Disrupting and Reimagining the Behavioral Healthcare Services Delivery System for Diverse Youth

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Funding Disclosures

Culturally Adapted Linking Individuals Needing Care (CA-LINC)
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Bridge to Better Mental Health
NC DHHS Funding

Disclaimer: The opinions expressed in this presentation and on the following slides are solely those of the presenter and do not represent the agencies affiliated.
Learning Objectives

1. Discuss the need to disrupt and reimagine the behavioral health service delivery system for vulnerable youth.

2. Identify culturally inclusive strategies for meeting the needs of vulnerable youth and families.

3. Discuss innovative interventions and service delivery models being developed for vulnerable youth.
Ubuntu

I am because we are.
We are because I am.
Treatment vs. Punishment

Treatment Definition
Medical care that is given to a client for an illness or diagnosis.

Punishment Definition
A consequence that reduces the likelihood of a targeted or undesirable behavior from happening

Treatment vs. Punishment for Families & Providers
Case Example: Punishment in the System
Case Example: Provider Experiences (IIH)

Provider Experiences
• Families needed help but not punishment
• 95% of clients served in IIH were Black youth and families involved in multiple systems
• “Authorization Starvation” Period
• Person Centered Plans (PCP) were too positive. Needed to be more deficit focused to receive services
• Burdened with services that were inconvenient and excessive at times
• Introduction of Intensive Family-Based Services as a new intervention but contracts limited to certain providers
• Heavily regulated service made it burdensome to sustain
• Difficult approval processes delayed treatment for families
Case Example: Provider Experiences (IIH)

- **NC Medicaid: Are MCOs Biased?**

...it’s troublesome to know that entities that provide federal funding to these healthcare providers have been doing their absolute best to *rid the remaining African-American behavioral healthcare providers*. For years, Managed Care Organizations (“MCOs”) have contracted with these providers to fund expenses pursuant to Medicaid billing. MCOs have repeatedly attempted to terminate these contracts with African-American providers without cause, unsuccessfully; until recently. ...It has been *estimated that 99%* of behavioral healthcare providers in NC that have been terminated have one thing in common. You guessed it. They are African-American owned. Once terminated, most healthcare providers cannot operate without these Federal Medicaid Funds and, ultimately, are forced to close their respective practices.
Case Example: Provider Experiences (IIH)

NC Clinical Coverage Policy (8A)

For IIH beneficiaries, all aspects of the delivery of this service occurring per date of service shall equal one per diem event of a two hour minimum. It is the expectation that service frequency shall decrease over time: at least 12 face-to-face contacts per beneficiary are required in the first month, and at least 6 face-to face contacts per beneficiary per month are required in the second and third months of IIH services. The IIH service varies in intensity to meet the changing needs of beneficiaries, families, and caregivers; to assist them in the home and community settings; and to provide a sufficient level of service as an alternative to the beneficiary’s need for a higher level of care.

The IIH team works together as an organized, coordinated unit under the direct supervision of the team leader. The team meets at least weekly to ensure that the planned interventions are implemented by the appropriate staff members and to discuss beneficiary’s progress toward goals as identified in the PCP.

This service is billed per diem, with a 2-hour minimum. That is, when the total contact time per date of service meets or exceeds 2 hours, it is a billable event. Based on the percentages listed below, the 2 hours may include:

a. direct clinical interventions as identified in the PCP; or
b. case management interventions (face-to-face, telephone time, and collateral contacts).

Services are delivered face-to-face with the beneficiary, family, and caregivers and in locations outside the agency’s facility. Each provider agency must assess and document at least annually the aggregate services delivered at each site using both of the following quality assurance benchmarks:

a. at least 60% of the contacts shall occur face-to-face with the beneficiary, family, and caregivers. The remaining units may be either telephone or collateral contacts; and
b. at least 60% of staff time shall be spent working outside of the agency’s facility, with or on behalf of the beneficiaries.

## Case Example: Family Experiences (IIH)

<table>
<thead>
<tr>
<th>We enjoy working with the team, but the services are too much. We don’t want to have to go through this again.</th>
<th>There were usually conflicts with the parents’ work schedules.</th>
<th>Assumptions were made that the youth was not involved with other activities in the community and was at home daily waiting for services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes authorizations weren’t approved, therapy wasn’t working, and there were no options for us.</td>
<td>Outpatient therapy wasn’t enough, we needed more, but not this much more.</td>
<td>We don’t necessarily want or trust people in our homes.</td>
</tr>
<tr>
<td>We do not want someone in the home 2-6 hours weekly, several days a week</td>
<td>We had to witness all of our child’s and family’s problems on paper in a written plan (PCP) that was shared with their primary care physician, psychiatrist, and other stakeholders.</td>
<td>Having access to the case manager and therapist was helpful.</td>
</tr>
</tbody>
</table>
Case Example: Ethical Considerations

- Focus on extreme deficits of child and family to get services approved.
- Providing a service that families are not fully receptive to but are required to receive as a result of other systems (i.e., Child Welfare)
- Providers not getting authorizations to provide necessary services.
- Families having to see negative, deficit oriented documentation about themselves and their child. Strengths limited to certain sections of documents.
- Service delivery rigid and not fully inclusive of cultural aspects and components
- Certain families and providers are policed with these services.
- Families being sent to other service providers with limited choice
Reimagining
Suicide Rates for Black or African American Populations by Age, United States 2011-2020
Context

- Black Youth Suicide has been amplified as a National Crisis.¹,²
- In North Carolina (NC), suicide is the second leading cause of death for ages 10-18.⁷
- In NC, the state is fourth in the U.S. for Black teen suicides. ⁷,⁸
  - Mecklenburg County, this study’s location, has the highest youth suicide rate in NC’s 100 counties.⁶
  - Approximately 19% of Black youth in Mecklenburg County identify as LGBTQ+SGL.⁸
Existing Problems and Interventions

- Existing suicide interventions have not been developed or adapted to address the unique cultural, linguistic, and developmental needs of diverse Black youth.\(^3,4\)
- Furthermore, there is a lack of rigorous research on how psychosocial stressors and environmental barriers experienced by Black youth and caregivers (defined as parents or guardians) impact existing prevention and intervention approaches.\(^5\)
- As a result, current interventions are not sufficiently positioned to decrease SIB in diverse Black youth.\(^6\)
- Interventions aimed at decreasing Black youth suicide risk (SR) have been recommended to focus on identifying and treating mental health (MH) symptoms by increasing access to MH care, improving problem-solving skills, and enhancing family relationships.\(^3-6\)
The Barriers

**Systemic Factors:**
- Racism
- Historic oppression
- Dehumanization of Black populations

**Individual/Family Barriers:**
- Lack of trust and engagement with non-Black providers
- Racial battle fatigue
- Stigma with LGBTQ+SGI identities
- Family conflict
- Lack of resources

**Provider/Organizational Barriers:**
- Limited training on culturally responsive services and suicide risk identification
- Lack of confidence in the competency of providers
- Limited awareness of community resources
- Poor community collaboration

**Community Barriers:**
- Stigma
- Negative perceptions of MH supports

**Inappropriate, inadequate, discontinued, or no care for high-risk Black youth**
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Inappropriate, inadequate, discontinued, or no care for high-risk Black youth

Proposed Solutions

Cultural Adaptation Framework (AIM 1)

CA-LINC Care Coordination Intervention (AIM 2)

Positive alliance with providers
Cultural Humility
Affirming perceptions of provider engagement
Supportive family relationships
Retention in MH and non-MH services
SIB Reduced
Care coordination models have been found to enhance treatment motivation and adherence, strengthen coordination and access to health and behavioral health (BH) services, and improve patient outcomes.\textsuperscript{9,10}

However, existing models have not been designed to specifically target adolescent SR, nor have they integrated system-level strategies to coordinate suicide prevention (SP) and/or intervention efforts at the community level.\textsuperscript{11}
LINC Model

• A 90-day intervention that infuses suicide risk management and care coordination strategies via caring contacts provided in any mode of communication.
  • Contacts begin within 24–72 hours of discharge, followed by weekly sessions for the first 30 days, and then monthly (up to at least 90 days).\textsuperscript{12}
  • The frequency and intensity of contacts were dependent on the needs of the youth. During each care coordination visit, care coordinators reassessed suicide risk and safety plans, discussed mental health and service needs, and reviewed coping skills and social supports (e.g., formal and informal sources of help).\textsuperscript{12}
  • Care coordinators documented care coordination strategies and participant progress and outcomes via standardized mental health and suicide risk assessment and LINC-developed measures.\textsuperscript{12}
LINC Pilot Data

- A longitudinal pilot study of 460 youth participants was conducted with youth during and following inpatient psychiatric hospitalization for suicide risk to examine whether participation in the LINC intervention was followed by improved engagement in services and mental health outcomes for at-risk youth.\(^\text{12}\)
  - Received LINC for approximately 90 days following discharge from crisis services
  - Participants significantly increased the use of various beneficial, least restrictive services (individual therapy, medication management, and non-mental health supports) over the 90-day intervention.
  - Significant decreases were observed in depressive symptoms, suicide ideation, and engagement in suicide-related behaviors.\(^\text{12}\)
  - Time was a significant predictor of all services, suggesting service use significantly increased over 90 days. For every 30 days of the intervention, the odds of receiving individual therapy increased by 54%, family therapy by 32%, medication management by 24%, non-mental health support by 54%, school services by 48%, and other services by 30%.\(^\text{12}\)
LINC Pilot Data

• An open trial pilot was conducted to examine the effectiveness of LINC in increasing access to and engagement in mental health and non-mental health services among suicidal youth (N = 587). Other variables of interest included service use facilitators and service use barriers.¹³
  • Service utilization differences were found between Black and White youth. While Black and White youth were both likely to engage in individual therapy (OR = 1.398, \( p < .001 \)) and non-mental health services (OR = 1.289, \( p < .001 \)), utilization rates for mental health and medication management services were lower for Black (55.1% to 60.6%) youth compared to White (66.0% to 71.0%).
  • Black youth were significantly less likely than Whites to receive medication management (OR = .466, \( p = .002 \)).¹³
  • Culturally adapted models attending to cultural and social assets of Black families are needed to reduce disparities and suicide risk among Black youth.
<table>
<thead>
<tr>
<th>CA-LINC – Cultural Adaptation</th>
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<tbody>
<tr>
<td><strong>Community-Engaged Participatory Research Methods</strong></td>
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<tr>
<td>Equitable approach to research that builds community trust, improves community health, enhances the relevancy of the research and application of the data, and uses community expertise to help solve complex problems.</td>
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<td><strong>Consumer and Community Driven</strong></td>
</tr>
<tr>
<td>The needs and wants of the consumer and community drive and promotes the intervention.</td>
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<tr>
<td><strong>Faith-Based Organization (FBO) Involvement</strong></td>
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<tr>
<td>Faith-based organizations (FBO) have successfully mobilized Black communities to promote positive health behaviors; therefore, partnerships with these organizations have the potential to increase access to mental healthcare and decrease health disparities.</td>
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<tr>
<td><strong>Community Health Workers</strong></td>
</tr>
<tr>
<td>Lay and professional health advisors who have been recruited from diverse communities and trained in evidence-based approaches</td>
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</table>
Phase I of this study will use community-based participatory research strategies to adapt the intervention to address youth, familial, provider, and system-level barriers contributing to low service utilization, access to care disparities, and suicide risk among Black youth.

Aim I: Adapt the LINC intervention to address the practical, systemic, linguistic, cultural, and developmental needs of Black youth and Black LGBTQ+SGL youth and families. Tasks include:

| Identify/assess stakeholder (youth, family, provider, community) perceptions/needs to enhance suicide risk detection, service referrals/linkages, and service engagement using focus groups. | Conduct focus groups to obtain provider perceptions/feedback on clinical workflow processes (screening, eligibility protocol, warm hand-off referrals) and implementation strategies (assessment, contact sessions). | Adapt service delivery components and workflow/implementation strategies using an iterative process. |
CA-LINC Study – Phase II

In Phase II, an open trial and a two-arm parallel-comparison single-blinded pilot randomized controlled trial will explore the “fit” (i.e., feasibility) of the adapted LINC intervention in these minoritized communities and inform a scalable RCT for a future R01 study.

Aim II: Evaluate the feasibility and assess initial outcomes of the adapted LINC intervention via a small-scale pilot RCT. Tasks include:

<table>
<thead>
<tr>
<th>Task</th>
<th>Details</th>
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<tbody>
<tr>
<td>Assess stakeholder perceptions on the acceptability/appropriateness</td>
<td>Assess stakeholder perceptions on the practicality and integration of implementing and sustaining the adapted intervention using existing</td>
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<tr>
<td>of the adapted intervention.</td>
<td>community resources/infrastructure.</td>
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<tr>
<td>Evaluate treatment adherence, fidelity, and study retention.</td>
<td>Evaluate the feasibility of study procedures for screening, recruitment, and randomization.</td>
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<tr>
<td>Examine effect size estimates for differences in the primary outcome</td>
<td>Examine differences in potential change mechanisms (therapeutic alliance, service utilization, cultural humility, family relationships,</td>
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<td>(SIB measured by the Suicidal Ideation Questionnaire⁹ and Self-Harm</td>
<td>engagement behaviors, and barriers to participation) between LINC and TAU.</td>
</tr>
<tr>
<td>Harm Behavior Questionnaire¹⁰) among Black youth randomly assigned</td>
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<td>to mental health hubs, to CA-LINC vs. Treatment as Usual (TAU, no</td>
<td></td>
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<td>follow-up care).</td>
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# Status of the Study and Lessons

<table>
<thead>
<tr>
<th>Community-Engaged Participatory Research Methods</th>
<th>Consumer and Community Driven</th>
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<tbody>
<tr>
<td>• Community Collaborative Board</td>
<td>• Focus Groups</td>
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<tr>
<td>• Research Fundamentals Training</td>
<td>• Soliciting Feedback</td>
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<tr>
<td>• Creating an Ecosystem</td>
<td>• Identifying needs</td>
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<td>• Identifying Gatekeepers and Building Trust</td>
<td>• Word of Mouth Support and Validation</td>
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<tr>
<td></td>
<td>• Validating the Knowers</td>
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<td></td>
<td>• Paying participants for labor</td>
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<thead>
<tr>
<th>Faith-Based Organization (FBO) Involvement</th>
<th>Community Health Worker or Peer Support Model</th>
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<tr>
<td>• Flow through FBOs</td>
<td>• Member of the Local Community</td>
</tr>
<tr>
<td>• Zip Codes and Demographics</td>
<td>• Training</td>
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<tr>
<td>• Community-Based</td>
<td>• Trained as Mental Health First Aid</td>
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<tr>
<td>• Psychoeducation/Outreach</td>
<td>Train the Trainer</td>
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References