Talk It Out: Addressing Behavioral Health Challenges

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National Council for Behavioral Health
Overview

• How do behavioral health challenges affect rural and underserved areas, especially in the areas of substance use disorder and suicide.
• Examples of solutions and/or strategies states are using to address these challenges.
• What can states accomplish using their existing resources?
• Are there new or innovative programs states are using?
• Opportunities for collaboration with other agencies?
76% of Americans think mental health is just as important as physical health yet access remains difficult...

- **Cost** – One in four Americans have had to choose between getting mental health treatment and paying for daily necessities.

- **Distance** – Nearly half (46 percent) of American adults have had to, or know someone who has had to, travel more than one-hour roundtrip to get to their most recent mental health care appointment.

- **Knowledge Gaps** – 46 percent of those who have never sought treatment would not know where to go if they needed to seek mental health services for themselves or a family member/friend.

- **Wait Times** – 96 million American adults (38 percent) have had to wait longer than one week for mental health services.

- **Stigma** – 52 percent have tried to “grin and bear it” instead of seeing a doctor when feeling depressed or mentally unstable.

Suicide rising across the US
More than a mental health concern

Suicide rates rose across the US from 1999 to 2016.

- Increase 38 - 58%
- Increase 31 - 37%
- Increase 19 - 30%
- Increase 6 - 18%
- Decrease 1%

SOURCE: CDC’s National Vital Statistics System;
CDC Vital Signs, June 2018.
Governor’s Council Recommendations

Take a Comprehensive, Collaborative Approach
Governors can set the vision and establish common goals across state government to drive cross-sector collaboration for addressing the factors that contribute to suicide and related self-injury. Data-informed coordination among public health, health and human services, behavioral health, public safety/corrections and other agencies that touch high-risk populations are instrumental in identifying opportunities and directing resources. Such a collaborative approach, guided by a shared plan, can expedite adoption of best practices to reduce suicide.

Foster Strategic Partnerships
Governors can convene and mobilize key stakeholders across systems to complement local efforts—including families, health care and social service providers, faith-based organizations, schools, senior centers, veteran organizations, tribal leaders and related sectors—to prevent suicide and promote resilience. More unique partnerships aimed at reducing suicide by highly lethal means, such as firearms, include state suicide leads, public health officials, firearm dealers, shooting ranges and gun shows.

Invest in Upstream Prevention Efforts
Governors can encourage policy, programmatic and budgetary alignment across agencies specifically aimed at modifying risk factors associated with suicide and promoting protective factors. Investing in primary prevention efforts at the individual and family levels as well as the community and societal levels is key. For example, many programs start with the school as a hub, and current emphasis on social emotional learning in schools may be effective in this effort.

Opiate Epidemic

A deadly dose
United States, overdose deaths involving opioids
By county, 2015

Per 100,000 population

New Hampshire 31.7
Ohio 28.5
Rhode Island 29.3
West Virginia 39.3
Kentucky 28.8

Source: Centres for Disease Control and Prevention
3 Waves of the Rise in Opioid Overdose Deaths

- **Wave 1:** Rise in Prescription Opioid Overdose Deaths
- **Wave 2:** Rise in Heroin Overdose Deaths
- **Wave 3:** Rise in Synthetic Opioid Overdose Deaths

**Other Synthetic Opioids**
- e.g., Tramadol and Fentanyl, prescribed or illicitly manufactured

**Commonly Prescribed Opioids**
- Natural & Semi-Synthetic Opioids and Methadone

**Heroin**

Deaths per 100,000 population

Annual Deaths from Alcohol, Drugs, and Suicide in the United States, 1999–2017

Source: Trust for America’s Health and Well Being Trust analysis of data from National Center For Health Statistics, CDC
Correlates of Addiction

Source
2017 ASTHO President's Challenge: Public Health Approaches to Preventing Substance Misuse and Addiction
State-level Evidence-based Response

Evidence-based framework recognizes the need for state legislative leadership and cross-sector as well as cross-state partnerships to leverage four key strategies:

1. Training & Education
2. Monitoring & Surveillance
3. Treatment, Recovery & Harm Reduction
4. Primary & Overdose Prevention
Crisis in the Safety Net: Access to Care

Only **65%** of people with a serious mental illness receive treatment each year.

Only **10%** of people with an addiction receive treatment.

Where do the others go?
Crisis in the Safety Net: Workforce

- Psychiatrists particularly hard to recruit/afford
- Chronic staff shortages at every level
- High turnover

“We’re competing with grocery stores and fast food for our staff.”
Crisis in the Safety Net: Financing

• Low payment rates = unsustainable
• Funding cuts year after year
• No support for key, non-billable activities that improve health
• Behavioral health providers excluded from critical health care & funding bills
Practical Solutions

• The Certified Community Behavioral Health Center Model

• Mental Health First Aid
Certified Community Behavioral Health Center (CCBHC): A New Model

Built on the concept that the way to expand care is to pay for it

- **National definition** re: scope of services, timeliness of access, etc.
- **Standardized data and quality reporting**
- **Payment rate** that covers the real cost of opening access to new patients and new services…
  ...including non-billable activities like outreach, care coordination, and more…
Two funding tracks:

• Medicaid demonstration
  – 8 states, 2 years
  – Clinics receive Medicaid prospective payment rate
  – Set to ended in 2019

• Federal grant funding
  – Open to clinics in all 24 planning grant states
  – 2-year grant terms (first year of grants was FY 2018)
  – Clinics do not receive enhanced Medicaid rate
Status of Participation in Certified Community Behavioral Health Clinic (CCBHC) Demonstration

Note: Demonstration ended on March 31, 2019 in OR & OK, and on June 30, 2019 in the remaining 6 demonstration states.
### CCBHCs Across the Country

<table>
<thead>
<tr>
<th>States Participating in Medicaid Demonstration</th>
<th>Clinics in Demo (# also Receiving Expansion Grants)</th>
<th># Receiving Expansion Grants Only</th>
<th>Total CCBHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Missouri</td>
<td>15 (3)</td>
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<tr>
<td>Nevada</td>
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<td>N/A</td>
<td>3</td>
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<tr>
<td>New Jersey</td>
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<td>9</td>
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<tr>
<td>New York</td>
<td>13 (3)</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>3 (2)</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Oregon</td>
<td>12 (2)</td>
<td>N/A</td>
<td>12</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>7 (2)</td>
<td>1</td>
<td>8</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>66</strong></td>
<td><strong>12</strong></td>
<td><strong>78</strong></td>
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</table>

<table>
<thead>
<tr>
<th>States Receiving Expansion Grants Only</th>
<th># Clinics</th>
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</thead>
<tbody>
<tr>
<td>Colorado</td>
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</tr>
<tr>
<td>Connecticut</td>
<td>1</td>
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<tr>
<td>Illinois</td>
<td>1</td>
</tr>
<tr>
<td>Indiana</td>
<td>2</td>
</tr>
<tr>
<td>Iowa</td>
<td>2</td>
</tr>
<tr>
<td>Kentucky</td>
<td>2</td>
</tr>
<tr>
<td>Maryland</td>
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<tr>
<td>Massachusetts</td>
<td>5</td>
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<td>Michigan</td>
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</tr>
<tr>
<td>North Carolina</td>
<td>1</td>
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<tr>
<td>Rhode Island</td>
<td>1</td>
</tr>
<tr>
<td>Texas</td>
<td>6</td>
</tr>
<tr>
<td>Virginia</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>35</strong></td>
</tr>
</tbody>
</table>

There are currently 113 CCBHCs across the United States
CCBHC Scope of Services

- Pt. Centered Treatment Planning
- Outpatient MH/SA
- Psychiatric Rehab
- Peer Support
- Crisis Services
  - Mobil Emergency
  - Crisis Stabilization
- Screening, Assessment, Diagnosis

Targeted Case Management
Primary Health Screening & Monitoring
Armed Forces and Veteran’s Services

Must be delivered directly by CCBHC
Delivered by CCBHC or a Designated Collaborating Organization (DCO)
Care Coordination: The “Linchpin” of CCBHC

• Partnerships or care coordination agreements required with:
  – FQHCs/rural health clinics
  – Inpatient psychiatry and detoxification
  – Post-detoxification step-down services
  – Residential programs
  – Other social services providers, including
    • Schools
    • Child welfare agencies
    • Juvenile and criminal justice agencies and facilities
    • Indian Health Service youth regional treatment centers
    • Child placing agencies for therapeutic foster care service
  – Department of Veterans Affairs facilities
  – Inpatient acute care hospitals and hospital outpatient clinics
In the first 6 months of implementation:

87%

of CCBHCs report an increased number of patients served, representing up to a 25% increase in total patient caseloads for most clinics.
By end of Year 1:

68% of CCBHCs have *decreased* patient wait times

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*After initial call or referral, how long (on average) does it take CCBHC patients to access services?*

- **Same-day access**: 46%
- **Between 1-3 days**: 16%
- **Between 4-7 days**: 16%
- **Between 8-10 days**: 16%
- **11 or more days**: 4%
CCBHCs are reaching beyond the 4 walls of the clinic

- **Oregon**: Dedicated outreach workers for homeless individuals, aimed at managing chronic health conditions
- **Minnesota**: using telemedicine to provide access to non-physician clinicians
- **Pennsylvania**: outreach workers use service utilization reports to spot gaps in care and provide assertive follow-up outside the 4 walls of the clinic

**Spotlight On: Law Enforcement Center Liaison**

Family Guidance Center in Missouri created a full-time position in their local jail, to work as a discharge planner with individuals set to be released from incarceration. The Liaison completes assessments, connects individuals to behavioral health treatment and provides crisis services or mental health services on site at the correctional facility.
What activities do you engage in to reduce hospitalization and improve care transitions for any CCBHC patient who is discharged from the hospital? (more than one may apply)

- Work with patients to establish emergency plans to prevent future hospitalization: 90%
- Engage an onsite or offsite care coordinator (peer, case worker, or other staff) to manage care during transition to outpatient services: 81%
- Engage patients in shared decision-making to increase motivation and follow-through in discharge instructions: 81%
- Implement protocols to identify when patients are at risk of hospitalization and intervene early (e.g., risk stratification, care...): 79%
- Educate patients about medication options, including long-acting injectables: 75%
- Receive notification from hospital when patients are hospitalized (e.g., via formal data-sharing agreement or information...): 75%
- On day of hospital discharge, ensure CCBHC follow-up appointment is scheduled: 73%
- Expand access to crisis and/or urgent care services so that patients have a place to get help in emergencies: 69%
- Use mobile or web technologies to provide post-discharge patient support: 21%
Mental Health First Aid® is the help offered to a person experiencing a mental health challenge, mental disorder or a mental health crisis. The first aid is given until appropriate help is received or until the crisis resolves.

*Mental Health First Aid® does not teach people to diagnose or to provide treatment.*
Mental Health First Aid® USA

More than 2 Million people trained by more than 18,000 instructors in all 50 states, Puerto Rico and Guam.

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Population</td>
<td>60.7%</td>
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<tr>
<td>Education</td>
<td>17.4%</td>
</tr>
<tr>
<td>Public Safety</td>
<td>9.3%</td>
</tr>
<tr>
<td>Faith Communities</td>
<td>3%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>2.6%</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>7%</td>
</tr>
</tbody>
</table>
Mental Health First Aid Action Plan

- **A**ssess for risk of suicide or harm
- **L**isten nonjudgmentally
- **G**ive reassurance and information
- **E**ncourage appropriate professional help
- **E**ncourage self-help and other support strategies
Curricula and Curriculum Supplements
Why Mental Health First Aid?

WHY MENTAL HEALTH FIRST AID IN COUNTIES?

▪ Provides an existing network of engaged stakeholders to address mental health and addictions
▪ Offers community-led tangible action with clear evidence-based outcomes
▪ Builds trust providing a 'quick win' when part of a robust public health and community engagement plan
▪ Focuses on addressing a high need issue with robust support
▲ Increases in **confidence** and **likelihood** to perform the Mental Health First Aid action plan

▲ People with minimal or no past mental health training gained the most knowledge

▲ Increases in **referrals** and **assessing suicidality** and **safety**

▲ Positive change in their attitudes and beliefs towards mental illness demonstrating a **reduction in stigma**
Youth MHFA: Research & Evidence

• Independent 2018 research from the University of Central Florida shows Youth MHFA works for educators. Teachers who took the training showed:

▲ increased mental health literacy

▼ a reduction in negative attitudes toward youth with mental health concerns

▲ increased confidence in their ability to identify and respond to students with mental health problems

▲ increased intentions to engage in help-seeking behavior with high risk students
Curricula Overview

- **Risk factors and warning signs** of mental health and substance use problems (including typical adolescent development in YMHFA),

- **Information** on anxiety, depression, trauma, substance use (including opioids), non-suicidal self injury, disorders in which psychosis may occur, disruptive behavior disorders, (including ADHD for Youth MHFA), and eating disorders

- **A 5-step action plan** to help someone who is developing a mental health problem or in crisis(e.g. suicide, panic attack or overdose)

- Available evidence-based professional, peer and self-help resources
General Fund

**Colorado** appropriates around $210k annually for MHFA. This year, the supplemental appropriation is through the Colorado Department of Public Health and Environment under the Injury and Violence Prevention- Mental Health Promotion line item.

**Florida** has allocated $6.2M each year for the past two years from the General Revenue Fund to the Department of Education to train school personnel in YMHFA or similar programs. This funds the Marjory Stoneman Douglas Act.

**North Dakota** has appropriated (SB 2048) $900,000 to the Department of Human Services all of which is from the general fund, for partial funding for a behavioral health activities facilitator and for establishing and administering a voucher system.

Grant Programs

**Nebraska** proposed a bill (LB568) that would provide YMHFA training for teachers and other school personnel, funded through the innovation grant programs provided by the Nebraska Education Improvement Fund.

**Texas** provides grants for the training of Mental Health First Aid trainers (SB 955 Sec. 1001.202).
Examples of Funding Models Cont’d

Non-legislative approaches:

Denver city/county voted to increase sales and use taxes for the Caring for Denver Foundation to distribute $35m per year to fund mental health and addiction services, beginning January 2019.

New Mexico’s Children, Youth and Families Department provides MHFA training to foster parents using funds dedicated for childcare, foster care maintenance, and adoption assistance.

The Pennsylvania Department of Corrections embedded Mental Health First Aid as part of its training academy and trained all the state’s 16,000 employees. The department further garnered a $250,000 grant from the state safety council to defray costs of manuals for all trainees.
Training Mandates

**Florida:** Requires all school personnel to be trained in a youth mental health awareness and assistance. Youth Mental Health First Aid was the first program selected to meet the requirements and funding is available now through the Department of Education (Marjory Stoneman Douglas Act).

**Rhode Island:** Requires training and instruction in Mental Health First Aid for police officers and trainees (SB 2401).

**North Dakota:** Created new sections of the North Dakota Century Code that requires competency in youth mental health training for licensure of teachers, administrators, and ancillary staff (SB 2048).

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### Best Practices of Training Mandates

1. **Establish clear and comprehensive training objectives.**
2. **Target the training needs of specific populations.**
3. **Provide funding for training that is sustained and right-size for the stated goals and target populations.**
4. **Mandate training for public sector employees who engage directly with vulnerable populations, including youth.**
5. **Ensure Mental Health First Aid is included as an option to satisfy professional development credits.**
Teen Mental Health First Aid
Teens learn how to recognize the signs of developing mental illnesses, mental health crises, suicide, and substance use. Participants are trained to reach out to a trusted adult to address the issue.

**Audience:**
- 10th-12th grade students

**Format:**
- Three 75-minute sessions
- Schools/organizations offering TMHFA training are required to train all classes in the 10th grade.
- At least 10% of adult faculty and staff must be trained in YMHFA.

Building a foundation for Teen Mental Health First Aid

**California (SB 428):** If passed, this bill would mandate 10% of teachers and school personnel in each CA school be trained in MHFA (or similar) training.

**New Jersey (S-3172):** An act requiring public school instruction in suicide prevention to be provided in grades kindergarten through 12.

**Illinois (SB1731):** A trailer bill to a mental health training mandate passed last year for teachers; it declares YMHFA as the suggested program to satisfy this requirement.
No Simple Solutions

“There are no simple solutions only intelligent choices.”

-1977 Caterpillar Tractor Company Advertisement
Discussion & Questions

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