

Public Health and Mental Health Partnerships: Historical and Future Perspectives

Robert Oldham, M.D., M.S.H.A
Health Officer, Placer County
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Learning Objectives

- * To give a brief historical overview of public health approaches to mental health
- * To introduce current “best practices” and possible future directions in public health/ mental health partnerships
- * To set the stage for a great day of learning and collaboration!

Disclosures

- * I have no commercial interests related to this presentation topic.
- * I believe there is no health without mental health.



* *Only connect! That was the whole of her sermon. Only connect the prose and the passion, and both will be exalted, and human love will be seen at its height. Live in fragments no longer. Only connect, and the beast and the monk, robbed of the isolation that is life to either, will die.*

* E.M. Forster, *Howards End* (1910)

Overview

- * Mental Health: Why is it not more connected? (10 minutes)
 - * Historical explanations
 - * Financial explanations
 - * Professional explanations
- * Building Connections (15 minutes)
 - * Mental health prevention efforts
 - * Population-based mental health interventions
 - * Integration with primary/ specialty care
 - * The Recovery Movement , connection to community, and social determinants of health

Historical Perspectives

- * Asylums/ state hospitals
- * Psychoanalysis
- * Mental health “carve outs”
- * Community mental health centers
- * Largely “immune” from capitation

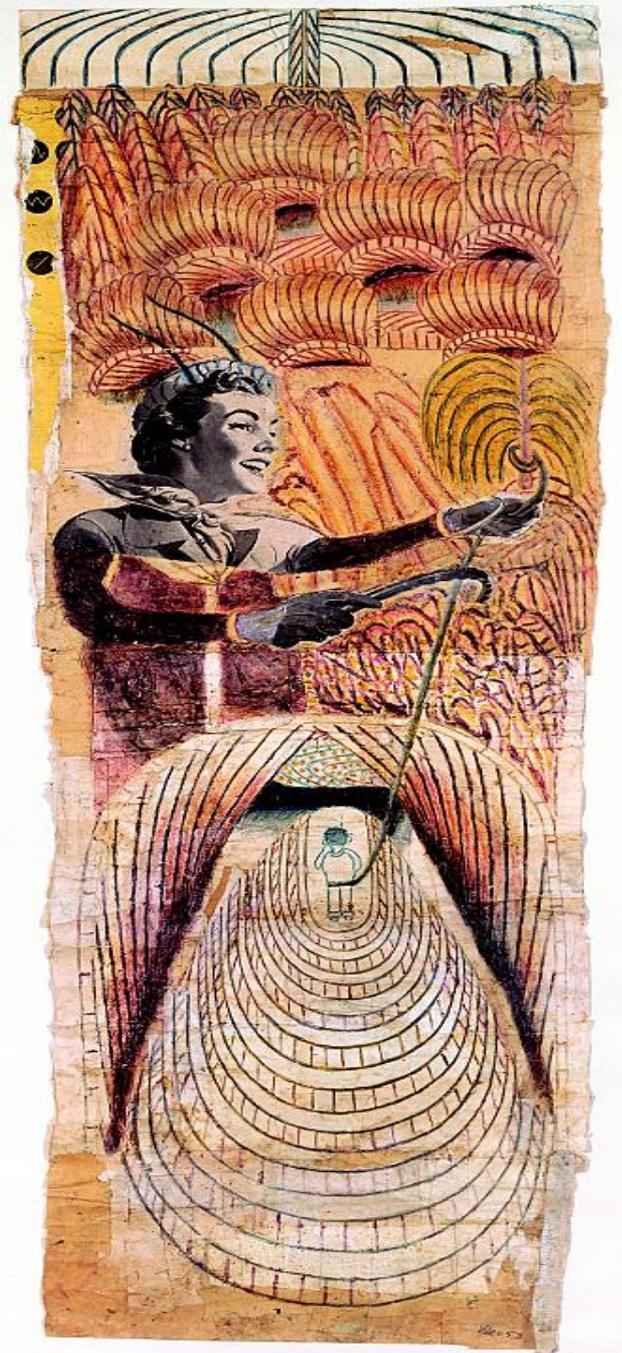
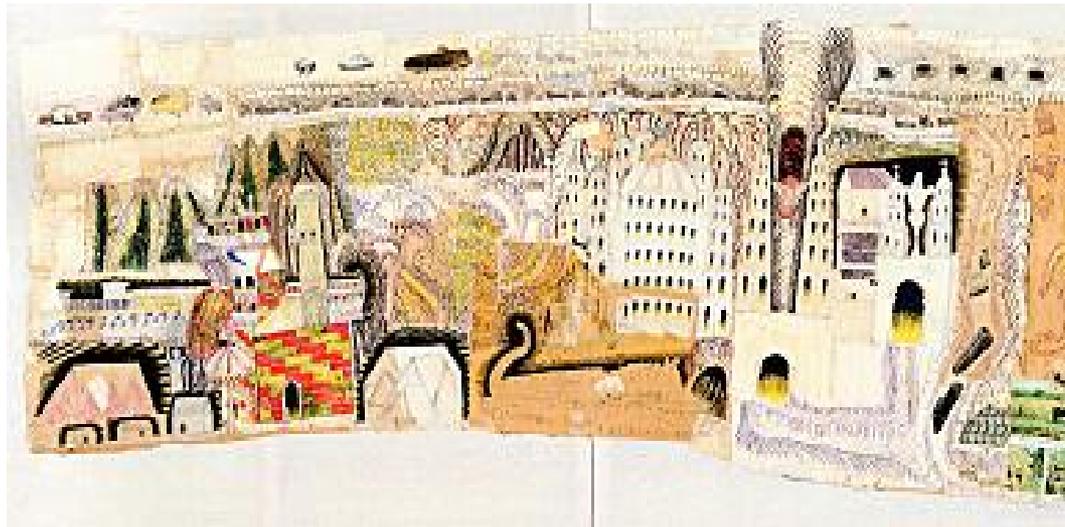
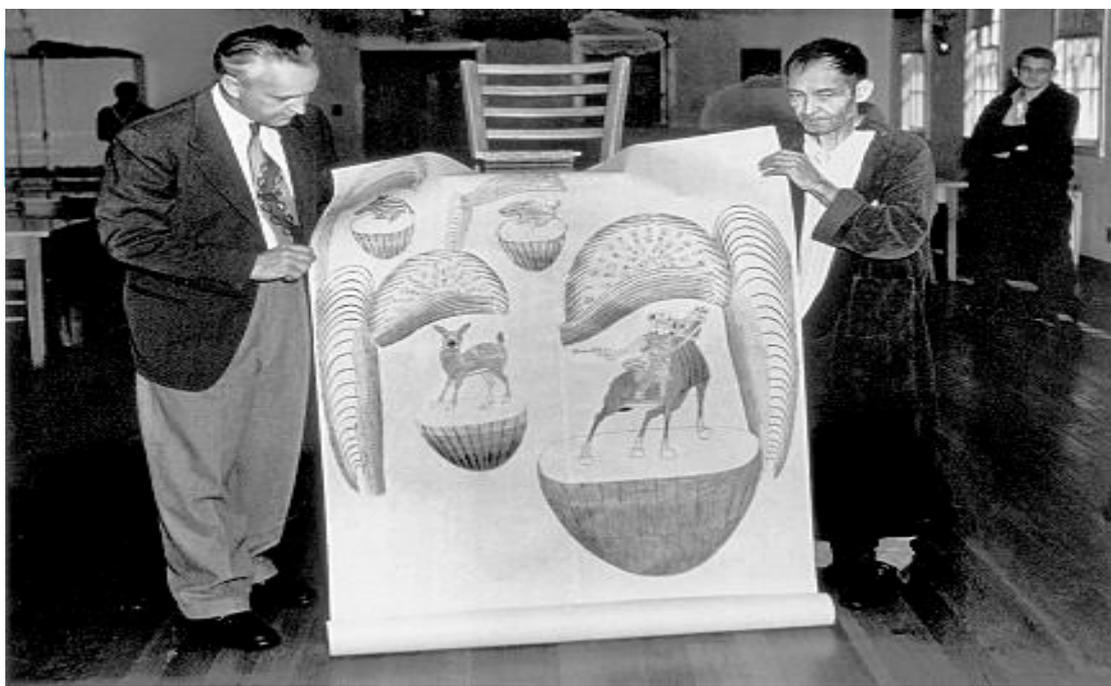


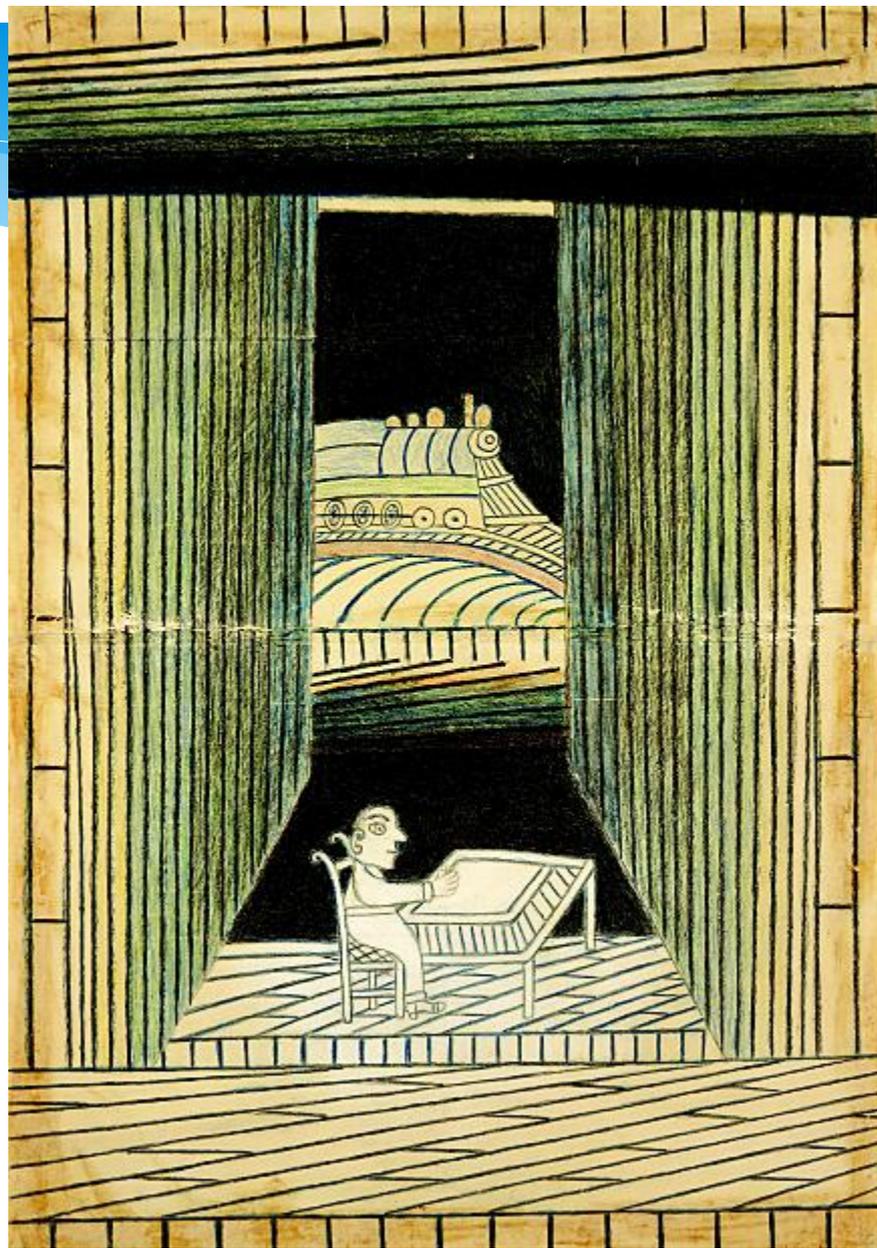
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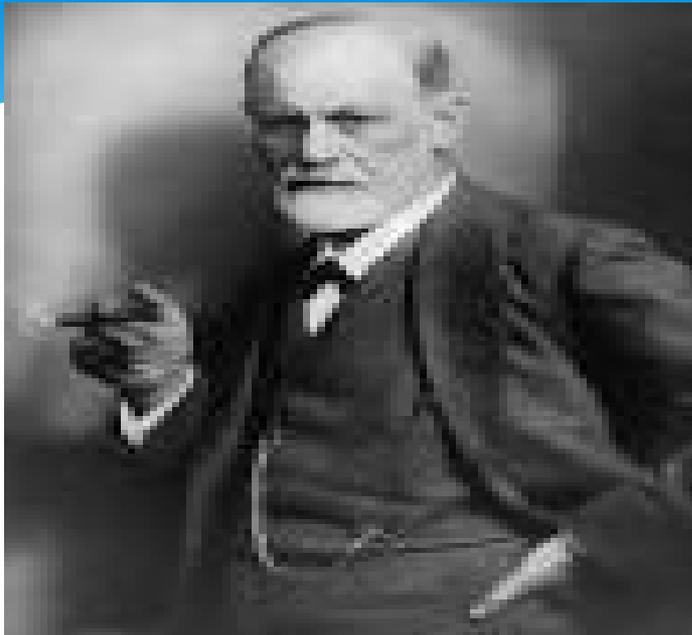
ORIGINAL BUILDING OF THE RETREAT, YORK. INSTITUTED 1796.

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Injection, 25 mg./ml. Syringe, 100 mg./ml. and Suppositories, 25 mg. and 100 mg. Concentrations, 50 mg./ml. and 100 mg./ml.



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The advertisement features a collection of Thorazine dosage forms arranged on a wooden chessboard. The pieces include several bottles of different sizes, some with labels, and a few small glass ampoules. The chessboard is set on a light-colored surface. The text at the top provides the product name and dosage information. The bottom right corner contains the manufacturer's name and location.

Financial Perspectives

- * Due to legacy of state hospitals, mental health care for SMI was believed to be a state responsibility.
- * Efforts to exclude mental health with the beginning of Medicare and Medicaid.
- * Also, commercial insurers did not gravitate toward paying for mental health services
 - * Difficult to predict costs/ outcomes
 - * Employers had no incentive to cover SMI
- * Specialty mental health plans often “carved out” to manage these benefits
- * Largely immune from capitation or prospective payment
- * FFS encouraged “illness” model
- * Disincentives for “physical health” providers to address mental health, or vice versa

Professional Perspectives

- * Little training on mental health in most medical training
- * Psychiatric training has largely decreased emphasis on medical training, and virtually nothing on population/community health
- * Psychiatry almost completely out of community mental health centers
- * Little coordination between mental health and public health (sometimes in competition for limited resources)
- * Shortage of referral resources

Bridging the Gap

- * 1999 U.S. Surgeon General's Report
- * Increased interest in mental illness epidemiology, risk and protective factors, and evidence-based prevention efforts
- * Increased focus on family members of people with mental illness
- * Increased focus on community-level interventions
- * Mental health professionals increasingly see their role in achieving broad prevention goals (beyond the prevention of mental illness)

Primary prevention interventions in mental health

- * Community-based interventions have shown that primary prevention interventions have considerable promise when they:
 - * address multiple risk/ protective factors,
 - * focus on multiple settings
 - * target communities with a higher level of risk and need (e.g. abused/neglected children or children of parents with mental illness)
 - * Communities That Care
 - * High/Scope Perry Preschool Program
 - * The Incredible Years teacher classroom management program
 - * Victorian Health Promotion Foundation's Mental Health Promotion Framework
 - * Prenatal/ Early Infancy Project

Secondary Prevention in Mental Health

- * Most people with mental illness go undiagnosed and untreated until they reach crisis
- * Routine screening for common mental illnesses like depression, anxiety and substance use disorders in schools and primary care can increase rates of detection and effective treatment of these illnesses.
 - * Universal screening for depression in primary care with IMPACT
 - * Improved screening and care coordination for persons with SMI and cardiovascular risk factors

Tertiary Prevention in Mental Health

- * Decreasing the disability associated with mental illness
- * Programs such as supportive housing, employment, case management, psychotherapy, peer support, medication adherence
- * Income supports!
- * *Mental Health Policy in the United States Since 1950: Better But Not Well* (Frank and Glied, 2006)- argues that people with mental illness are better off since deinstitutionalization, largely due to improvements in social services, not advances in treatment

The Recovery Movement

- * Recovery defined as:
 - * “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”
 - * four major dimensions that support a life in recovery:
 - * Health : overcoming or managing one’s disease(s) as well as living in a physically and emotionally healthy way;
 - * Home: a stable and safe place to live;
 - * Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
 - * Community : relationships and social networks that provide support, friendship, love, and hope
- * Borrows concepts from “health promotion” and health consumer movement.
- * Also recognizes the important role of communities in mental health.

Future Opportunities for MH/PH Collaboration

- * MHSA
 - * FSPs
 - * “Know the Signs” Campaign
 - * Expansion of “Wellness” models utilizing peer support providers
- * Incentives for integration and population-based approaches to MH with ACA
 - * Capitation (e.g. Macro version of “The Village”)
 - * “Accountable Care Communities”
- * Work together (with common metrics) to capture true “ROI” for PH and MH programs
- * Targeted programs in communicable disease, tobacco prevention, and chronic disease prevention.

Questions?