Behavioral Healthcare Deficits & Interventions

Executive Summary

Behavioral health care (which includes mental health care), can include any services that aid in behaviors that affect mental or physical well-being, such as emotional management, disorders in behaviors like eating or substance abuse, and cognitive illnesses. Deficits in behavioral care with respect to the needs of Missouri residents exist and have worsened as a result of the COVID-19 pandemic. States have taken various measures to address mental health and substance abuse needs, such as through workplace recruitment and retention and programs that identify and deliver services to vulnerable populations. Recent federal funding for mental health (including nearly ~$2 billion in funds to Missouri) may be used for community or school-based mental health program development and delivery.

Highlights

- Nearly 1/3 of Missouri adults reported symptoms of anxiety or depression in 2021, and there are significant shortages in mental health service providers, with only 6% of mental service needs being met in the state.
    - Approximately 1 in 20 adults reported an alcohol use disorder and 1 in 33 adults reported an illicit drug use disorder.
- Workforce recruitment and retention strategies for behavioral health professionals (e.g., physicians, nurses) have been employed to incentivize or ease burdens on the ability of professionals to practice (such as changes in certifications and scopes of practice).
    - An additional 140 practitioners would be needed to remove the state from the federal list of Healthcare Professional Shortage Areas.
- Early intervention programs vary significantly from state-to-state, and can include policy measures on screening, treatment and delivery systems, reducing inequities, and school-based mental health.
- Federal funding from the U.S. 2021 American Rescue Plan has been allocated to Missouri for both state and municipal mental health program development and service delivery and for school-based mental health services.
    - Telehealth has increased in the share of mental health visits.

Limitations

- Many state-level measures in behavioral health programs are recent, and further retrospective analysis in the future will be needed to determine ultimate efficacy.

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Research Background

Behavioral Health Diseases & Mental Healthcare Deficits

During 2021 in Missouri, roughly 33.6% of adults reported symptoms of anxiety or depression, approximately 1 in 20 adults reported an alcohol use disorder (AUD), and 1 in 33 adults reported an illicit drug use disorder (Figure 1).[1,2] In 2019, nearly 40% of adults with a mental illness did not receive treatment for their ailments. Over 41% of adults with a mental illness had no private health insurance coverage.[1]

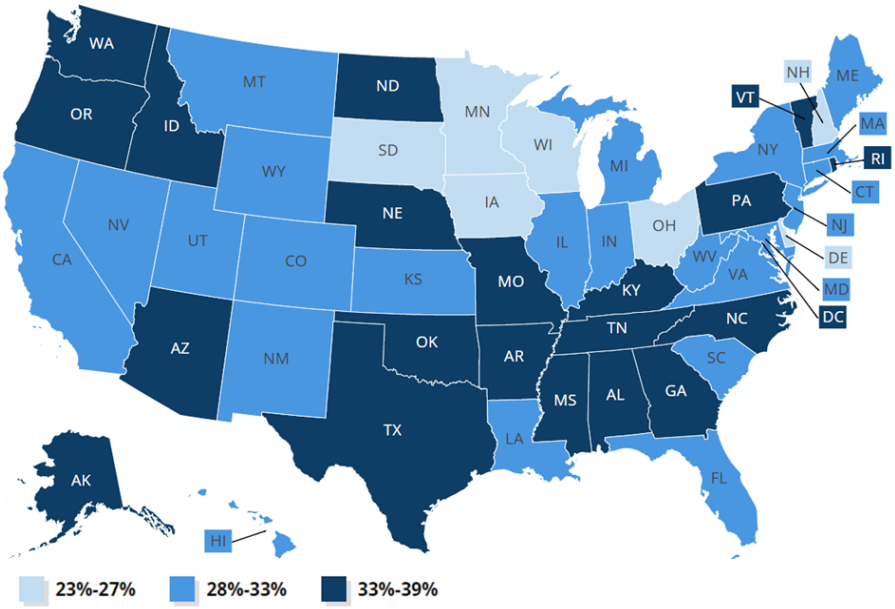

Figure 1. Map of states showing the percentage of adults with symptoms of anxiety or a depressive disorder.[2] States with darker shades of blue contain higher percentages of adults with mental health issues than lighter shaded states. Map reproduced from the Kaiser Family Foundation.

Coverage Deficits

According to the Kaiser Family Foundation, only about 6% of mental health care needs in Missouri are covered. An additional 140 practitioners would be needed to remove the state from the federal list of Healthcare Professional Shortage Areas.[1] Several Medicaid services that are present in other states, including residential psychiatric treatment, adult group homes, and outpatient partial hospitalization services are also not covered by MO HealthNet.[1]

For more information on how COVID-19 has affected mental health and substance abuse issues, and methods for treating substance abuse, please see the Science Notes: COVID-19, Mental Health & Substance Abuse, Substance Abuse & Naltrexone Hydrochloride.

Minority Discrepancies in Coverage

Black and Latino minorities have indicated higher rates of stress, substance abuse and suicidal ideation since the start of the pandemic. A 2020 CDC survey found that 44% of Black Americans and 52% of Latino Americans reported adverse behavioral health symptoms, higher than their White counterparts at 37%.[3] Given that data has shown that therapeutic relationships are stronger and lead to better recovery outcomes if the ethnicity of the provider matches the patient,[4] several states have promoted policies aimed at alleviating this need.

These include: 1) incorporating minority communities and ethnic-minority mental healthcare students in culturally-competent program development, 2) building culturally-sensitive behavioral health programs with providers that address local issues, such as trauma, linguistic barriers, and elevated incarceration, and require those programs to consistently renew the training, 3) understanding factors leading to attrition in the minority workforce and addressing these issues, 4) incentivizing students to practice in the areas they originate from or are in need through financial incentivization or a diversity component in contracting, and 5) encouraging cooperation with state agencies and legislators.[5]

For more information on incentive programs for medical residents and rural physicians, please see the Science Notes: Medical Residency, Rural Physician Grants.

Workforce & Financial Incentives

Several states have also modified scope of practice requirements that may serve as a barrier to workforce entry. While all states require licensing and education requirements for fields like psychiatry, psychology, and social work, some states have loosened strict definitions of the scope of mental health services providers can offer in certain fields (such as prevention specialists, peer recovery specialists, and psychiatric aides).[6] Twenty-two states have also expanded the ability for advanced practice nurses (which may include psychiatric nursing) to practice any and all skills they were trained for and can do so independently without needing oversight from a physician.[7,8]

Several states have attempted to address the substance abuse healthcare shortage by varying the level of education needed to be credentialed as an addiction counselor, or by delegating credentialing authority to a state agency or other entity as opposed to a private board.[7] Recruitment and retention measures have also varied; examples of this are in **Table 1**.

Policy Area	Specific Measure	States
Tax Credits & Federal Funding	*Small-Town Health Professional Credit, Rural Health Professional Tax Credit, Loan Repayment, Funds to Address Pandemic-Related Behavioral Health Needs*	LA, NM, ME, MA
Loan Forgiveness	*Primary care & psychiatry residents repayment, rural area primary care loan forgiveness, loan repayment for behavioral health professionals in shortage areas*	KS, MN, UT
Training, Development, & Licensure	*Short-term training in recession resistant fields, reactivation of retired or inactive healthcare provider, retired resident license renewal during states of emergency*	KY, HI, VT

Table 1: Areas for recruitment and retention policies for healthcare workers. This table lists various varies measures states have taken to improve healthcare professional recruitment and retention because of staffing attrition. Table was replicated from the National Conference of State Legislators.[9]

For more information on licensing reciprocity agreements that may ease the burden for out-of-state medical providers to practice in Missouri, please see the Science Notes: Advance Practice Registered Nurse Scope of Practice, Interstate Medical Licensure Compact.

Early Intervention Programs

Broadly, many early intervention programs enacted from the state level fall into improvements in: Screening, Treatment and Delivery Systems, Reducing Inequities, and School-based Mental Health Systems.[10] For examples of state-level measures, see **Table 2**.

Category of Policy Option	Specific Measure	States
Screening	*Adolescent depression screening, maternal depression screening through Medicaid and well-child visits*	OR, MN, WA, NM, MI, MS, GA, PA, MD, NJ
Treatment & Delivery Systems	*Foster-care-specific coordinated healthcare services, creating third-party Medicaid-accountable programs to coordinate services, full integration of contracted providers with specific geographic requirements & reimbursement parity*	TX, WI, CO, MN, RI, IN, WA
Reducing Inequities	*Community health worker engagement to address ethnic disparities in service; supported employment strategies like finding job placements, on-the-job coaching, benefits counseling; mental health consultation/advisory groups*	MA, NY, CT, OK, TN, WA, MN, DE, CO, OH
School-based Mental Health	*Task forces, school guidance, universal school screening, expanding on-site availability of professionals, improving school staff training, Medicaid-accountable service programs for school*	NC, IL, NJ, DC, PA, MI, AZ

Table 1: Areas for early intervention strategies in mental health. This table lists various measures that states have taken to improve early intervention programs and increase services to vulnerable groups. Table was replicated from the National Conference of State Legislators.[10]

For more information on youth suicide prevention in Missouri, please see the Science Note: Suicide & Prevention Programs. For more information on crisis response strategies, please see the report: Behavioral Health Crisis Response Strategies: Partnerships, Programs, & Personnel.

Telehealth

Telehealth (which includes broad non-clinical health-related services provided over distance) options have had an increased role in mental healthcare since the start of the COVID-19 pandemic. While most medical services have returned to in-person activities, mental health and substance abuse telehealth visits have remained relatively stable. Forty percent of mental health visits were administered via telehealth in March 2020 and that percentage was nearly replicated in 2021, with 36% of visits administered via telehealth by August 2021. Further, there is a clear demand divide for mental telehealth usage, with 55% of mental health and substance use disorder services in rural areas being administered via telehealth compared to 35% in urban areas, and consistent use among 19-64 year-olds compared to diminishing use in older populations.[11] Major mental health conditions that may be serviced through telehealth can include trauma, obsessive-compulsive disorder, bipolar disorder, anxiety, depression, disruptive-impulsive disorder, neurodevelopmental disorders, schizophrenia, alcohol abuse, opioid abuse, and other stimulants.[11]

For more information on telehealth, please see the Science Note: Broadband & Telemedicine.

Federal Legislation

The federal American Rescue Plan Act (ARPA) of 2021 allocated $3 billion in funds to the Substance Abuse and Mental Health Services Administration (SAMHSA) to be distributed equally between the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant programs to address addiction and mental health crises.[12] As well, ~$420 million have been committed to the Certified Community Behavioral Health Clinics program.[13] These have also separately included increases in the federal Medicaid matching rate for mobile crisis intervention services, increased funds for home and community-based centers, and stabilization or infrastructure funds for regional call centers, crisis receiving facilities, and mobile crisis response teams.[14,15] Missouri has been allocated a combined ~$45 million in these SAMHSA funds.

Several states have also accessed ARPA funding through the Elementary and Secondary School Emergency Relief Fund, which has committed $122.8 billion in grants to support schools by: 1) developing partnerships between state education and health agencies, 2) supporting partnerships between schools and community-based mental health agencies, 3) increasing the school mental health workforce, 4) providing mental health training for school staff, and 5) providing guidance to municipal agencies for comprehensive school mental health programs.[16] Missouri was allocated $1.9 billion in these funds, and ARPA funds need to be committed to a project by December 31, 2024.

According to the Brookings Institution, St. Charles County and St. Louis City were the only Missouri municipalities listed to develop projects utilizing ARPA funds to address mental health and substance abuse. They did this by: 1) adding a facility unit to address the increase in pretrial mental health and substance abuse disorders, 2) committing to non-profit support funds for mental health support, 3) sanctioning an outdoor space or a housing facility model for unhoused people to access substance abuse treatment, and 4) developing community programs aimed at interrupting cycles of violence through behavioral health resources.[17]

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