



# Policy Solutions for Ohio's Addiction & Mental Health Crisis

## Abstract

Ohio needs a full range of prevention, early intervention, treatment, and recovery supports that promote behavioral health for individuals, families, and communities.

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## The Ohio Council of Behavioral Health & Family Services Providers

### Policy Solutions for Ohio’s Addiction & Mental Health Crisis

#### Table of Contents

<b>Introduction</b> .....	2
<b>Statement of Priorities</b> .....	2
<b>The Problem</b> .....	2
<b>Policy Priorities</b> .....	5
<b>Access:</b> Access to addiction and mental health services is critically important for many Ohioans. Policy makers must maintain Medicaid expansion and continue essential health benefits standards so that Ohioans seeking mental health and addiction treatment can get well and stay well. ....	5
<b>Parity:</b> Stronger and more robust enforcement of the Mental Health Parity and Addiction Equity Act and regulations (Parity laws) must be a priority if Ohio is to effectively deploy public and private insurance resources to the behavioral health crisis. ....	6
<b>Workforce:</b> There is a severe workforce shortage in the community behavioral health system. To meet the increased demand for such services, Ohio must grow the workforce, develop talented professionals, and retain their services in the community behavioral health system.....	7
<b>Policy Solutions for Ohio’s Mental Health and Addiction Crisis</b> .....	8
<b>Prevention:</b> To save lives, Ohio must implement policies and practices that address environmental contributors to mental illness and addiction, as well as develop and deploy targeted evidence based prevention programs. ....	8
<b>Access to Treatment &amp; Services:</b> With access to appropriate treatment and services, people living with mental health or substance use disorders can and do enter long-term recovery. Ohioans must have access to a full continuum of care with services and supports that meet individual needs. ....	9
<b>Work to address systemic issues across the continuum of care:</b> Ohio needs sound insurance and Medicaid policies that sustain and expand access and capacity for community behavioral health services for adults, children, and families in every Ohio community. ....	10
<b>Increase positive outcomes through recovery supports:</b> Evidence shows that recovery supports help people achieve long-term recovery, prevent relapse, and lower overall cost of care. ....	12
<b>Building Workforce Capacity to Provide Quality Services:</b> As more focus is placed on the mental health and addiction needs of Ohioans, the workforce must be available to handle the demand. ....	13
<b>Appendices</b> .....	15
<b>Endnotes</b> .....	22

# Policy Solutions for Ohio's Addiction & Mental Health Crisis

## Introduction

The Ohio Council of Behavioral Health & Family Services Providers (the Ohio Council) is a statewide association representing nearly 150 community-based mental health and addiction services providers. Ohio Council members operate in all parts of the state and serve children, adults, and families through prevention, treatment, and recovery support services. The Ohio Council strategically pursues effective policy solutions to meet the rising demand for community-based mental health and addiction services and address Ohio's opioid epidemic.

Real-world experience and academic studies show that investing in Ohio's community behavioral health system is sound public policy and a wise fiscal decision. For every dollar spent on community behavioral health services, the return on investment is many times over.<sup>i,ii</sup> Moreover, providing timely and high-quality mental health and addiction services ensures that other public investments made in the health, education, employment, children's services, and criminal justice systems are effective and yield better long-term outcomes for all Ohioans.

## Statement of Priorities

The opioid epidemic is the number one crisis facing Ohio in the 21<sup>st</sup> century, causing unprecedented social and economic ruin in our state. To effectively respond to this crisis and face the challenges of mental illness and addiction across Ohio, mental illness and addiction must be treated as chronic diseases – not moral failings. Indeed, once these conditions are accurately viewed through the health care lens, a more effective response can be developed, financed, and implemented in Ohio. Specifically:

**It takes years - *not days or months* - for people to stabilize in their recovery and wellness. With anything less than one year of recovery a person has over a 60% chance of relapse.<sup>iii</sup>**

**Behavioral health care must be financed as health care. There are no other health conditions for which *treatment* is as heavily financed by grants and local tax levies.**

**Ohio must grow the behavioral health workforce to provide access to the full range of mental health and addiction treatment, recovery, and prevention services needed in every community.**

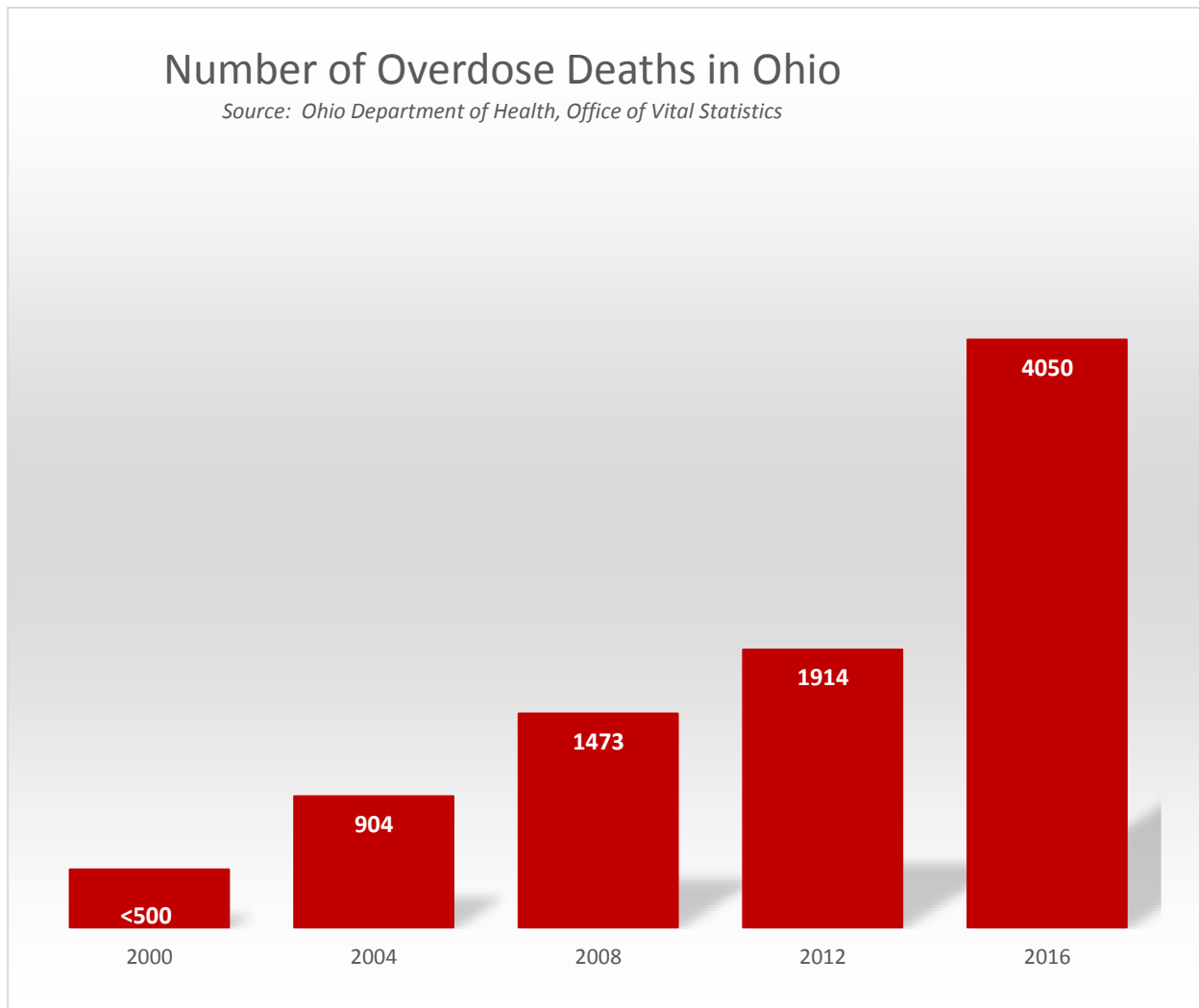
**The State must prioritize quality in services and patient safety regardless of payer.**

## The Problem

Addiction and mental illness are getting unprecedented attention as public health issues from policy makers and the media. Much of this attention rises from the fact that Ohio ranks second in the nation for overdose deaths with over 4,000 people dying from an overdose in 2016 (see chart).<sup>iv</sup> And it is only getting worse with Ohio's total drug overdose deaths increasing by 39% from 3,763 deaths for the 12-months ending in July 2016 to 5,256 for the 12-months ending in July 2017.<sup>v</sup>

## Number of Overdose Deaths in Ohio

Source: Ohio Department of Health, Office of Vital Statistics



Ohio's current crisis was years in the making, and it will take decades to fully recover. More must be done to prevent mental illness and addiction. More must be done to intervene sooner when signs of illness begin. More must be done to treat people and help them recover. The Ohio Council is leading the push for a fully-resourced continuum of care that includes prevention, early intervention, treatment, and recovery supports such as peer support, housing, and employment services.

Jail and prison are ineffective, expensive, and inhumane responses to mental illness and addiction.<sup>vii</sup> The child welfare system is overwhelmed by children orphaned by the opiate epidemic<sup>viii</sup> and families seeking continued access to treatment for their child when all other resources have been exhausted.<sup>ix</sup> The suicide rate among Ohioans rose 36% between 1999 and 2016.<sup>x</sup> Adults and kids in mental health crisis spend days in emergency rooms before being sent home because Ohio doesn't have enough inpatient beds for them.<sup>xi</sup> Families send sons and daughters several counties away, sometimes out of state, to get the help that they need.

Poor economic conditions lead to anxiety, depression, and self-medication with alcohol and drugs.<sup>xii</sup> Ohio has seen clearly what happens when people take prescribed opiates to relieve their physical and emotional pain. Recently published research reveals that people with anxiety and depression receive 50% of the opiate prescriptions in the United States.<sup>xiii</sup> Ohio is gripped by heroin and fentanyl, and meth is making a deadly comeback. Currently, only 4 of 10 people with a mental illness and 1 of 10 of people with addiction get access to the treatment and services they need<sup>xiv</sup>, and more Ohioans are dying from overdose death than ever before.

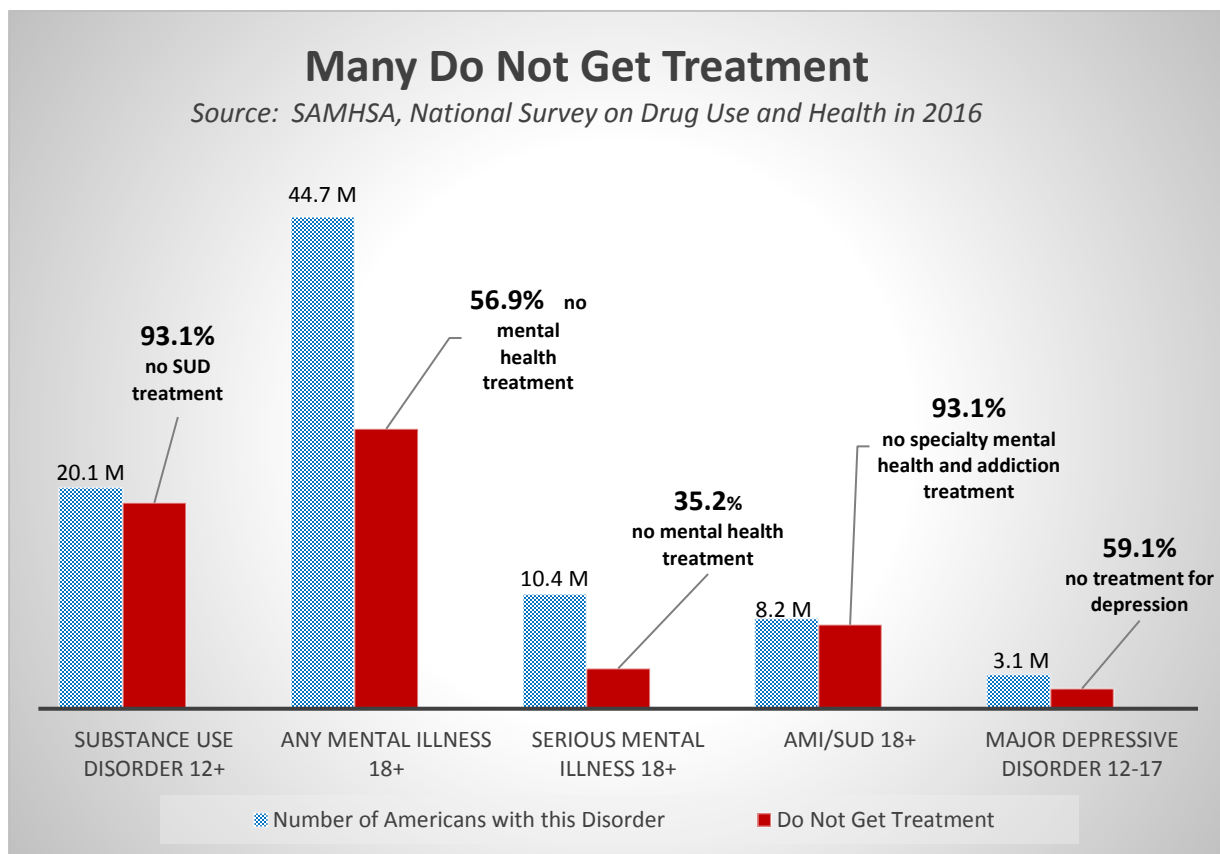
**When people don't have access to behavioral health care, the economic health of Ohio is drained by the money spent on jails, prisons, foster care, ambulance runs, emergency room visits, hospitalizations, lost productivity and unemployment.**

## Policy Priorities

- **ACCESS:** Access to health care, including addiction and mental health services is critically important for many Ohioans. Policy makers must maintain Medicaid expansion and continue to require the essential health benefits standards of the ACA so that Ohioans seeking mental health and addiction treatment can continue to access such care.

**Fact:** Individuals with mental health and substance use disorders were the single largest beneficiaries of Medicaid expansion. An Ohio Department of Medicaid assessment of Medicaid expansion enrollees found that one-third met the criteria for depression or anxiety disorders and that 32 percent had been diagnosed with substance use disorder or dependence. These groups reported improved access to care as the result of Medicaid expansion, in particular those with opioid addiction.<sup>xv</sup>

The National Survey on Drug Use and Health (NSDUH)<sup>xvi</sup> provides up-to-date information on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States. The following chart is based on the NSDUH 2016 survey. Among the 3.1 million adolescents aged 12 to 17 who had a past year major depressive episode (MDE), less than half received treatment for depression.



- PARITY:** Stronger and more robust enforcement of the Mental Health Parity and Addiction Equity Act and regulations (Parity laws) must be a priority if Ohio is to effectively deploy public and private insurance resources to this health crisis. Too many times families tell stories about individuals forced to pay additional out-of-pocket costs or even being flatly denied in their attempts to access addiction or mental health services. A more robust and coordinated effort by state regulators to investigate and enforce federal and state Parity laws is critical to expanding access to mental health and addiction treatment and to appropriately allocate the costs of such services between public and private insurers.

**Fact:** A recent Milliman, Inc. report found that individuals with behavioral health conditions are more likely than those with physical health conditions to pay for higher-cost, out-of-network care, and their providers are paid less than primary care providers for similar services. The report reveals that nationally, in 2015, the proportion of behavioral health care provided out of network was 3.6 to 5.8 times higher than medical/surgical care, and that patients who used out-of-network providers generally paid more in out-of-pocket costs. Additionally, insurers paid primary care providers 20 percent more for the same types of care than they paid addiction and mental health care specialists, including psychiatrists.<sup>xvii</sup>

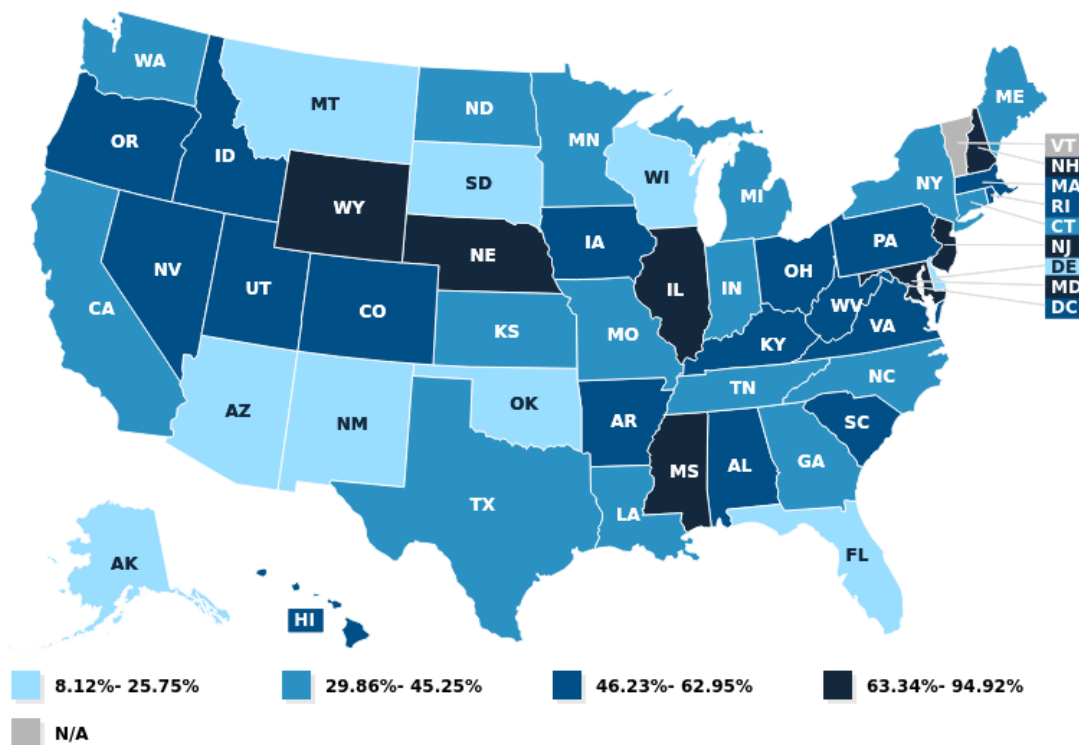
Red Flags for Failure to Comply with Parity <sup>xviii</sup>		
Coverage Limitations	Different Co-Payments, Deductibles, and Caps	Barriers to Receiving Covered Services
<p>No coverage of residential MH/SUD treatment.</p> <p>No coverage of medication-assisted treatment (MAT) for addiction, such as methadone, buprenorphine (e.g., Suboxone), and injectable naltrexone (e.g., Vivitrol).</p> <p>Limitations on coverage of medication-assisted treatment (for example, paying for only one year of MAT).</p> <p>Limits on the number of days MH/SUD treatment, or on the number of visits to a MH/SUD provider.</p> <p>No coverage of preventative screenings and services for MH/SUD when such services are covered for other medical/surgical conditions.</p> <p>No coverage of recovery supports for MH/SUD when chronic disease management services are covered for other medical/surgical conditions.</p>	<p>Higher co-payments for routine MH/SUD visits than for routine medical/surgical visits.</p> <p>A separate deductible for MH/SUD services.</p> <p>Limits on how much your health plan will pay per year, or during your lifetime, for MH/SUD benefits.</p>	<p>Requirement that you “fail first” at a lower level of treatment (such as outpatient) before being approved for a higher level of treatment (such as inpatient).</p> <p>Refusing to cover MH/SUD treatment because you failed to complete previous treatment or because “the patient is not improving.”</p> <p>Requiring frequent pre-authorization or concurrent review for MH/SUD services (for example, only approving a few days of services at a time before requiring another pre-authorization).</p> <p>Your plan says it covers a particular service, such as outpatient SUD treatment, but has no providers for that service in its network.</p> <p>Insufficient and/or incorrect information in denial letters. Examples include: no information about the criteria and evidence used to make the decision; application of incorrect; and failing to consult with your treatment provider.</p>

- **WORKFORCE:** There is a severe workforce shortage in the community behavioral health system. To meet the increased demand for such services, Ohio must invest in and support strategies to grow the workforce, develop talented professionals, and retain their services in the community behavioral health system.

**Fact:** The federal government has projected the national supply and demand for 9 common types of behavioral health practitioners spanning both mental health and addiction care. Their projections show that all nine categories will fall short of demand and that by 2025 seven of the nine professions will have shortages of more than 10,000 FTEs. Professionals included were: psychiatrists; behavioral health nurse practitioners (NPs); behavioral health physician assistants (PAs); clinical, counseling, and school psychologists; substance abuse and behavioral disorder counselors; mental health and substance abuse social workers; mental health counselors; school counselors; and marriage and family therapists.<sup>xix</sup>

The following chart shows Mental Health Care Health Professional Shortage Areas (HPSA) based on the number of health professionals relative to the population with consideration of high need. In order to be considered as having a shortage of mental health providers, the population to provider ratio must be at least 30,000 to 1. **Ohio is only meeting 53.23 percent of need.**

**Mental Health Care Health Professional Shortage Areas (HPSAs): Percent of Need Met, as of December 31, 2016**



SOURCE: Kaiser Family Foundation's State Health Facts.



Community behavioral health providers serve on the front lines of this public health emergency. There is no time to waste for policymakers, advocates and the public to fully engage in a comprehensive, long-term effort to support the health, wellness, and recovery of people living with the chronic health conditions of mental illness and addiction.

To achieve success, Ohio's response must be strategic in its focus and include a fully-resourced continuum of care that includes evidence-based prevention, early intervention strategies, comprehensive treatment services, and recovery supports. Accordingly, the Ohio Council submits the following priority recommendations to be considered by policy makers.

## **Policy Solutions for Ohio's Mental Health and Addiction Crisis**

### **Prevention**

To save lives Ohio must implement policies and practices that address the environmental contributors to mental illness and addiction, as well as develop and deploy targeted evidence-based prevention programs. Investment in prevention and early intervention is critical to preventing the development of mental health and substance use disorders as well as disability, unemployment, homelessness, poverty, and death from suicide or drug overdose.<sup>xx</sup>

#### **Develop and expand school-based behavioral health services leveraging school and community partnerships.**

- Provide a stable funding source for prevention services in schools, the ideal environment for the delivery of prevention, early intervention, and timely referrals to community treatment.
- Expand partnerships between schools and community behavioral health organizations to provide mental health and addiction services, deliver prevention programming and increase coordination of care through regular communication between schools, families, and behavioral health providers.
- Increase school-based screening efforts to identify youth with mental health and substance abuse needs and provide them with the resources they need as required by the Individuals with Disabilities Education Act (IDEA) and Americans with Disabilities Act (ADA).
- Target prevention programs to youth who have risk factors, such as ADHD, anxiety and depression, and have a family history of mental illness or substance use disorders.

#### **Recognize that prevention of substance use and mental illness should be viewed as a public health service, like other chronic disease prevention strategies, which require trained and certified personnel.**

- Increase the presence of evidence-informed prevention programs for mental health and substance use disorders in schools and local communities offered by licensed or certified professionals.

- Ensure that children and families on Medicaid can access the prevention services to which they are entitled under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).
- Enforce federal and state parity protections that allow children and families that receive insurance in the commercial market access to care.

**Focus on population health by developing strategies to address the broader physical, social, cultural and institutional forces that contribute to trauma, untreated mental illness, substance use, addiction, and suicide.**

- Educate the public about alternative pain-management efforts and implement non-opioid pain relief strategies.
- Support and fund a diverse, effective suicide prevention workforce that can coordinate public awareness campaigns and lead community coalitions.
- Perform an environmental scan of what is happening in Ohio today that either prevents or contributes to mental illness and addiction and use this information to better coordinate resources and planning.

## **Access to Treatment & Services**

With access to appropriate treatment and services, people living with mental health or substance use disorders can and do enter long-term recovery. Unfortunately, analysis of the latest data from SAMHSA reveals that many people in need of treatment never receive it. Only about 40 percent of those with mental health conditions obtain care. The situation is far worse for those with substance use conditions: A mere 10 percent of this population receives treatment.<sup>xxi</sup> Many factors contribute to this “treatment gap,” but the biggest barrier to treatment is the lack of timely, quality, and affordable treatment services in many communities, especially rural areas.

Treatment includes not only medication, crisis stabilization, inpatient psychiatric treatment, or withdrawal management, but also individual, group, and family therapy where people learn to develop the skills and tools needed to live in recovery. Ohioans must have access to a full continuum of care with services and supports that meet their individual needs. Merely offering a service because it is the only service available is not a long-term solution.

**Strengthen and enhance access to health care by financing mental illness and addiction services as part of integrated health care system.**

- Maintain Medicaid expansion and protect the Medicaid program from attempts to implement block grants, per capita or service caps, or cuts to programs and services.
- Prevent any changes to Essential Health Benefits, ensuring that individuals who rely on coverage from the employer, the individual market, or Medicaid expansion maintain access to mental health and addiction services.

### **Prioritize access to services in Ohio's newly redesigned behavioral health care system.**

- Ensure that Ohio's efforts to integrate the behavioral health benefit in managed care results in sustained capacity for services by comparing current data in the managed care environment to historical patterns of access and investment in the fee for service model.
- Ensure that contracts with managed care plans include terms that prohibit unfair contracting practices with providers to optimize access to care.
- Build and resource crisis stabilization and behavioral health urgent care services by allowing the use of codes in the national code set and associating a fair rate with them.
- Return group counseling and nursing rates to the sustainable rate that existed prior to January 1, 2018.

### **Support and fully fund a complete continuum of behavioral health care services that is well coordinated with physical health care services.**

- Ensure that individuals enrolling in Ohio's managed care programs have access to existing providers, sufficient provider panels, and robust care coordination through their managed care plans.
- Build connections between physical and mental health care providers to ensure integrated and coordinated care planning.
- Increase access to behavioral health services through community planning for prevention, treatment, and recovery supports and by ensuring adequate provider networks throughout the state and rates that attract and retain quality organizations and workforce.

### **Increase access to quality Medication Assisted Treatment (MAT) that meets the needs of individuals with substance use disorders.**

- Ensure that MAT is accompanied by treatment services that ensure people develop the skills and structure for long-term recovery.
- Make all forms of FDA-approved MAT accessible and ensure that prescribing is based on individual need not determined by insurance companies' preference and payment models.
- Ensure that MAT providers are providing high quality services through implementation of best practices and standards, including national accreditation and state certification.

### **Prioritize quality in services and patient safety regardless of payer.**

- Require state certification of all organizations providing behavioral health services, regardless of the source of payment.

## **Work to address systemic issues across the continuum of care**

Adequate investments in behavioral health and addiction services across the continuum of care lead to better outcomes for individuals and healthier communities. This investment also saves taxpayer dollars, not only in health care costs but also in spending for education, criminal justice, child welfare, and other social services. Cost-benefit studies of addiction treatment have found returns of \$4-\$7 per dollar spent.<sup>xxii</sup> Similarly, it is estimated that the economic

benefits of the treatment of depression and anxiety have a return on investment of \$4 for every \$1 invested.<sup>xxiii</sup> To capitalize on these cost savings, Ohio needs sound insurance and Medicaid policies that sustain and expand access and capacity for community behavioral health services for adults, children and families in every community in Ohio.

**Pursue greater education and enforcement of the Mental Health Parity and Addiction Equity Act so that people receive cost-effective and appropriate coverage for mental health and addiction services.**

- Encourage the Department of Insurance to conduct greater and more in-depth pre-approval reviews of commercial and private health plans' contract provisions.
- Address stigma and discrimination in the health-care system by advancing Parity education and enforcement strategies, including collecting Parity-complaint data and conducting trend analyses.
- Ensure that a full range of health care continuum of services is available to individuals with mental health and addiction service needs similarly to those with chronic physical health concerns in commercial, private, and publicly funded plans.
- Bolster the authority of the Attorney General's office to protect consumers and enforce through legal strategies the Mental Health Parity and Addiction Equity Act as it is applied to commercial and Medicaid managed care organizations.
- Fund and execute public awareness and education campaign about Parity.
- Fully recognize eligible professionals in insurance panels.
- Address network adequacy by enforcing requirements that necessitate enough providers for the population to receive appropriate services and supports.
- Work with Ohio's Congressional Delegation to support efforts to reform the IMD rule.

**Continue efforts to implement recommendations of the Joint Legislative Committee on Multi-System Youth<sup>xxiv</sup> and expand services for Ohio's children beginning at birth.**

Multi-System Youth refers to a child or youth with significant mental health, addiction and/or developmental delays who is involved or at risk of being involved with child protection and/or juvenile justice due to not being able to access the right services or supports to remain stable and in their own home. Multi-system youth have complex needs that cannot be met by a single system. In some cases, two or more systems are used to fill gaps in services offered by single agencies or when the cost of providing services becomes prohibitive for a single agency.

- Invest in programs such as respite care, youth mentors, and family peer support for children and families impacted by trauma and chronic, toxic stress.
- Deploy structural changes needed for all Family and Children First Councils to allow families to access the services that they need.
- Ensure that youth have access to and receive appropriate mental health services instead of entering into the criminal justice system.
- Support programs that provide housing, work, and education supports for young adults.

**Expand, fully fund, and implement a coordinated effort to incorporate trauma informed care strategies throughout human services programs recognizing the connection of Adverse Childhood Events with the social determinants of health.**

- Continue to provide resources for training and support for health and social service agencies to engage in Trauma Informed Practice.
- Provide an updated report on the implementation of trauma informed care practices across the entire services system, including education and health and human services agencies, with recommended next steps.

**Recognize that mental health and substance use disorders are diseases that need a public health and treatment response, not jail or prison.**

- Support Specialized Dockets and their community partners in efforts to divert individuals from the criminal justice system to treatment and recovery.
- Ensure that individuals who are re-entering the community after incarceration have access to health care coverage and get connected to treatment and recovery supports.
- Increase awareness of those re-entering the community after receiving addiction treatment while incarcerated of quality recovery housing options that can assist them with a safe, affordable, place to call home with appropriate peer and recovery supports.
- Eliminate laws and practices that allow non-medical professionals such as judges and probation departments, from requiring specific types of treatment. People with mental health and substance use disorders should be informed of their treatment options by a qualified health professional and decide their course of treatment with the advice and guidance of a health care provider.

## **Increase positive outcomes through recovery supports**

Recovery and treatment are not the same. Recovery focuses on health, residential stability, and connection to meaningful relationships and a sense of purpose. Recovery requires a long-term effort and includes multiple supports and services, including various treatment options. Evidence shows that recovery supports are key in helping individuals achieve long-term recovery, preventing relapse, and lowering overall costs of substance use care.<sup>xxv</sup> Expanding recovery supports - such as using peer specialists, vocational rehabilitation counselors, and recovery housing, can help meet the increasing demand for behavioral health services and promote recovery management.<sup>xxvi</sup>

**Ensure that when individuals transition from hospital, detox, criminal justice, or treatment settings they have the services and supports they need to be successful in the community.**

- Establish in-reach practices to increase coordination between jails and prisons and treatment services providers and recovery support providers.
- Provide resources and support for individuals who are transitioning from jail, prison, and inpatient care to the community, including housing, peer support, transportation, and employment development.

- Support family reunification and stability for parents with mental illness and addiction whose children are involved with protective services and may be living in foster care or with relatives.
- Establish a comprehensive system within the Ohio Department of Mental Health and Addiction Services for the collection of data on recovery supports and long-term outcomes.

### Increase the ability of individuals with mental health and substance use disorders to access and maintain sustainable employment opportunities.

- Improve Ohio's vocational rehabilitation programs for individuals with mental health and substance abuse disorders, including increased access to supported employment services.
- Establish mechanisms for Opportunities for Ohioans with Disabilities to engage meaningfully with representatives from the mental health and addiction services field, including providers.
- Increase access to employment or education programs for transition age youth (18 to 24).

### Increase access to affordable housing in healthy and safe communities.

- Ensure a variety of housing options are included in policies and resources to create true choice for individuals and families living with mental illness and addiction - both for those who are experiencing homelessness and those who do not meet the definition of homelessness.
- Take steps to address the shortage of affordable housing units, especially those for the lowest income residents (Individuals with mental health and/or substance use disorders are often in this low-income category).
- Educate community members, providers, advocates, and housing industry to support better understanding of roles and responsibilities to people recovering from mental illness and addiction under Fair Housing law.

## Building Workforce Capacity to Provide Quality Services

There is a great need for an educated, well-trained workforce in the field of mental health and addiction services. Community behavioral health providers report high turnover rates and difficulty in filling vacant positions. It is particularly challenging to recruit physicians and nurses as well as clinicians who specialize in the treatment of children and adolescents, older adults, and people with co-occurring mental health and substance use conditions. Salaries in behavioral health care—particularly in addiction services—are well below those for parallel positions in other health care sectors and in business.<sup>xxvii</sup>

Recent policy decisions in Ohio may contribute to the problem rather than the solution. For example, Medicaid rates for widely used evidenced-based therapies such as group counseling have been reduced by 30% for addiction group counseling and 60% for mental health group counseling as of January 1, 2018. This incentivizes individual therapy over group counseling which is not indicated for good outcomes and will decrease capacity with the existing workforce. The same is true for nursing services where rates were cut on average by 50%, making it more difficult for organizations to employ this necessary part of the behavioral health

workforce. Finally, Ohio Department of Medicaid rules on background checks create barriers to employment and interfere with the authority of Ohio's licensing and credentialing boards in determining ability to practice.

While the hours are long, and the work is difficult there are many dedicated people who are passionate about contributing to their communities and willing to enter in to this field if provided with the education, resources, and support to be successful at their profession. More needs to be done to encourage young people to pursue careers in behavioral health, recruit and retain talented individuals entering the professions, and to ensure a high-quality workforce. As more people have access to coverage, more is understood about behavioral health's contribution to total health. As more focus is placed on the mental health and addiction treatment needs of Ohioans, the workforce must be available to handle the demand.

### **Advance strategies to address the shortage of qualified professionals to provide behavioral health and substance abuse treatment services.**

- Address payment rates to provide a competitive wage.
- Provide tuition reimbursement and student loan repayment options.
- Increase incentives to work in high-demand jobs and / or high-need areas.
- Reward longevity and experience to encourage professionals to stay in the field.
- Offer young people opportunities to learn about careers in behavioral health.
- Require commercial insurance and managed care plans to include sufficient number of community providers on insurance panels to guarantee access and robust choice of providers.

### **Ensure enough professionals are trained to provide all approved types of medication assisted treatment and the accompanying community support services.**

- Incorporate training on comprehensive addiction treatment services in medical and clinical education curriculum at higher education institutions.

### **Encourage Ohio Professional Licensing Boards to streamline regulatory processes for professional licensing.**

- Ohio licensing boards should reduce bureaucracy and expensive fees that keep well trained and qualified individuals from receiving a license and expanding the workforce.
- Ohio should offer an opportunity for trained professionals with bachelor's degrees to gain licensure in efficient and cost-effective manner.
- Ohio should review its reciprocity standards to make it easier for qualified candidates to move to and practice in Ohio with education, training, and licenses acquired in other states.

### **Eliminate Collateral Sanctions for Behavioral Health Workforce with Criminal Histories**

- Eliminate policies that extend collateral sanctions to those Ohioans who have already satisfied the terms of their sentence. Review rules and policies within the Ohio Departments of Medicaid and Mental Health & Addiction Services that prevent people with criminal backgrounds who otherwise meet the requirements of Ohio's licensing and credentialing boards from being able to bill Medicaid for services.

## APPENDICES

The Ohio Council offers the following appendices as valuable resources informing our policy recommendations and to shaping providers' delivery of behavioral health services to children, families, women, and men across Ohio.

### Adverse Childhood Experiences

#### Adverse Childhood Experience Study (ACES)

These infographics provided by the CDC document how exposure to traumatic events in childhood negatively impact health over a lifetime, including the development of substance use disorders and mental illness.

[https://vetoviolence.cdc.gov/apps/phl/resource\\_center\\_infographic.html](https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html)

This TED Talk by Dr. Nadine Burke Harris walks the viewer through an understanding of ACES and the impact for a public health approach to effectively preventing and treating diseases such as addiction and mental illness.

[https://www.ted.com/talks/nadine\\_burke\\_harris\\_how\\_childhood\\_trauma\\_affects\\_health\\_across\\_a\\_lifetime/discussion?CMP=](https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime/discussion?CMP=)

### Alcoholism, Addiction, and Substance Use Disorders (SUDs)

#### Addiction is a Chronic Disease

The National Institute of Drug Addiction (NIDA) delivers these basics on the chronic disease of addiction. In this document, NIDA compares relapse rates for substance abuse disorders with those of other chronic diseases and finds that relapse rates for drug-addicted patients are comparable with those suffering from diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses (as is adherence to medication). Thus, addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.

<https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics>  
[https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/mediaguide\\_11\\_16.pdf](https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/mediaguide_11_16.pdf)

This research supports the understanding of addiction as a chronic disease that requires a long-term plan inclusive of a variety of physical, psychological, and social strategies for success. This report shows that a person needs 3 to 5 years of support before entering long-term recovery.



With anything less than one year of recovery, a person has over a 60% chance of relapse.

[https://www.researchgate.net/publication/5859497\\_An\\_Eight-Year\\_Perspective\\_on\\_the\\_Relationship\\_Between\\_the\\_Duration\\_of\\_Abstinence\\_and\\_Other\\_Aspects\\_of\\_Recovery](https://www.researchgate.net/publication/5859497_An_Eight-Year_Perspective_on_the_Relationship_Between_the_Duration_of_Abstinence_and_Other_Aspects_of_Recovery)

### **Excessive Alcohol Use**

These resources from the CDC demonstrate the cost of excessive alcohol use in the U.S.

[https://www.cdc.gov/alcohol/pdfs/excessive\\_alcohol\\_cost.pdf](https://www.cdc.gov/alcohol/pdfs/excessive_alcohol_cost.pdf)

<https://www.cdc.gov/features/costsofdrinking/index.html>

The CDC provides information on healthy and unhealthy alcohol consumption. The most recent data for Ohio estimates that it cost \$8.5 billion in 2010, or \$739 per capita and \$2.10 per drink.

<https://www.cdc.gov/alcohol/fact-sheets/binge-drinking.htm>

<https://www.cdc.gov/alcohol/pdfs/alcoholyourhealth.pdf>

### **Prevention Strategies for Excessive Alcohol Use**

This document provides policy recommendations for effectively decreasing excessive alcohol use and the dangers and costs associated with it for Ohioans.

<https://www.cdc.gov/alcohol/fact-sheets/prevention.htm>

### **Teens and Alcohol**

The National Institute for Drug Abuse (NIDA) created this information for educating parents and teens about the dangers of underage alcohol use.

<https://teens.drugabuse.gov/drug-facts/alcohol>

### **Teens and Marijuana**

The CDC documents the impact of marijuana use on the developing teen brain.

<https://www.cdc.gov/marijuana/factsheets/teens.htm>

### **Medication Assisted Treatment**

The U.S. Department of Health & Human Services Substance Abuse and Mental Health Administration (SAMHSA) released this best practice guidance on the integration of behavioral health care and medication for the treatment of opiate use disorders.

<https://store.samhsa.gov/shin/content//SMA18-5063FULLDOC/SMA18-5063FULLDOC.pdf>

The Legal Action Center provides comprehensive resources related to the access to medication assisted treatment. Here are links to both the comprehensive resources and specific guidance for drug courts to ensure that individual rights to medical care are upheld.

<https://lac.org/resources/substance-use-resources/medication-assisted-treatment-resources/>

<http://lac.org/wp-content/uploads/2016/04/MATinDrugCourts.pdf>

## Mental Health

### Children's Mental Health

The physical and mental health of children and youth are important building blocks for their positive experiences as adults. These resources from the CDC provide an entry level understanding of children's mental health.

<https://www.cdc.gov/childrensmentalhealth/basics.html>

<https://www.cdc.gov/childrensmentalhealth/data.html>

<https://www.cdc.gov/childrensmentalhealth/features/kf-childrens-mental-health-report.html>

This resource documents social and emotional disorders in **early childhood, kids ages 2-8**.

<https://www.cdc.gov/ncbddd/childdevelopment/features/key-finding-factors-mental-behavioral-developmental-early-childhood.html>

This is the first mental health report that describes the number of U.S. **children aged 3–17 years** who have specific mental disorders used data collected from 2005-2011.

<https://www.cdc.gov/childrensmentalhealth/data.html> For a full report:

<https://www.cdc.gov/childrensmentalhealth/features/kf-childrens-mental-health-report.html>

### Mental Illness: Prevalence, Access to Treatment among Adults and Young Adults

These resources from the National Institute of Health give information about the prevalence of mental illness among young adults and adults and offer data on access to treatment. This includes information on severe and persistent mental illness and on any mental illness.

<https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>

### Suicide Impact

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016, 36% for Ohio. This resource provides insight into suicide prevalence, prevention, factors, and statistics.

<https://www.cdc.gov/vitalsigns/suicide/index.html>

The Centers for Disease Control and Prevention (CDC) documents the ten leading causes of death by age group.

[https://www.cdc.gov/injury/images/lc-](https://www.cdc.gov/injury/images/lc-charts/leading-causes-of-death-age-group-2014-1050w760h.gif)

[charts/leading-causes-of-death-age-group-2014-1050w760h.gif](https://www.cdc.gov/injury/images/lc-charts/leading-causes-of-death-age-group-2014-1050w760h.gif)

## Policy Discussions on Behavioral Health, the Opiate Crisis

### **Policy Guide for Medicaid Managed Care Contracting:**

*Medicaid Managed Care Contracting* is a concise blueprint for creating fair contracting practices and a regulatory environment through the Department of Medicaid that promotes accountability for the use of Ohio's resources to ensure access to services for Medicaid enrollees and financial stability for behavioral health providers.

<https://www.thenationalcouncil.org/wp-content/uploads/2018/07/Medicaid-Managed-Care-Contracting-Guide-for-State-Associations-FTLF-2018.pdf>

### **Cost of the Opioid Epidemic to Ohio**

In October 2017, researchers from The Ohio State University's C. William Swank Program in Rural and Urban Policy released the report, *Taking Measure of Ohio's Opioid Crisis*. The researchers arrive at two policy recommendations: The state should prioritize expanding access to treatment in underserved areas and on improving educational investments as a way of deterring drug abuse and overdose, particularly noting the substantial evidence linking early childhood interventions on improved employment outcomes later in life.

[https://aede.osu.edu/sites/aede/files/publication\\_files/Swank%20-%20Taking%20Measure%20of%20Ohios%20Opioid%20Crisis.pdf](https://aede.osu.edu/sites/aede/files/publication_files/Swank%20-%20Taking%20Measure%20of%20Ohios%20Opioid%20Crisis.pdf)

### **Health Policy Institute of Ohio (HPIO) – Health Value Dashboard**

The HPIO *Health Value Dashboard* is a tool to track Ohio's progress towards health value — a composite measure of Ohio's performance on population health outcomes and healthcare spending. The *Dashboard* examines Ohio's performance relative to other states, tracks change over time and examines Ohio's greatest health disparities and inequities. Ohio ranks 46 out of 50 states and the District of Columbia (D.C.) on health value, landing in the bottom quartile. This means that Ohioans are living less healthy lives and we spend more on health care than people in most other states. Ohio ranks 49<sup>th</sup> for overdose deaths, 37<sup>th</sup> for youth tobacco use and 43<sup>rd</sup> for adult tobacco use, 26<sup>th</sup> for unmet need for access to addiction treatment, and 18<sup>th</sup> for youth marijuana use.

[http://www.healthpolicyohio.org/wp-content/uploads/2017/07/2017Dashboard\\_FullWithAppendix.pdf](http://www.healthpolicyohio.org/wp-content/uploads/2017/07/2017Dashboard_FullWithAppendix.pdf)

### **Health Policy Institute of Ohio (HPIO) – Addiction Evidence Project**

HPIO is undertaking a project to provide policymakers and other stakeholders with information needed to evaluate Ohio's policy response to the opiate crisis, and accelerate and continually improve strategies to address substance use disorders in a comprehensive, effective and

efficient way. This policy brief sets the foundation for the project by describing the basics of addiction and a framework for a comprehensive policy response.

<http://www.healthpolicyohio.org/tools/addiction-evidence-project/>

Ohio Policy Inventory and Scorecard: [https://www.healthpolicyohio.org/wp-content/uploads/2018/06/AddictionScorecard\\_PreventionTreatmentRecovery\\_06062018.pdf](https://www.healthpolicyohio.org/wp-content/uploads/2018/06/AddictionScorecard_PreventionTreatmentRecovery_06062018.pdf)

### **U.S. Surgeon General’s Report on Alcohol, Drugs, and Health**

In 2017, the U.S. Surgeon General issued the United States’ first report on addiction and health. This comprehensive report reviews best practices and policy recommendations for the prevention, treatment and recovery.

<https://addiction.surgeongeneral.gov/>

### **Recovery Housing Toolkit**

The National Council for Behavioral Health published the first-ever policy guide for expanding quality recovery housing entitled *Building Recovery: State Policy Guide for Supporting Recovery Housing*. It calls on states to adopt recovery housing quality standards, establish a certification program and support recovery residences as they work to meet nationally-recognized standards. In the guide, the National Council recommends concrete policies and practices that policymakers can enact to strengthen the road to recovery from addiction.

[https://www.thenationalcouncil.org/wp-content/uploads/2018/05/18\\_Recovery-Housing-Toolkit\\_5.3.2018.pdf](https://www.thenationalcouncil.org/wp-content/uploads/2018/05/18_Recovery-Housing-Toolkit_5.3.2018.pdf)

### **Joint Principles of Organizations Representing Front-line Physicians in Ending the Opioid Crisis**

This document outlines 8 strategies to address opiate addiction as a chronic illness, including addressing focusing on families addressing addiction crises other than opioid use disorder.

<https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/risk/ST-AddressingOpioidEpidemic-061118.pdf>

### **Policing Responses to Mental Illness and Addiction**

These documents provide guidance on how collaboration among law enforcement and community behavioral health providers can safely and effectively address the needs of persons with mental illnesses and addictions, link them to appropriate services, and divert them from the criminal justice system if appropriate.

Crisis Intervention Team (CIT) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769782/>

Ten Standards of Care: Policing and the Opioid Crisis

[https://americanhealth.jhu.edu/sites/default/files/inline-files/PolicingOpioidCrisis\\_SHORT\\_final.pdf](https://americanhealth.jhu.edu/sites/default/files/inline-files/PolicingOpioidCrisis_SHORT_final.pdf)

## Behavioral Health Workforce Development

### Behavioral Health Integration and Workforce Development

This report from Milbank Memorial Fund discusses policy opportunities and provides case reviews of how other states are addressing behavioral health workforce shortages.

<https://www.milbank.org/wp-content/uploads/2018/05/Milbank-Memorial-Fund-issue-brief-BHI-workforce-development-FINAL.pdf>

### The Behavioral Health Workforce Research Center

This center is located within the University of Michigan's School of Public Health and works with a national consortium of partners and experts in mental health, substance abuse, and health workforce research. The three priority research areas for the Center include establishing a minimum data set for the behavioral health workforce, conducting studies on worker characteristics and practice settings, and analyzing legal and professional scopes of practice. Their publications also include recommendations for policy makers to consider in building, recruiting and retaining a highly skilled behavioral health workforce.

<http://www.behavioralhealthworkforce.org/publications/>

## Mental Health and Addiction Insurance Parity

The Milliman report examined the rate at which commercial insurance plans reimbursed providers compared to what Medicare reimburses. Any percentage less than 100% means that commercial insurance plans were reimbursing at rates lower than what Medicare pays. Any percentage over 100% means that commercial insurance plans were reimbursing at rates greater than what Medicare pays. These charts indicate the disparity documented for Ohio.

<https://www.paritytrack.org/report/ohio/ohio-milliman/>

The Legal Action Center (LAC) provides resources and information to support access to prevention and treatment services. Here are links to the LAC's website and to information specific to federal parity law.

<http://lac.org/wp-content/uploads/2016/06/LAC-Parity-Guide-2016.pdf>

<https://lac.org/what-we-do/substance-use/>

## Ohio Council Policy Briefs

The following briefs were written by the Ohio Council of Behavioral Health & Family Services Providers to provide perspective on Ohio’s behavioral health system, document evidence-based practices for replication in Ohio, and make policy recommendations related to priority areas identified in communities across the state.

### **School Based Services**

This document provides an overview of the research related to school based services. It also includes “Partnership Profiles” completed by the behavioral health provider organization that describe individual provider organization and school district collaborations from the perspective of the behavioral health provider.

<https://obc.memberclicks.net/assets/School%20Based%20BH%20Services%20Guide.FINAL.2017.02.pdf>

### **Substance Use Prevention and Mental Health Promotion**

This document discusses what works and what doesn’t work in the prevention of substance use and mental health disorders. It makes policy and practice recommendations for Ohio.

<https://obc.memberclicks.net/assets/Pv%20advocacy%202016.pdf>

### **Inpatient Capacity for Children**

This paper discusses the need for inpatient services for children with severe emotional disorders in Ohio and makes recommendations for expanded capacity to meet their distinctive needs and better support parents and families.

<https://obc.memberclicks.net/assets/Child%20and%20Adolescent%20Inpatient%20Services%20Capacity%20Expansion.pdf>

### **Health Families, Healthy Ohio Logic Model**

Ohio has several urgent initiatives that prioritize the social, emotional, physical, intellectual, financial, occupational, environmental, and spiritual well-being of Ohio’s children and youth. In this document, the Ohio Council lays out a roadmap for environmental and individual supports that promote healthy families and a healthy Ohio regardless of whether the family is in rural Ohio, Appalachia, an urban center, or suburban neighborhood.

<https://obc.memberclicks.net/assets/Healthy%20Families%20Logic%20Model%2002-25-2013.pdf>

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