Mental Health Services –First Psychotic Symptom Treatment

Session Law 2016-94, Section 12I.1.(v)

Report to the

House of Representatives Appropriations Committee on Health and Human Services

Senate Appropriations Committee on Health and Human Services

and

Fiscal Research Division

By

North Carolina Department of Health and Human Services

December 29, 2016

Introduction:

In Session Law, 2016-94, Section 12I.1.(v):

The sum of six hundred forty-three thousand four hundred ninety-one dollars ($643,491) appropriated in this section in the Mental Health Services Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for each year of the 2015-2017 fiscal biennium the 2015-2016 fiscal year and the sum of one million four hundred thirty thousand eight hundred fifty-one dollars ($1,430,851) for the 2016-2017 fiscal year is allocated for Mental Health Services –First Psychotic Symptom Treatment. The Division shall report on (i) the specific evidence-based treatment and services provided, (ii) the number of persons treated, and (iii) the measured outcomes or impact on the participants served. The Division shall report to the House of Representatives Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division no later than December 31, 2016.

In its Federal fiscal year (FFY) 2014 appropriation, the Substance Abuse and Mental Health Services Administration (SAMHSA) was directed to require states to set aside 5% of their Mental Health Block Grant (MHBG) allocation to support "evidence based programs that address the needs of individuals with early serious mental illness, including psychotic disorders." This funding is dedicated to treatment of persons with early serious mental illness and not for primary prevention or preventive intervention for people at high risk of serious mental illness. In North Carolina, the 5% set-aside was $643,491.00.

Evidence-Based Treatment and Services Provided:

In developing guidance in the use of funds, SAMHSA worked collaboratively with the National Institute of Mental Health (NIMH) to review possible evidence-based treatments. NIMH had recently released the publication *Evidence Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care (CSC)*. CSC is a team based collaborative, recovery oriented approach involving individuals experiencing first episode psychosis, treatment team members, and, when appropriate, family members as active participants. CSC components emphasize outreach, low dosage medications, cognitive and behavioral therapy, supported employment, supported education, case management and family psychoeducation. CSC also emphasizes shared decision making as a means to address individuals' with First Episode Psychosis (FEP) unique needs, preferences and recovery goals. Untreated psychosis increases a person's risk for suicide, involuntary emergency care and poor clinical outcomes. Research indicates that early intervention through a CSC program can alter the illness trajectory and enable individuals experiencing FEP to live in community settings and participate fully in family and community life.

As required by SAMHSA, North Carolina submitted its proposal for utilization of the 5% set-aside as part of the revised MHBG FFY2014-15 application. Following approval of the plan, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) issued an *Invitation to Apply/Organizational Readiness Survey* in August 2014, to the then nine (9) Local Management Entity – Managed Care Organizations (LME/MCOs). Coastal Care (now Trillium Health Resources) and Alliance Behavioral Healthcare were accepted for funding. Trillium Health Resources released a Request for Proposal (RFP) to select a provider to implement a Coordinated Specialty Care model. They selected RHA Health Services, Inc. for the development of a CSC in the southeastern part of the state. The RHA SHORE (Supporting Hope, Opportunities, Recovery and

Empowerment) program began accepting clients in February 2015. Alliance Behavioral Healthcare received funding to expand a current contract with University of North Carolina (UNC) Center for Excellence in Community Mental Health for a CSC site in Wake County, NC. The program is based on the OASIS (Outreach and Support Intervention Service) program in Carrboro, NC. OASIS is a CSC program that has been in operation since 2005, and is based on the initial research by the National Institute of Mental Health. The Wake program is located in Raleigh, North Carolina. Funding was also provided, through Alliance, for the UNC OASIS program to provide technical assistance, consultation and development and implementation of a database to all funded programs.

The Division was notified in January 2016 that SAMHSA increased the First Episode Psychosis (FEP) set-aside to 10% for a total amount of $1,430,851.00. SAMHSA required an update of the DMH/DD/SAS plan for the additional funds. This plan, which included an additional CSC program, was approved. An *Invitation to Apply* was again issued to the current LME/MCOs. DMH/DD/SAS is in the process of reviewing the applications and expects to make a decision and move forward with implementation in early 2017. Division staff have had routine monitoring meetings and site visits with the two current programs and discussions with LME/ MCO staff to ensure that programs are complying with SAMHSA requirements.

Outcomes:

Client data has been maintained and analyzed for the period of October 1, 2015-September 30, 2016. During this time period seventy five (75) clients were served. At program entry, clinician rated symptoms with the Brief Psychiatric Rating Scale. On admission overall, symptoms were on average mild to moderate. On average positive symptoms (hallucinations/delusions) and negative symptoms (e.g. motivation, drive, blunted emotions) were mild to moderate, with disorganization and mood symptoms rated as very mild to mild. By six months follow-up, symptoms improved, on average rated very mild or less. On admission, patients reported seeing friends on average less than once a week, and seeing family members about four times a week. Generally, patients were dissatisfied with relationships. By six month follow up, patients reported seeing family members more frequently, on average five times a week, and were generally satisfied with family relationships. However, there was no change in frequency or satisfaction with peer relationships. In terms of vocational function, on admission 49% of patients were either enrolled in school or working at least part-time. By six months follow-up, this had increased to 63% either enrolled in school or working at least part-time. Only 2/52 (4%) of clients were receiving disability payments at follow up. All patients were either living with family or living independently at six month follow-up. Regarding service utilization, for the six months prior to program approximately 50% of the patients were hospitalized, with average duration about 11 days. For the first six months of program involvement less than 20% were hospitalized, and the average duration of hospitalization was only five days.