U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

# CASE STUDY:

# EARLY ASSESSMENT OF THE MENTAL HEALTH BLOCK GRANT SET-ASIDE PROGRAM FOR ADDRESSING FIRST EPISODE PSYCHOSIS AND OTHER EARLY SERIOUS MENTAL ILLNESS

September 2015

## Office of the Assistant Secretary for Planning and Evaluation

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This report was prepared under interagency agreement #AMH14001 between HHS's ASPE/DALTCP and the National Institute of Mental Health. For additional information about this subject, you can visit the DALTCP home page at https://aspe.hhs.gov/office-disability-aging-and-long-term-care-policy-daltcp or contact the ASPE Project Officer, Kristina West, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Kristina.West @hhs.gov.

# CASE STUDY:
# Early Assessment of the Mental Health Block Grant Set-Aside Program for Addressing First Episode Psychosis and Other Early Serious Mental Illness

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This research was conducted under contract with ASPE. The project was conducted with ASPE input, however, the material contained in this report is the responsibility of the research team alone, and does not necessarily reflect the views of the sponsoring agency.

# ACRONYMS

The following acronyms are mentioned in this report and/or appendix.

| | |
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| ACT | Assertive Community Treatment |
| ANSA | Adult Needs and Strengths Assessment |
| ASPE | HHS Office of the Assistant Secretary for Planning and Evaluation |
| AVATAR | EHR Software |
| BPRS | Brief Psychiatric Rating Scale |
| Cal Poly | California Polytechnic State University |
| CANS | Child and Adolescent Needs and Strengths Assessment |
| CBTp | Cognitive Behavioral Therapy for Psychosis |
| CI | Confidence Interval |
| CMBHS | Texas Clinical Management for Behavioral Health Services |
| CMHC | Community Mental Health Center |
| CSB | Virginia Community Service Board |
| CSC | Coordinated Specialty Care |
| DCF | Connecticut Department of Children and Families |
| DCHS | Virginia Department of Community and Human Services |
| DHCS | California Department of Health Care Services |
| DMHAS | Connecticut Department of Health Care Services |
| DUP | Duration of Untreated Psychosis |
| EASA | Early Assessment and Support Alliance |
| EHR | Electronic Health Record |
| EP-TAP | North Carolina Early Psychosis Technical Assistance Program |
| ePEP | Texas Enhanced Program for Early Psychosis |
| EPPIC | Early Psychosis Prevention and Intervention Center |
| ESMI | Early Serious Mental Illness |
| FEP | First Episode Psychosis |
| FOT | California First Onset Psychosis Team |
| FSP | Full Service Partnership |
| FY | Fiscal Year |
| GAP | Governor's Access Plan |
| GR | General Revenue |
| HHS | U.S. Department of Health and Human Services |

| | |
|---|---|
| IOL | Connecticut Institute of Living |
| JMHC | Wisconsin Journey Mental Health Center |
| LMHA | Texas Local Mental Health Authority |
| MASQ | Mood and Anxiety Symptoms Questionnaire |
| MCO | Managed Care Organization |
| MHBG | Mental Health Block Grant |
| MHMRA | Mental Health and Mental Retardation Authority |
| NAVIGATE | CSC treatment program for people experiencing FEP |
| NIMH | HHS National Institute of Mental Health |
| NOMS | National Outcomes Measurement System |
| NSDUH | National Survey on Drug Use and Health |
| NTBHA | North Texas Behavioral Health Authority |
| OASIS | North Carolina Outreach and Support Intervention Services |
| PANSS | Positive and Negative Symptom Scale |
| PHQ | Patient Health Questionnaire |
| PIER | Portland Identification and Early Referral |
| PREP | Prevention and Recovery in Early Psychosis |
| PRS | Psychiatric Rehabilitation Services |
| RAISE | Recovery After an Initial Schizophrenia Episode |
| RSN | Washington Regional Support Networks |
| SAMHSA | HHS Substance Abuse and Mental Health Services Administration |
| SFS | Social Functioning Scale |
| SMHA | State Mental Health Authority |
| SMI | Serious Mental Illness |
| STEP | Connecticut Specialized Treatment Early in Psychosis |
| TAY | Transitional Age Youth |
| TEDS | Treatment Episode Data Set |
| TESS | Transitional Engagement Supportive Services |
| TIP | Transitions to Independence Process |
| TOPPS | Treatment Outcome Program Performance System |
| TRAILS | Transitioning Adults into Living Successfully |

| | |
|---|---|
| UNC | University of North Carolina |
| UT | University of Texas |
| Wake STEP | North Carolina Wake Schizophrenia Treatment and Evaluation Program |

# EXECUTIVE SUMMARY

The 5-percent set-aside policy was conceived as a legislative initiative to promote greater access to evidence-based services for people with early serious mental illness (ESMI), a population with a large unmet need for health care that stems from its transitional age, complex health care needs, and inadequate insurance coverage. The legislation directed the U.S. Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) to require that states set-aside 5 percent of their Mental Health Block Grant (MHBG) allocation to develop or enhance existing evidence-based programs for this population starting in 2014. SAMHSA has collaborated closely with the HHS National Institute of Mental Health (NIMH) throughout the implementation of the policy.

Although states were encouraged to fund treatment programs that would deliver a specific multicomponent model--coordinated specialty care (CSC)--and serve young individuals with first episode (non-affective) psychosis (FEP), they were given the options of funding other evidence-based interventions and targeting their programs to individuals with ESMI other than FEP (i.e., early stages of affective psychotic disorders such as bipolar disorder, and early stages of any non-psychotic serious mental illness (SMI) with a gradual onset, such as obsessive-compulsive disorder). States were encouraged to leverage funds through inclusion of services reimbursed by Medicaid or private insurance, and they were informed that the policy included an expectation that program effectiveness needed to be demonstrated through a formal evaluation.

Given the latitude that states have with respect to using the set-aside funds, NIMH, SAMHSA, and the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) sought to better understand how the funds are being used within states, particularly the strategy used by each of the states to implement and evaluate the policy. RAND conducted a series of case studies across 12 states selected by NIMH and ASPE to provide an early assessment of the set-aside policy. States were classified into three tiers according to their stage of implementation of ESMI programs and intended use of the set-aside funds, representing a gradient from most advanced in their implementation (Tier 1) to least (Tier 3). The states were California, Connecticut, and New York (Tier 1); Idaho, North Carolina, Texas, Virginia, and Wisconsin (Tier 2); and Colorado, Nevada, Iowa, and Washington (Tier 3).

The case study states varied with regard to a number of characteristics and developments that can affect the implementation of the policy or its success (e.g., whether states operated ESMI programs or had been study sites for an NIMH-funded initiative on the feasibility and effectiveness of CSC prior to the launch of the policy, states' Medicaid expansion and 1915(i) adoption status, the extent to which other funds were used to develop or expand services, degree of decentralization).

The case study states also varied in their strategies for implementing the set-aside policy. While only Tier 1 states with existing programs could use the funds to expand those programs, Tier 2 and Tier 3 states used the funds to develop new programs. Most states funded one or two grantees, with one team per grantee, but there were some notable exceptions (for example, Virginia funded eight grantees, with one team per grantee). There were differences among the case study states in the degree of prescriptiveness of the State Mental Health Authority (SMHA) with regard to the model to be implemented, target population, training curriculum, and uses of the set-aside funds. The SMHAs also varied in regard to having an explicit expectation that the set-aside funds would be supplemented by third-party reimbursement when services were rendered to insured clients. ESMI programs in most states served youth and young adults, with the majority of programs serving individuals within or near the age range of 15-25. Maximum or expected program caseloads varied across states, spanning from 15 individuals to 151 individuals per team. Most grantees leveraged existing partnerships and collaborations, both for referrals and the design/implementation of the evaluation component. In most states, the SMHA deferred to the grantees to design the evaluation component, and most grantees were still in the planning stages by the time these case studies were conducted. The evaluation plans were typically focused more on the measurement of process of care and outcomes than on structure, but all grantees were aware of the need to monitor fidelity.

Several barriers to implementation were identified in the course of these case studies, including the challenge of developing programs for a low-incidence disorder, dealing with eligibility criteria that are narrower than for most social service programs, hiring appropriately trained staff in the setting of the workforce shortages that are common in public mental health service systems across the county, and conducting program evaluations in the setting of limited data collection and analysis capability. Some facilitative factors were also identified, including strong state guidance; existing programs for transitional age youth and provider networks; and existing expertise in CSC and other ESMI models.

A number of themes emerged during these case studies that could inform evaluation approaches for CSC and other ESMI programs being implemented across the country. These pertain to maintaining model fidelity, selecting process and outcomes domains and measures, measurement of program quality and effectiveness, and the value of monitoring the referral process.

In conclusion, all case study states embraced the set-aside policy as a mechanism for developing or expanding services for people with FEP and other ESMI, but the case studies revealed wide variation among states in how funds were used. While most states implemented CSC programs or modified existing programs to become CSC-like, many expanded their clinical population focus to disorders beyond FEP, mainly to broaden access and enhance sustainability. States varied in the sophistication and state of implementation of their evaluation plans, but all of them were committed to the goal of evaluating program fidelity and effectiveness. Although most of the states had not yet developed sustainable models for their programs and were reliant on continuing MHBG

support, all states expressed interest in eventually tapping into third-party reimbursement to cover at least some operational costs.

It is possible to conclude at this early stage that the set-aside policy is improving access to services for individuals experiencing their first episodes of SMI. To ensure success of the policy, however, there is a need for ongoing federal guidance on best practices for program implementation and evaluation.