs.

HIT provides the overall framework to describe the comprehensive management and secure exchange of health information electronically among providers, pharmacies, insurers, States, Territories, Tribes, communities, consumers, and other entities. It also provides the context from which the EHR evolves and drives discussion about privacy and confidentiality. HIT is a broad construct that extends beyond EHR and includes telemedicine and other technologies. HIT can improve health care quality, prevent medical errors, increase administrative efficiencies, decrease paperwork, and improve patient health. It also has the potential to enhance medical decisionmaking, promote patient monitoring, and involve consumers in their own care.

According to U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius, "Electronic health records will provide major technological innovation to our current health care system by allowing doctors to work together to make sure patients get the right care at the right time." She has described patient privacy in HIT as "our top priority."[118]

Purpose of Initiative #6

Ensure the behavioral health provider network, including prevention specialists and consumer providers, fully participates with the general health care delivery system in the adoption of HIT.

SAMHSA is focusing on HIT in general and EHRs specifically to ensure that behavioral health is integrated in to the Nation's broader health system. As noted in a recent Hogg Foundation position statement, "For electronic health records to be comprehensive, they must incorporate data related to all key components of health. Behavioral health information should be included in the process of creating secure, consumer-centered information technology systems."[119]

In the current health care system, general practitioners are supported by various specialty areas. Professionals in pediatrics, cardiology, oncology, orthopedics, and behavioral health (mental health and substance use disorder services) need to be able to exchange critical information with primary care practitioners. Emergency and urgent care centers, often unfamiliar with a presenting patient, need accurate and timely information quickly. EHRs linked across clinical practice areas allow the transfer of information seamlessly; improve patient care; and provide complete, accurate, and searchable health information at the point of diagnosis and care.

HIT in general and EHRs specifically will allow behavioral health practitioners to engage the individual receiving services without waiting for the exchange of records and paperwork and without requiring unnecessary or repetitive tests and procedures. Other medical and social factors occur simultaneously with and impact behavioral health. Thus, access to a patient's medical history, medication history, and other information is essential to identifying potential medication interactions, factors that may affect the effectiveness of treatment, and/or other potentially harmful consequences to a course of treatment.

With the promises held by HIT comes the need to protect the privacy and security of health information. Privacy and security are essential to fostering trust between patient and provider. Because of the sensitive nature of information shared by individuals receiving behavioral health services, privacy and confidentiality concerns are captured by additional laws and regulations. Consequently, SAMHSA and the HHS Office of the National Coordinator for Health (ONC) are committed to making interoperable EHRs available so that behavioral health and primary care

providers can use all available patient information while honoring the principle that all health information should be secure and controlled by the person receiving care.

Disparities

The necessary infrastructure and expertise to support the effective use of health information technology is lacking in nearly every community in the United States, particularly among behavioral health providers. Rural communities may lack access to the Internet, especially high speed Internet; poor communities may find HIT unaffordable; and communities of color vary in use of technology. Deficits in technology also affect Tribal communities. Because of past issues with Tribal data, extra sensitivity is needed around the protection and use of data housed in EHR systems and how such information is aggregated or reported. ONC has funded the National Indian Health Board (NIHB) to create the American Indian/Alaska Native National Regional Extension Center (AI/AN National REC) to assist Tribal health providers with achieving meaningful use of EHRs. The project is expected to reach into all of Indian Country to support EHR deployment and meaningful use implementation, with an objective impacting approximately 3,000 providers in 35 States at more than 500 individual Tribal provider sites. SAMHSA will work with NIHB and ONC to promote behavioral health issues in HIT.

SAMHSA is also collaborating with the Indian Health Service (IHS) to ensure behavioral health HIT activities include Tribal requirements. SAMHSA will continue to collaborate with IHS and to reach out through consultation with Tribes and Tribal organizations to make sure national behavioral health HIT efforts support their special requirements.

Health Reform

Health information technology is essential to the transformation of the health care delivery system and the promotion of preventive care and patient self-care. The Affordable Care Act contains incentives for providers to adopt EHRs and will drive integration of services, allowing for greater benefits from and need for the adoption of HIT. By facilitating nonduplication of services, the tracking of prescription medications, and the sharing of critical health information, the health care delivery system can avoid excessive costs, promote therapeutic efficiencies, and enhance quality of care. Behavioral health HIT holds the promise of managing behavioral health care across the multiple service inputs, documenting appropriate clinical practices, informing evidence-based strategies, and tracking preventative care over time. However, these promises cannot be achieved without the participation of the behavioral health delivery system and the linkage of behavioral health with the primary care delivery system. As a good and modern behavioral health system evolves within the framework of health reform, behavioral health HIT linked with HIT in general through EHRs and other technologies will allow for the documentation of effectiveness, efficiencies, and quality of care.

Behavioral Health Workforce

Generalized adoption of behavioral health HIT requires the involvement of the behavioral health workforce. Not only must the various treatment settings addressing mental and substance use disorders—such as community mental health centers and substance use disorder treatment programs—implement EHR systems, their staff must be trained to function within an EHR environment and to adapt to HIT. SAMHSA will promote the adoption of EHRs and the use of HIT through its discretionary program and Block Grant technical assistance efforts. In addition, SAMHSA will promote the awareness of Department of Labor (DOL) programs targeted to training entry level staff in health information technology.

Components of the Initiative

SAMHSA has collaborated on several HIT initiatives with many Federal Agencies, including the Department of Veterans Affairs (VA), IHS, Centers for Medicare and Medicaid Services (CMS), and Department of Defense (DoD). SAMHSA has awarded a $3.2-million per year, 5-year contract to incorporate behavioral health clinical data standards so that States, Territories, and other government jurisdictions have viable EHR options to offer providers that treat safety-net populations. SAMHSA activities also have targeted open-source EHR software, privacy protection, and confidentiality. For example, SAMHSA is supporting meetings of representatives from the National Association of State Mental Health Program Directors (NASMHPD), National Association of State Alcohol and Drug Abuse Directors (NASADAD), and the National Association of State Medicaid Directors (NASMD) to discuss common issues in State and Territorial data interoperability and EHR adoption.

This SAMHSA HIT Initiative operates under the ONC umbrella with the goal of ensuring the behavioral health provider network's participation with the general health care delivery system in the adoption of health information technology, including EHRs. SAMHSA is providing leadership to the behavioral health community and will align HIT activities in order to participate in health care reform and the integration of behavioral and primary health care.

The primary role of SAMHSA's HIT effort is to support the behavioral health aspects of the EHR based on the standards and systems promoted by ONC. EHR content must be created in a standard format with standard terminology so that it can be readily shared among providers. Standardized data are also required to facilitate the creation of clinical decision support. The agency is working with State and Territorial partners and emphasizing the importance of creating a holistic HIT strategy that includes comprehensive recovery-oriented programs. Another aspect of the SAMHSA's HIT effort is to facilitate the use of technology to promote, educate, monitor, and assist service recipients and persons in recovery to self-direct and succeed.

Goals

Goal 6.1: Develop the infrastructure for interoperable EHRs, including privacy, confidentiality, and data standards.

Goal 6.2: Provide incentives and create tools to facilitate the adoption of HIT and EHRs with behavioral health functionality in general and specialty healthcare settings.

Goal 6.3: Deliver technical assistance to State HIT leaders, behavioral health and health providers, patients and consumers, and others to increase adoption of EHRs and HIT with behavioral health functionality.

Goal 6.4: Enhance capacity for the exchange and analysis of EHR data to assess quality of care and improve patient outcomes.

Specific Goals, Objectives, and Action Steps

Goal 6.1: Develop the infrastructure for interoperable EHRs, including privacy, confidentiality, and data standards.

Objective 6.1.1: Actively participate and provide leadership in national forums for the creation of standard approaches and protocols to protect the privacy of patients and consumers and their confidential information.

Action Steps:

1. Collaborate with ONC and other relevant entities to create computer executable privacy policies to support patient consent using segmented patient data.
2. Prepare privacy and confidentiality domain analysis models for submission to the Health Level 7, a standards development organization, balloting process for national and international standardization.
3. Participate in ONC security and privacy initiative as a part of the effort to include behavioral health as a national priority in HIT.

Objective 6.1.2: Actively participate and provide leadership in national forums for the creation of data and outcome measurement standards for behavioral health care.

Action Steps:

1. Collaborate with sister HHS agencies, other Departments such as VA and DoD, and measure developers to submit new meaningful use measures for quality and outcome/performance through measure consensus bodies, such as National Quality Forum (NQF).
2. Propose and fund at least two new behavioral health behavioral health quality measures for inclusion in Stage 3 of the meaningful use standard adoption.
3. Promote the adoption of national clinical standard terminology for behavioral health evidence-based practices.

Objective 6.1.3: Provide support substance abuse and mental health treatment and prevention service providers to participate in health information exchanges.

Action Steps:

1. Provide cooperative agreements as incentives to providers for the adoption of certified EHR applications that can exchange clinical information using the continuity of care document (CCD) and related State or national health information exchanges (HIE).
2. Provide cooperative agreements to demonstrate innovative approaches that support primary care and behavioral health integration.
3. Support the adoption of standards-based privacy and confidentiality policy and consent management using State or national HIE infrastructure.
4. Support the enrollment of behavioral health providers in HIEs.

Objective 6.1.4: Ensure that EHR or HIT systems used by SAMHSA or supported by SAMHSA funds conform to national standards for functional certification and interoperability.

Action Steps:

1. Host demonstrations of certified EHR applications that can exchange clinical information using the CCD through State or national HIE infrastructure.
2. Provide open source behavioral health EHR modules that can be adopted by States and providers and incorporated into commercial EHR applications.
3. Work with CMS develop and disseminate guidelines to assist State Medicaid and behavioral health agencies in activities that support the acquisition and use of interoperable IT systems that effectively integrate Medicaid and behavioral health data and that may be supported with Medicaid administrative funds.

Goal 6.2: Provide incentives and create tools to facilitate the adoption of HIT and EHRs with behavioral health functionality in general and specialty healthcare settings.

Objective 6.2.1: Include incentives for the use of EHRs and HIT in SAMHSA grants.

Action Steps:

1. Prepare and publish new guidance for grants that encourage the adoption of EHRs.
2. Support the acquisition or upgrade of EHRs in provider settings with a focus on the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) program.

3. Support innovative pilots in HIT to facilitate primary care and behavioral health integration at the provider, local, State, Territorial, and Tribal levels.

Objective 6.2.2: Facilitate the dissemination of information on the acquisition and effective use of EHRs and HIT to the behavioral health community.

Action Steps:

1. Identify sources of online information on the use of EHRs and HIT and create a Web site to provide access to the information.
2. Encourage sharing of information and resources among providers via the Web and national or regional meetings.
3. Collect and disseminate best practice information on the implementation process for EHRs in behavioral health settings.
4. Publish results of pilot or ongoing projects applying HIT in behavioral health settings.
5. Provide HIT and EHR Webinars to behavioral health specialty providers.

Objective 6.2.3: Facilitate the development of a standardized patient encounter form for Screening, Brief Intervention, Referral, and Treatment (SBIRT) protocols used in primary care, specialty behavioral health, and numerous medical facility applications.

Action Steps:

1. Convene discussions with HHS, ONC, National Opinion Research Center, VA, and SAMHSA to agree on the participants, assignments, and priority actions needed to produce a standard SBIRT patient encounter form, consistent with Systematized Nomenclature of Medicine-Clinical Terms.
2. Agree on format that could be incorporated into an EHR patient record or used as a referral and transition of care EHR document delivered through an HHS ONC Nationwide Health Information Network (NWHIN)-CONNECT gateway to a referral specialist.
3. Develop a Web-based version of the format that supports transmission via the HHS ONC NWHIN-CONNECT gateway and the use of segmented data model.
4. Assess the utility of a handwritten version of this form when access to an electronic version is unavailable.
5. Train an initial group of health care providers already trained in SBIRT to use the form. Implement in a pilot project setting.
6. Engage vendors and health information exchanges in ensuring data are transferred electronically into EHRs.

7. Evaluate the pilot project implementation and usefulness of the SBIRT EHR protocol, improve as needed, and take to scale as a front-end behavioral health EHR tool for use in primary care and many other settings.
8. Through HHS ONC, NWHIN-CONNECT, direct resources and participation and assess the SBIRT utility and EHR record usability as an initial, simple gateway for behavioral health integration into mainstream medical provider and facility systems.

Goal 6.3: Deliver technical assistance to State HIT leaders, behavioral health and health providers, patients and consumers, and others to increase adoption of EHRs and HIT with behavioral health functionality.

Objective 6.3.1: Educate and train behavioral health constituent groups on the options for including State laws, 42 CFR part 2 protections, and mental health privacy within the EHR and HIE environment.

Action Steps:

1. Develop additional frequently asked questions covering 42 CFR part 2 within an HIE environment.
2. Create and disseminate one or more Webinars that educate constituents on the implementation of 42 CFR Part 2 (a Federal regulation governing the confidentiality of alcohol and drug abuse service records) within an EHR and HIE environment.
3. Create and disseminate one or more Webinars that educate constituents on the implementation of privacy and confidentiality policy, including State law as appropriate, consent management, and referral management within and EHR and HIE environment.

Objective 6.3.2: Educate and train patients and consumers, especially those in recovery, on the options for including 42 CFR part 2 protections and mental health privacy associated with State laws within the EHR and HIE environment.

Action Steps:

1. Create and disseminate one or more Webinars or podcasts that educate patients on the implications of 42 CFR part 2 within and EHR and HIE environment on personally identifiable health information.
2. Create and disseminate one or more Webinars that educate patients on their right to privacy and confidentiality and the policies they should know about including the patient consent process and patient referral within an EHR and HIE environment.

Objective 6.3.3: Assist local groups and regional extension centers in outreach and communications efforts within the provider community and the public.

Action Steps:

1. Work with ONC on outreach efforts to the regional extension centers (RECs) to support behavioral health providers.
2. In consultation with ONC and CMS, as well as other entities, develop outreach materials targeted for specific populations, such as American Indians and Alaska Natives, veterans, patients in recovery, and families.

Objective 6.3.4: Work with the State HIT coordinators to ensure the close coordination of federally and State-funded HIT initiatives, especially within the behavioral health community.

Action Steps:

1. Include State HIT coordinators in the SAMHSA regional meetings being planned in conjunction with ONC, CMS, and Health Resources and Services Administration (HRSA).
2. Support State Behavioral Health IT representatives to attend the Annual Medicaid Management Information System (MMIS) conference.
3. Collaborate with CMS to ensure the inclusion of topics specific to behavioral health data systems and HIT interoperability in the conference.
4. In conjunction with CMS, sponsor periodic conference calls or meetings with State Medicaid and Behavioral Health IT representatives for the purpose of disseminating information and technical assistance, and for providing a forum for discussion of common issues.
5. Jointly develop a plan with CMS to offer State-specific technical assistance to aid in the identification and assessment of State Medicaid and behavioral health IT system issues, and the development of options for addressing them.
6. Develop a technical assistance resource to encourage and assist behavioral health care providers in applying for Federal Communications Commission broadband grants for rural health care entities.

Objective 6.3.5: Add geographic information system (GIS) capacity to the operations center for SAMHSA National Suicide Lifeline and Veterans Administration Suicide Prevention Hotline.

Action Steps:

1. Convene a meeting with appropriate staff of the Department of Army, VA, SAMHSA and HHS' ONC to improve the use of contract resources and agree to project outcomes.

2. Deliver the SAMHSA treatment facility and crisis center electronic files in a point-face geocodable format to be added to the existing national base map. Use the ONC NWHIN-CONNECT gateway as a portal for the Suicide Prevention operations center and to generate referrals for urgent treatment in support of the DoD, VA, and SAMHSA suicide prevention missions.
3. Assess the effectiveness and utility of the demonstration project and develop future steps as appropriate to include additional behavioral health provider and facility locations to the system with potential linking to crisis centers nationally with EHR referrals and patient information protocols in place, consistent with SAMHSA and ONC privacy and security standards using NWHIN-CONNECT gateway.

Goal 6.4: Enhance capacity for the exchange and analysis of EHR data to assess quality of care and improve patient outcomes.

Objective 6.4.1: Ensure that behavioral health data can be exchanged on a local, regional, State, and national basis.

Action Steps:

1. Facilitate adoption of national clinical data exchange standards for behavioral health, especially in the areas of substance abuse treatment and recovery.
2. Facilitate adoption of standardized privacy and confidentiality policy, including consent management, with patient data segmentation.

Objective 6.4.2 In consultation with State and national experts, develop standards to assess the quality of care and patient outcomes.

Action Steps:

1. Facilitate the creation of exemplar projects that use national data standards to demonstrate the use of current behavioral health best practices and standard data collection.
2. Adopt a state-of-the-art data warehouse environment to collect and report on quality of care and patient outcomes with clearly delineated national data standards-based clinical and administrative information.

Objective 6.4.3 Establish uniform reporting requirements across all grantees and other federally funded behavioral health initiatives to ensure effective analyses of data on the quality of care and patient outcomes.

Action Steps:

1. Deploy a state-of-the-art data warehouse environment to collect and report on quality of care and patient outcomes with clearly delineated national data standards-based clinical and administrative information and make reporting available to SAMHSA grantees.
2. Facilitate access to a state-of-the-art data warehouse environment to collect and report on quality of care and patient outcomes with clearly delineated national data standards-based clinical and administrative information and make data available to SAMHSA researchers.
3. Collaborate with CMS to develop and implement a common set of requirements designed to encourage collaborative HIT planning among Medicaid and behavioral health authorities and to assess State progress in creating interoperable/integrative HIT systems conforming to Federal data standards.

Strategic Initiative #6 Measures

Population-Based

- Increase the percentage of behavioral health organizations/providers that adopt and use certified electronic medical records by 2013.

SAMHSA Specific

- Increase the percentage of SAMHSA discretionary grantees that adopt and use certified electronic medical records by 2013.

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Strategic Initiative #7: Data, Outcomes, and Quality

Lead: Pete Delany, Director, Center for Behavioral Health Statistics and Quality

Key Facts

- Access to comprehensive health insurance coverage and the provision of services with a strong evidence base leads to improved health and behavioral health outcomes.[120, 121]
- Fragmented data systems reinforce the historical separateness of service systems.
- Discrete service systems can limit access to appropriate care, lead to uneven quality in service delivery and coordination, and increase information silos.
- Distinct funding streams for State, Territorial, and Tribal mental health, substance abuse, and Medicaid agencies underscore the importance of common measures and data collection reporting strategies.[122]
- Increasing understanding of practice-based evidence and making data and research more accessible for policy audiences significantly impact their use by policymakers.[123]

Overview

The transformation of health care systems is expected to improve the quality of life and behavioral health outcomes for millions of Americans. It will also significantly reduce death, illness, and overall health care expenditures. However, without an adequate system to understand behavioral health needs and measure appropriate behavioral health outcomes, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Nation have a limited capacity to assess the transformation's impact on individuals, families, and communities. Additional limitations in the ability to identify and address behavioral health disparities result from the lack of specificity, uniformity, and quality in data collection and reporting procedures. This SAMHSA Initiative aims to improve the quality and availability of data and analysis and promote the dissemination of effective, evidence-based interventions and services. SAMHSA will facilitate efforts within States, Territories, Tribes, and communities to advance policies and programs that contribute to better health and behavioral health outcomes for individuals, families, and communities.

Purpose of Initiative #7

Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.

The U.S. Department of Health and Human Services (HHS) and SAMHSA seek to make programming decisions supported with high-quality data. These efforts are consistent with the Government Performance and Results Act (GPRA) Modernization Act of 2010 that amends the GPRA of 1993 and endorses improved accountability through quarterly performance data reporting, priority setting and regular senior leadership meetings. Both emphasize the importance of transparency in these decisions by making data readily available to the public. SAMHSA

continues to strive toward improving the national, State, Territory, Tribe, community, and program-level data collected. However, many budgetary and programmatic decisions are still made with incomplete data.

Through this Initiative, SAMHSA will formulate an integrated data strategy for informing policy, measuring program impacts, and disseminating results. This data strategy will improve the quality of services provided through SAMHSA, Medicaid, and other public and private funding, and, therefore, improve outcomes for individuals, families, and communities.

In recent years, SAMHSA has promoted the coordinated use of data for the formulation of policy and programming. This strategy has focused on:

- Collecting information both to inform national, State, Territorial, and Tribal mental health and substance abuse policy decisions and increase the effectiveness of SAMHSA programs and activities;
- Managing programs and monitoring performance; and
- Advancing activities to promote the interoperability of data systems and the uptake of electronic health records (EHRs).

SAMHSA has made progress in each of these areas and has active and ongoing efforts with Federal, State, Territorial, Tribal, community, and other stakeholders.

The new Initiative takes advantage of a revitalized national interest in data activities and new technologies to establish a more robust behavioral health information infrastructure for the Nation. SAMHSA will serve as the lead voice in addressing mental and substance use disorders within national health reform efforts. SAMHSA also will work to ensure that those most vulnerable have access to high-quality prevention, treatment, and recovery services.

High-quality services are not enough. Quality services may or may not improve behavioral health at the population level. Policymakers must have valid outcome data to allocate resources to services that are both high quality and meet the needs of the population served. Quality and outcome measures for behavioral health services have been developed that are accepted by the much of the field. SAMHSA can capitalize on the opportunity to develop a quality and outcome framework for the field based on these accepted measures.

Expanding access to data for policy development and decisionmaking is a guiding principal of SAMHSA's approach to transforming health care. This expansion includes collecting and assessing national, State, Territorial, Tribal, community, and program-level data and information as well as measuring the impact and effectiveness of service investments. It will require systems-level research to examine new strategies to improve the quality and outcomes of behavioral health care across primary care, specialty care, and social service sectors. Coordination and cooperation across the SAMHSA's Centers and Offices will be essential.

Improved data systems are central to SAMHSA's goal of improving the quality of behavioral health services in the United States. Better use and availability of data will enable providers to

more fully understand individual needs and provide person-centered care that works for consumers. Using a range of data effectively will drive accountability, leading to higher quality, safer, more accessible, and more reliable care. Accountability can also improve the experience of individuals receiving care and support active engagement of consumers and families.

Disparities

Because American Indians and Alaska Natives (AI/AN) make up a relatively small proportion of the broader population, national surveys often do not have sufficient numbers of Tribal respondents to provide a detailed or responsive picture of their behavioral health status and needs. Further AI/AN data collection will be required to obtain a better understanding of the behavioral health needs of this community. To address concerns about appropriate use of their data, research and data collection efforts must be conducted in a collaborative fashion. Protections must be in place. SAMHSA is committed to working with Tribes to address these issues.

The same issues also apply to other minority groups including racial and ethnic minorities and the LGBTQ population. In addition to these concerns, data and performance systems often do not capture items like identification with ethnic subpopulations (i.e. Vietnamese as an Asian subpopulation) or sexual and gender identity. Tracking these items can allow for a better understanding of public health issues related to specific groups. The desire for more and better data is balanced by limitations in sample sizes and resource constraints, but SAMHSA will work to improve its collection and understanding of problems across the population.

Health Reform

Activities within the Data, Quality, and Outcomes Initiative are focused on monitoring progress toward the achievement of health reform goals and objectives. SAMHSA's existing survey and surveillance activities will play an important role in tracking changes in access to and coverage of behavioral health services to needed populations. In addition, SAMHSA's planned development of an annual behavioral health barometer report will provide a snapshot of the status of various behavioral health indicators both nationally and within States. This snapshot show trends and anticipated progress in promoting mental health and in preventing and treating the substance abuse and mental illness of individuals, families, and communities across the country. Moreover, SAMHSA's efforts to advance a national behavioral health quality strategy that parallels the national quality strategy required annually through the Affordable Care Act provides SAMHSA an opportunity to exert leadership in the identification and reporting of important behavioral health quality and outcome measures reflective of key health reform goals.

Behavioral Health Workforce

Significant information and data needs are related to behavioral health workforce development. At present, limited data are available to inform strategic planning efforts aimed at recruitment and retention of a highly skilled, diverse, and culturally competent behavioral health workforce. SAMHSA is committed to broadly disseminating existing data about the behavioral health workforce through publications, such as *Mental Health, United States, 2008,* as well as identifying and addressing informational gaps to assist the efforts of educators, providers,

stakeholders, and policymakers toward achieving a knowledgeable, experienced, and compassionate behavioral health workforce.

More specifically, SAMHSA is providing training through the Projects for Assistance in Transition from Homelessness (PATH) on a number of topics, including the use of the U.S. Department of Housing and Urban Development (HUD) homelessness data collection system. Several SAMHSA workforce efforts target quality improvement through workshops, intensive training and resources that promote the adoption of evidence-based practices; training and technical assistance on process improvement activities through the NIATx program; and activities to advance the delivery of clinical supervision to foster competency development and staff retention. The annual National Survey of Substance Abuse Treatment Services (N-SSATS) and the biannual Mental Health Services Survey also collect data on standard operating procedures, continuing education requirements for staff; and accreditation, licensing, and certification of programs.

Goals

Goal 7.1: Implement an integrated approach for SAMHSA's collection, analysis, and use of data.

Goal 7.2: Create common standards for measurement and data collection to better meet stakeholder needs.

Goal 7.3: Improve the quality of SAMHSA's program evaluations and services research.

Goal 7.4: Improve the quality and accessibility of surveillance, outcome and performance, and evaluation information for staff, stakeholders, funders, and policymakers.

Specific Goals, Objectives, and Action Steps

Goal 7.1: Implement an integrated approach for SAMHSA's collection, analysis, and use of data.

Objective 7.1.1: Create a coordinated SAMHSA-wide performance measurement and monitoring system for SAMHSA discretionary, formula, and Block Grant programs.

Action Steps:

1. Develop and launch an integrated platform for the collection, analysis, and dissemination of grant-related performance data.
2. Develop and implement standard procedures for internal and external data users to successfully use data to monitor progress and outcomes of grants, including Block Grants.

Objective 7.1.2: Expand SAMHSA's internal analytic capacity that realizes an integrated data collection and behavioral health services system research program.

Action Steps:

1. Organize the Center for Behavioral Health Statistics and Quality (CBHSQ) to include an analytic support unit with expertise in mental health and substance abuse epidemiology, survey and statistical methodology, health service systems research, and program evaluation.
2. Promote collaborations across SAMHSA Centers; Federal partners; State, Territorial, and Tribal governments; and other stakeholders to create timely and relevant analyses to inform health reform and other initiatives with special attention to issues related to Tribal communities and minority populations based on standards outlined in the Institute of Medicine (IOM) *Report on Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* funded by the Agency for Heathcare Research and Quality (AHRQ).
3. SAMHSA/CBHSQ will work with the Open.Gov Initiative to identify innovative strategies, including data.gov, to make data available as soon as possible while protecting confidentiality of survey respondents.

Goal 7.2: Create common standards for measurement and data collection to better document the quality and outcomes of behavioral health services.

Objective 7.2.1: Build and disseminate standard definitions and metrics to measure performance and quality of services and programs funded by SAMHSA.

Action Steps:

1. Work with partners and stakeholders—including representatives of diverse ethnic, racial and sexual minority populations—to develop a set of quality and performance indicators for SAMHSA's Block and discretionary grant programs that are consistent with Affordable Care Act guidelines and SAMHSA's recovery-oriented approach to care and that support SAMHSA's Strategic Initiatives.
2. Develop an annual report of the state of behavioral health in the United States.
3. Conduct a rigorous review of SAMHSA's GPRA measures to ensure that each program included in the GPRA Report and Plan captures the numbers served, the key goal of the program, and, when appropriate, an outcome to measure recovery.
4. Develop a recommendation on inclusion of efficiency measures in the GPRA Report and Plan.

5. Present proposed measures to SAMHSA leadership, Advisory Councils, Federal partners (e.g., other HHS agencies, Office of Management and Budget [OMB], and Office of National Drug Control Policy [ONDCP]), and SAMHSA constituents.
6. Incorporate revised indicators into SAMHSA's performance measurement systems.
7. Include sexual identity questions in SAMHSA's national surveys and program evaluations, building on the Intra-Agency Agreement with the National Center for Health Statistics Sexual Identity Question Design and Development Center.

Objective 7.2.2: Create a national behavioral quality framework consistent with the National Health Quality Framework.

1. Develop and implement a quality framework with examples of measures for behavioral health programs, including those funded by SAMHSA and other public sources and develop or identify population-based measures for tracking the performance of the Nation's behavioral health system.
2. Develop and implement a behavioral health service and system quality improvement framework—including processes, mechanisms, and outcomes for use by individual practitioners, programs, States, Territories, Tribes, and other funders—that is coordinated with EHR adoption and implementation.

Objective 7.2.3: Establish standards for defining and measuring resilience and recovery for substance abuse and mental health.

Action Steps:

1. Develop initial working definitions and metrics for resiliency and recovery.
2. Present proposed definitions and metrics to SAMHSA leadership, Advisory Councils, Federal partners (HHS, OMB, ONDCP), and constituents.
3. Work across SAMHSA's Centers and Offices to incorporate definitions and metrics into SAMHSA funded programs and throughout the Nation's behavioral health system.

Goal 7.3: Improve the quality of SAMHSA's program evaluations and services research.

Objective 7.3.1: Develop and implement a SAMHSA-wide evaluation policy to assess the effectiveness of SAMHSA programs.

Action Steps:

1. Finalize and implement a SAMHSA-wide evaluation policy in time for inclusion, where appropriate, in FY 2011 contracts.

2. Develop and implement a Web-based proposal and tracking system for SAMHSA-funded evaluations, including summaries of projects, timelines, and findings.

Goal 7.4: Improve the quality and accessibility of surveillance, outcome and performance, and evaluation information for staff, stakeholders, funders, and policymakers.

Objective 7.4.1: Create a single access point for disseminating State, Tribal, Territorial, and community data and information.

Action Steps:

1. Develop a new searchable State/Territorial/community Web page on www.samhsa.gov that draws from existing data systems and includes a "link farm" based on frequently asked questions.
2. Develop a Web-based, dashboard-driven State, Territorial, Tribal, and community data link on SAMHSA's Web site that includes material relevant to diverse communities and provide technical assistance and support for users.

Objective 7.4.2: Increase accessibility to data reports that demonstrate improvements in access to services and physical and behavioral health outcomes within and across populations.

Action Steps:

1. Work with Federal, State, Territorial, Tribal, community partners, and other stakeholders to encourage the use of national survey and program performance data to document and monitor progress toward improving access to physical and behavioral health services (e.g., through acquisition of health insurance).
2. Develop and implement a data users conference for State, Territorial, Tribal, and community stakeholders and academic partners, including representatives of groups that experience behavioral health disparities.
3. Create opportunities to support behavioral health service researchers in using SAMHSA and related behavioral health data through training, accessibility, and internships.

Strategic Initiative #7 Measures

Population-Based

- Increase the number of States adopting the Behavioral Health Barometer for planning and reporting purposes.

SAMHSA Specific

- Reduce contract evaluation expenditures by 10 percent by 2012 through implementation of an SAMHSA-wide evaluation strategy.

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Strategic Initiative #8: Public Awareness and Support

Lead: Mark Weber, Director, Office of Communications

Key Facts

- In 2009, 12.0 million adults aged 18 and older (5.3 percent) reported an unmet need for mental health care in the past year. These respondents included 6.1 million adults who did not receive any mental health services in the past year. Among the 6.1 million, several barriers to care were reported, including cost, lack of health insurance coverage, and not knowing where to access care.[124]
- Only about half of American children and teenagers with some common mental disorders (generalized anxiety disorder, panic disorder, eating disorders (anorexia and bulimia], depression, attention deficit hyperactivity disorder [ADHD], and conduct disorder) receive professional services.[125]
- Two-thirds of Americans believe that treatment and support can help people with mental illnesses lead normal lives.[126]
- One in five Americans feels that persons with mental illness are dangerous to others.[127]
- Two-thirds of Americans believe addiction can be prevented.[128]
- Just over 95 percent or 19.8 million of the 20.8 million people classified as needing substance use treatment because of the problems they experienced did not feel they needed treatment.[129]
- Among persons aged 12 and older who needed but did not receive treatment at a specialty facility and perceived a need for treatment, lack of coverage or the inability to cover the cost of treatment was the most common reasons given for not receiving illicit drug or alcohol use treatment.[130]
- Seventy-five percent of Americans believe recovery from addiction is possible.[131]
- Twenty percent of Americans say they would think less of a friend or relative if they discovered that person is in recovery from an addiction.[132]
- Thirty percent of Americans say they would think less of a person with a current addiction.[133]
- Ninety-four percent of primary care physicians in a study conducted in 2000 failed to diagnose substance use disorders properly.[134]

Overview

Social marketing is a well-established, science-based process to influence a target audience to voluntarily accept, reject, modify, or abandon a behavior for the benefit of individuals, groups, or society as a whole. The National High Blood Pressure Education Program is a prominent example of successfully using a strategic planning framework and marketing techniques. When the program was launched in 1972, less than one-fourth of Americans knew of the relationship between hypertension, stroke, and heart disease. Today, more than three-fourths of the population are aware of this connection. Virtually all Americans have had their blood pressure measured at least once, and three-fourths of the population have it measured every 6 months.

Purpose of Initiative #8

Increasing the understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

Just as Americans are aware of the connection between hypertension, stroke, and heart disease, they should be aware of the connection between mental and substance use disorders and take action to prevent and treat these problems.

Opportunities for preventing or intervening early to reduce the death and illness associated with mental and substance use disorders are often missed. Half of all mental illnesses begin by age 14, and three-fourths begin by age 24. Initial symptoms typically precede a disorder by 2 to 4 years. Preventing and delaying initiation of substance abuse can reduce the potential need for treatment later in life. For example, among the 14 million adults aged 21 and older who were classified in the past year with alcohol dependence or abuse, more than 13 million (95 percent) had started drinking alcohol before age 21.

Suicide is another example. Every year, more than 34,000 persons die by suicide in the United States. Approximately 90 percent of those who die by suicide had a mental disorder, and 40 percent had visited their primary care doctor within the past month. Yet, the topic of suicide was seldom raised. Suicide is also strongly related to alcohol and other substance use, 20 to 50 percent of the people who die by suicide had alcohol or drug abuse problems.[135]

People do not receive help for many reasons. Just over 95 percent of the 20.8 million people (19.8 million) classified as needing substance use treatment because of the problems they experienced did not feel they needed treatment. People who reported an unmet need for mental health care in the past year—and those who perceived a need for substance use treatment and did not receive it—reported cost and lack of insurance coverage as the top reasons for not receiving care. With the passage of the Affordable Care Act and enhanced access to mental and substance use disorder prevention and treatment services, cost and insurance barriers should begin to decline.

The opportunity to reduce the gap between people who need and people who receive prevention and treatment services is largely a public education challenge. SAMHSA can improve the rates at which people with mental and substance use disorders receive services, attain, and sustain recovery by:

- Increasing public knowledge about the effectiveness of treatment and opportunities for recovery;
- Educating the public about self, peer, and family care;
- Improving understanding about how to obtain insurance coverage and access treatment; and
- Confronting discrimination and misinformation.

Disparities

Segmenting SAMHSA's market outreach includes development of specific strategies to reach and engage diverse cultural, racial, and sexual minority groups. Although these populations have similar rates of behavioral health disorders to the general population, they bear a heavier burden of disease, often due to lack of information, access, and appropriate services. SAMHSA will align its communication strategy to improve the reach of SAMHSA's media in these communities; increase the cultural relevance of its outreach, awareness, and media strategies; and establish networks of culturally diverse consumers, families, and stakeholders to better share information and inform SAMSHA's work.

Health Reform

In recognition that behavioral health is essential to overall health, the Affordable Care Act makes the prevention and treatment of mental and substance use disorders part of the essential benefits package. Under the new law, mental and substance use disorders will no longer be used to deny coverage as a "pre-existing conditions." People with mental and substance use disorders and those at risk can greatly benefit from the new health reform law, but only if they are aware of and know how to access the benefits. Raising public awareness about prevention, early intervention, treatment and recovery support service benefits will increase demand for these services and provide an unprecedented opportunity and challenge for the behavioral health community. The Initiative will meet this need by building capacity and raising public awareness about the benefits of health reform, parity, and other developments in Federal behavioral health policy.

Behavioral Health Workforce

Increasing the relevance, effectiveness, and accessibility of training and education is an urgent priority for the behavioral health field. SAMHSA remains committed to supporting an effective behavioral health workforce, which means ensuring that the workforce has the latest information about effective services, supports, and trends. It also means the behavioral health workforce is connected to a broader dialogue that emphasizes the importance of self-direction for people with mental and substance use disorders and the critical roles that peers and family members play in recovery. Though this Initiative, SAMHSA will work to ensure that the behavioral health workforce has access to the information needed to provide successful prevention, treatment, and recovery services. SAMSHA will also support the workforce to engage people with mental and substance use disorders and empower them on the path to recovery.

Components of Initiative

SAMHSA's Strategic Initiative on Public Awareness and Support articulates a clear strategy to engage the public through multiple communications channels and satisfy customer needs at the moment and in the format information is desired. To maximize the effectiveness of these efforts, SAMHSA will tailor communications to a variety of audiences, including providers, policymakers, payers, current and potential service recipients, educators, family members (e.g., caregivers, children, youth, and young adults), researchers, community advocates, individuals, and the media.

Each audience has a distinct set of wants, needs and communications channels. Market research—including the employment of Web-based public engagement strategies and platforms—will be used to inform the development and evaluation of messages, products and services, and communications channels. This communications approach and public engagement strategy will include Web, social media (e.g., Twitter, Facebook, YouTube, and blogs), analytics and metrics, media monitoring, graphic design, mapping/geospatial, data and application program interface (API) development, video and multimedia, mobile messaging, and ongoing assessments of new and emerging technologies (e.g., gaming). In addition to these communications channels, cultivating relationships and collaborating with public and private sector organizations will further strengthen SAMHSA's effort to influence attitudes and actions related to behavioral health.

SAMHSA is aligning and focusing its communications assets on achieving the goals of the Public Awareness and Support Initiative and the other seven Strategic Initiatives. The agency has reframed its mission and is sharpening its presence and visibility. SAMHSA intends to disseminate a consistent set of messages across multiple platforms. As an example, SAMHSA is consolidating 88 Web sites, combining multiple 1-800 numbers into a single point of entry, creating one user-friendly facility locator service, and building a public engagement strategy with social media.

To lead this effort SAMHSA has created a Communications Governance Council (CGC). The Council is charged with setting the strategic direction and policy for SAMHSA's public communications activities. It will provide guidance on the development and implementation of the communications plan for each Strategic Initiative and make decisions on concept and content clearances for SAMHSA's public communications activities, including Web, new media, and electronic and written publications based on the plans.

Through the use of the strategic initiative strategic planning framework and the latest marketing techniques, SAMHSA will deliver content when and where it is needed and serve as the principal source for the American public to find accurate and timely information about behavioral health services, including prevention, treatment, and recovery supports.

Goals

Goal 8.1: Increase public understanding about mental and substance use disorders, the reality that people recover, and how to access treatment and recovery supports for behavioral health conditions.

Goal 8.2: Create a cohesive SAMHSA identity and media presence.

Goal 8.3: Advance SAMHSA's Strategic Initiatives and HHS priorities through strategic communications efforts.

Goal 8.4: Provide information for the behavioral health workforce.

Goal 8.5: Increase social inclusion and reduce discrimination.

Specific Goals, Objectives, and Action Steps

Goal 8.1: Increase public understanding about mental and substance use disorders, the reality that people recover, and how to access treatment and recovery supports for behavioral health conditions.

Objective 8.1.1: Raise public awareness of behavioral health issues.

Action Steps:

1. Coordinate development of public education campaigns within SAMHSA and in collaboration with private and nonprofit organizations, including populations affected by disparities.
2. Solicit and use stakeholder feedback, including responses from representatives of other groups affected by disparities, and market research to inform content development.
3. Facilitate inter- and intra-agency collaboration for content development and evaluation using the Behavioral Health Coordinating Council and other Federal, State, Tribal, Territorial, and community partners.
4. Facilitate inter- and intra-agency collaboration to improve awareness in targeted populations and through specific delivery systems.
5. Engage behavioral health organizations—including those serving diverse racial, ethnic and sexual minority communities; guilds; the private sector, and government entities—to extend the reach of campaigns and efforts.
6. Develop and implement a plan to increase the amount of donated media connected with SAMHSA communications efforts.
7. Develop scheduled news media events to promote behavioral health access issues, such as suicide prevention and children's mental health services.
8. Develop and enact a plan for SAMHSA leadership to speak in nontraditional settings and to nonbehavioral health audiences.
9. Consolidate and coordinate national public events and awareness days and months sponsored by SAMHSA.
10. To measure and report change, establish an annual survey of American attitudes and awareness.

11. Engage stakeholder groups that represent populations affected by health disparities to ensure that the action steps included under this goal target diverse audiences and are conducted in a culturally competent manner.

Objective 8.1.2: Deliver evidence-based behavioral health information to the public in a meaningful way.

Action Steps:

1. Complete the SAMHSA's Health Information Network redesign and knowledge management project.
2. Inventory current communications product in development.
3. Improve the design and accessibility of training and educational materials while ensuring that materials are appropriate to varied audiences and adapted to their unique needs (e.g., create materials in plain language, in accessible formats, and in multiple languages when appropriate).
4. Train SAMHSA staff on how to plan, produce, distribute, and promote training and educational materials.
5. Work with Centers and Offices to coordinate public release of studies, grants, and other announcements.
6. Host regular media workshops highlighting key behavioral health issues.
7. Use product inventory metrics to help identify content gaps and outdated materials that need updating.
8. Ensure that campaigns and products are connected to a tailored distribution and marketing plan that is inclusive of diverse ethnic, racial, and sexual minority communities.
9. Work with other HHS and Federal agencies to reduce multiple public education efforts on similar topics.

Objective 8.1.3: Increase the public's awareness of signs and symptoms of mental and substance use disorders and how to access services.

Action Steps:

1. Inventory SAMHSA-supported information service telephone numbers and develop a single 1-800 number to access SAMHSA information services and a strategy to promote awareness of this number across all groups.
2. Consolidate and improve the SAMHSA treatment locators.
3. Develop public education activities and materials to cover changes resulting from health reform and parity, and materials and focus efforts on specific populations to address behavioral health disparities.

4. Centralize the public's access to SAMHSA technical assistance providers and grantees.

Objective 8.1.4: Use emerging technology and social media to engage and inform the public.

Action Steps:

1. Develop pilots based on SAMHSA priorities and best practices established by other Federal Agencies.
2. Use evidence from pilot campaigns to develop a comprehensive new media strategy.
3. Develop tools and processes to support greater engagement with the public and with diverse stakeholders and audiences, including groups affected by disparities.
4. Establish metrics and benchmarks to evaluate the effectiveness of new media and new technologies to effectively support the SAMHSA priorities.
5. Develop content ready for use with traditional and emerging news media (e.g., blogs and social networking).

Goal 8.2: Create a cohesive SAMHSA identity and media presence.

Objective 8.2.1: Streamline and coordinate SAMHSA's Web presence.

Action Steps:

1. Create a SAMHSA-wide Web program that provides infrastructure support for a content-rich, up-to-date, and effective Web presence.
2. Ensure accessibility for a variety of audiences on SAMHSA's Web site, including people with disabilities, and support access to Spanish and other high-frequency language materials.
3. Develop common templates, standards, infrastructure, and operating system for the SAMHSA Web program that ensures ease of use and 508 compliance.
4. Develop a common set of metrics to benchmark SAMHSA Web performance for multiple audiences, including racially and ethnically diverse end users and lesbian, gay, bisexual, transgender, and questioning (LGBTQ) populations.
5. Implement a Web Content Management System (WCMS) to facilitate publishing content.
6. Eliminate redundancy in SAMHSA's Web presence by consolidating and centralizing content.
7. Consolidate and redesign SAMHSA's Web site with the appropriate page links and search capacity to create one place to find Federal behavioral health services information.

Objective 8.2.2: Create common design elements, formats, and standards for SAMHSA materials.

Action Steps:

1. Develop templates and standards for SAMHSA materials. Include templates that are appealing to and reflective of diverse populations.
2. Establish and facilitate SAMHSA staff adherence to a set of quality review criteria for SAMHSA products that includes attention to cultural and linguistic needs of diverse audiences.
3. Develop SAMHSA standards for key engagement technologies (e.g., video, application programming interface development, and mobile).

Objective 8.2.3: Develop a consistent set of messages and a common language for behavioral health across HHS.

Action Steps:

1. Implement strategies to ensure that SAMHSA's messages and products are consistent with Culturally and Linguistically Appropriate Standards (CLAS) to address the diverse populations served by HHS.
2. Refine consistent SAMHSA talking points to ensure that they reflect, where appropriate, a behavioral health approach including prevention, treatment, and recovery, are culturally appropriate, and meet the health literacy of their intended audiences.
3. Disseminate and promote SAMHSA talking points in all areas possible (e.g., news releases, Administrator speeches, SAMHSA reports, and presentations).
4. Conduct a communications audit to solicit feedback from diverse groups of stakeholders to inform and improve how the SAMHSA defines and promotes behavioral health language, including focus group testing for messages and materials.
5. Provide the Office of the Assistant Secretary for Public Affairs with standard language to use in public outreach materials for a wide range of behavioral health issues, including for diverse cultural and linguistic populations.
6. Work with HHS and other partners through the HHS Behavioral Health Coordinating Committee to develop common terminology and outreach approaches on behavioral health issues that cut across multiple professions and areas of expertise and multiple populations and languages.
7. Develop and implement a crisis communications plan to support disaster response and recovery efforts. Work with the news media to provide consistent and clear messages on these issues and explanations of their importance.
8. Inform and engage the public during public incidents and current events related to behavioral health.

Goal 8.3: Advance SAMHSA's Strategic Initiatives and HHS priorities through strategic communications efforts.

Objective 8.3.1: Provide communications support to SAMHSA's Strategic Initiatives.

Action Steps:

1. Establish a SAMHSA-wide Communications Governance Council to implement a shared operating framework and decisionmaking process for SAMHSA communications.
2. Create and implement a communications plan for each Strategic Initiative that ensures input from, is appropriate for, and reaches out effectively to a broad range of behavioral health stakeholders, including individuals in recovery and their families, culturally and linguistically diverse audiences, and community coalitions.
3. Use research gathered from consumers, family, and community members from racially and ethnically diverse groups and LGBT communities to inform content development priorities for each Initiative.
4. Establish internal mechanisms for making content decisions based upon stakeholder feedback.
5. Build a culturally and linguistically diverse corps of effective SAMHSA spokespeople on these initiatives, particularly individuals in recovery.
6. Develop recovery and resiliency oriented, culturally and linguistically appropriate multimedia materials (e.g., news releases, news bulletins, and factsheets) highlighting accomplishments.

Objective 8.3.2: Engage stakeholders to inform and receive feedback about policy directions.

Action Steps:

1. Establish a standard approach for involving individuals in recovery from mental or substance use disorders, racially and ethnically diverse individuals, Tribes, and members of the LGBT community in all aspects of SAMHSA's outreach capabilities, including SAMHSA news, news releases, social media, and Web site, in serving diverse groups of stakeholders.
2. Provide transparent mechanisms to solicit and respond to stakeholder input on key policy issues.
3. Develop the workforce to establish and maintain a recovery and resiliency oriented, culturally and linguistically diverse behavioral health communications network of States, Territories, Tribes, providers, consumers, and other audiences.

Goal 8.4: Get information to the behavioral health workforce.

Objective 8.4.1: Improve the design and accessibility of technical materials and resources.

Action Steps:

1. Establish a common recovery- and resiliency-oriented, culturally and linguistically appropriate approach and product lines for SAMHSA's practice improvement portfolio for both mental health and substance use conditions (e.g., Treatment Improvement Protocols, Toolkits, Clinical Guidelines, and Community Planning Guides).
2. Solicit input from a diverse representation of the workforce on types of resources and formats they would prefer to receive information.
3. Evaluate different channels of sharing information (e.g., Webinars) to respond to needs of the field more quickly.
4. Work with mainstream and culturally and linguistically diverse practitioners and provider groups to increase awareness and implementation of evidence-based practices, promising programs, practice-based interventions, and emerging knowledge to improve practice and outcomes through tailored materials and communications efforts.
5. Work to coordinate resources provided by SAMHSA technical assistance providers to reduce duplication and ensure broader dissemination and use of technical assistance resources and materials.

Objective 8.4.2: Use new technology and media to engage and inform the workforce.

Action Steps:

1. Inventory SAMHSA-supported meetings and conferences and leverage opportunities to advance SAMHSA priorities.
2. Enhance the quality and availability of workforce-related information, including information relevant for diverse populations on SAMHSA's existing new media channels and Web site.
3. Pilot and evaluate the use of new media platforms that are not currently being used by SAMHSA and are relevant to a diverse workforce (e.g., LinkedIn and e-Learning platforms).
4. Establish platform (e.g., wiki, UserVoice) for program offices to use to engage targeted audiences.

Goal 8.5: Increase social inclusion and reduce discrimination.

Objective 8.5.1: Engage consumers, families, and persons in recovery to identify key messages and strategies.

Action Steps:

1. Provide ongoing training opportunities for key mainstream and diverse audiences, including consumers, peers, persons in recovery, providers, LGBTQ populations, and researchers on discrimination reduction and social inclusion.
2. Infuse discrimination reduction and social inclusion throughout communications related to the Strategic Initiatives.
3. Convene diverse consumer and family stakeholder groups to seek input to establish public education and awareness efforts to reduce discrimination and improve public attitudes associated with behavioral health conditions and promote social inclusion, acceptance, support, and recovery.
4. Establish supports and awards for consumer-run and persons-in-recovery run organizations to establish social inclusion efforts on the State, Territorial, Tribal, and community level.
5. Develop impact statement tools that can be used to examine programs and policies for impact on the social inclusion of people in recovery and those traditionally affected by disparities, including LGBTQ populations.
6. Through a systematic outreach effort, develop a network of consumers, families, and persons in recovery from diverse perspectives, including racial and ethnic minority, disability and LGBTQ groups.

Objective 8.5.2: Engage media and stakeholders in communication around discrimination reduction and social inclusion.

Action Steps:

1. Coordinate and consolidate public recognition and awareness events for mainstream and diverse cultural and linguistically diverse audiences (e.g., award shows and awareness days and months) to improve exposure and salience of messages.
2. Increase SAMHSA expert and material placement on news, ethnic, and popular media outlets (e.g., talk and reality shows)
3. Maintain an entertainment awards program that recognizes the efforts of diverse entertainment media outlets and consumer and persons in recovery leaders to promote accurate representations of people in recovery and break down the misperceptions and stereotypes so often perpetuated by the entertainment media.

Objective 8.5.3: Engage the public, employers, educational systems, and others to enhance their understanding and support of resilience, recovery, and social inclusion.

Action Steps:

1. Identify and consistently deliver key messages around resilience and recovery across SAMHSA communications channels and ensure relevance to a culturally, linguistically, and geographically diverse audience
2. Identify areas of misconception and misrepresentation across diverse populations, particularly when additional risk factors related to social, economic, and environmental conditions negatively impact recovery and resilience.
3. Increase SAMHSA expert and material placement on news, ethnic, and popular media outlets (e.g., talk and reality shows).
4. Collaborate with a broad representation of constituency groups and stakeholders, including groups affected by disparity, to identify common priorities and leverage work to educate the public.
5. Partner with constituency groups, stakeholders, and diverse ethnic groups to send news releases through their systems and networks.
6. Work with the Primary and Behavioral Health Care Integration Technical Assistance Center as it develops recovery-oriented curricula and materials for medical schools, nursing programs, doctoral psychology programs, schools of social work, and other relevant training programs.

Objective 8.5.4: Work with other Federal agencies, providers, and the health and human services field to enhance their understanding and support of resilience, recovery, and social inclusion.

Action Steps:

1. Identify best communications channels for engagement and engage various provider groups, including strategic outreach to LGBT communities and those traditionally affected by disparity, to identify common priorities related to social inclusion.
2. Leverage other work to encourage shared decisionmaking with consumers, families, youth, and people in recovery.

Strategic Initiative #8 Measures

Population-Based

- Increase the percentage of persons reporting knowledge of how to find treatment services for mental and substance use disorders.

SAMHSA Specific

- Increase the number of persons receiving behavioral health focused prevention information from SAMHSA-supported advertising, broadcast, or Web site.

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List of Abbreviations and Acronyms

Addiction Technology Transfer Centers (ATTCs)

Administration for Children and Families (ACF)

Administration on Aging (AoA)

Administration on Children, Youth and Families (ACYF)

Agency for Healthcare Research and Quality (AHRQ)

American Indian and Alaska Native (AI/AN)

American National Standards Institute (ANSI)

Application program interface (API)

Army Study to Assess Risk and Resilience in Service Members (Army STARRS)

Assistant Secretary for Planning and Evaluation (ASPE)

Attention deficit hyperactivity disorder (ADHD)

Behavioral Risk Factor Surveillance System (BRFSS)

Bureau of Justice Affairs (BJA)

Center for Behavioral Health Statistics and Quality (CBHSQ)

Center for Medicare and Medicaid Systems (CMS)

Center for the Application of Prevention Technologies (CAPT)

Centers for Disease Control and Prevention (CDC)

Community health centers (CHCs)

Centers for Medicare and Medicaid Services (CMS)

Crisis Counseling Program (CCP)

Content management system (CMS)

Continuity of care document (CCD)

Culturally and Linguistically Appropriate Services (CLAS)

Disaster Technical Assistance Center (DTAC)

Drug Abuse Warning Network (DAWN)

Drug and Alcohol Service Information System (DASIS)

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

Electronic health record (EHR)

Federal Emergency Management Agency (FEMA)

Federal health architecture (FHA)

Federal poverty level (FPL)
Federally qualified health centers (FQHCs)
Food and Drug Administration (FDA)
Government Performance and Results Act (GPRA)
Health reform (HR)
Health information exchange (HIE)
Health information technology (HIT)
Health Resources and Services Administration (HRSA)
Indian Health Service (IHS)
Institute of Medicine (IOM)
Interagency Policy Council (IPC)
Interim Final Rule (IFR)
Lesbian, gay, bisexual, and transgender (LGBT)
Lesbian, gay, bisexual, transgender, and questioning (LGBTQ)
Memorandum of understanding (MOU)
The Mental Health Parity and Addiction Equity Act (MHPAEA)
Mental Health Transformation Employment Work Group (FPEWG)
National Association of State Alcohol and Drug Abuse Directors (NASADAD)
National Association of State Medicaid Directors (NASMD)
National Association of State Mental Health Program Directors (NASMHPD)
National Center for Trauma-Informed Care (NCTIC)
National Child Traumatic Stress Network (NCTSN)
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
National Institute on Drug Abuse (NIDA)
National Institute of Mental Health (NIMH)
National Institutes of Health (NIH)
National Quality Forum (NQF)
National Registry of Evidence-based Programs and Practices (NREPP)
National Survey on Drug Use and Health (NSDUH)
National Training and Technical Assistance Center (NTTAC)
Nationwide Health Information Network (NWHIN-CONNECT)
Office of Justice Programs (OJP)

Office of Juvenile Justice and Delinquency Prevention (OJJDP)
Office of National Drug Control Policy (ONDCP)
Office of the Assistant Secretary for Planning and Evaluation (ASPE)
Office of the National Coordinator for Health (ONC)
Post traumatic stress disorder (PTSD)
Prevention Prepared Communities (PPCs)
Primary and Behavioral Health Care Integration (PBHCI)
Screening, Brief Intervention, Referral, and Treatment (SBIRT)
Social Security Disability Insurance (SSDI)
SSI/SSDI Outreach, Access and Recovery (SOAR)
State Systems Development Program (SSDP)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Supplemental Security Income (SSI)
Traumatic brain injury (TBI)
U.S. Department of Agriculture (USDA)
U.S. Department of Defense (DoD)
U.S. Department of Education (ED)
U.S. Department of Health and Human Services (HHS)
U.S. Department of Housing and Urban Development (HUD)
U.S. Department of Labor (DOL)
U.S. Department of Justice (DOJ)
U.S. Department of Veterans Affairs (VA)
USICH (United States Interagency Council on Homelessness)
Youth Risk Behavior Survey (YRBS)

Substance Abuse and Mental Health Services Administration
SAMHSA
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