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Western Interstate Commission
For Higher Education

NATIONAL MENTAL HEALTH TRENDS

Presented by: April Hendrickson

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Agenda

Action items:

16. Ways to increase provider competencies through practice, training
20. Real outcome data and fidelity piece (Governor's Work Group slides 30-31: Aggression Replacement Training [ART], Functional Family Therapy [FFT], Systems of Care [SOC])
25. Indication of trends/impact on Criminal Justice system
27. Statistics on children with an Serious Emotional Disturbance (SED) that end up as adults with Serious Mental Illness (SMI)

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Maximizing the Public Mental Health Workforce Capacity via Competencies

Ensuring mental health professionals can operate within the full scope of their practice

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Mental health provider qualifications

- Medicaid is the primary payor of public mental health services
- Types of mental health providers include, but are not limited to:
  - Psychiatrist
  - Clinical Psychologist
  - Social Worker
  - Licensed professional counselor (LPC)
- States have flexibility in determining the types and qualifications of providers that can be reimbursed

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Medicaid: Joint federal and state health care program for those with limited income. States follow federal guidelines to determine eligibility and benefits

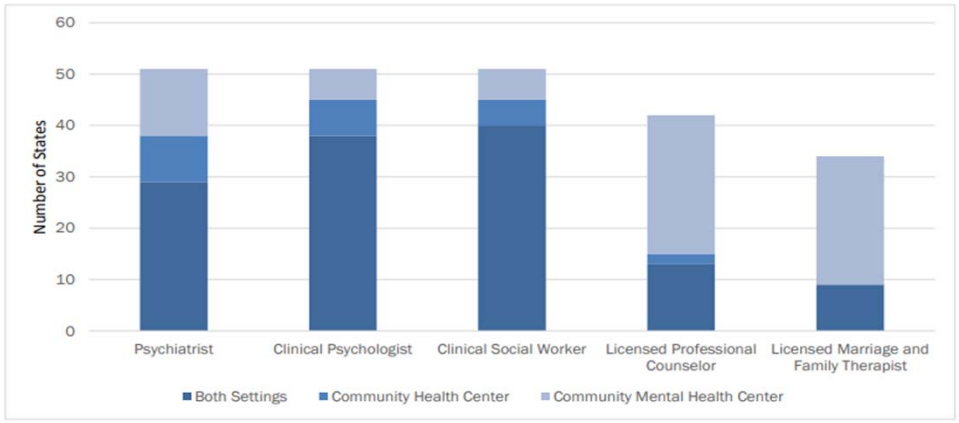
Medicare: Federal health insurance program for certain disabilities and ages 65 and older. Federal government determines eligibility and benefits

Medicaid and Medicare differ in the types of providers that can be reimbursed for mental health services.

It is important to note that marriage therapists, family therapists, and licensed professional counselors are not reimbursable by Medicare.

States differ in mental health reimbursement

Medicaid Eligible Provider Types for Psychotherapy (30 minutes) across Service Settings[1]



Note: Refers to CPT Code 90832

[1] http://www.behavioralhealthworkforce.org/wp-content/uploads/2017/01/FA3P4_Billing-Restrictions_Full-Report.pdf

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Current Procedural Terminology (CPT) codes are used to report procedures and services to payers (i.e., for Medicaid and Medicare).

Community health centers were analogous to federally qualified health centers (FQHCs).

Dark blue indicates the provider type was eligible in both community health centers and community mental health centers. The next darkest shade indicates the provider type was eligible in only community health centers. The lightest blue indicates the provider type was eligible in only community mental health centers.

Licensed psychologists and licensed clinical social workers were most commonly recognized and eligible to provide psychotherapy services, while licensed marriage and family therapists were eligible in fewer states.

Important to note that states may have changed their reimbursement policies since this study was conducted. For instance, we know that South Dakota has.

South Dakota requirements for CMHC staff[1]

Degree/Experience Needed	Services Provided
Associate's degree in the social sciences or human services	Case management; Family education and support; Liaison services; Direct assistance; Psychosocial rehabilitative services; Recovery support services
• Master's degree in psychology, social work, counseling, or nursing • Social work license • Bachelor's degree in a human services field and two years of related experience	Services above or other mental health services
• Licensed physician or psychiatrist • Resident operating within the Board of Medical and Osteopathic Examiners guidelines • Licensed physician assistant • Licensed certified nurse practitioner	Psychiatric services
• Registered nurse • Licensed practical nurse	Psychiatric nursing services

[1] Requirements for staff providing direct services and supports to clients. http://sdlegislature.gov/rules/DisplayRule.aspx?Rule=67:62:06:03

South Dakota requirements for independent providers[1]

- An independent mental health provider must be a:
  - Psychologist
  - LPC-mental health (LPC-MH)
  - Clinical nurse specialist
  - Certified social worker-Private or Independent Practice (CSW-PIP)

[1] http://sdlegislature.gov/rules/DisplayRule.aspx?Rule=67:62:06:03

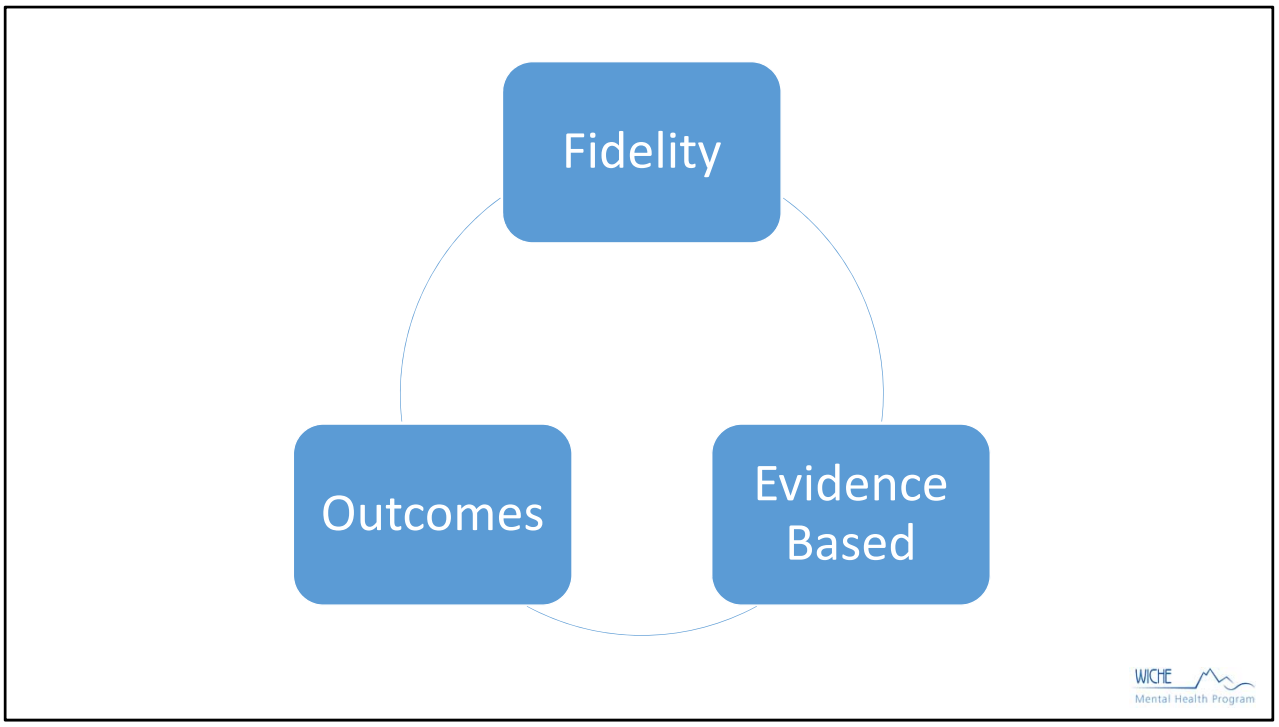
Strategies for maximizing workforce capacity

- Review state billing and reimbursement policies
  - Ensure providers can be reimbursed for services that fall within their scope of practice
  - Ensure a variety of provider types are eligible to provide services
  - If a code is not reimbursable, use another code to provide similar or more targeted services

South Dakota's work towards maximizing workforce capacity

- Eligible independent providers will expand to include LPCs and CSWs working towards the highest level of licensure (LPC-MH and CSW-PIP) under a plan of supervision with the boards

Outcome Data and Fidelity



The concepts of Outcomes, Fidelity, and Evidence Based are inter-related

Fidelity

- Degree to which a practice/ program/intervention is implemented as intended
  - Are all components implemented?
  - Are components implemented in the correct order?
  - Are implementors sufficiently trained?
- Indicates how and why something works
- Impacts outcomes
  - Higher fidelity = greater likelihood of effectiveness

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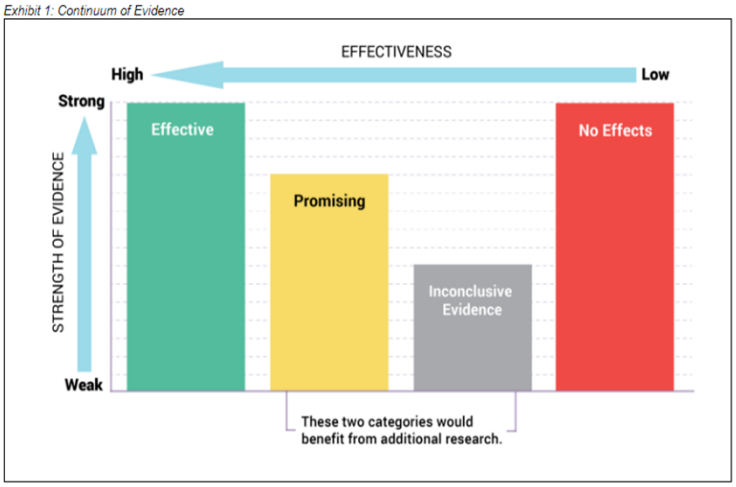
Recipe for how to deliver an intervention in order to achieve outcomes demonstrated by the developer

Evidence-based practice/program/intervention (EBP)

- Research-based evidence of effectiveness
- Expect to achieve outcomes when implemented with fidelity
- Different criteria/definitions
  - Effective: strong evidence for achieving outcomes
  - Promising: some evidence for achieving outcomes
  - Inconclusive: not enough evidence to rate
  - No effects: strong evidence no or harmful effects



https://www.crimesolutions.gov/about_evidencecontinuum.aspx

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Different criteria/organizations that rate EBPs (e.g., Substance Abuse and Mental Health Services Administration's [SAMHSA's] National Registry of Evidence-based Program and Practices [NREPP]; Center for the Study and Prevention of Violence (CSPV) Blueprints for Healthy Youth Development; Office of Juvenile Justice and Delinquency Prevention's [OJJDP's] Model Programs Guide [MPG]; Washington State Institute for Public Policy Inventories of Evidence-and Research-Based Practices].

Effectiveness: outcomes in relation to the goals of the EBP. Where an EBP sits on the Effectiveness (horizontal) axis shows how well an EBP works in achieving outcomes.
Strength of Evidence: determined by the rigor and design of the outcome evaluation and the number of evaluations. Where an EBP sits on the Strength of Evidence (vertical) axis shows the level of confidence in the outcomes evaluation.

There are costs and benefits of implementing an EBP.

Costs:
Selection
Training
Program development
Monitoring

Benefits:
Consistent practice
Quality care
Better outcomes

EBP implementation cycle[1]

Exploration	• Identify needs, review options, select the right EBP
Installation	• Make needed structural and/or instrumental changes
Initial Implementation	• Learn how to implement the EBP
Full Implementation	• Processes and procedures in place • Assess fidelity & determine if adaptations are needed
Sustainability	• Full implementation achieved • Assess effectiveness and quality

[1] https://nrepp.samhsa.gov/legacy/courses/implementations/NREPP_0103_0010.html

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It's important to note that you should not expect to see results of the EBP until it is fully operational

Implementation timeline examples

- Implementation timelines vary for each organization
- Assertive Community Treatment (ACT)
  - Many organizations have taken a year to complete the initial implementation stages and several years to reach high fidelity[1]
- Functional Family Therapy (FFT)[2]
  - Three implementation phases
    - Phase I – Clinical Training: 12-18 months
    - Phase II – Supervision Training: 12 months
    - Phase III – Maintenance Phase: renewed annually

[1] https://www.centerforebp.case.edu/resources/tools/act-timeline;https://www.centerforebp.case.edu/client-files/pdf/act-timeline-booklet.pdf
[2] https://fftllc.com/documents/Phases_of_Implementation.pdf

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Outcomes

Type	Description	Examples	Timeframe
Short-term	Changes that occur right after implementation	Changes in knowledge, attitudes, beliefs	Immediately after implementation
Intermediate	Interim results that provide a sense of progress toward reaching long-term goals	Changes in behaviors, skills	1-3 years after implementation
Long-term	The ultimate effect or impact	Changes in organizational structure, systems, social conditions, policies	4-6 years after implementation

Outcomes are expected effects of the EBP on the intended population and how this is measured.

Example: Participants in a partial hospitalization program.

Short-term outcome: increase in the percentage of program participants who showed an interest or activity in vocational areas

Intermediate outcome: increase in the percentage of program participants involved in some form of vocational activity

Long-term outcome: increase in program participants' quality of life

Functional Family Therapy (FFT)

- Effective[1]
- Outcomes[2]
  - Reduced delinquency
  - Reduced criminal behavior
  - Reduced illicit drug use
- Cost-benefit[3]
  - 96% chance benefits will be greater than the costs

[1] https://www.crimesolutions.gov/ProgramDetails.aspx?ID=122
[2] https://www.blueprintsprograms.org/factsheet/functional-family-therapy-fft
[3] http://www.wsipp.wa.gov/BenefitCost/Program/32

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FFT is a structured family-based intervention that uses a multi-step approach to enhance protective factors and reduce risk factors in the family.

It's important to note that the cost-benefit analyses conducted by the Washington State Institute for Public Policy (WSIPP) examine costs and benefits for Washington state taxpayers and how much it would cost/benefit Washington residents to achieve improved outcomes. WSIPP notes that as estimates pertain specifically to Washington, cost-benefit results will vary from state to state.

Moral Reconation Therapy (MRT)

- Evidence-based[1]
- Outcomes[2]
  - Lower recidivism
  - Improvements in personality
  - Enhanced treatment compliance
  - Higher staff satisfaction
- Cost-benefit[3]
  - 95% chance benefits will be greater than the costs

[1] http://www.wsipp.wa.gov/ReportFile/1673/Wsipp_Updated-Inventory-of-Evidence-Based-Research-Based-and-Promising-Practices-For-Prevention-and-Intervention-Services-for-Children-and-Juveniles-in-the-Child-Welfare-Juvenile-Justice-and-Mental-Health-Systems_Inventory.pdf (Analysis of Cognitive-Behavior Therapy (CBT); little variation found among type of program)
[2] http://www.moral-reconation-therapy.com/
[3] http://www.wsipp.wa.gov/BenefitCost/Program/438 (Analysis of CBT; little variation found among type of program)

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MRT is a cognitive-behavioral treatment system typically conducted in weekly groups where clients present workbook exercises completed as homework. Group facilitators use objective criteria to evaluate how successfully participants' complete each of the program's steps.

It's important to note that the cost-benefit analysis reviewed Cognitive-Behavior Therapy (CBT) programs, which emphasize individual accountability and teaches offenders that cognitive deficits, distortions, and flawed thinking processes can cause criminal behavior and are delivered to juveniles in a group setting in both the institutional and community settings ranging from 3 to 12 months. Programs, including Reasoning and Rehabilitation, Moral Reconation Therapy (MRT), and Situational-Decision Making, as well as "homegrown programs," were included in the analysis. The authors conducted additional analyses and found little variation based upon program brand.

Aggression Replacement Training (ART)

- Effective[1]
- Outcomes[1]
  - Decrease in felony recidivism
  - Decrease in problem behavior
  - Improved social skills
- Cost-benefit[2]
  - 64% chance benefits will be greater than the costs

[1] https://www.crimesolutions.gov/ProgramDetails.aspx?ID=254
[2] http://www.wsipp.wa.gov/BenefitCost/Program/33

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ART is a multidimensional cognitive-behavioral intervention designed to promote prosocial behavior in chronically aggressive and violent adolescents that consists of three coordinated components: 1) social skills training; 2) anger control training; and 3) moral reasoning.

Systems of care

- SAMHSA's Children's Mental Health Initiative (CMHI) supports a systems of care approach for individuals with an SED and their families[1]
- CMHI Grantee Outcomes[1]
  - Suicide attempt rates decreased more than 38%
  - School suspensions/expulsions decreased more than 42%
  - Unlawful behavior decreased more than 40%

[1] Substance Abuse and Mental Health Service Administration (SAMHSA), https://docs.house.gov/meetings/IF/IF14/20180719/108572/HHRG-115-IF14-Wstate-McCance-KatzE-20180719.pdf

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Systems of care is a strategic approach to the delivery of services and supports that incorporates family-driven, strength-based, and culturally and linguistically competent care in order to meet the physical, intellectual, emotional, cultural, and social needs of children and youth.

Assertive Community Treatment (ACT)

"ACT is an evidence-based practice considered one of the most effective approaches to delivering services to people with SMI and has been disseminated by SAMHSA for widespread use through its Evidence-Based Toolkit series beginning in 2008"

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Service Administration (SAMHSA)
Hearing on 21st Century Cures Implementation: Examining Mental Health Initiatives, July 19, 2018

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Assertive Community Treatment (ACT)

- Evidence-based[1]
- Outcomes[2]
  - Reduced hospital stays
  - Higher levels of housing stability
  - Improved symptoms and social functioning
  - Higher quality of life
  - Increased consumer and family satisfaction with services
- Cost-benefit[3]
  - 11% chance benefits will be greater than costs
  - Benefit to cost ratio: -$0.46
    - $1,161 total benefits from changes to health care associated with psychiatric hospitalization
    - $307 total benefits from changes to crime

[1] https://www.samhsa.gov/ebp-resource-center
[2] https://store.samhsa.gov/shin/content//SMA08-4345/EvaluatingYourProgram-ACT.pdf
[3] http://www.wsipp.wa.gov/BenefitCost/Program/283

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ACT is a team-based, comprehensive service delivery model for consumers with SMI. The goal is recovery through community treatment and habilitation. There is no pre-set limit on service amount or duration.

Costs examined : Crime, Labor market earnings associated with alcohol abuse or dependence, Property loss associated with alcohol abuse or dependence, Health care associated with illicit drug abuse or dependence, Health care associated with general hospitalization, Health care associated with psychiatric hospitalization, Health care associated with emergency department visits, Adjustment for deadweight cost of program. Benefit to cost ratio was primarily driven by program cost ($9,148). Positive benefits included: Changes to crime ($307), Changes to health care associated with psychiatric hospitalization ($1,161), Health care associated with emergency department visits ($70), and Health care associated with general hospitalization ($65).

It is important to note that early analyses found ACT to be cost effective compared to traditional treatment in producing better outcomes for the same or lowered hospitalization and mental health care costs and in client outcomes relative to per-patient costs.[1] A 2013 study found that ACT produced cost savings for those with more than 95 inpatient bed days in the year prior to ACT and while ACT mental health care costs were $1,361 higher than similar, non-ACT clients', ACT costs were lower for inpatient treatment (21%) and mental health rehabilitation treatment (62%).[1]

[1]SAMHSA's National Registry of Evidence-based Program and Practices (NREPP) Learning Center Evidence Summary: Assertive Community Treatment (ACT) for Behavioral Health Conditions (2017).

Mental Health and the Criminal Justice System

https://pmhctoolkit.bja.gov/

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Mental health and the criminal justice system

- Incarcerated individuals with mental illness[1]:
  - cost more
  - stay longer
  - are more likely to commit suicide
  - are more likely to be abused
  - are management problems due to their impaired thinking
  - have a greater risk of recidivism

[1] http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf; https://stepuptogether.org/the-problem

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Costs of incarcerating a person with mental illness

- Jails spend two to three times more on adults with a mental illness[1]
- States that spend less on community mental health services have more incarcerated individuals[2]
  - Housing someone with mental illness in jail = $31,000 vs. community mental health services = $10,000[3]

[1] https://stepuptogether.org/the-problem
[2] http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf
[3] https://www.nami.org/Blogs/From-the-Executive-Director/May-2015/Treatment,-Not-Jail-It%E2%80%99s-Time-to-Step-Up

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National initiatives

- Medicaid does not pay for care while incarcerated
  - Individuals can enroll or stay enrolled
- Comprehensive Justice and Mental Health Act
  - Funding for local and state efforts to reduce the number of incarcerated mentally ill people
- Mental Health and Safe Communities Act
  - Supports training to help officers recognize the signs of mental illness and expands re-entry treatment
- Stepping up (https://stepuptogether.org/)
  - Helps local agencies develop diversion initiatives for mentally ill individuals

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Community-based diversion initiatives

- Crisis Intervention Team (CIT)
  - Promising[1]
  - Outcomes[2]
    - Reduces arrests
    - Increases likelihood that individuals will receive needed mental health services
    - Improves officers' attitudes towards mental illness
    - Reduces time officers spend responding to a mental health crisis
  - Cost-benefit[3]
    - 1% chance benefits will be greater than costs[2]
    - Benefit to cost ratio: -$2.92
    - Analysis based on one study comparing diverted to non-diverted individuals

[1] http://www.wsipp.wa.gov/ReportFile/1682/Wsipp_Inventory-of-Evidence-Based-Research-Based-and-Promising-Programs-for-Adult-Corrections_Inventory.pdf
[2] https://www.nami.org/Get-Involved/Law-Enforcement-and-Mental-Health
[3] http://www.wsipp.wa.gov/BenefitCost/Program/738

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CIT is a community-based approach to safely and effectively address the needs of persons with mental illnesses, link them to appropriate services, and divert them from the criminal justice system, when appropriate.

Promising: A program or practice that, based on statistical analyses or a well-established theory of change, shows potential for meeting "evidence-based" or "research-based" criteria.

The cost-benefit analysis focused on pre-arrest diversion programs, which are police-based programs that divert participants to mental health treatment services without applying criminal charges. It is important to note that the analysis was based on one study and the number and type of cost examined was somewhat limited. The study examined outcomes for individuals who had co-occurring SMI and substance use disorders who were diverted compared to jail detainees eligible for diversion but processed through standard criminal justice methods without diversion. Costs examined included: Crime (-$3,628 total benefits), Property loss associated with alcohol abuse or dependence (-$2.00 total benefits), Labor market earnings associated with illicit drug abuse or dependence (-$7,010 total benefits), Health care associated with illicit drug abuse or dependence (-$905 total benefits), Adjustment for deadweight cost of program (-$2,383 total benefits).

Thus, additional cost-benefit analyses would be beneficial to more fully understand the potential costs and benefits of CIT.

Community-based diversion initiatives

- Mental Health Courts
  - Evidence-based[1]
  - Outcomes[2]
    - Reduced recidivism
    - Increased treatment engagement
  - Cost-benefit[3]
    - 96% chance benefits will be greater than costs[2]
    - Benefit to cost ratio: $5.62

[1] http://www.wsipp.wa.gov/ReportFile/1682/Wsipp_Inventory-of-Evidence-Based-Research-Based-and-Promising-Programs-for-Adult-Corrections_Inventory.pdf
[2] https://www.bja.gov/Publications/CSG_MHC_Research.pdf
[3] http://www.wsipp.wa.gov/BenefitCost/Program/52 (Programs included in the analysis ranged from 6-24 months of delivered services)

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Mental Health Courts are modeled after other therapeutic courts (e.g., drug courts, DUI courts) and divert individuals with mental health issues from incarceration to commiunity-based treatment.

Evidence Based rating definition: A program or practice that has been tested in heterogeneous or intended populations with multiple randomized and/or statistically-controlled evaluations, or one large multiple-site randomized and/or statistically-controlled evaluation, where the weight of the evidence from a systematic review demonstrates sustained improvements in outcomes of interest. can be implemented with a set of procedures to allow successful replication in Washington, and when possible, has been determined to be cost-beneficial.

Statistics on children with SED that end up as adults with SMI

SED and SMI

SED

- Birth-age 18
- Disorders affecting academic learning and achievement
  - Attention-Deficit Disorders
    - ADHD
  - Disruptive Behavior Disorders
    - Conduct disorder
- Excludes Developmental Disorders
  - Mental retardation
  - Autism
- Exclude Substance Use Disorders

SMI

- Age 18 and over
- Psychotic disorders
  - Schizophrenia
- Borderline personality disorder
- Affective/mood disorders
  - Major depressive disorder, bipolar disorder, hypomania
- Anxiety disorders
  - Obsessive compulsive disorder (OCD), panic disorder
- Eating disorders
  - Anorexia and bulimia
- Excludes dementias and mental disorders due to a general medical condition
- Excludes Substance Use Disorders

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SED and SMI: Individuals who have a diagnosed mental health disorder that substantially interferes with or limits one or more major life activities.

SED and SMI have different types of diagnoses. SED/SMI diagnosis is a qualification for the level of public mental health services.

Excludes Substance Use Disorders, developmental disorders, and dementias and mental disorders due to a general medical condition unless they co-occur with SED/SMI.

Age of onset

Disorder	Typical Age of Onset
Attention-deficit/hyperactivity disorder (ADHD)	7–9 years
Phobias and separation anxiety disorder	7–14 years
Conduct disorder	9-14 years
Schizophrenia	15-35 years
Mood disorders	25–45 years
Panic disorder, generalized anxiety disorder, post-traumatic stress disorder	25–53 years

[1] Kessler, R.C.; Amminger, G. P.; Aguilar-Gaxiola, S.; Alonso, J.;Lee, S.; & Bedirhan Ustun. T.B. Age of onset of mental disorders: A review of recent literature. Curr Opin Psychiatry. 2007 July ; 20(4): 359–364.

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Behavior disorders and some anxiety disorders emerge during childhood.
Most of the high prevalence (i.e., more common) disorders (e.g., anxiety, mood, and psychotic disorders) do not emerge until adolescence and early adulthood.

Age of onset & time to treatment

- Early age of onset is associated with:
  - greater disorder severity[1]
  - a longer duration of untreated illness[2]
  - lack of treatment response[1]
  - poorer clinical and functional outcomes[2]
- Many wait more than ten years after first onset before seeking treatment[1]

[1] Kessler, R.C.; Amminger, G. P.; Aguilar-Gaxiola, S.; Alonso, J.;Lee, S.; & Bedirhan Ustun. T.B. Age of onset of mental disorders: A review of recent literature. Curr Opin Psychiatry. 2007 July ; 20(4): 359–364.
[2] McGorry, P. D.; Purcell, R.; Goldstone, S.; & Amminger, G. P. Age of onset and timing of treatment for mental and substance use disorders: implications for preventive intervention strategies and models of care. Current Opinion in Psychiatry: July 2011 – Vol. 24 (4): 301–306. Edited by Mariano Bassi and Giovanni de Girolamo.

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Early intervention for psychosis[1]

- Better outcomes than treatment as usual at the end of treatment for
  - all-cause treatment discontinuation
  - at least 1 psychiatric hospitalization
  - involvement in school or work
  - total symptom severity
  - positive symptom severity
  - negative symptom severity
- Better outcomes at 6, 9 to 12, and 18 to 24 months for
  - all outcomes except general symptom severity and depressive symptom severity at 18-24 months

[1] https://www.samhsa.gov/sites/default/files/sites/default/files/early-intervention-services-vs-treatment-as-usual-for-early-phase-psychosis.pdf

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Thank you!

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