

Mental Health Disparities & Health Policy: *Reducing Disparities in Psychiatric Care*

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DISCLOSURES

National Institute Minority Health Disparities Translational Health Disparities Training August 2014

The course provides an introduction to the principles and practice of health disparities research. Focusing on concepts, methods, key issues, and applications, the course aims to provide the knowledge and research tools needed to conduct and develop translational and transdisciplinary research and interventions to eliminate health disparities. The course content is developed in the context of the history of health and health disparities in the United States, and addresses biological and non-biological determinants of health and a range of social, political, economic, cultural, and legal theories related to health disparities.

DISCLOSURES

The Health Policy Writing Collaborative is sponsored in part by the **Robert Wood Johnson Foundation for Health Policy** at Meharry, and the Department of Health and Human Services Health Resources and Services Administration (HRSA), D76HP0862 grant award. It was also funded in part by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The content is solely the responsibility of the author and does not necessarily represent the official view of the Robert Wood Johnson Foundation, the Department of Health and Human Services, or the Substance Abuse and Mental Health Services Administration.

OBJECTIVES

1. Discuss general landscape of Mental Health in America.
2. Identify health care disparities.
3. Point to public policy that addresses disparity issues.
 - a. NC Budget & Policy
 - b. Benchmarking other States
4. Offer policy recommendations that will help address needs of our community, hospital, and patients.

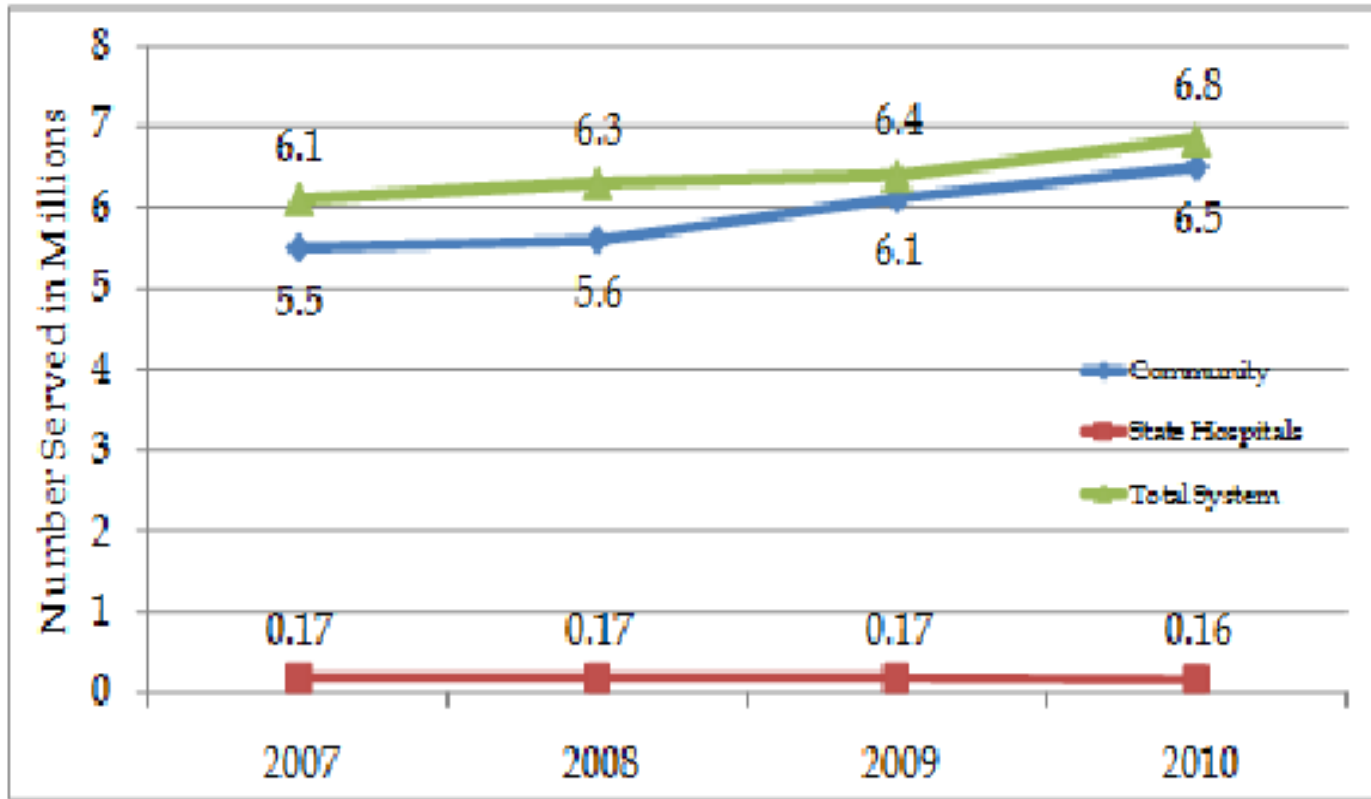


**MENTAL
HEALTH
LANDSCAPE:**
*A Move from
Parity to
Disparity*

Approximately, one in five Americans will have a mental health problem in any given year. Only a little over one in three people with a mental health problem will receive mental health services.¹

1. Kessler, R., McGonagle, K., Zhao, S., Nelson, C., Hughes, M., Eshleman, S., et al. (1994). Lifetime and 12-month Prevalence of DSM-III-R Psychiatric Disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry*, 51(1), 8-19.

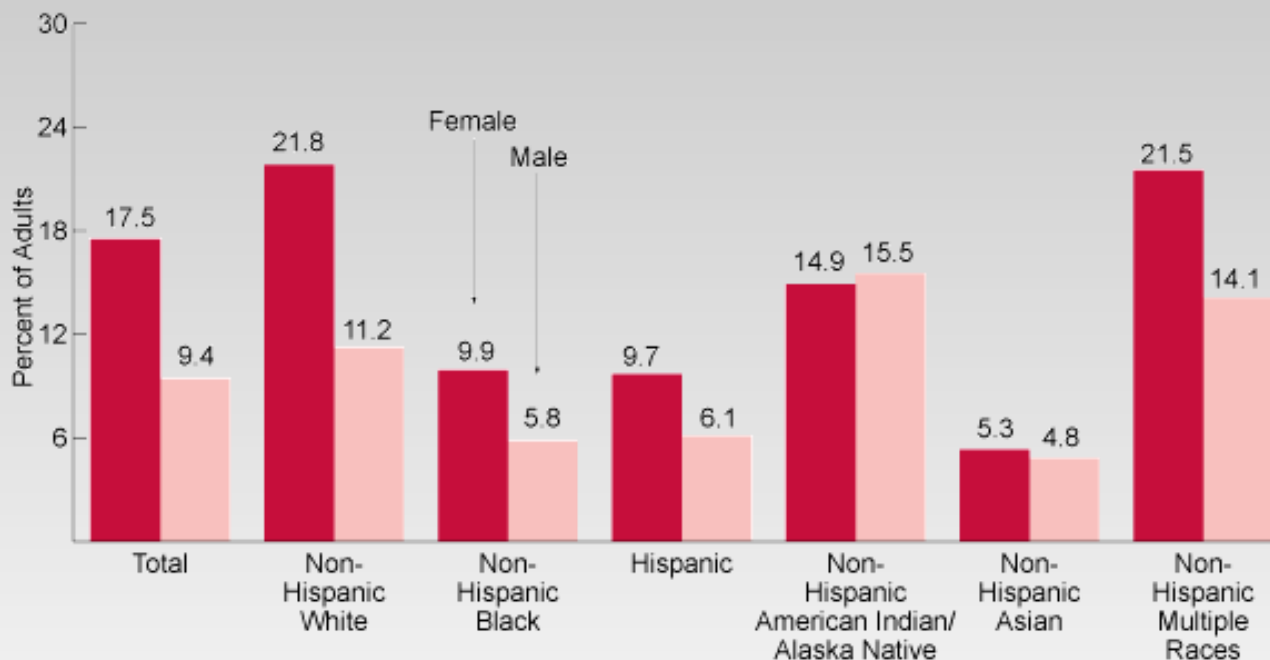
Number of Consumers Receiving Mental Health Services from State Mental Health Systems (2007 to 2010)



http://www.nasmhpd.org/docs/Policy/SummaryCongressional%20Briefing_2012.pdf

Mental Health: Treatment Rates

Past-Year Mental Health Treatment/Counseling* Among Adults Aged 18 and Older, by Race/Ethnicity and Sex,** 2009–2011



*Excludes treatment for alcohol or drug use; all estimates are age-adjusted. **The sample of non-Hispanic Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.

Source: United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Applied Studies. National Survey on Drug Use and Health, 2009-2011. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2013-06-20. doi:10.3886/ICPSR34481.v2. Analysis conducted by the Maternal and Child Health Epidemiology and Statistics Program.

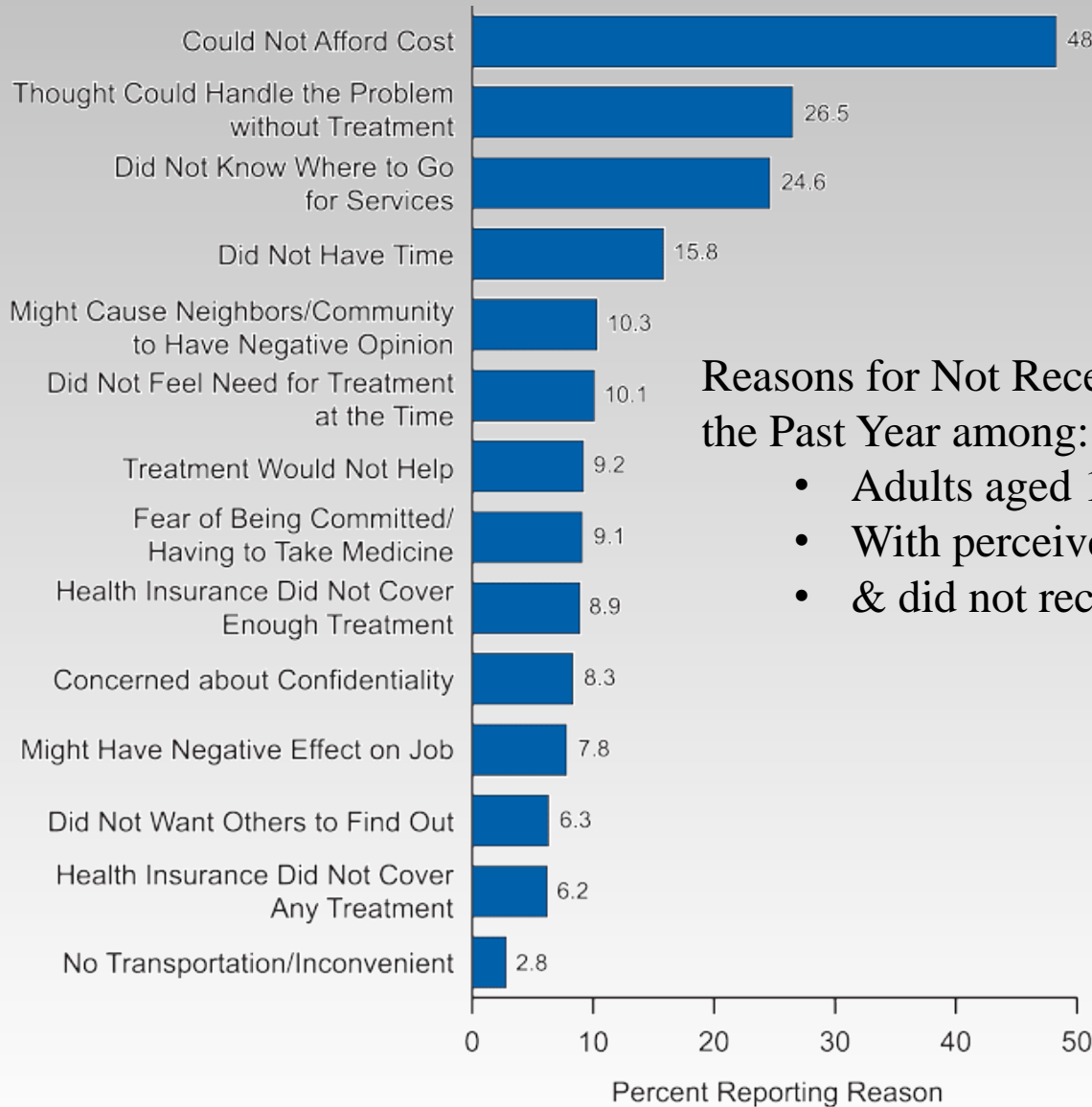
Mental Health: Treatment

AFFORDABLE: Between 2007-2009, *the average expenditure per adult ages 18-26 for the treatment of mental health disorders was about \$2,000.* Of this population, average expenditure for treatment of mental health problems was higher for young adults ages 18-21 estimated at \$2,300 per year than for those ages 22–26 estimated at \$1,800.²

EFFECTIVE: *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.*³

2. Davis, K. (2012). Statistical Brief #358: Expenditures for Treatment of Mental Health Disorders among Young Adults, Ages 18-26, 2007-2009: Estimates for the U.S. Civilian Noninstitutionalized Population. Rockville, MD: Medical Expenditures Panel Survey, Agency for Healthcare Research and Quality. 3. Harding, C., Brooks, G., Ashikaga, T., Strauss, J.S., & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness. *American Journal of Psychiatry*, 144 (6), 727–735.

SAMHSA 2013 National Survey on Drug Use and Health Mental Health Findings



Reasons for Not Receiving Mental Health Services in the Past Year among:

- Adults aged 18 or older
- With perceived unmet need for mental health
- & did not receive mental health services

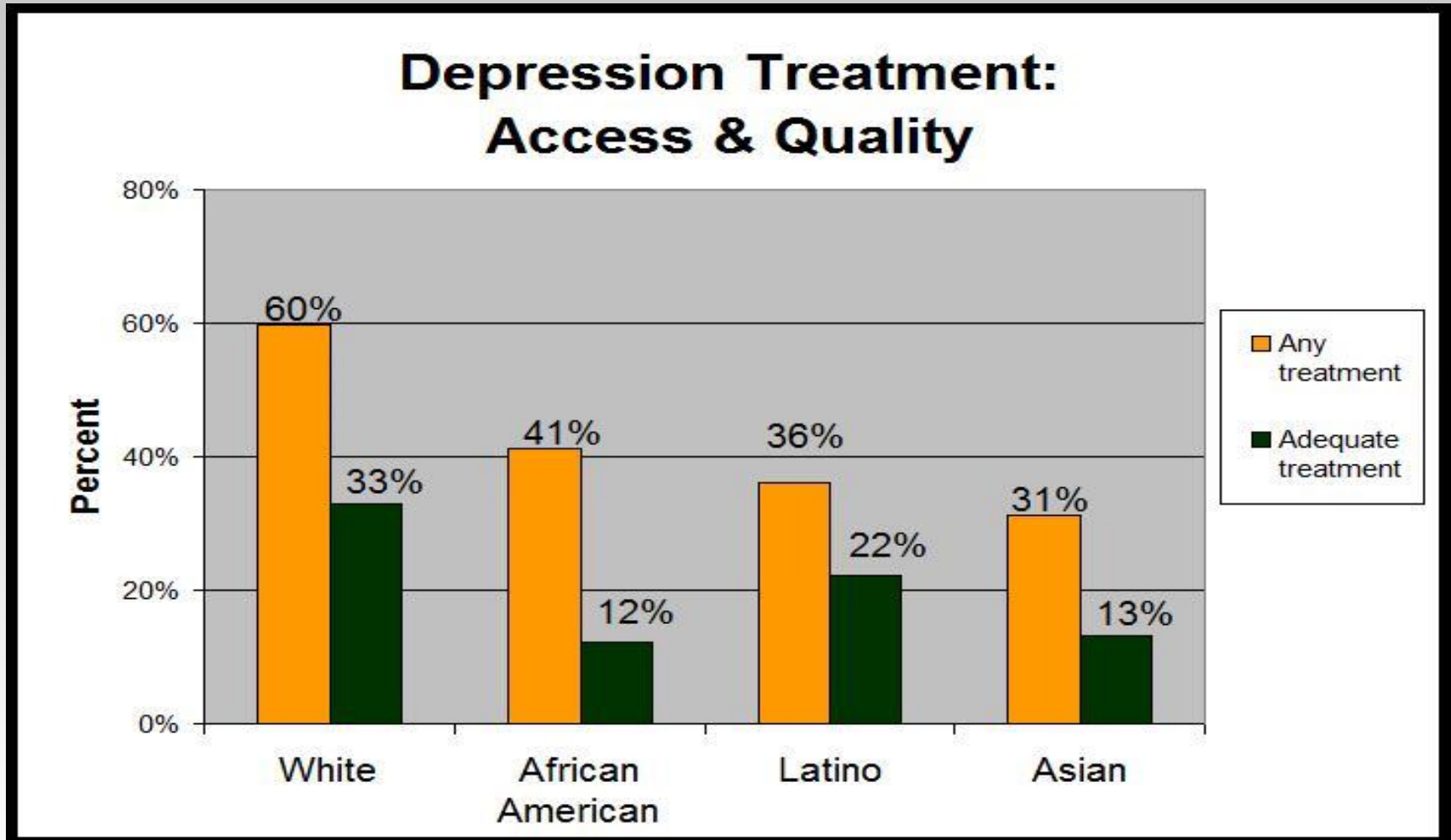
Mental Health: Disparity & Race

African-American men are disproportionately exposed to social and environmental conditions which adversely affect their mental health⁴:

- Poverty
- Low levels of education
- Community violence

4. Ayalon L, Alvidrez J. The experience of Black consumers in the mental health system--identifying barriers to and facilitators of mental health treatment using the consumers' perspective. *Issues in mental health nursing*. 2007;28(12):1323-1340.

Mental Health: Disparity & Race

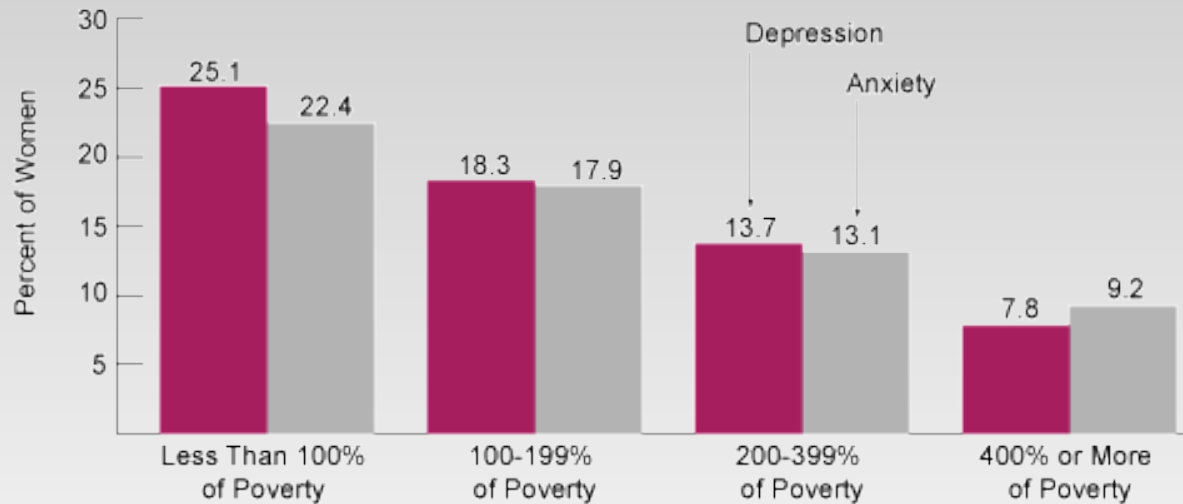


Alegria, M. et al. (2008) Disparity in Depression Treatment Among Racial and Ethnic Minority Populations in the United States. *Psychiatric Services*, 59(11), 1264-72

Mental Health: Disparity & Poverty

Frequent Depression and Anxiety* Within the Past Year Among Women Aged 18 and Older, by Poverty Status,** 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported they had been frequently depressed or anxious during the past 12 months. **Poverty level, defined by the U.S. Census Bureau, was \$21,027 for a family of four in 2007.

Mental Health: Disparity & Poverty

Chronic Health Problems Among U.S. Adults, by Poverty Status -- 2011

Poverty status is based on Gallup's best estimate of those in poverty according to the U.S. Census Bureau's 2011 thresholds

	In poverty	Not in poverty	Difference (pct. pts.)
 % Depression	30.9	15.8	15.1
% Asthma	17.1	11.0	6.1
% Obesity	31.8	26.0	5.8
% Diabetes	14.8	10.1	4.7
% High blood pressure	31.8	29.1	2.7
% Heart attack	5.8	3.8	2.0
% Cancer	6.3	7.1	-0.8
% High cholesterol	25.0	26.0	-1.0

Jan. 2-Dec. 31, 2011

Gallup-Healthways Well-Being Index

GALLUP®

Mental Health: Disparity & Homelessness

January 2010 HUD Point-in-Time (PIT) counts⁵:

- 26.2 percent of sheltered adults who were homeless had a severe mental illness.
- 46 percent of sheltered adults on the night of the PIT count had a chronic substance abuse problem and/or a severe mental illness.
- **Prejudice and discrimination associated with mental and substance use disorders create enormous housing challenges for these individuals.**

5. U.S. Department of Housing and Urban Development. (2011). The 2010 Annual Homeless Assessment Report to Congress (HUD No.11-121). Retrieved from <https://www.onecpd.info/resources/documents/2010homelessassessmentreport.pdf>;
Folsom, D., Hawthorne, W., Lindamer, L., et. al. (2005). Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. *American Journal of Psychiatry*, 162(2), 370-376.



MENTAL HEALTH: Cost- Benefit Analysis?

MENTAL HEALTH

Cost-Benefit Analysis?

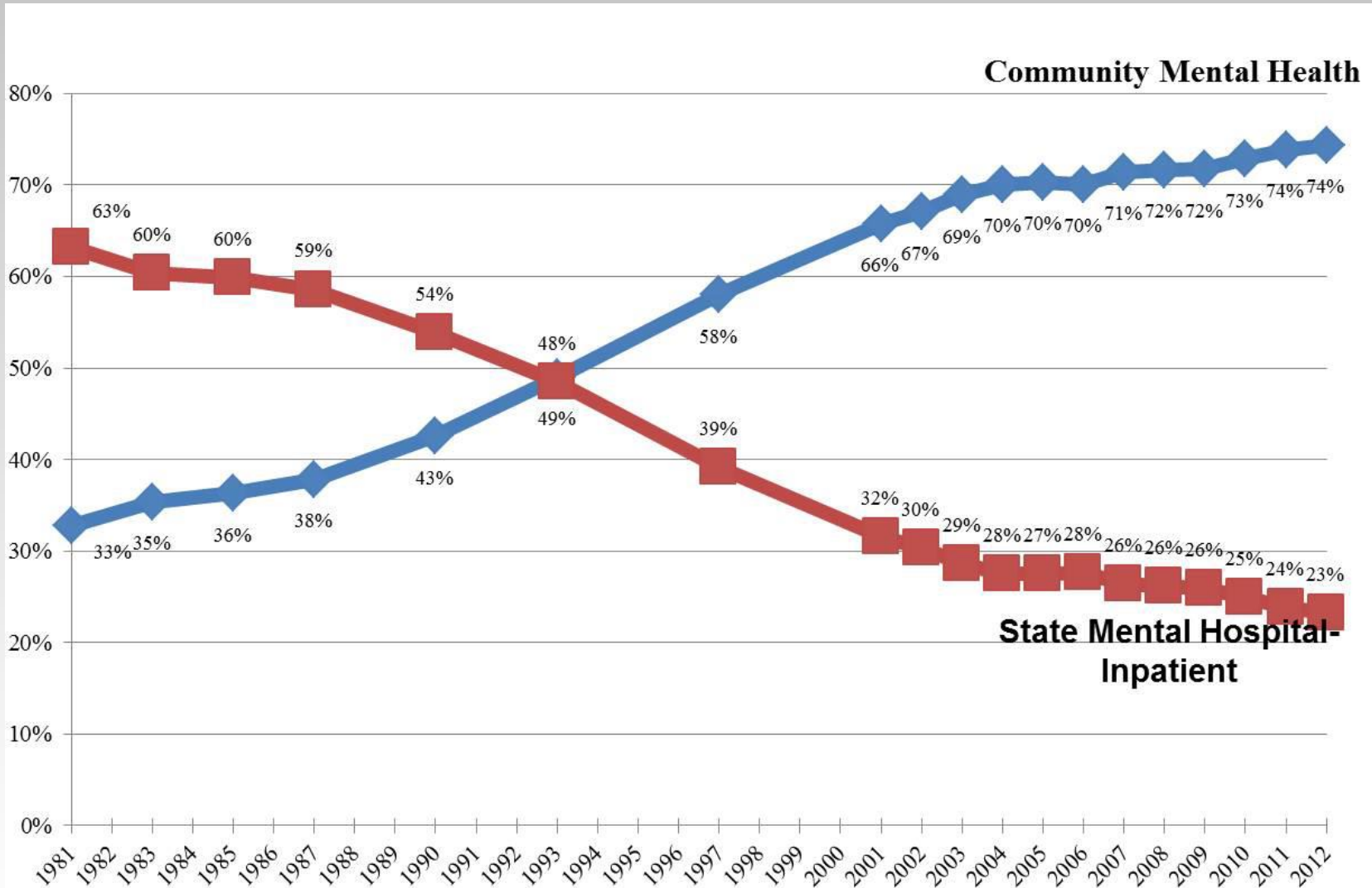
Serious mental illnesses cost the U.S. an estimated \$193.2 billion in *lost earnings per year*.⁶

In 2006, 186,000 young adults received social security disability benefits because their mental illness was so severe that they were found to be unable to engage in substantial gainful activity.⁷

Of the *more than six million people served by state mental health authorities across the nation, only 21 percent are employed*.⁸

6. Kessler, R., Heeringa, S., Lakoma, M., Petukhova, M., Rupp, A., Schoenbaum, M., et al. (2008). The individual-level and societal-level effects of mental disorders on earnings in the United States: Results from the National Comorbidity Survey Replication. *American Journal of Psychiatry*, 165(6), 703-11. doi: 10.1176/appi.ajp.2008.08010126. 7. United States Government Accountability Office. (2008). *Young Adults with Serious Mental Illness: Some States and Federal Agencies Are Taking Steps to Address Their Transition Challenges* (Report to Congressional Requestors, GAO-08-678). 8. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2009). 2009 CMHS Uniform Reporting System output tables. Retrieved from [http:// www.samhsa.gov/dataoutcomes/urs/urs2009.aspx](http://www.samhsa.gov/dataoutcomes/urs/urs2009.aspx)

State Mental Health Agency Controlled Expenditures for State Psychiatric Hospital Inpatient and Community-Based Services as a Percent of Total Expenditures: FY'81 to FY'12





Level of SMHA Budget Reductions

FY2009 to FY2012 Total \$4.35 Billion in Cuts*

Year	Average	Maximum	Total
FY 2009 (39 states)	\$36,849,116	\$554,003,000	\$1,216,020,843
FY 2010 (38 States)	\$29,123,575	\$213,591,000	\$1,019,325,136
FY 2011 (36 states)	\$35,294,953	\$132,000,000	\$1,270,618,291
FY 2012 (41 states)	\$28,074,541	\$242,500,000	\$842,236,221

**Preliminary Results based on 41 SMHAs Reporting Winter 2011-2012*

http://www.nasmhpd.org/docs/Policy/SummaryCongressional%20Briefing_2012.pdf

Types of Services SMHAs are Cutting

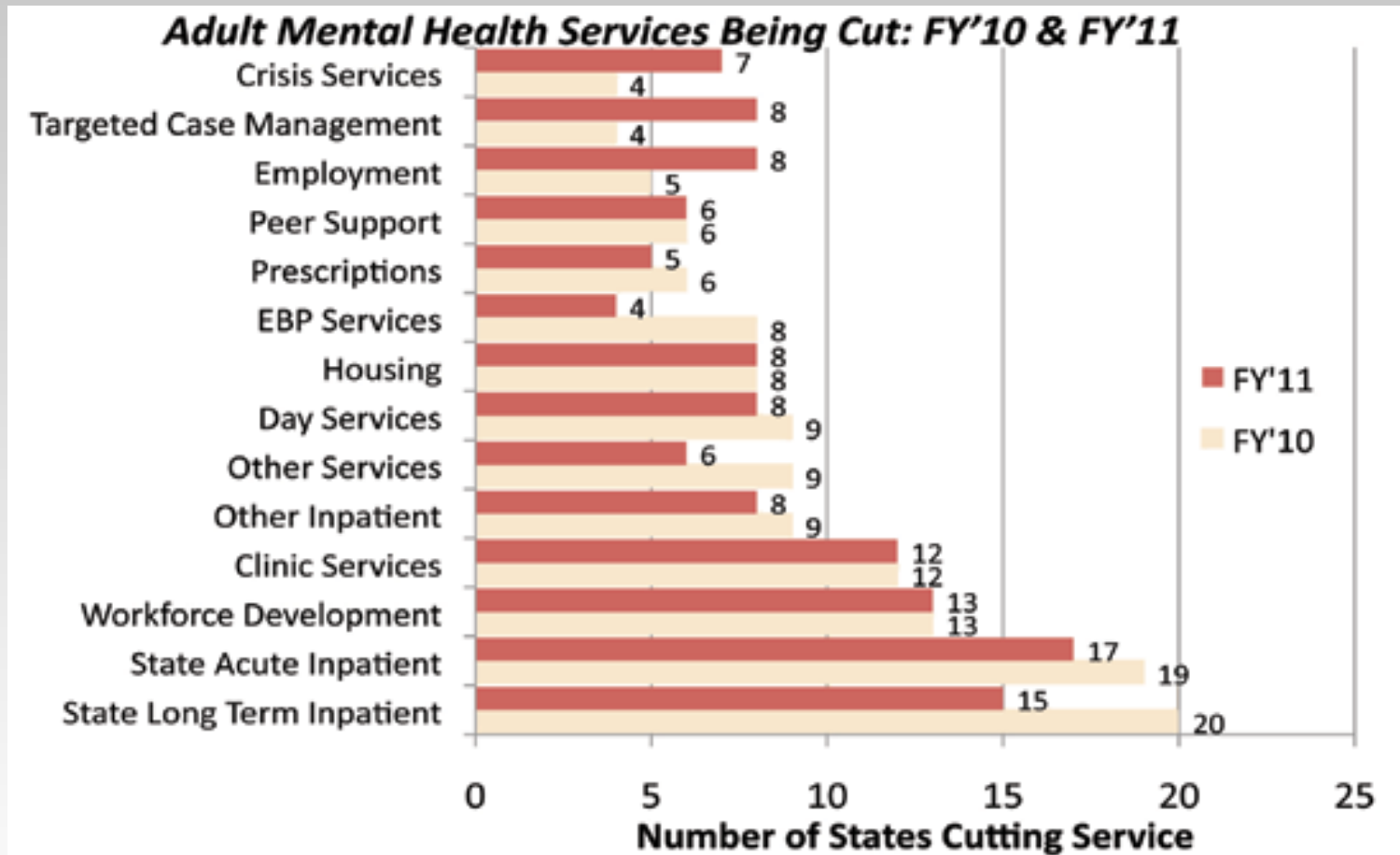


Chart courtesy Ted Lutterman, NASMHPD Research Institute, Inc (NRI), Oct. 12, 2010

Implication of Budget cuts in Four States

1. Ohio

- Once had one of the **top** mental health systems **in the country**.
- After several years of **significant** budget cuts, thousands of youth and adults living with serious mental illness are unable to access care in the community and are ending up either on the streets or in far more expensive settings such as hospitals and jails⁹.

2. Illinois

- After three years of budget cuts totaling **\$113.7 million**, Illinois' community mental health system is in ruins.
- According to Christopher Larrison, professor of social work at the University of Illinois, these reductions in mental health funding, on top of already inadequate funding, has resulted in the “decimation” of community mental health services, particularly boarding in public in the rural southern part of the state.
- “Imagine a small rural community where there are people with schizophrenia left untreated,” said Larrison. “If you dry up the services, then the hospital emergency rooms and police, who are also at the breaking point, will have to deal with an increasing number of people suffering from untreated mental illness¹⁰.”

9. C. Candisky, “Ohio’s Mental-Health System Falls Far Short, Report Finds”, *Columbus Dispatch*, Jan. 26, 2011 10. P. Ciciore, “State Cuts to Community Mental Health Services Continues Disturbing Trend,” News Bureau, Illinois, Aug. 5, 2010

Implication of Budget cuts in Four States

3. Arizona

- Eliminated \$108.4 million from its mental health budget between 2009 and 2011, reducing services to about 14,000 Arizona citizens living with mental illness.
- **This led to the elimination of case management, brand name medications, access to support groups and housing and transportation subsidies for people living with serious mental illness^{11, 12}.**

4. Rhode Island

- It has cut mental health funding since 2008.
- **Since 2008, Rhode Island has experienced a 65% increase in the number of children living with mental illness hospital emergency rooms, with no place to go for treatment.**

11. N. Santa Cruz and A. Powers, "Mental Health in Arizona: A Case Study," *Los Angeles Times*, Jan. 19, 2011 12. H. Clarke Romans, Video Interview on Democracy Now, Jan. 11, 2011.

The following 11 states made the largest cuts by percentage of their overall state mental health general fund budget from 2009 to 2011¹³.

California \$587.4 million

Kentucky \$193.7 million

New York \$132 million

Illinois \$113.7 million

Arizona \$108.4 million

Wisconsin \$107.1 million

Massachusetts \$63.5 million

Ohio \$57.7 million

Alaska \$47.9 million

Washington, D.C. \$44.2 million

It is important to note that individual states differ significantly in terms of population, numbers of children and adults living with mental illness, and the size of the overall budget. It is important to also evaluate cuts in terms of the overall state general fund budget for mental health services.

13. Honberg, R., Diehl, S., Kimball A., Gruttadaro, D., Fitzpatrick, M. 2011. *State Mental Health Cuts: A National Crisis*. NAMI, the National Alliance on Mental Illness

The following 10 states made the largest cuts by percentage of their overall state mental health general fund budget from 2009 to 2011¹³.

Kentucky 47%

Alaska 35%

South Carolina 23%

Arizona 23%

Wisconsin 22%

Washington, D.C. 19%

Nevada 17%

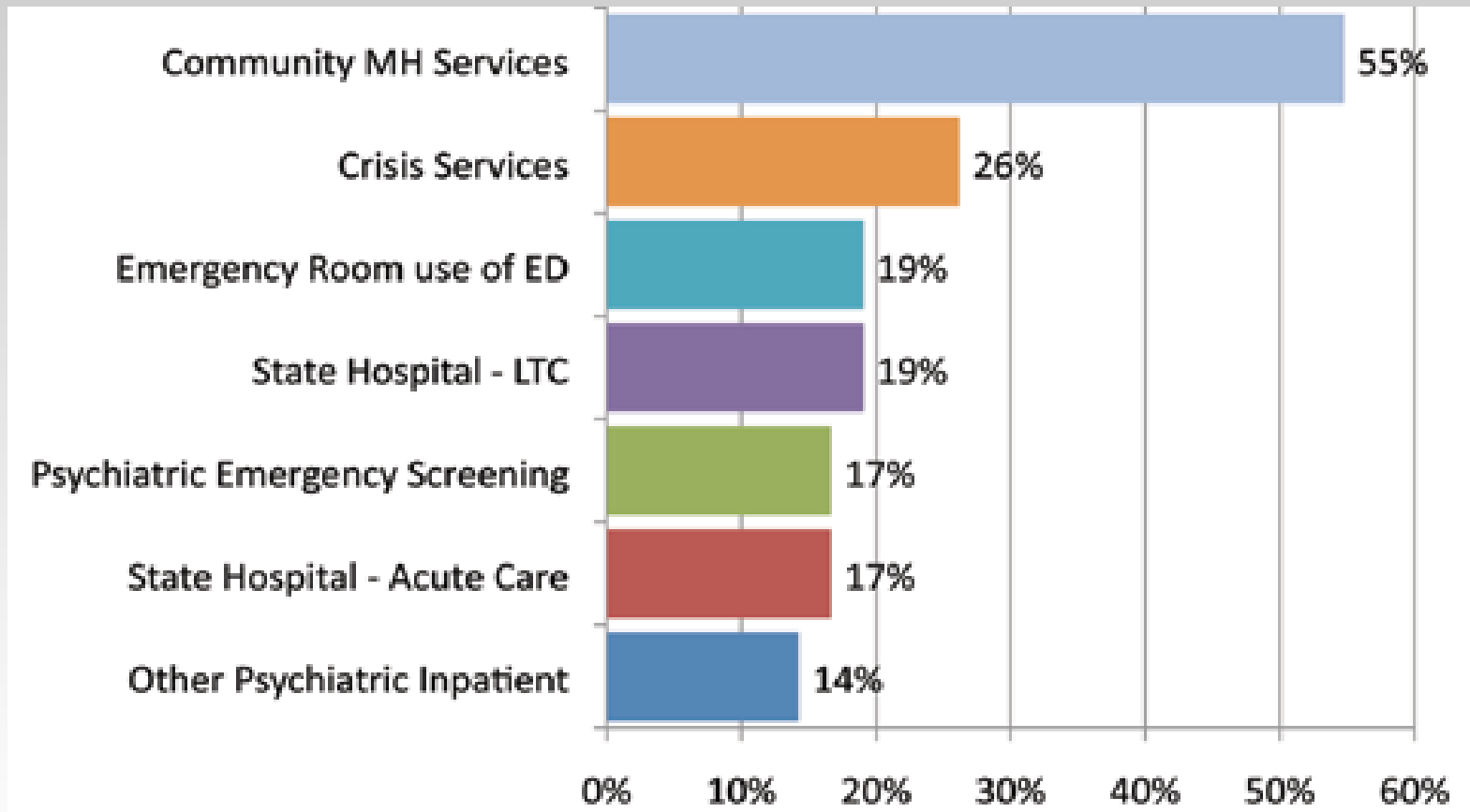
Kansas 16%

California 16%

Illinois 15%

13. Honberg, R., Diehl, S., Kimball A., Gruttadaro, D., Fitzpatrick, M. 2011. *State Mental Health Cuts: A National Crisis*. NAMI, the National Alliance on Mental Illness

Increased Demand for Mental Health Services During the Recession: Percentage of States Experiencing Increased Demand for Services



Closing State Psychiatric Hospitals & Hospital Beds (2009-2012)

	SMHA Has Closed	SMHA is Considering Closing	Total Closed or Considered for Closure
State Psychiatric Hospitals	8 States 9 State Hospitals	4 States 6 State Hospitals	12 States 15 State Hospitals
State Hospital Beds	29 States 3,222 Beds	10 States 1,249 Beds	4,471 Beds*

** 4,471 beds represents over 9% of State Psychiatric Hospital Bed Capacity*

Preliminary Results based on 41 SMHAs Reporting Winter 2011-2012

http://www.nasmhpd.org/docs/Policy/SummaryCongressional%20Briefing_2012.pdf

Types of Services SMHAs are Cutting

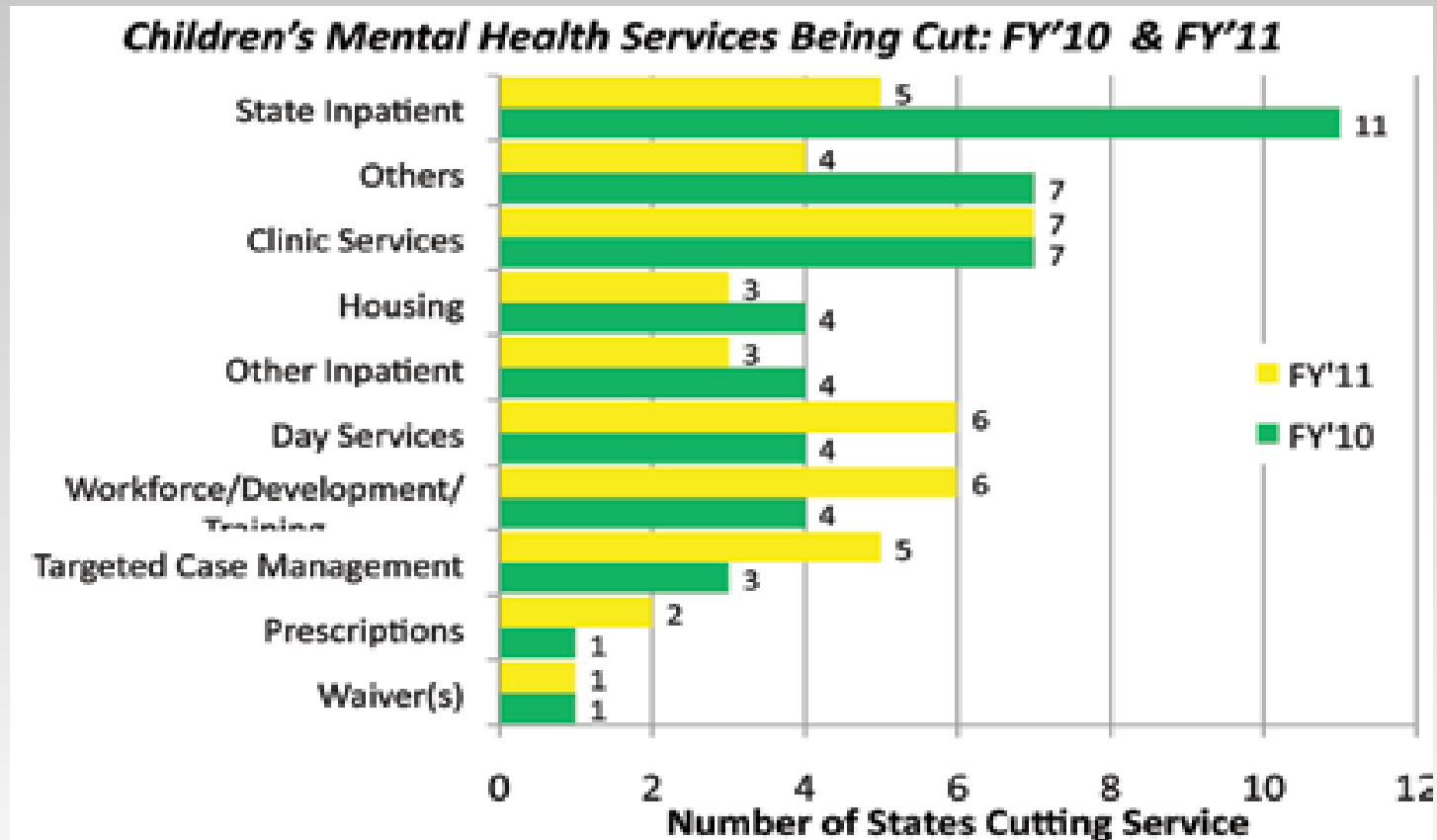


Chart courtesy Ted Lutterman, NASMHPD Research Institute, Inc (NRI), Oct. 12, 2010

Several States with Critical safety net services for youth and adults living with mental illness have either already been eliminated or are threatened for elimination.

Washington

- In October 2010, the Governor of Washington announced across the board cuts of \$17.7 million in state mental health funding for 2011 and 2012.
- These decrease reduced the availability of crisis and involuntary commitment services as well as outpatient and medication monitoring services.
- The reductions also mandated the additional closures or downsizing of inpatient psychiatric treatment facilities.

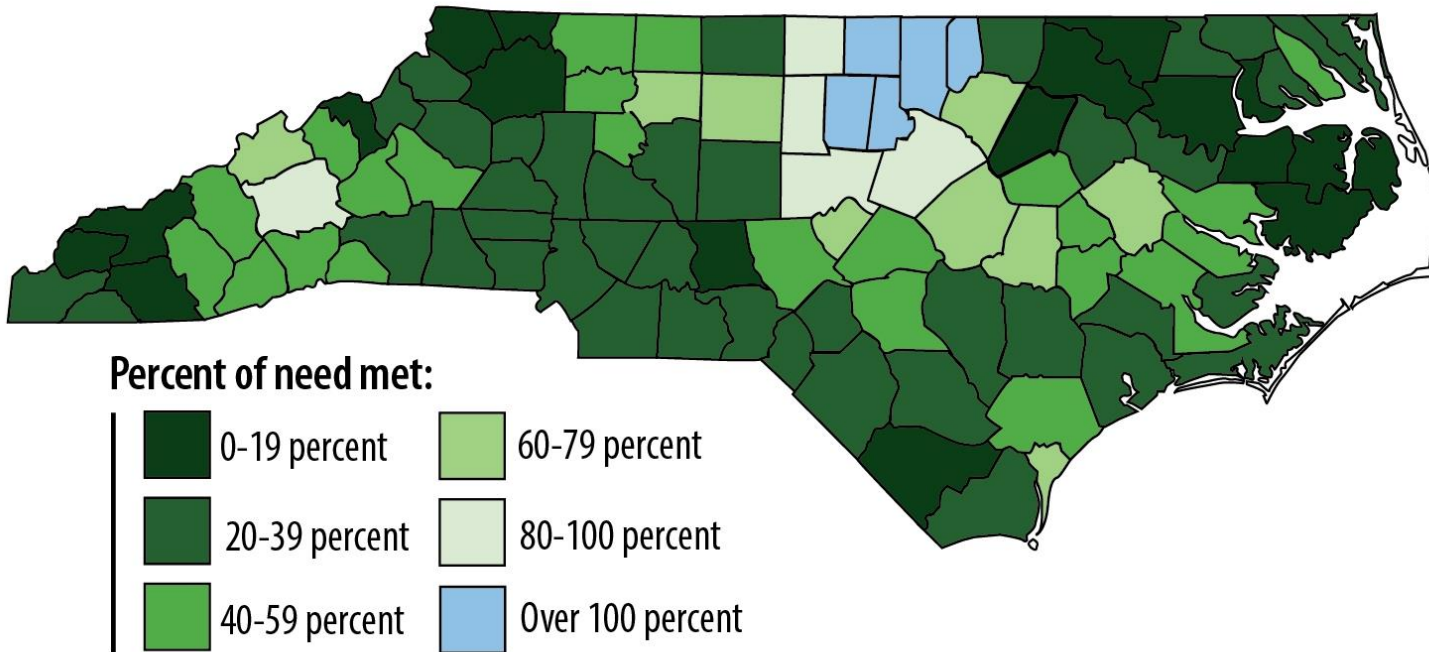
Kansas

- Has cut \$19 million in state mental health funding since 2008.
- As a consequence of these cuts, nine of Kansas' 27 Community Mental Health Centers are experiencing deficits and are in jeopardy of being closed.
- Most of these Centers serve rural areas of the state¹⁴.
- In 2011, the Governor's budget proposed an additional **\$15 million in cuts**, which would primarily affect services for **uninsured children and adults living** with serious mental illness¹⁵.

14. J. Roszak, "My Turn: Can we Afford Mental Health Cuts?" *Kitsap Sun*, www.kitsapsun.com/news2011/jan28/my-turn-can-we-afford-mental-health-cuts/ 15. K. Conner, "Mental Health Advocates DeCry Cuts", Hays Daily News, 2/8/2011, <http://www.hdnews.net/Story/mentalhealth020811>

Mental health prescribers in extreme shortage for rural N.C.

Of North Carolina's 100 counties, 95 do not meet the total need for mental health professionals who are able to prescribe medication. These professionals tend to be concentrated in areas with large medical institutions.



SOURCE: NORTH CAROLINA MEDICAL JOURNAL

DTH/KAITLYN KELLY

<http://www.dailytarheel.com/article/2015/01/north-carolinians-seeking-mental-health-care-might-encounter-problems>

Patients with Mental Illness are now going to the ER for treatment¹⁶.

- According to the North Carolina Hospital Association, in 2013, NC hospitals had 162,000 behavioral health emergency department visits and 68,000 inpatient behavioral health admissions.
- **In 2010, patients with mental illness made up about 10 percent of all emergency room visits in North Carolina**, according to a study by the Centers for Disease Control, and people with mental health disorders were admitted to the hospital at twice the rate of those without.
- **Nationally, greater than 6.4 million visits to emergency rooms in 2010, about 5 percent of total visits, involved patients whose primary diagnosis was a mental health condition or substance abuse.**
- **That is up 28 percent from just four years earlier**, according to the latest figures available from the Agency for Healthcare Research and Quality in Rockville, MD
- **By one federal estimate, costs to general hospitals in order to care for these patients is expected to nearly double to \$38.5 billion in 2014, from \$20.3 billion in 2013.**

16. Cresewell, J. **E.R. Costs for Mentally Ill Soar, and Hospitals Seek Better Way**, NY Times, DEC. 25, 2013
http://www.nytimes.com/2013/12/26/health/er-costs-for-mentally-ill-soar-and-hospitals-seek-better-way.html?_r=0

The Cost of Chronic Homelessness

\$22,372 Per Person Per Year

Dr. Stephen Poulin with colleagues at the University of Pennsylvania conducted a study that identified 2,703 persons meeting the federal criteria for chronic homelessness (one year of continuing homelessness or four episodes of homelessness within three years)¹⁷.

- They assessed cost data for these individuals for outreach and public shelter services, psychiatric inpatient and outpatient care, and jail costs.
- They found that a subgroup of **20 percent** of these individuals **accounted for 60 percent of the costs of the total group.**
- **Among the 20 percent of the high-users, 81 percent had a diagnosis of schizophrenia or major affective disorders.**

17. Service use and costs for person experiencing chronic homelessness in Philadelphia: A population-based study by Poulin et al., *Psychiatric Services* 2010;61:1093–1098.

The Cost of Chronic Homelessness Costs \$22,372 Per Person Per Year

- This means **438** seriously mentally ill individuals- who were chronically homeless- **cost on average \$22,372 per person, per year** in service costs. **Together, these individuals cost the city of Philadelphia almost \$9.8 million per year.**
- This was only a partial cost; the researchers indicated "*the study did not include the costs associated with police, courts, emergency medical services, and health care not associated with behavioral health*."¹⁸
- The true cost was much higher than \$22,372 per person; *for this kind of money, one can provide excellent psychiatric services if they are organized correctly.*

18. Service use and costs for person experiencing chronic homelessness in Philadelphia: A population-based study by Poulin et al., *Psychiatric Services* 2010;61:1093–1098.

Financial Benefits of Comprehensive Treatment & Integrated Care

Effective nationwide school-based substance abuse prevention programming can offer states savings within 2 years ranging from¹⁹:

- \$36 million to \$199 million in juvenile justice
- \$383 million to \$2.1 billion in education
- \$68 million to \$360 million in health services

Supported employment programs that help people with the most serious mental illnesses place more than 50 percent of their clients into paid employment.²⁰

19. Miller, T. & Hendrie, D. (2008). Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis (DHHS Pub. No. (SMA) 07-4298). Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration. 20. Cook, J., Leff, H., Blyler, C., Gold, P., Goldberg, R., Mueser, K., et al. (2005). Results of a multisite randomized trial of supported employment interventions for individuals with severe mental illness. *Archives of General Psychiatry*, 62(5), 505–512.



**MENTAL
HEALTH
POLICY:
Modern
Trends
Guided by
Current
Events**

Mental Health Policy:

Modern trends guided by current events

- Striking just before state legislative sessions convened, the mass shooting in Newtown, Connecticut engaged the nation's attention on *the eroded condition of mental health services in this country.*
- The White House report, produced in response to the tragedy, recommended strengthening gun ownership background check systems, making schools safer and *increasing access to mental health services*²¹.
- *Current events related to Michael Brown case.*
- *Current events related to officer shootings in TX and IL over last week.*

21. White House (Jan. 16, 2013) Now is the Time; the president's plan to protect our children and our communities by reducing gun violence. White House. http://www.whitehouse.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf

Reaction to Tragedy: Legislation after Newtown

- The shooting at Sandy Hook Elementary School in Newtown, Conn. provided a major impetus for lawmakers to propose legislation which would impact children and adults living with mental illness.
- Mental illness came to the forefront of the nation's attention when medical records revealed that the shooter's mother was increasingly concerned about his deteriorating mental health and had been dissatisfied with the lack of school services dating back to middle school.²²
- Mass shootings over the past several years have shaped the debate about the **lack of access to mental health services and the barriers** that many families and individuals face in light of the nation's fragmented and grossly inadequate mental health system.

22. Griffin, A. & Kovner, J. (2013, June 30). Adam Lanza's medical records reveal growing anxiety. The Courant.
<http://www.courant.com/news/connecticut/newtown-sandy-hook-school-shooting/hc-adam-lanza-pediatric-records-20130629,0,7137229.story>

Mental Health Policy: Changes

Many provisions of the **Patient Protection and Affordable Care Act (ACA)** were implemented in FY 2013-2014. *Numerous state legislative sessions are actively working to expand Medicaid under this law.*

- During the initial first six month enrollment period in October 2013, in all states under the ACA, an estimated **2.65 million people with mental illness qualified for subsidies to buy private health insurance** in the Health Insurance Marketplaces.²³
- The **ACA requirement for all Qualified Health Plans to provide mental health benefits in compliance with federal mental health parity law benefits an estimated 62 million Americans²⁴** prompting mental health parity legislation in a number of states.

23. Exchanges: A Focus on Those with Behavioral Health Conditions in each State. <http://www.samhsa.gov/healthreform/enrollment.aspx>. Ibid.

24. Beronio, K., Po, R., Skopec, L., Glied, S. (Feb. 2013). Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm

Mental Health Policy: Changes

After years of attempting to meet rising demand with diminishing resources, **public mental health systems are stretched to the breaking point.**

An improving economic outlook has allowed state legislatures to begin rebuilding state mental health budgets in acknowledgement that there is a need to monitor and improve mental health service delivery.

However, as we have seen in North Carolina, that does not necessarily mean more funding for mental health services²⁵.

- The NC legislature budget for 2014-2015 cuts funding to the Department of Mental Health by \$25 million.
- This slash in funding marks the second year of deep cuts for mental health in NC.
- Mental Health does not fare better in the 2015-17 as we discuss later with respect to Medicaid reform.
- *Cuts are in the face of a \$445 million surplus and in the face of an overall increase in funds (\$10 million) to the Dept. of Health and Human Services.*

25. <http://www.citizen-times.com/story/news/2015/08/26/agreement-reached-nc-spending-targets-teacher-salaries/32423869/>



MENTAL HEALTH: North Carolina Budget & Policy

North Carolina Policy 2015

\$21.47 billion budget²⁶

Public education (public schools, University of North Carolina, community colleges)

\$12.05 billion

Health and Human Services (Medicaid, public health, mental health)

\$5.12 billion

Justice and Public Safety (courts, prisons, State Bureau of Investigation)

\$2.44 billion

Natural and Economic Resources (commerce, environment, agriculture)

\$372 million

General Government (Cultural Resources, state auditor, revenue, small agencies)

\$425 million

Debt Service

\$715 million

Additional salary and benefits

\$349 million

Reserve to handle unresolved budget matters

\$121 million

Capital projects

\$30 million

26. <http://www.citizen-times.com/story/news/2015/08/26/agreement-reached-nc-spending-targets-teacher-salaries/32423869/>

North Carolina Policy 2015

Calls for closure of the Wright School in Durham for children with behavioral problems^{27, 28}

Fails to expand Medicaid to the half million people in the Coverage Gap^{27, 28}

Dismantles Community Care North Carolina (CCNC) and creates a new Medicaid system^{27, 28}: *complete overhaul of the state's program to provide health care for low-income children, some adults, people with disabilities and poor elderly who live in nursing homes.*

- Places control in the hands of managed care companies
- Removes administration of Medicaid from the Department of Health and Human Services and creating a Health Benefits Authority with an independent board empowered to make all planning, policy and spending decisions.
- Creation of a legislative oversight committee to monitor the authority, which would be created and staffed within the next six months.

27. <http://www.northcarolinahealthnews.org/2015/06/16/ncga-senate-health-and-human-services-budget-first-look/>

28. <http://pulse.ncpolicywatch.org/2015/08/26/medicaid-expansion-the-state-by-state-picture/>

North Carolina Policy 2015

- NC would be divided into six regions.
 - In each of these regions, two provider-led organizations could bid to provide Medicaid services.
- The plan also allows for three statewide Medicaid plans, which could be administered by managed care companies or by provider-led organizations, all of which will be paid a monthly fee per patient rather than on a fee-for-service basis.
- The plan would also require any organization managing Medicaid to cover the *entire population*, from low-cost children's services to expensive nursing home patients with multiple problems, something few, if any, other states have asked of managed care Medicaid providers.
- **Mental health services would remain with the managed care entities created by the state in 2010²⁹.**
- **Senators want the entire transformation to be complete by August 2017¹⁹.**

29. <http://www.northcarolinahealthnews.org/2015/06/16/ncga-senate-health-and-human-services-budget-first-look/>

North Carolina Policy 2015

Creation of a statewide health information exchange (HIE)²⁹

- Requires every Medicaid provider, including hospitals and individual physicians, to be part of the data exchange.
- The HIE would be used for paying Medicaid claims and would make data available to state regulators to assess the outcomes of treatment for Medicaid patients.
- Creates a new Department of Information Technology to monitor the two systems and also creates a subcommittee to manage further implementation of NCTracks and NC FAST.
- Create a new computerized tracking and case management system for children in the child-welfare system.

29. <http://www.northcarolinahealthnews.org/2015/06/16/ncga-senate-health-and-human-services-budget-first-look/>



MENTAL HEALTH: How does NC stack up?

Rebuilding State Mental Health Budgets

- State mental health budgets were gutted during the recession. With reductions totaling \$4.35 billion from FY2009 to FY2012.³⁰
- In 2013, economic prospects brightened- somewhat- with a 5.3 percent combined growth in state revenue.³¹
- *Most* states have either increased or maintained state mental health authority budgets at current levels.
- Of special note is **Texas** which allocated a \$259 million increase over the previous biennial budget, *the largest mental health budget improvement in the state's history.*³²

30. Joel E. Miller, et al., Nov. 2012. The Waterfall Effect: Transforming the Cascading Impact of Medicaid Expansion on States, National Association of State Mental Health Program Directors.

31. NCSL (Aug. 2013) 2013 Presents a Dichotomy for State Budgets. NCSL News.

32. Grissom, B (May 18, 2013) With Consensus and Money, State Takes on Mental Health Care.

Budget Changes

- **South Carolina** reversed previous cuts to its mental health budget while Illinois restored \$32 million that had been cut in 2011 due to an administrative error.
- In **California**, an additional \$143 million was allocated to create crisis and triage positions throughout the state.³³
- As part of a 21.6 percent increase necessary to implement the ACA, **Oregon** allocated \$67 million in the 2014-15 biennial budget for psychiatric residential treatment and children's mental health.³⁴
- While these increases are encouraging, much remains to be done to restore drastic cuts in state mental health budgets nationally between 2008 and 2012.

33. Buchanan, W (June, 27 2013) Governor Brown Proudly Signs Balanced Budget. 34. Gray, CD (Jul. 3, 2013) House Passes \$15 Billion Budget for Oregon Health Authority. The Lund Report.

http://www.thelundreport.org/resource/house_passes_15_billion_budget_for_oregon_health_authority

Budget Changes

Not every state moved to increase general fund allocations to mental health.^{33, 34}

- **North Carolina continues to cut funding for mental health. Last year, funding to the sector was cut by \$25 million. This continued decrease in funding greatly impacts treatment and care delivery in our state.**
- Following precipitous general fund cuts amounting to 32 percent from 2009 to 2012, **Alaska** continued with a 3.4 percent reduction in the FY2014 mental health budget.
- **Wyoming** reduced mental health and substance abuse allocations by \$4.8 million as part of an overall 8 percent cut to the Department of Health.

33. Buchanan, W (June, 27 2013) Governor Brown Proudly Signs Balanced Budget. 34. Gray, CD (Jul. 3, 2013) House Passes \$15 Billion Budget for Oregon Health Authority. The Lund Report.



MENTAL HEALTH POLICY: Integrated Care & Early Intervention

Policy towards Integrative Care

13 state legislatures have recently enacted policies to monitor and improve mental health service delivery.

- **Utah** (HB 57) is a bellwether, *requiring the state mental health authority to promote integrated health care programs that address*
 - Substance abuse
 - Mental health
 - Physical health care needs
 - Evaluating the effectiveness of integrated programs
 - Encouraging local mental health authorities to do the same
- **Wyoming** (SF 60) is proceeding with Medicaid reform, strengthening mental health services for people living with serious and persistent mental illness or serious psychological distress.

Early Identification and Intervention

- After the Newtown tragedy NAMI advocated for policies supporting:
 - early identification and intervention
 - training for school personnel
 - families and the public
 - mental health services in schools and
 - increased access to care
- States' legislation was aimed at *providing increased mental health screening services for several populations primarily to identify emerging mental illness in children and adolescents and to ensure adequate access to care.*

Early Identification and Intervention

In addition, several states enacted related legislation focused on early intervention, school-based services and staff training to prevent potential tragedies such as the Sandy Hook shootings.

- **Nebraska** enacted LB 556 to develop behavioral health screenings and provide education and training on children's behavioral health.
- **Nevada** passed AB 386 to establish a pilot program for the administration of mental health screenings to students enrolled in selected secondary schools.
- **Minnesota** enacted HF 359 requiring that case management services continue to be available to youth living with mental illness after they turn 18.

Early Identification and Intervention

- **Virginia** (SB 1342) now requires the governing board of each public four-year institution of higher education to establish a written memorandum of understanding with its local mental health system and with inpatient facilities in order to expand the scope of services available to students seeking treatment.
- **Texas** enacted SB 460 to require training for public school teachers and students in recognizing and responding to signs of suicide or mental health disorders and the inclusion of mental health concerns in coordinated school health efforts.
- In **Utah**, HB 298 will require school districts to offer an annual seminar to parents with information on mental health, depression and suicide awareness.
- **Minnesota** passed two bills to strengthen school-linked mental health services (HB 2756)
- **Oregon** enacted HB 2756 calling for removal of seclusion rooms from all public schools

Rights Protection & Advocacy

Concern for civil rights of people who live with mental illness is typically an undercurrent for legislation.

Oklahoma (SB 755) establishes the role of “treatment advocate” to include:

- guardians
- persons granted general health care decision-making authority
- those designated as health care proxies in an advance directive granted durable power of attorney with health care decision-making authority.
- provides for release of information to the treatment advocate.

Family Involvement in Care

Understanding that informed and engaged families can lead to better mental health outcomes for children and adults the following states enacted:

- **South Carolina** enacted SB 117 which strengthens requirements for health care providers to give individuals the opportunity to authorize disclosure of information to designated family members or others.
- **Tennessee** passed SB 442 which allows family members and friends to transport individuals in mental health crisis to regional mental health institutes for civil commitment when safety would not be compromised.

Stigma Reduction

Two states passed recently bills addressing language and practices that have the effect of stigmatizing people living with mental illness.

- **Tennessee** (SB 1376) changed how the state code refers to people who live with mental illness to comply with ADA standards.
- **West Virginia** (HB 2463) repealed the law permitting sterilization of persons deemed mentally incompetent.
 - *No one has tried to use the law to sterilize an individual in West Virginia since 1956. But the 1929 law, which allows circuit courts to approve sterilizations for "mental defectives," has remained on the books.*



MENTAL HEALTH: Violence Prevention

Mental Illness & Violence Prevention

The New York Secure Ammunition and Firearms Enforcement (SAFE) Act of 2013 (S 2230) became the first piece of legislation enacted in 2013.

- broaden clinician duty to warn
- increase requirements to report mental health records for the purpose of limiting firearms purchases.
- Highly controversial due to the sweeping nature of its mandated strategies,
- the SAFE Act set a precedent for similar bills in other states which focused on increasing requirements to report mental health information to the National Instant Criminal Background Check System (NICS)
- more public access to civil commitment records
- expanding the duty of clinicians to warn about potential dangerousness.

Mental Illness & Violence Prevention

- **Connecticut** legislature enacted SB 1160 which strictly limits firearms possession and requires reporting of mental health information for gun permits.
 - Requires reporting of all people who receive inpatient psychiatric treatment, including those who enter hospitals voluntarily.
- **Colorado** enacted HB 1229 which requires background checks for purchases and transfers of firearms and limits possession of firearms.



MENTAL HEALTH POLICY: Crisis & Inpatient Treatment

Mental Health Facilities

Public inpatient mental health facilities were dramatically reduced during the recession as states struggled to stretch resources in the face of rising demand for services.

From 2007 to 2012 the number of patients served in state psychiatric facilities dropped by 30,079 (17 percent).³⁵

State legislation related to *psychiatric inpatient care concerned donation of property to*

- community mental health services (AR SB 801),
- staff functions (IA SF 406),
- complaint investigations (MO HB 351),
- a study of inpatient capacity (MT HJ 16),
- geropsychiatric facilities (ND HB 1089),
- deinstitutionalization (RI S680B) and
- limitations to restraint and seclusion (TX SB 1842).

35. Substance Abuse and Mental Health Services Administration (SAMHSA), Uniform Reporting System.

<http://www.samhsa.gov/dataoutcomes/urs/>

Crisis and Inpatient Treatment Legislation

A number of states also enacted legislation addressing civil commitment, court-ordered outpatient treatment (assisted outpatient treatment), crisis response, mental health facilities and suicide prevention.

- Civil commitment legislation, including SF 406 in **Iowa**, expands the scope of providers qualified to authorize inpatient admission from solely examining physicians to other professionals including physician assistants and psychiatric advanced registered nurse practitioners.
- **Indiana** passed HB 1130 which allows law enforcement to detain and transport persons with mental illness who are gravely disabled.

Crisis and Inpatient Treatment Legislation

- HB 16 in **Montana** clarified that the emergency detention standard in the civil commitment process includes individuals who are substantially unable to provide for their basic needs.

- **Washington** passed *three* civil commitment bills:
 1. HB 1114 to strengthen rights of people with mental illness during civil commitment and criminal incompetency procedures.

 2. SB 5480 requiring consideration of a person's history of symptoms or behavior when making a civil commitment decision.

 3. SB 5732 which improves planning and care coordination associated with discharge from inpatient civil commitment.

Crisis and Inpatient Treatment Legislation

- In **Nevada**, AB 287 broadened the use of assisted outpatient treatment by permitting courts to order outpatient treatment when it is determined that a person has a mental illness and is likely to harm self or others if left untreated.
 - The law mandates that courts must place individuals in the most appropriate course of community-based treatment available.
- SB 310 **Hawaii** established an assisted community treatment program for individuals not deemed dangerous to self or others.
- HB 1423, enacted in **Virginia**, stipulates that, pending the conclusion of a course of voluntary or involuntary treatment, the community services board in any county where an individual is to reside may petition the court for an order of mandatory outpatient treatment.

Crisis Response Services

In a crisis, psychiatric crisis response services help people stabilize, access care, and resume daily activities.

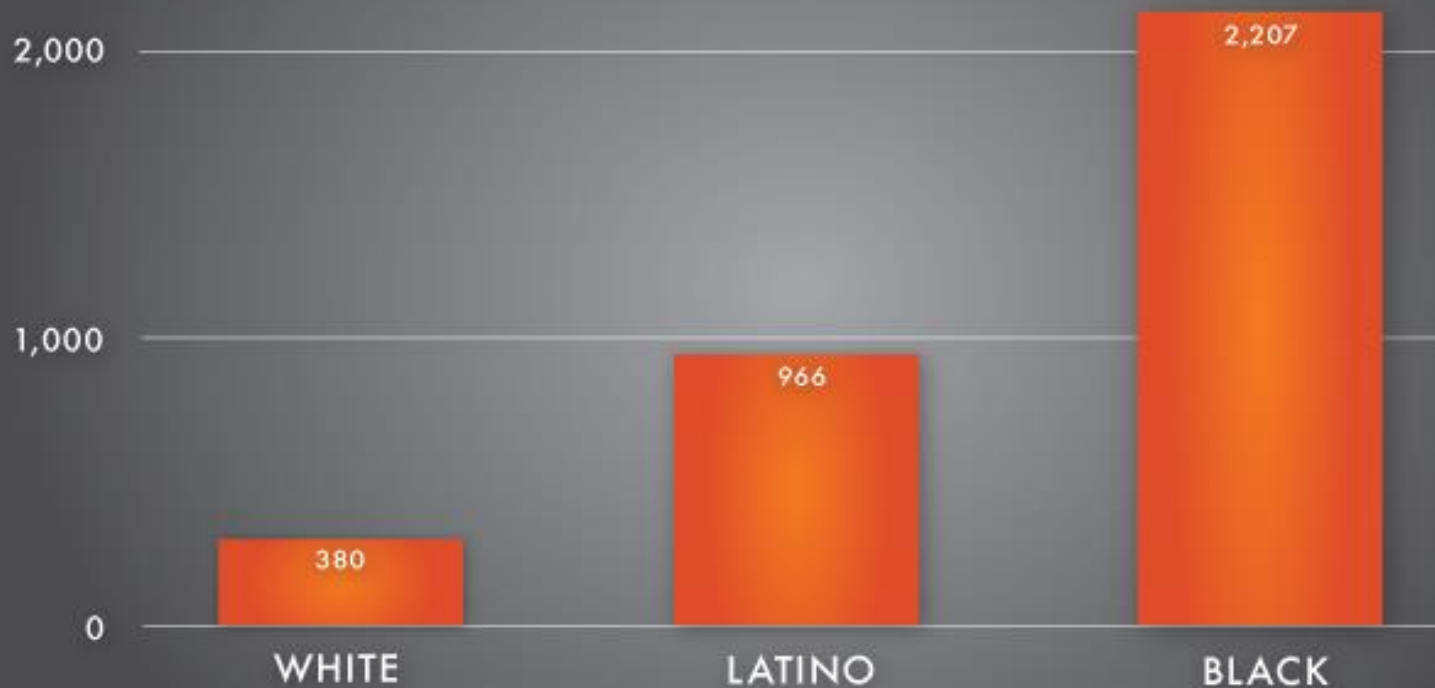
- Elements of a comprehensive crisis response system are reflected in **Colorado's legislation** (SB 266) to establish:
 1. 24-hour telephone crisis service to perform assessment and referrals
 2. Walk-in crisis services and crisis stabilization units for immediate evidence-based clinical intervention, triage and stabilization
 3. Mobile crisis units linked to the walk-in and crisis respite services
 4. Residential and respite crisis services
 5. A public information campaign.



MENTAL HEALTH POLICY: Criminal Justice

INCARCERATION RATES BY RACE & ETHNICITY, 2010

(Number of people incarcerated per 100,000 people in that group)



Source: Calculated by the Prison Policy Initiative from Bureau of Justice Statistics, Correctional Population in the United States, 2010 & U.S. Census 2010 Summary File 1.

Mental Illness & Criminal Justice

- **Disproportionate numbers of people with mental illness are involved in the criminal justice System³⁶ often as a result of untreated or undertreated mental illness.**
- NAMI oppose unnecessary arrests and incarceration, advocating for diversionary strategies such as
 - crisis intervention teams (CIT)
 - mental health courts.
- High profile violent acts by people living with mental illness make the task more difficult, and in 2013 lawmakers debated a variety of bills focused on the nexus between criminal justice and mental health.
- Legislation was enacted addressing law enforcement, the courts, incarceration, probation and parole and juvenile justice.

36. James, DJ., and Glaze, LE., (Sep. 2006) Bureau of Justice Statistics Special Report, Mental Health Problems of Prison and Jail Inmates, NCJ 213600.

Law Enforcement

Legislation was enacted in several states addressing procedures used by law enforcement officials to intervene when people display signs of mental illness.

- **Ohio (SB 7)** required that if a person convicted of an offense requires a mental health evaluation or treatment, the court shall report to the local law enforcement agency, which shall report the information to the national crime information center supervised release file.
- **Missouri (HB 404)** now allows psychological stress to be recognized as an occupational disease for purposes of workers compensation in possible violation of the Americans with Disabilities Act (ADA)
- **Tennessee (SB 175)** revised law enforcement officer qualifications to require certification that the applicant is free from any psychiatric impairment that would affect the ability to perform an essential function of the job, with or without a reasonable accommodation.

Courts

Legislatures dealt with a variety of bills concerning criminal courts and defendants with mental illness.

- **Arizona** (HB 2310) developed standards for the design, training and procedures to establish and implement mental health courts.
- **Missouri** (SB 118) created a veterans treatment court to handle cases involving substance abuse or mental illness of current or former military personnel.
- Without officially establishing a veterans' court **South Dakota** (SB 70) now requires
 - Magistrates and circuit judges to be trained on evidence-based principles,
 - Including use of behavioral health assessments and
 - Allows the court to consider treatment options when imposing a sentence if a defendant who is a military service member or veteran pleads guilty or no contest.

Incarceration

- Jails and prisons are neither designed nor funded to provide mental health treatment.
- Without appropriate treatment
 - Inmates with mental illness decompensate
 - Are vulnerable to abuse and
 - Are disproportionately segregated in solitary confinement
- Legislation enacted in **Maine (LD 1433/HP 1022)** raises concerns about unequal justice.
 - The bill provides that a person who is in prison for an offense and is found not criminally responsible by reason of insanity for another offense must finish the first prison term before beginning the commitment ordered by the court for the second offense.

Probation, Parole, & Release

Thoughtful release planning and progressive probation or parole procedures increase the likelihood of successful re-entry for prisoners living with mental illness.

- **Montana** enacted (SB 11) to revise the probation and parole system to work more effectively with prisoners who have a serious mental illness.
- The legislature also passed HB 68 creating a **re-entry task force pilot project to reduce recidivism.**

Probation, Parole, & Release: *Montana as a Model*

- **Montana HB 68** requires the department *in consultation with the reentry task force* to develop partnerships with and contract with community-based organizations that provide needed services to released inmates in areas such as:
 - Mental health
 - Chemical dependency
 - Employment
 - Housing
 - Health care
 - Faith-based services
 - Parenting
 - Relationship services
 - Victim impact

Juvenile Justice

As with the adult system, involvement with juvenile justice often represents the failure to identify and treat emerging mental illness.

As part of the examination of the mental health system as a whole, states enacted legislation to study, improve, and integrate juvenile justice systems with efforts of other child serving systems.

Legislation enacted in **Minnesota** (SF 671/ HF 724) commissioned a working group to examine juvenile justice and mental health. The group is composed of

- NAMI Minnesota
- Commissioners of human services
- District court judge designated by the Supreme Court
- Minnesota County Attorneys Association
- State public defender
- Indian Affairs Council
- Minnesota County Probation Officers Association
- Minnesota Association of Community Corrections Act Counties

Juvenile Justice

The group will examine:

- early identification and response, changes needed to ensure coordinated quality service delivery;
- changes to rules and statutes to remove barriers to achieving outcomes;
- an implementation plan to achieve integrated service delivery across systems and across the public, private and nonprofit sectors and financing mechanisms that include all possible revenue sources.
- NAMI Minnesota is required to report to the legislature on the results.



MENTAL HEALTH POLICY: Treatment & Clinicians

Clinician Duty to Warn: Tarasoff

Tarasoff vs. Regents of the University of California

17 Cal 3d 425,551 P2d 334, 131 Cal, Rptr 14 (1976)

Landmark case that set a standard for practitioners to reveal confidential information in their duty to warn others of the potential dangers from a client.

Clinician Duty to Warn

No statute or legal precedent to compel a provider to disclose threats of violence made by their client to an intended victim in North Carolina.^{36, 37}

Existing statute requires communication with clients to remain confidential.

Case law does impose the duty to warn/protect when the client is in the *physical and legal custody of the clinician (hospitalized)*.³⁶

- *Pangburn v. Saas* (1985) and *Davis v. North Carolina Department of Human Resources* (1995) both held that when an individual is involved in involuntary commitment the institution has a duty to exercise control and protect third parties from harm caused by the patient.
- Licensed Professional Counselors in North Carolina do **NOT** have the authority to involuntarily commit or release from commitment (i.e., control) a patient/ client hospitalized for their propensity for violence.

36. Mobley, A. K., & Naughton, E. (2011). Tarasoff and duty to protect in North Carolina. *NC Perspectives*, 4, 5-14.

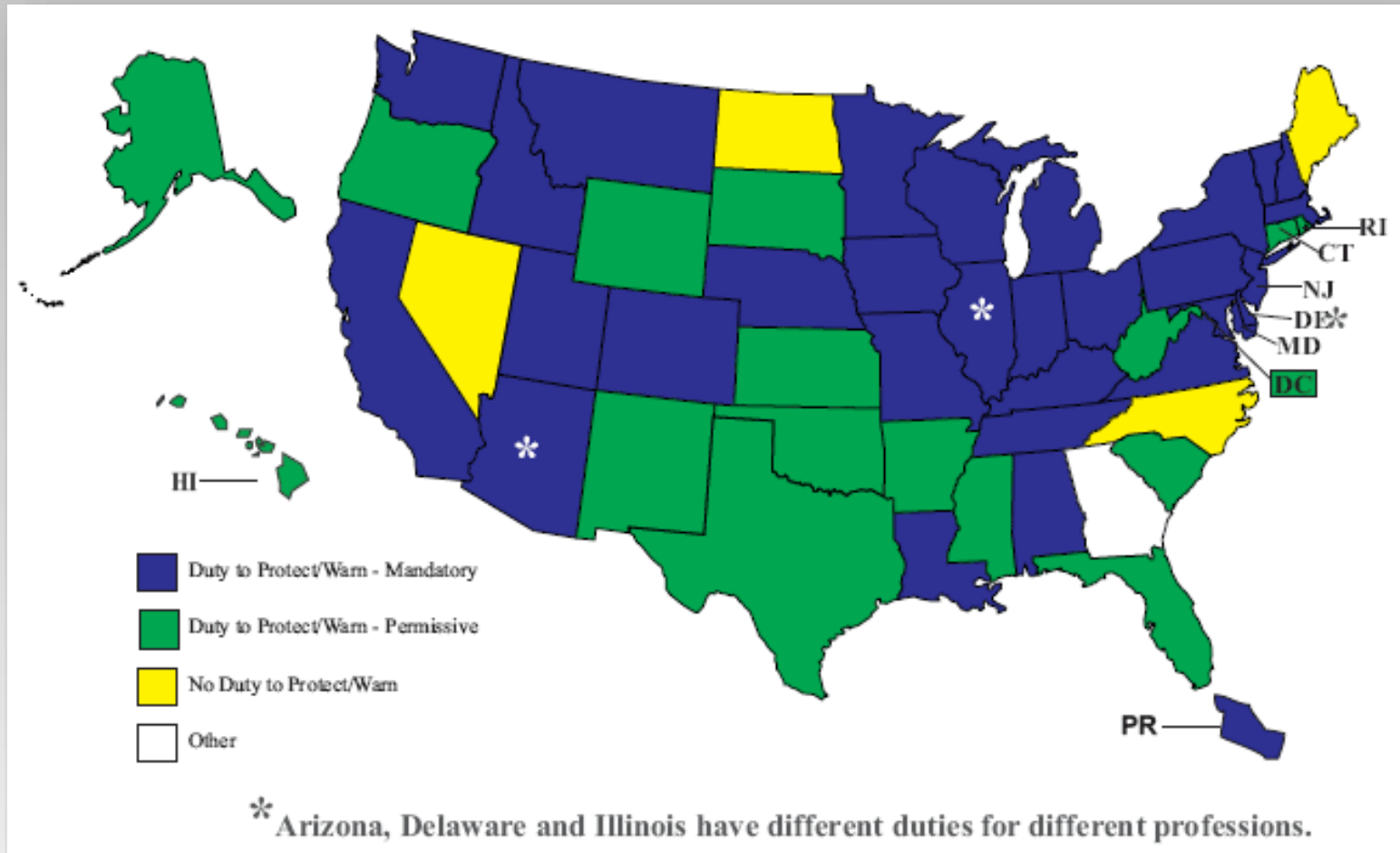
37. <http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx>

Clinician Duty to Warn

NORTH CAROLINA CASES³⁷

- *Currie vs. United States*, 836F 2d 209 (4th Circuit), 1987. The 4th Circuit did recognize Tarasoff as creating a duty to warn, *but limited it to potential identified victims*.
- *Cantrell v. United States* (1988) the United States District Court Eastern District of North Carolina, Raleigh Division, found that the victim's prior knowledge of the subject's “violent tendencies” was further reason for *not* supporting a clinician's duty to warn her.
- ***Gregory vs. Kilbride*, 150NC App. 601 (2002). This is the landmark NC case which represents current common law. It specifically does not recognize Tarasoff Duty to Protect.**

Clinician Duty to Warn



<http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx>

Clinician Duty to Warn: Other States³⁸

- **Arkansas** HB 1746 Requires a mental health services provider to warn a law enforcement officer of a credible threat by a patient.
- ★ **New York** S2230/ A2388 *Created the N.Y. Secure Ammunitions and Firearms Enforcement Act of 2013.* **Requires mental health professionals to report if an individual they are treating is likely to engage in conduct that will cause serious harm to him- or herself or others. The report will be used to crosscheck the individual's name against a comprehensive gun registration database.** If the individual possesses a gun, the license will be suspended and law enforcement will be authorized to remove the person's firearm or the individual may be prevented from obtaining one in the future.
- **Tennessee** SB 789/ HB 645 Requires mental health professionals to report any patient who makes an actual threat of bodily harm against a reasonably identifiable victim patient to NICS.

38. <https://www.nlm.nih.gov/hsrinfo/datasites.html>

Clinician Duty to Warn: A Question of Ethics over Legality

In North Carolina, this question creates a legal disparity as well as an ethical disparity for mental health providers to circumnavigate as they provide care for patients.

The absence of legal duty for a clinician/provider to disrupt confidentiality and warn a projected recipient of violence by a patient must be differentiated from the ethical considerations we have as clinicians.

How can providers handle situations in which we could prevent harm to someone who is not our client?

How can we navigate our ethical obligation and the legal requirement?

Health Information Privacy

- **Tennessee enacted SB 28 which allows a court hearing a child custody case to order disclosure of mental health information.**
 - As amended, the bill **restricts release of confidential mental health information for the purpose of litigation and requires return or destruction of records at the conclusion of the case.**
- **Oklahoma (SB 581) allowed access to court records related to treatment when a person having:**
 - Valid power of attorney with health care decision-making authority
 - Valid guardianship with health care decision-making authority
 - An advance health care directive
 - An attorney-in-fact as designated in a valid mental health advance directive

Prescription Medications

People who get the right treatment have greater success in managing their mental illness. In order to choose the treatment regimen that will work best and enhance adherence, individuals and their prescribers need access to the full range of medications.

In an effort to contain costs a number of states enacted legislation limiting access to psychiatric medications in public programs.

- **Arkansas** set a *troubling precedent* with HB 1185 which authorizes a pharmacist to substitute a therapeutically equivalent, less costly medication, upon authorization by the prescriber.
- **The pharmacist must inform the patient of the right to refuse the substitution.**
- The term “**therapeutically equivalent**” extends beyond substituting a generic for its brand name equivalent to substituting a chemically different medication from the same class.

Prescription Medications

Within its 2013 budget bill (SB 402), North Carolina imposed prior authorization and a restricted Preferred Drug List (PDL) for mental health medications prescribed to Medicaid and Health Choice recipients.

- The budget bill specifically *includes* **off-label prescriptions** for treatment of Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD) in youth.

On a more positive note, **New York** retained its “provider prevails” standard for prescribing psychiatric medications despite efforts to enact a more restrictive standard.

Provider Credentials

Bills governing provider licensure and scope of practice were enacted in a number of states:

- **Louisiana (HB281)** authorized development of a behavioral health license to facilitate the provision of integrated mental health and substance use care.
- **Minnesota (HF 358)** added family peer specialists (FPS) to the list of mental health practitioners covered by Medicaid for children's mental health services.
 - **FPS** must be parents of a child living with mental illness and they must undergo specialized training.
- **Oklahoma (HB 1109)** provided for certification of peer recovery support specialists who are employed by a behavioral services provider.



POLICY RECOMMENDATIONS

2015 Policy Recommendations

ENROLLMENT: NC should ensure that people living with mental illness are enrolled in the most appropriate type of coverage for their health and mental health care needs.

COMPLIANCE: Comply with mental health parity. The ACA requires mental health as an essential health benefit on par with medical/surgical benefits for all Qualified Health Plans and Medicaid Alternative Benefit Plans.

Build the bridge from Medicaid to private health coverage. State policy and resources should promote successful transition to private coverage by offering services such as case management, supported employment and peer support.

HIRING: Increase the mental health workforce capacity.

- With millions of Americans gaining health insurance coverage in 2014, there is likely to be an **acute shortage of mental health workers** available.
- States should ensure **active recruitment and training** of mental health professionals skilled in effective, **culturally competent** interventions for children and adults.
- States should assess mental health workforce shortages and enhance existing capacity by increasing telehealth and appropriate use of peer specialists and allied professions.

2015 Policy Recommendations

TRAINING: should be required to enable primary care clinicians to recognize mental health conditions and provide routine mental health care.

EARLY INTERVENTION: Identify mental illness and intervene early

- Essential to ensure that children, youth and adults living with mental illness have the opportunity to thrive and reach their full potential.
- Mental health screening should be routine in primary care.
- States should fully comply with Medicaid requirements for Early Periodic Screening Diagnosis and Treatment (EPSDT).
- Those who screen positive should be promptly linked with more comprehensive evaluation and an array of effective services for children, youth and young adults as indicated.

2015 Policy Recommendations

INCREASE INTEGRATED CARE: Integrated mental health, addiction and primary care for children and adults with multiple chronic conditions improves

- overall health
- reduces costs, prevents duplication and gaps in care
- makes more efficient use of service providers
- States should create incentives, remove barriers and allocate Medicaid resources to promote integrated care through health homes based in community mental health centers and federally qualified health centers.

2015 Policy Recommendations

EMPLOYMENT: For the first time in 2014, Medicaid beneficiaries with mental illness had the opportunity to return to the workforce leaving Medicaid rolls for guaranteed private health insurance, including mental health benefits.

- Increase access to supported employment services.
- Evidence-based supported employment programs help people with psychiatric disabilities prepare for and obtain employment and perform successfully in the classroom or workplace.
- States should enact policies and allocate resources to increase access to supported education and employment.

Thank you! Q & A



A Doctor's Prescription for **HEALTH CARE REFORM**

*The National Medical Association
tackles disparities, stigma, and
the status quo*

Rahn Kennedy
BAILEY,
MD, DFAPA

