

## Mental Health/Substance Abuse

### Environmental Data

- In the 1970s and 1980s, activists and parents of mentally ill children brought on a series of law suits that cast doubt on the level of care provided in state-run institutions for the mentally and emotionally handicapped. In 1982, the federal government initiated the Child and Adolescent Service System Program and its precepts still guide today's services for children's mental health in the US. Its system of care principles include: 1) attention to the individual needs, preferences and cultural characteristics of the child and family; 2) use of a strengths-based, rather than deficits-based perspective; 3) involvement of families in their children's care and in programs and systems development; 4) cross-agency coordination and collaboration in service system management and delivery; and 5) use of the least restrictive service setting that is clinically appropriate.
- Nationally and in New York, Medicaid has become the largest payer for mental health care. Medicaid pays for mental health care in multiple ways: as the dominant funder of care for Office of Mental Health provided and regulated services, as the primary payer of specialty mental health services within the Department of Health's overall Medicaid program (e.g., inpatient and general hospital outpatient psychiatric care) and for people with a mental illness within the overall health care system (e.g., medications) and long term care system (e.g., nursing homes, home care).
- *Rosie D. v. Romney* is a class action lawsuit that was brought under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) services provisions of the Medicaid Act to compel Massachusetts to provide intensive home-based mental health services that will enable children with severe emotional disturbance (SED) to receive treatment and support in their homes and home communities. The plaintiffs include eight named children and a class of over 15,000 other Medicaid recipients throughout the Commonwealth with serious psychiatric and emotional disabilities. On January 26, 2006, in a landmark decision with national implications, Judge Michael A. Ponsor issued a 98 page decision finding that the Commonwealth of Massachusetts is violating the federal Medicaid Act by failing to provide home-based mental health services to an estimated 15,000 children with serious emotional disturbance. "The result of this failure is that thousands of Massachusetts children with serious emotional disabilities are forced to endure unnecessary confinement in residential facilities or to remain in costly institutions far longer than their medical conditions require." The judge called the state's efforts to comply with the requirements of the federal law "woefully inadequate, with detrimental consequences to thousands of vulnerable children." He added, "(The) defendants' failure to provide adequate assessments, service coordination and home-based supportive services for Medicaid-eligible children with serious emotional disturbances was glaring from the evidence and at times, shocking in its consequence."

The major provisions of the Rosie D. Order (Massachusetts) are:

- improved education and outreach to MassHealth members, providers, members of the public, and private and state agency staff about Early Periodic Screening, Diagnosis and Treatment (EPSDT) services
  - implementation of standardized behavioral-health screening as a part of EPSDT “well-child” visits
  - improved and standardized behavioral-health assessments for eligible members who use behavioral-health services
  - the development of an information-technology system to track assessments, treatment planning and treatment delivery
  - a requirement to seek federal approval to cover several new or improved community-based services
- The New York State Office of Mental Health (OMH) has developed an implementation plan to significantly restructure outpatient clinics. OMH has undertaken a multi-year initiative to restructure the way the State delivers and reimburses publicly supported mental health services. The goal is to develop a system of quality care that responds to the individual needs of adults and children and delivers care in appropriate settings. See excerpt from OMH plan below:

### **Guiding Principles for Clinic Restructuring**

- Clinic is treatment with a defined set of services, (*e.g.* assessment, therapy, medication, crisis services).
- Restructuring should facilitate improvements in the quality of care including:
  - Identification and engagement of clients;
  - Access to treatment services (including off-site and in the home);
  - Clinical assessments including for co-occurring disorders;
  - Presumption that clinic is the “clinical home” for most clients;
  - Regular use of evidence-based and promising treatment practices; and
  - Commitment to individualized treatment planning and individual recovery.
- Financial Restructuring should:
  - Pay based on the efficient and economical cost of providing quality services;
  - Phase out rate add-ons such as COPs and CSP;
  - Provide regular evaluation of prices and cost;

- Set differential payments for procedures that reflect cost differences based on type of population, geography, staffing, venue, and service;
    - Provide sufficient funding to allow training and supervision to implement evidence-based and promising treatment practices;
    - Provide incentives for risk adjusted positive outcomes (to be developed);
    - Allow billing for multiple services in the same day; and
    - Use HIPAA compliant billing codes.
  - Restructuring should promote recovery, resiliency, wellness, and family and peer support.
  - Restructuring should promote staff retention and workforce development.
  - Restructuring should address how future professionals (*e.g.*, MSW and psychology interns) receive training in the delivery of clinic treatment services.
  - Restructuring should address the funding of indigent care.
  - Restructuring should address Medicaid managed care plans' underpayments to providers.
- In New York, the expiration of the state and local agency exemption on January 1, 2010 will require licensure in order to practice psychology, social work, or the mental health professions unless the programs are otherwise authorized or exempt under the law (with the exception of psychologists who may continue to be employed in salaried positions operated by state, county and municipal agencies). The expiration of the exemption in 2010 could have a dramatic impact on the delivery of needed services to vulnerable populations. Any extension, expansion or clarification of the exemption would require a change in law. Some of service providers fall under the current licensure exemptions which expire in 2010, but others may not be aware of the applicability of the licensing laws.
  - A November 2008 NYS Office of Mental Health planning document (the Children's Plan) identified key areas for reform focus:
    - Social and emotional development and learning form a foundation for success in school, in work and in life.
    - Every action should strengthen our capacity to engage and support families in raising children with emotional health and resilience.
    - One-family, one-plan: Ensuring integrated and effective services and supports.
    - The right service is available at the right time and in the right amounts.
    - An adequately sized workforce that is culturally competent and steeped in a new paradigm of integrated, family-driven care must be developed and sustained.

- Ongoing Implementation funding for the Children’s Plan in the 2009/10 New York State budget was approved at \$1.7 million.
- The Massachusetts School of Professional Psychology has expanded academic curriculum for school psychologists to emphasize counseling in addition to traditional roles of testing and assessment, seen as a way to deliver more services to youth.
- While New York State Governor Paterson proposed significant cuts to Mental Health Services in his 2009/10 proposed budget, most cuts affecting children and adolescents were restored in the budget that was finally enacted. New York State Budget items of note: 1) increased funding for year 2 of a 3-year plan to better recruit and retain clinical staff (but at a rate that is \$2 million less than originally planned); 2) no Cost of Living Adjustment (COLA) for community mental health programs (cost avoidance of \$56.6 million)
- The National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council’s recent report, documenting the fact that people with serious mental illness die about 25 years earlier than the general population, has created a renewed sense of urgency in addressing physical health disparities.
- In the fall of 2004, Massachusetts DMH was one of eight states selected by Substance Abuse and Mental Health Service Administration (SAMHSA) to receive a State Infrastructure Grant (SIG) to develop alternatives to restraint and seclusion in DMH-operated and contracted adult inpatient facilities, which also include three adolescent inpatient units. DMH kicked off this new initiative to reduce/eliminate restraint and seclusion in DMH facilities in July 2005. Between November 2000 and January 2005, episodes of restraint and seclusion (per 1,000 patient days) decreased 84.4%, 80.4% and 78.7%, respectively, in child (ages 5-12), adolescent and mixed child/adolescent units.
- In Massachusetts there has been an expansion of services for transition age youth, ages 16-25, with a legislative allocation of \$3M in new dollars for FY 2009, bringing to \$9M the amount of funding specifically dedicated to this population. This program area escaped significant cuts in the 2010 budget; for example, the 2010 budget included \$8 million for a summer jobs program for at-risk youth.
- Also in Massachusetts, training requirements for managing individuals with co-occurring disorders were included in the Department's FY 2004 Psychiatry Residency and Psychology Internship Training Program. DMH expects to re-procure the Training Program contracts during FY 2009 for a July 1, 2009 contract start date. Training requirements for managing individuals with co-occurring disorders, with an emphasis on integrating the physical and mental health aspects of co-occurring treatment, will again be included in the Request for Responses when issued. The Massachusetts Behavioral Health Partnership (MBHP) completed two performance incentive projects related to co-occurring disorders in FY 2007 and 2008. These projects related to enhancing the networking capacity for the treatment of adolescents and transition age youth with co-occurring disorders and developing guidelines for the use of Buprenorphine treatment.

- On July 30<sup>th</sup>, the Senate Appropriations Committee approved its version of the Labor, Health, and Human Services and Education Bill (LHHS), and in doing so allocated a \$40 million increase to the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), the largest funding increase that the SAPTBG has seen in the last several years. Although the Senate did approve increases for a number of SAMHSA programs, in general, the increases were smaller than those granted by the House. Notable increases approved by the Committee:
  - Receive a \$10 million increase for “evidence-based adolescent substance abuse treatment” to bring total funding to \$30.6 million.
  - “Treatment Drug Courts” within CSAT would receive a \$20 million increase with \$5 million specifically targeted at “families affected by methamphetamine abuse” for a total budget of \$48 million.
  - “Ex-offender Re-entry” Programs would receive a \$10 million increase under Criminal Justice Funding to bring the total funding to \$18 million.
  - “Primary and Behavioral Health Care Integration Program” in the Center for Mental Health Services would contain a \$2 million increase, for a total of \$9 million for the program, \$5 million less than the \$14 million recommended by the House.
- The federal stimulus package includes \$20 million for development of health information technology and electrical medical records management.
- Nearly 1.4 million people in New York State suffer simultaneously from mental health and substance use disorders. An assessment of Medicaid claims revealed that more than 60% of New Yorkers with claims for substance use disorders also had a psychiatric disorder, and more than 50% of persons with schizophrenia also had a substance use disorder diagnosis. However, the service system design and delivery is not responsive to people with co-occurring mental health and substance use disorders. For years, the two systems of care have operated in silos and have been constrained by clinical, regulatory, and financial barriers to integration. Because of these barriers, only 10% of the population with mental health and substance use disorders receives treatment for both conditions. The poor outcomes associated with substance use and mental health disorders are unnecessary with the existing advances in research and practice. Access to an integrated system at all levels of care, across all agencies, and throughout all phases of the recovery process should be the expectation of all New Yorkers, not the exception. To advance the goals of this priority area, NYSHealth, a private foundation, has committed \$3.2 million over the next four years to establish a Center of Excellence for the Integration of Care (CEIC) for individuals with co-occurring disorders.
- In 2008, Congress passed the Mental Health Parity and Addiction Equity Act, mandating that mental health and addiction be covered under the same terms and condition as all other medical conditions.

- According to the National Survey of Substance Abuse Treatment Services (NSSATS), the number of treatment facilities in Massachusetts has decreased from 352 in 2002, to 312 in 2006. The most recent N-SSATS survey showed that the majority of facilities were private nonprofit (250 or 80%), and another 49 facilities (16%) were private for-profit. Although facilities may offer more than one modality of care, in 2006 the majority of facilities (207 or 66%) offered some form of outpatient treatment. An additional 127 facilities (41%) offered some form of residential care, 58 facilities offered an opioid treatment program, and 276 physicians and 73 treatment programs were certified to provide buprenorphine treatment for opiate addiction.
- According to the 2006 National Survey of Substance Abuse Treatment Services (NSSATS), in 2006 the majority of treatment facilities in New York—736 of 1,030 facilities (71%)—were private nonprofit. An additional 143 facilities were private for-profit, and 5 facilities were owned or operated by a Tribal government.
- The number of mental health treatment facilities in New York State has declined from a high of 1,260 in 2002 to 1,030 in 2006. The difference is primarily accounted for by a loss of 150 private nonprofit facilities, 58 private for-profit facilities, and 10 facilities operated/owned by the State government.
- Although agencies may offer more than one modality of care, 707 of 1,030 agencies (68%) in New York in 2006 offered some form of outpatient care. There were 286 agencies that offered some form of residential care, and 209 that offered an opioid treatment program. In addition, 1,037 physicians and 282 programs were certified to provide buprenorphine treatment for opiate addiction.
- All of the following have been referred to committee:

H.R. 1710 – Rep. Mark Souder: Includes family therapists on list of professionals recognized to provide school mental health services.

H.R. 1931 – Rep. Patrick Kennedy: Improves treatment of juveniles with MH and SA disorders by creative, great programs for increased training, technical assistance, and coordination of service providers.

H.R. 1932 – Rep. Patrick Kennedy: Increase number of well-trained MH professionals, including school-based practitioners, providing clinical MH care to children and adolescents.