A quiet health care revolution is under way as Midwestern states revamp their delivery of mental health services with an increasing focus on behavioral health, which integrates mental health and substance abuse treatments, and an expansion of mental health services to children.

The changes reflect a growing realization that mental health and substance abuse disorders are interlinked; that effective treatment should run along a “continuum of care”; and that the earlier mental illnesses are recognized, diagnosed and treated in young people, the better for individuals and society.

One of the more striking transformations is set to begin in Illinois, which is about to undertake a complete overhaul of mental and behavioral health services for Medicaid recipients. In May, 19 months after applying for a “Section 1115” Medicaid waiver, the state got approval from the U.S. Centers for Medicare & Medicaid Services to launch 10 pilot projects collectively called the “Better Care Illinois Behavioral Health Initiative.”

The idea, state officials said in their waiver application, is to “rebalance the behavioral health ecosystem” through “the full-scale integration of behavioral and physical health services” to increase the chances that once treated for mental or behavioral health disorders, individuals won’t need to re-engage the system. This approach should reduce the state’s total cost of care.

The initiative’s pilot projects — some of which will be applied statewide while others will be more geographically targeted — will launch later this year for mental and behavioral health services not previously covered by Medicaid, to “build a continuum of services for mental health and substance use disorder,” according to a statement from the Illinois Department of Healthcare and Family Services.

“Continuum of care” (or services) is a model of mental and behavioral health treatment that encompasses four main components:

1) **Promotion** of an environment that encourages people to seek and successfully undergo treatment;

2) **Prevention** of problems before they occur (such as anti-drinking or anti-drug use campaigns);

3) **Treatment**; and

4) **Post-treatment recovery** services to help people live productively and abstain from substance abuse.

For example, because stable housing and employment are crucial for successful treatment, pilot projects in Illinois will help individuals stay in or keep their own homes, and remain employed rather than become homeless and/or unemployed.

Other pilot programs cover residential and inpatient treatment for individuals with substance use disorder (SUD) and SUD case management — with services ranging from withdrawal management in clinical settings, to peer support during recovery, to crisis intervention.

Post-recovery services will include evidence-based home-visiting programs for new mothers whose babies were born with withdrawal symptoms and respite care for families (the latter provides scheduled, short-term relief to prevent stressful situations from escalating).

The Illinois initiative’s initial focus will be on behavioral health and integrating that with physical health services, “due
to the urgency of the issue as well as the potential financial and human impact."

“There is also a large financial payoff in improving behavioral health: Medicaid members with behavioral health needs represent 25 percent of Illinois Medicaid members but account for 56 percent of all Medicaid spending,” the department says.

**Focusing on early intervention**

States, meanwhile, are increasingly looking to improve access to mental health services for young people. One idea gaining traction in state legislatures is to invest in programs and grants that bring these services to where the students spend much of their time — the schools.

In the wake of shootings such as the incident earlier this year at a Florida high school, more attention is being paid to not just the physical safety of students and young people, but also to their mental health needs. In Wisconsin, Gov. Scott Walker in March called a special session of the Legislature to address school safety issues. *AB 843*, the $100 million package he proposed — and that legislators approved — included:

- Creation of a new Office of School Safety, and inclusion of trauma-informed care and adverse childhood experiences among the training options to be offered by the office.
- Amending state bullying-notification statutes to require that parents or guardians be notified within 48 hours of a bullying incident involving their child. The law had previously required notification but did not have a specific time requirement.

The legislation included a $3.25 million fund from which schools can apply for grants next summer to partner with community providers to get their students access to mental health services, as well as about $1 million to fund training for school staff in recognizing mental health challenges, referring kids for additional help, and using approaches that are sensitive to trauma that kids may have experienced. It also allocated about $3 million for the 2018-'19 school year to help districts boost social worker staffing levels, which fall below industry recommendations across the state.

Wisconsin’s state budget also includes $1.25 million in funding for state health officials to create one or more shelters, known as “crisis stabilization facilities,” for children. The state, through grant funding awarded to nonprofits, currently operates three such shelters, where adults nearing a mental health crisis can temporarily stay to receive support and hopefully avoid hospitalization.

Gov. Walker’s wife, Tonette, leads *Fostering Futures*, an initiative she began in 2011 to raise awareness about how childhood traumas can shape a person’s life. Currently, it aims to prevent and reduce childhood trauma and toxic stress while working to improve the well-being of children and their families.

Earlier this year in Iowa, Gov. Kim Reynolds created the *Children’s Mental Health Board* to take a comprehensive look at what resources are available and develop a strategic plan to better help children with mental health issues.

Gov. Reynolds in March signed a significant expansion of mental health services: *HF 2456*, which creates six new regional “access centers” to help people who are having mental health crises, but don’t need hospitalization. The law also adds “assertive community treatment” teams, which go out into communities and help residents with serious mental illnesses stay on their medication and in treatment so they don’t spiral out of control and need hospitalization. And the law encourages development of “subacute” treatment facilities, which could take patients who are ready to be released from hospitals but still need significant oversight.

Outside the Midwest, New York is becoming the first state in the country to require school districts to incorporate mental health into their existing health-education curricula for elementary and high schools, thanks to *A 3887*, which was approved by legislators and signed into law in 2016.

The idea isn’t to mandate a completely new class that must be fit into existing school schedules, but to update health classes with a mental health component, says John Richter, director of public policy for the Mental Health Association of New York.

“Our thinking was, if we could get the legislature to say, ‘Schools should be teaching this,’ we could get legislators to give schools a ‘green light’ to teach this,” Richter says. “We’d like to see schools really embrace it and not only weave it into existing health classes, but go a little further and create a schoolwide climate of mental health..."
wellness,” he adds.

**Systematic systemwide reform?**

State legislators also have been considering myriad bills to improve, expand or better fund their entire mental and behavioral health systems. Michigan legislators, as detailed by Rep. Klint Kesto in the April edition of Stateline Midwest [9], are mulling seven bills aimed at improving the state’s mental health services and easing a mental-health worker shortage in the state.

HB 5085 [10] would dedicate a portion of state liquor tax revenue to local community mental health agencies, while HB 5439 [11] would create a state database of available psychiatric beds that could be tapped by health care facilities and providers to help ensure beds are available to those who need them.

In Minnesota, the Governor’s Task Force on Mental Health [12] issued its final report in November 2016. Among its recommendations: Create a comprehensive mental health continuum of care, and convene a group to examine how the system can be better governed.

The task force also recommended using a cultural lens to reduce mental health disparities by working with tribal authorities and minority communities to develop strategies for doing so. Its report also called for promoting mental health awareness and mental illness prevention, and implementing short-term improvements to acute care capacity (the number of available inpatient psychiatric beds).

Assistant House Majority Leader Roz Peterson says HF 2945 [13], which would remove a requirement that providers of “intensive residential treatment services” must have contracts with a host county agency, to instead require that the “IRTS” facility give specific information to the state health commissioner, is a result of the report.

The idea is to make it easier for such facilities to open where they’re most needed, she adds.

A pending omnibus education spending bill, HF 4328 [14], includes an additional $5 million for school-based mental health grants and aims to better align school systems with their counties’ health systems (in Minnesota, counties provide social services), Peterson says.

“The focus is on getting the right service at the right place at the right time,” she adds.

In April, North Dakota’s Department of Human Services and the Human Services Research Institute — a national research group that studies mental health, substance abuse prevention, developmental and intellectual disabilities, and children and family services — released a 249-page study [15] of the state’s behavioral health system with 66 recommendations aimed at shifting the system away from an over-reliance on residential and inpatient services.

The report calls on the state to aspire to a “good and modern behavioral health system” by refocusing money and effort on awareness education to reduce misconceptions and stereotypes of mental illness, investing in prevention and early intervention services, and expanding outpatient and community-based services.

It also calls for expansion of telehealth services, creation of partnerships with tribal governments to improve health parity, and development of a comprehensive plan to implement the recommendations.

The report further recommends that the state continue implementing criminal justice reform.

This summer, an interim study group of South Dakota legislators [16] will take a deep dive into their state’s mental health system and report back to their colleagues before the Legislature’s next session begins in January.

The group will look at the current scope of mental health services in South Dakota, funding — including whether new dollars are needed or if resources should be better allocated — current benchmarks and best practices, to then ask what (if anything) the Legislature should do, says South Dakota Sen. Deb Soholt, who is serving as chair of the group.

“What we want to do is get a clear look at what is happening … get a sense of the landscape,” Soholt says. “What is working? Where should we spend our money? What treatment modalities actually work for our citizens?”

Sen. Alan Solano, a member of that group who is also CEO of Behavior Management Systems, a Rapid City-based community mental/behavioral health provider, says he hopes to get “a better understanding of where we have gaps in the continuum of care … and develop strategies as a state for how we fill those gaps.”

He also hopes the study will help legislators get a better grip on staffing needs — something Solano says he sees in
his own organization as older, experienced employees retire while not enough new people are entering the field. That problem is exacerbated by South Dakota’s “rural/frontier” nature as the need for service is growing, he adds.

“We’ve seen in our organization a pretty steady growth. Not necessarily exponential growth, but just a steady increase as awareness grows and mental health is mainstreamed,” Solano says.

Funding parity remains a work in progress in Midwestern states

The U.S. Mental Health Parity and Addiction Equity Act (a.k.a. the federal parity law) of 2008 requires health insurance plans to cover behavioral health benefits and physical health benefits equally. Under the law, health insurance plans cannot have higher co-payments and other out-of-pocket expenses for behavioral health benefits than they do for other medical benefits; cannot put higher limitations on the number of visits or days of coverage for behavioral health care than they do for other medical care; and cannot use more-restrictive managed-care practices for behavioral health benefits than they use for other medical benefits.

The law does not require that all health insurance plans cover behavioral health care, but if they do, the coverage must be comparable to what’s in place for other medical care. The catch, according to ParityTrack (a website co-sponsored by The Kennedy Forum and the Scattergood Foundation), is that parity laws “do not apply to all plans in the same way, and not all types of health insurance are covered by the federal parity law or a state parity law.

The Midwest doesn’t fare well under ParityTrack’s rankings of states’ parity legislation or regulation: Only Illinois is listed as “promising” in both categories. For legislation, Indiana, Kansas, Minnesota, Nebraska and Wisconsin are rated “neutral” while Iowa, Michigan, North Dakota, Ohio and South Dakota are rated as “needs work.”

While the federal parity law is a good idea, “in practice, implementation has been a lot more piecemeal,” says Rebecca Farley David, vice president of policy and advocacy at the National Council for Behavioral Health.

States are moving ahead of the federal government in applying parity laws to policies not regulated by the federal law, she says.

“Parity has not been the tool that has completely lifted prior restraints … and a lot of folks are really disappointed by that,” David says. “The positive thing is that states are moving forward, but more needs to be done.”

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