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WHITE PAPER

MOVING MENTAL HEALTH CARE OUT OF THE OFFICE: POLICY OPTIONS TO EXPAND SERVICES IN "NONTRADITIONAL" SETTINGS

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The U.S. is experiencing shortages of mental health services in a range of locations and service delivery contexts. Just over one in five people in the U.S. reported having a mental health condition in 2021, and of those, about half received any services for those conditions (NIMH, 2023).[1] For some groups of people, including youth and people of color with certain mental health conditions, rates of receiving services are lower than for other groups (Panchal et al., 2022; Alegría et al., 2002). The poorest communities in the U.S. have the lowest rates of availability of mental health providers. The gap between apparent need for mental health services and receipt of them is longstanding, and takes on urgency, as rates of reported mental health conditions, as well as suicide rates, have increased (CDC, 2023). These gaps impose significant human and societal costs.

As part of efforts to expand access to mental health care, some policymakers have proposed engaging more people in mental health care services outside of traditional, office-based health care settings. For example, in last year's Bipartisan Safer Communities Act, Congress established policies and grants to advance provision of Medicaid-covered health and behavioral health services in schools, building on previous grant investments through the Department of Health and Human Services (HHS) and Department of Education (ED) to expand mental health services in schools (BSCA, 2022).[2] Last year, the Administration also proposed to integrate mental health expertise into social service and early childhood programs (ASPE, 2022; Tsai, 2023a).

The goal of these policies is to expand access, reduce unmet need for mental health services, and address maldistribution of mental health providers. They aim to "meet people where they are" by reducing barriers people face accessing services and making them available in the settings people prefer. Barriers include geographic limits on available providers, travel costs, and challenges scheduling appointments during typical provider office hours. They are also intended to diminish stigma that can be associated with mental health care (which can deter people from seeking services when they need them), expand culturally competent service provision, and increase person-centeredness. Some proposals are developed with a recognition that notable groups of people, including people of color, obtain services at lower rates than do others, and that some longstanding approaches to providing mental health services are not adequately meeting the needs of those groups. These approaches can be an alternative to telemedicine to establish immediate, in-person connections, or to serve in place of telemedicine in places where telemedicine is not available or preferred (Williams and Shang, 2023). Policies to advance mental health services outside of health care settings are not new. Grant programs that the Substance Abuse and Mental Health Services Administration (SAMHSA) administers, as well as Medicaid home and community-based services programs, have long supported such services (SAMHSA, 2023; CMS, 2023). But policy proposals to promote services outside of traditional office-based settings are receiving increased attention now.

Policymakers face several challenges with respect to expanding access to mental health services outside of traditional health care settings. Efforts to expand access outside of traditional health care settings can encompass a range of goals and approaches, from broad approaches that seek to augment services provided in traditional health care settings to efforts to serve as an access point or conduit to treatment. This makes it difficult for policymakers to

[1] This includes people with a range of degrees of impairment from these conditions, from no impairment to severe impairment.

[2] Policy proposals related to expanding access to schools including through implementation of these provisions, are discussed in Frank and Wachino, 2022.

match specific interventions with specific policy or system goals. In addition, there is limited evidence on the impact of some of these policy interventions on the people who receive them, including whether they connect people to needed services. This makes it difficult for policymakers to assess the likely impact of policy or funding changes. A third challenge is that some interventions have been well-researched, resulting in solid evidence of their impact on people, but these interventions are not yet widely available. To help address these policy challenges, this paper a) describes some mental health interventions that are provided outside of traditional, office-based health care settings and available evidence of their impact, and b) proposes policies to advance access to these interventions, including in some cases policies to develop a stronger evidence base. These policy options are aimed at federal policymakers; some are also relevant to state and local policymakers.

Methods

We reviewed available literature to identify a range of approaches that have been used in the United States to offer mental health services or supports outside of traditional health care settings (e.g., offices, hospitals). This review encompassed peer-reviewed studies of approaches that address the impact and efficacy of specific programs and models as well as studies and information from the grey literature. The populations that the interventions and services we identified serve, and the type and acuity of their mental health needs, varied. We excluded services that develop specific areas of the workforce, such as peers.

Following this initial review, we elected to focus on two specific categories of interventions. The first helps some community members play a more active role in addressing peoples' mental health needs. The second offers treatment delivered by health care providers for mental health conditions in homes and communities. We also convened a group of mental health policy and practice experts to discuss these approaches and policy options.

Discussion

This section describes the interventions in each of the two categories and the research we reviewed, followed by policy options.

1) Strengthen the ability of some community members to respond to peoples' mental health needs

Some recent approaches seek to augment existing mental health services by training community members, focusing on those who are not mental health professionals, in responding to peoples' mental health needs and promoting connections to and engagement in treatment when needed. They serve diverse functions, including providing low-intensity non-medical supports, normalizing discussion of mental health and/or addressing stigma, increasing access points to mental health treatment, and in some cases, equipping people to address the needs of people in crisis. The development and use of these strategies is relatively recent and they are generally localized, not widespread. Four such approaches are:

a) **Making mental health-related services available in libraries and other settings.** In some states and cities, libraries have developed programs to better respond to community mental health and substance use needs by training staff to engage people with mental health conditions or people who are experiencing homelessness. Some staff

perform care coordination and intervene during a patron's mental health episode. Some libraries employ social workers, who are trained mental health professionals, to work with patrons with mental health and substance use needs (Bolt, 2015; Stringer, 2020). These programs are generally funded through local governments or philanthropy. For example, the California Mental Health Initiative is working with libraries throughout the state to provide training and resources to library staff to identify and respond to mental health challenges (California State Library, 2020). Salt Lake City, Utah; Boise, Idaho; Avon, Connecticut; and Hewitt, Texas are also among the communities that have adopted these approaches (Knology, 2022; Azallion, 2022; Stringer, 2020, Bolt, 2015). By one estimate, more than 50 U.S. cities have full-time social workers on their public library staffs to assist homeless patrons and individuals struggling with mental illness (O'Malley, 2022).

Similar approaches are being deployed in other settings. The Department of Housing and Urban Development (HUD), for example, has committed resources in its Fair Housing Program to providing evidence-based training to staff to help them connect people who show signs of mental distress to resources (FHEO, 2023). Our review did not identify research results that assessed the impact of or outcomes from offering services in libraries or other settings.

b) **Mental health awareness training.** Mental health awareness training prepares community members to recognize signs of mental health and substance use issues, serve as an initial source of support to people who need it, and help connect people to assistance. Mental health first aid is one well-known form of awareness training (National Council for Mental Wellbeing, 2023). Training can be deployed in a range of settings, including workplaces, schools and colleges, and health care settings (SAMHSA Advisory, 2022). Research on mental health first aid suggests that it is effective in increasing the knowledge and confidence of the people who receive the training. Studies have identified modest improvements in the knowledge level of the people who received training, confidence in addressing mental health problems, and some reduction in stigma (SAMHSA Advisory, 2022). However, although research has examined the impact on people who received the training, we did not identify evidence of its impact on the population whose health it seeks to improve.

c) **Pastoral counseling**. Historically, people with mental health conditions have turned to clergy members for support at relatively high rates (Wang et al., 2003). Members of the clergy can be a trusted resource who are familiar with the context of peoples' lives and possess knowledge of available community resources. Some members of the clergy are trained in mental health, counseling, and other relevant skills and expertise, though the type and amount of training varies (Young et al., 2003). Certified pastoral counselors have advanced degrees in theology or mental health (The Partnership Center, 2020). A review of research of the potential role of clergy in Black churches in improving the mental health of members of Black churches found that the evidence of the impact on members' mental health was inconclusive, but noted that some health programs in Black churches had helped address medical issues (Hankerson and Weissman, 2012).

d) **Community-initiated care. "**Community-initiated care" models seek to equip individuals who play specific roles in the community to identify people with mental health needs and help support them in accessing services and resources (Gilbert et al., 2023). This promotes community involvement and engages multidisciplinary actors in addressing mental health challenges. The Confess Project, for example, trains barbers to serve as

informal mental health support systems, aims to strengthen informal access to mental health services, initiate conversations about mental health, and overcome stigma (The Confess Project, 2023).[3] Qualitative research identified the potential for barbers to address issues of mental health, interpersonal violence, and trust among people of color, (Gelzhiser and Lewis, 2023) but the impact of the barbershop model or other approaches to "community-initiated care" has not yet been established in the research literature.

Policy approaches to expand the role of community members in responding to mental health needs:

Dedicate resources to evaluation through the Department of Health and Human Services. Research on the overall impact of approaches that strengthen the role that key community members play in responding to mental health needs is needed to inform decisions about whether and how policies should be developed to advance these approaches. This research should examine quality, outcomes, and connections to and use of services, as well as the impact on specific populations of interest, impact on equity, and context specific factors that affect their availability or effectiveness. Federal policymakers can develop a stronger evidence base for these engagement programs.

The Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute on Mental Health, the Agency for Healthcare Research and Quality, and the office of the HHS Assistant Secretary for Planning and Evaluation are possible venues for supporting or conducting such research. They could evaluate engagement programs such as mental health first aid that states or localities are financing through federal SAMHSA grants as well as through state, local, or private funding. The executive branch could make funding available for these from existing resources, or Congress could appropriate additional resources to new evaluations. This should include specific resources to assist the organizations that are carrying out these models, who typically have resource constraints that inhibit investment in data collection and evaluation, in evidence development.

Tie additional grantmaking to developing an evidence base for specific interventions. The federal government could additionally create a new program to marry grant funding to the development of an evidence base and prioritize awards of federal funding to the most effective types of programs. This program could be modeled on two existing programs that are not specific to mental health, Maternal and Infant Early Childhood Home Visiting (MIECHV) and Families First Preventive Services Act (FFPSA), that the federal government has recently used to both build the evidence base and advance evidence-linked service availability through federal grantmaking.

Congress created MIECHV in 2009 as a grant program that awards funds to states, territories, and tribal organizations to fund home visiting programs.[4] Home visiting provides services, generally in a home setting, to pregnant mothers, new parents, and their young children; services are aimed at strengthening the parent/child relationship and include parent education, screenings, and care coordination (Burak and Wachino, 2023). A specific HHS-run program, Home Visiting Evidence of Effectiveness

[3] Programs such as Cut it Out train hair care professionals to address intimate partner violence.
[4] Congress recently reauthorized MIECHV with increased funding.

(HomVEE), reviews research across eight different domains and rates the quality of the research (Administration for Children and Families, 2023). At least half of a state's, territory's, or tribe's MIECHV grant funding must fund programs designated as evidence based by HomVEE.[5] MIECHV also allows a portion of funds to support promising home visiting approaches as a more robust evidence base is developed. Similarly, the FFPSA, which Congress first authorized in 2018, encourages states to use Title IV-E foster care funds for preventive activities for children at risk of entering the foster care system (Bipartisan Budget Act, 2018; Children's Bureau, 2023). The Administration for Children and Families (ACF) reviews evidence and rates specific programs and interventions. Evidence-based services qualify for federal Title IV-E matching payments if they meet ACF's criteria, with half of a state's funding reserved for "well-supported" interventions.

The FFPSA/MIECHV research and grantmaking model could be applied to preventive mental health interventions to expand the evidence base and spread the adoption of evidence-based practices.

2) Expanding access to treatment by providing it in homes and communities

Meeting people where they are can mean offering services to people who need them where they live. This reduces access barriers posed by transportation and geography, which can be particularly acute for people with disabilities and some seniors, and provides services in a setting some people prefer. Three approaches to providing mental health treatment at home or in communities are:

a) **Providing services to older adults with depression at home.** Some home-based interventions have been identified as effectively addressing depression in older adults. The Program to Encourage Active Rewarding Lives for Seniors (PEARLS) is primarily delivered in a home setting. A trained social worker or mental health counselor working under the supervision of a psychiatrist delivers treatment that is aimed at problem solving and assists in planning social and physical activities and events. The intervention lasts several months and takes place through a combination of home visits and telephone consultations. PEARLS is associated with significantly reducing or eliminating depressive symptoms, increased health-related quality of life, and was associated with reduced hospitalizations (CDC and NACDD, 2009). 133 organizations operating in 26 states offered PEARLS as of 2021, according to the Department of Health and Human Services' Administration for Community Living (ACL, 2021a). Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) is provided as part of case management services for older adults with chronic health conditions and functional limitations. Trained case managers use tools to identify and address depressive symptoms by providing education and coaching to patients and their caregivers, as well as supporting access to ongoing services when they are needed. Participants in the program experienced reduced depression severity and pain, as well as increased knowledge about how to get help and reduce symptoms through increased activity levels (CDC and NACDD, 2009). ACL has identified both PEARLS and Healthy IDEAS as evidence-based prevention practices (ACL, 2021b).

[5] MIECHV programs must also meet additional programmatic criteria established by HHS in order to receive grant funding.

A policy option to advance depression services in conjunction with home care services:

Federal policymakers could advance PEARLS and Healthy IDEAS by developing a Medicare payment mechanism that facilities access to these evidence-based depression interventions, potentially as part of the Medicare home health benefit. State Medicaid programs could similarly advance these programs through Medicaid's home health benefits, case management benefits, and through 1915c home and community-based services waivers. The Centers for Medicare and Medicaid Services (CMS) could encourage state take up issuing guidance that highlights these interventions, identifying ways expand them and remove any service barriers, and encouraging states to adopt them. Older Americans Act programs are another a potential source of support for Healthy IDEAS and PEARLS.

b) Expanding access to mental health treatment through supportive housing. It is widely recognized that having stable housing is a determinant of health and mental health. Housing can be a key service access point. Making mental health and related services available to people who need treatment in a housing setting can be an effective intervention for low-income people who face housing instability and have serious mental illnesses and/or substance use disorder. Supportive housing, which facilitates access to services such as case management, supportive services like personal care services, counseling and/or assertive community treatment, serves people with a serious mental illness or disabling condition who have experienced or are at risk of homelessness. Supportive housing has been associated with increased housing stability, reduced use of hospital and emergency room services in some circumstances, and reduced health care costs in some studies (AcademyHealth, 2016). It has also been associated with improvements in self-reported mental health outcomes and access to care (AcademyHealth, 2016). Housing First, which makes supportive housing available quickly without preconditions, has been associated with reduced homelessness and reduced emergency room and other hospital services (National Alliance to End Homelessness, 2022). These models also have higher reported rates of consumer satisfaction or perception of consumer choice. However, the evidence of supportive housing's impact varies, and research has not demonstrated that supportive housing or Housing First have an impact on mental health and substance use, although one study identified reduced use of alcohol among people with significant alcohol issues (Aubry et al., 2020; Rog et al., 2014).

Policy options to expand access to mental health treatment through supportive housing:

Leverage new Medicaid policies to expand access to services through supportive housing. CMS has recently expanded the ways in which states can cover some housing and housing support services. In a few recent 1115 demonstration waiver approvals, CMS has authorized some states to cover six months' rent for people who are transitioning from institutions, as well as tenancy support services and case management (Ross, 2022; Casart, 2023). CMS is also authorizing states to cover some housing support and other services as "in lieu of" services that Medicaid managed care plans provide. CMS and states could maximize the impact of these new policies by tying the authorization of Medicaid coverage of housing to providing services using evidence-based supportive housing models. CMS and states could also use transitional housing services, such as support for a security deposit for someone who is leaving institutional

care, as an on-ramp to permanent supportive housing. Given high rates of mental illness and homelessness among people leaving prison and jail and the positive impact that offering supportive housing can have on housing stability, public safety, and other outcomes, CMS and states may wish to connect Medicaid beneficiaries to supportive housing as they return to communities (HUD, 2022). States can use new Medicaid reentry policies that are available through Medicaid demonstration waivers to help connect people to supportive housing as they leave prison or jail (Tsai, 2023b).

Advance provision of mental health services in housing through federal agency alignment and technical assistance. Responsibility for advancing the provision of housing in concert with services for people with mental health or substance use conditions is shared at the federal level by SAMHSA, HUD, and CMS. At the state and local levels, responsibilities are similarly shared across housing, behavioral health, and health financing agencies. Advancing the provision of mental health services in conjunction with housing requires collaboration across agencies and providers, the ability to understand and bring multiple programmatic and funding sources to bear, and developing operational infrastructure. One model for achieving this coordination is the section 811 Project Rental Assistance program, which provides affordable housing and connections to Medicaid services to people who are eligible for Medicaid home and community-based services (HUD, 2023). The program is administered through a collaboration between HHS and HUD at the federal level, and similar cross-agency partnerships at the state level.

De-siloed leadership and implementation at the federal level can help build a playing field on which housing, behavioral health, and health care agencies who seek to advance health and mental health access can best provide services. At the cabinet level, the federal Interagency Council on Homelessness promotes cross-agency coordination and leadership. The council committed to providing technical assistance, streamlining processes for braiding federal funding, and identifying model state practices to advance supportive housing in the Administration's national plan to prevent and end homelessness (U.S. Interagency Council on Homelessness, 2022). These activities could be advanced through a technical assistance partnership between SAMHSA, CMS, and HUD modeled on the cross-agency behavioral health crisis and school Medicaid technical assistance centers that Congress recently authorized. These agencies should also align federal grantmaking to reduce the extent to which different programmatic rules and timeframes that pertain to specific funding sources conflict and create administrative and programmatic barriers at the state and local levels. Convening state policymakers from diverse sectors would also help advance supportive housing, as it did in 2016 when CMS led a health and housing program that convened state level partnerships between state Medicaid programs, housing programs, and other state agencies to strengthen the intersection of health and housing (CMS, 2016).

c) **Assertive Community Treatment.** Assertive Community Treatment (ACT) serves people with serious mental illnesses and/or substance use disorder in their homes and communities. It is a high intensity approach that is staffed by multidisciplinary teams (such as physicians, social workers, and peer supports) with small caseloads. ACT teams provide integrated, 24-7 treatment, rehabilitation, and support services to promote person-centeredness and recovery, and can serve discrete populations, including people who are returning from incarceration, inpatient psychiatric treatment, and people who face housing instability. As noted above, ACT can be one of the services facilitated through supportive housing.

ACT has been extensively evaluated over the decades it has been practiced. Results across different settings generally find positive effects on indicators such as reduced psychological symptoms, reduced hospitalization and emergency department use, both in absolute terms and relative to other interventions. Although findings vary across studies and populations served, some analyses have associated ACT with reduced jail involvement, increased housing stability, increased quality of life and reduced substance use (AcademyHealth, 2016). Some studies have also demonstrated higher patient engagement with treatment and higher utilization of other health resources (i.e., more outpatient visits, better adherence to medication protocol for SUD) among people who participate in ACT. Evidence also suggests ACT is most effective for the highest need individuals, with those who have had significant hospital stays seeing the largest improvements from the ACT intervention.

ACT is funded through a variety of sources, including grant funding and Medicaid. Medicaid programs in forty states and the District of Columbia cover Assertive Community Treatment, but it is unclear how widely ACT is available within the states that cover it. National estimates suggest that the rates at which mental health facilities offer ACT is low, vary across states, and that ACT is not available to most of the people who are eligible to receive it. These challenges have existed for some time (Rocherfort, 2019). Additionally, the services that are provided as part of ACT vary and may not have fidelity to the ACT models that have been most extensively studied (Spivak et al., 2019). A policymaking challenge is to expand the availability of ACT to people who would benefit from it without diluting its impact by either providing it to groups of people who will not benefit the most from it, or by departing from the practices that have been demonstrated to be effective.

Federal policy options for advancing ACT include:

Expanding financing sources: Expanding the payers that finance ACT could help advance its availability. Currently, Medicaid and grant funding are the primary federal sources of funding; state and local governments also fund ACT. The Biden Administration FY2024 budget proposes that Medicare cover ACT (HHS, 2023). Medicare coverage could expand the availability of ACT to seniors and people with disabilities, and broaden the financing base for ACT beyond state and local funding, grant funding, and Medicaid, potentially making it more viable for providers to offer ACT in some places. In the Consolidated Appropriations Act of 2023, Congress increased grant funding for ACT for tribes and tribal organizations (2022); SAMHSA has also awarded additional grants to states to develop ACT this year (SAMHSA, 2023).

Strengthening Medicaid payment for ACT: States and the federal government can review Medicaid payment rates for ACT to ensure that they are sufficient to incentivize providers to offer this complex, multidisciplinary service on a 24/7 basis to the people who need it. Paying on a monthly basis may support ensuring that services are available when they are needed better than more episodic, service-based payments do. Additionally, in contracting with Medicaid managed care organizations, states can set specific performance goals, standards, and value-based payment mechanisms that incentivize plans and providers to make ACT services more available, and to measure their quality and outcomes. These standards and mechanisms should include fidelity mechanisms and clear parameters regarding eligibility for services to ensure that people who will benefit most from the service are offered it.

Historically, Medicaid has been limited in its ability to finance some components of ACT, such as services that are related to education or employment. CMS may be able to revisit the coverage of some of these services through 1915c home and community-based waivers and new policies that it is developing to address health related social needs through Medicaid, using 1115 authority and managed care "in lieu of service" authority.

Advancing availability of ACT in rural areas. Testing modified versions of ACT that involve less intensive approaches and piloting them in rural areas could help inform the development and expansion of services in areas of the country in which they are lacking. The federal government could also establish provider capacity development grants to develop capacity for ACT and other services in rural areas and support development of telehealth for ACT. Grants could be modeled on the provider capacity development grants for substance use disorder that were established for 10 states through the 2018 SUPPORT Act.

Conclusion

Federal policymakers have an array of tools at their disposal to strengthen the response to national challenges in mental health. These tools can be creatively and effectively deployed to bring mental health services closer to where people live, work, and recreate. Policymakers can expand the evidence base regarding approaches that expand the role of community members in addressing peoples' mental health needs, and more closely align evidence development and grantmaking. In addition, policymakers can spread and scale three effective interventions that provide treatment to people in home and community settings: depression screening and services for older adults, supportive housing, and assertive community treatment. Policies that advance effective federal financing will be central to expanding access to mental health services in new settings.

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