



February 5, 2014

To: Madeleine Biondolillo, MD Associate Commissioner, Department of Public Health
From: Vicker V. DiGravio, Association for Behavioral Healthcare
Re: Informational Survey – 2014: Health Resource Planning for Behavioral Health Services

On behalf of the membership of the Association for Behavioral Healthcare (ABH), thank you for the opportunity to comment on the health resource planning process. ABH is a statewide association representing over eighty community-based mental health and addiction treatment provider organizations. Our members are the primary providers of publicly-funded behavioral healthcare services in the Commonwealth, serving approximately 81,000 Massachusetts residents daily and over three-quarters of a million residents annually, and employing 37,500 people.

1. How do you anticipate health resource planning for Behavioral Health to help you in your work? How do you expect to use the information resulting from the effort?

ABH strongly believes the health resource planning process is vital for the Commonwealth to have a better picture of the behavioral health service system throughout the entire state. Behavioral health services in Massachusetts are historically underfunded and underutilized. We know that individuals who need treatment do not have access to the appropriate services. The Substance Abuse and Mental Health Services Administration (SAMHSA) recently released their *Behavioral Health Barometer: Massachusetts*, which includes astounding data about the availability and utilization of treatment services in Massachusetts. SAMHSA reports that only 49.1% of individuals aged 18 or older with any mental illness received treatment and/or counseling and only 42.6% of children aged 12-17 with a major depressive episode received any treatment for depression. The addiction treatment data is even more startling. SAMHSA reports that only 4.2% of heavy alcohol users aged 21 or older in Massachusetts received treatment.¹

The national narrative on behavioral health treatment focuses on reducing stigma, but a recent Kaiser Health Tracking Poll contradicts this narrative. By far the biggest barrier in getting mental health care was cost, followed by insurance coverage issues and confusion over where to go for such care. Least commonly expressed reasons were that people were afraid or embarrassed to seek help. Although 76 percent of Americans say people with serious mental illness experience discrimination, and have discomfort in interacting with people with serious mental illness, stigma is NOT a barrier to care for people with mental illness and their families.²

The behavioral health planning process should help address gaps in the service treatment system. ABH would use the data in our advocacy with the state and federal governments and with both public and private payers.

¹ Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Massachusetts, 2013*. HHS Publication No. SMA_13-4796MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

² The Henry J. Kaiser Family Foundation. *Kaiser Health Tracking Poll: February 2013*. The Kaiser Family Foundation Publication #8418-T. Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2013.

2. Are there specific services within Mental Health & Substance Abuse that you would like to see studied, and were not already included in the list of services on page 6? Please describe with as much specificity as possible. Please indicate how they can be addressed through health resource planning.

ABH commends the Department of Public Health for its commitment to addressing a robust continuum of mental health and addiction treatment services in the health planning process. As the Council examines all service levels, we recommend the supplied list include more specificity moving forward. For example, opiate treatment service providers should include both methadone and suboxone treatment. Acute inpatient psychiatric units should include examination of intensive community based acute treatment (ICBAT & CBAT) for children. Mental health long term services and supports should include close examination of Programs for Assertive Community Treatment (PACT) and Community Support Programs (CSP). Acute Inpatient Substance Abuse Programs needs to include both Clinical Support Services (CSS) and Transitional Support Services (TSS), both step-down services from detox. ABH also recommends the inclusion of the following additional service areas that we believe are a vital part of the behavioral health continuum of care.

DMH Community Based Flexible Services (CBFS) – The majority of individuals in the care of the Department of Mental Health (DMH) receive their community-based services through CBFS. CBFS allows individuals to live successfully in the community with a full range of flexible supports for their individual needs.

Clubhouses - Funded by DMH, Clubhouses are community-based centers that offer members opportunities for friendship, employment, housing, education, and access to medical and psychiatric services through a single caring and safe environment, so members can achieve a sense of belonging and become productive members of society.

Jail Diversion Initiatives – DMH has committed substantial resources to working with law enforcement on education and programming because police officers frequently encounter individuals with severe and persistent mental illness on the job.

Peer-led Services – Peer-led services are a vital and growing part of the behavioral health continuum of care in both the mental health (peer specialists) and addictions (recovery support specialists) service continuum.

3. Given the importance of prevention and also “post-acute” services for mental health & substance abuse, what critical evidence-based services & programs are available, should be expanded, or need to be developed? Are there specific models you suggest we study?

ABH strongly encourages the Health Planning Council to take a closer look at post-acute and long term community-based services for both mental health and addiction treatment. Services that are not deemed “medically necessary” by insurance payers are vital for individuals to live full and complete lives in the community. Residential recovery homes for individuals transitioning from previous addiction levels of care, and DMH’s CBFS programs offer the necessary supports for individuals to live and work in the community. We believe it is essential that this committee investigate whether insurance plans should cover this programming. The Commonwealth is paying for these services which help minimize costs for insurers.

4. Obtaining capacity, workload/volume, and demand data for outpatient & community mental health & substance abuse services is a challenge. Do you have ideas for data sources or suggestions for collecting data now or in the future? Are there specific “data gaps” that you feel are important for future data collection?

We strongly suggest that the Health Planning Council examine SAMHSA's recent *Behavioral Health Barometer: Massachusetts* referenced above (and attached to this submission). In addition, the Health Policy Commission has examined the All Payer Claims Database and includes compelling data in its 2013 Cost Trends Report on the average spending per patient based on behavioral health and chronic condition comorbidities. Individuals with both a behavioral health disorder and another chronic condition covered by a commercial health plan have health care costs that are 4.2 times more than the average individual, and costs that are 7 times more costly for Medicare recipients.³ This data proves the importance of offering a robust behavioral health continuum of care in order to meet the state's goal of containing health care costs.

³ 2013 Cost Trends Report. Massachusetts Health Policy Commission. Boston, MA.