

FOUR PRIORITY CORE PROGRAMS FOR PREVENTION AND EARLY INTERVENTION (PEI)

HEALTH PLANS, SCHOOLS, WORKPLACES, INTERNET

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Counties developed their initial prevention and early intervention plans around 2009. At that time the best knowledge led to strategies mostly around identifying high risk populations and where their mental health problems might be observed or screened and then leading people to care. Most of those programs are in two of the core program locations of primary care and schools. However, very few are as comprehensive as this paper envisions. If we can make these four core programs a norm throughout most of the state, other strategies should eventually be viewed as secondary approaches to be used only for those populations missed by what I will describe below as the four priority core programs for PEI which reflects a concept based upon what has been learned about prevention and early intervention through what counties have funded, through what CalMHSA has funded for statewide projects and through developments outside of California's MHSA.

Putting all of this together, I have concluded that our PEI goals can best be achieved by building PEI programs around four primary settings or gateways through which we can develop and provide nearly everyone with the preventive and early intervention services and supports which they need and truly transform mental health from fail first to help first.

Two of these are the environments in which most of us spend our week day time- school and work. The other two are where people go when they have health related problems more than anywhere else – health care (mainly primary care or the emergency room) and the internet.

These should be the main portals for our prevention and early intervention strategies and for accessing the right care at the right place at the right time. **Moreover, for health plans, schools and workplaces there is now solid evidence that the actions we want to have taken pay for themselves in a bottom line return on investment measurement for the total costs for those systems.** These systems can also share in the costs and benefits of the internet supports which can make all of these three even more effective.

Exactly what needs to be done varies by setting but the basic concepts are fairly simple and well known. Moreover, there are examples of all of them currently in place in some locations so the challenge is how to educate partners on the value of establishing these programs by leveraging our available resources to promote and expand what we know

works to where these models become standard practices across the state (and the nation).

REDUCING DISPARITIES

A primary purpose of virtually all prevention and early intervention strategies is to reduce the disparities in access to mental health services affecting Latino and Asian and Pacific Islander populations and better quality and outcomes for these and other underserved and inappropriately served populations. Only one in three African Americans who needs mental health care receives it, according to the National Institute of Mental Health. The American Psychiatric Association reports that Native American youths and adults suffer a disproportionate burden of mental disorders. The MediCal External Quality Review Organization (CaEQRO) reported that in 2009 (as PEI programs were started) that the MediCal penetration rate among Latinos was 3% as compared to 12% for Caucasian and African Americans. Their reports showed that, three years later in 2012, the penetration rate for Latinos had risen to 4% while that for Caucasians and African Americans had fallen to 11% reflecting an increase of 50,000 Latinos served without an increase in total numbers served. This is almost certainly due largely to the success of some of the initial prevention and early intervention strategies. These four pathways should eventually close most of the remaining gap- if and when they are fully implemented. However, that will likely take many years and many of the current strategies for reducing disparities will still be needed even after these four pathways are established reflecting that there are still likely to be many populations likely to be missed and the need to make sure all services are culturally appropriate.

HEALTH PLANS

It is estimated that a behavioral health problem is present for 1/3 of the people who go to their primary care doctor and those without one who go to the emergency room for any reason. (that is three to four times the rate of behavioral health conditions among all people meaning that having any kind of health problems significantly increases one's likelihood of having a behavioral health condition.) Simple screening tools can identify those who probably have such conditions. These tools are becoming a requirement under MediCal and should be used universally for all health plans. The key issue is making sure that there is immediate follow up and connection to someone who can complete the diagnosis and initiate treatment once a screen is positive. Ideally this is done through co-located behavioral health staff. However, this is not always feasible. When it is not, the health plan needs to provide for some type of tele-health communication with a behavioral health professional at that time as studies also show that efforts at simple referral without consultation do not usually succeed.

There is no question that this represents a cost to the primary care offices and to behavioral health professionals. Health plans should pay for that cost because it is well documented that untreated behavioral health conditions lead to much greater physical and behavioral health costs that could have been avoided with more timely identification and treatment of behavioral health problems.

Within MediCal the state has started the process to require plans to screen for alcohol and depression. That needs to be expanded to cover screening for all of behavioral health. In addition the existing MOUs between counties and health plans must be expanded to ensure that anyone who screens positive is quickly seen (either through co-location, or a warm hand off) by a comprehensive behavioral health provider who can address any type or level of severity of a behavioral health problem, and start the process of care management to support follow-up and related issues.

Every pilot project doing this has demonstrated that the costs for behavioral health and for primary care are more than fully offset by savings in reduced hospitalizations and other physical health care costs. Accordingly the MediCal implementation of this should not only provide for the health plans to pay the primary care providers and county networks for their added costs but also incentivize them to perform well through sharing of the savings that would be expected to occur within the second year.

Since it is known that it is cost effective for health plans to make sure that this form of integrated care takes place it should be a standard practice for all health plans. However, it is not.

What we don't know is why it is not advancing significantly beyond MediCal and what can be done to change that paradigm. A task force must be created to determine what the barriers are and what the roles of state and county government should be in facilitating and incentivizing these changes.

This is the way to ensure early intervention through health plans. Prevention strategies in health plans for behavioral health are not that different from what is being promoted in physical health which is to promote healthy lifestyles – including avoidance of tobacco and other addictive substances, moderation of alcohol consumption and unhealthy foods, exercise, social connectivity and balance between productivity and relaxation. However, given the connection between behavioral health problems and much greater incidence of most major chronic health problems these prevention measures become much more important for anyone diagnosed as having a behavioral health disorder. Moreover, people with behavioral health disorders have much higher incidence of smoking, social isolation, lack of exercise and obesity so that there is much greater need and the value of having special prevention programs for people with behavioral health conditions.

Such programs have not received a great deal of attention. **Behavioral health leaders should promote these programs directly for the populations that they serve and work with health plans so that health plans provide greater attention to these prevention strategies for people with known behavioral health problems while supporting health plans in expanding their general health prevention strategies for everyone.**

SCHOOLS

It is well known that most children who receive any kind of mental health care get it at school. It is equally well known that teachers can identify the children who are most at risk of having a behavioral health problem. It is also well known that delays in identifying and treating a child's mental health problem early in its onset leads to significantly greater incidence of school failure at considerable cost to schools. Similarly, schools are also the site and source of traumatic experiences that lead to behavioral health problems. School culture matters a lot for prevention and anti bullying and positive behavior and supports programs are part of strategies to provide supportive school environments.

While there are many examples of excellent school mental health programs, they appear to vary from school to school without a consistent established systematic approach.

An emerging best practice that is demonstrated to pay for itself in reduced high cost special education placements is a three tiered model teaming teachers with mental health professionals combining a positive school culture to prevent and reduce the incidence of mental health problems with timely treatment for those showing moderate symptoms and intensive services for those who meet special education criteria.

Several funding streams are combined to make this model work and there is a need for a partnership between the school district and county mental health that is centered around having a comprehensive behavioral health provider who has a county contract to access MediCal funding on campus who can provide all of the levels of care. Once in place preliminary data from programs started in the Alameda, San Francisco and San Bernardino counties shows that it pays for itself for schools in reduced high cost special education placements.

Workgroups have already been established to consider this approach. What is required is for state and local education and mental health leaders to collaborate to identify the steps and incentives required to make this a broadly utilized model and to provide funding for more pilot programs to give greater exposure and demonstration of the value of these programs.

WORKPLACES

It is known that the median and most common age of onset of schizophrenia and bipolar disorder is in the early 20s- a time at which most people are in the workforce. In addition it is known that untreated depression costs employers \$100 to \$200 billion annually in lost productivity, absenteeism, and disability. Annually one in four people will have a behavioral health problem and at any given point in time it is one in 12.

What is also known is that only one in three people will seek help for their mental health problems.

Just like in schools, people in workplaces are able to observe each other on a daily basis. It is actually a manager's job to observe, evaluate and provide feedback on employee behavior through the process of performance management. By building capacity to address performance more effectively when mental health issues are underlying the problem, workplaces contribute to prevention and early intervention. When an employee is at risk for developing mental health challenges or is experiencing them at work, there is compelling evidence that it is cost effective for employers to

1. equip managers to address issues early and effectively,
2. create and maintain a supportive de-stigmatizing inclusive environment and
3. put in place comprehensive multi tiered systems that address psychological health and safety in the workplace. These three actions serve to increase the likelihood that an employee will seek treatment, and have a healthy work environment to support recovery.

Like schools, there are emerging models to create such programs. However, unlike schools there are very few employers who have created systems to address this problem.

One promising program is Wellness Works a program funded by CalMHSA and operated by Mental Health America of California. This program has delivered training to over 2200 managers, employees and organizational leaders in California in its first two years of operation in California. It is based upon an award-winning program that began 12 years ago in Toronto, Canada under the name Mental Health Works. It has been evaluated as significant in reducing stigmatizing attitudes, which is key for employees who have mental health challenges to be able to feel included and supported by their managers and co-workers

The training for managers enables managers and supervisors to be able to have collaborative and effective conversations with employees through a needs-based approach. This approach serves to affirm support, and reduce self-stigma in the

employee who may be avoiding seeking help due to fear. The supportive work environment can lead to an increase in help seeking behaviors which will reduce untreated mental illness. The approaches taught in Wellness Works can also reduce absenteeism, disability leave and turnover, while increasing productivity, producing the savings that more than pay for the program.

What is needed most is to broadly publicize and market this program and demonstrate its value to employers so that it becomes a standard workplace training, first for managers, then for all employees, while supporting organizational leaders to implement a psychological health and safety management system as the overarching intent of a comprehensive multi tiered systemic approach. In addition Wellness Works needs to be expanded to include a research and consulting arm that can provide continuous follow-up with dedicated organizations who are committed to strategic and systemic change, with comparative analysis and evaluation.

INTERNET

Where do people go for help with problems? Increasingly the answer is the internet to virtually all types of problems including behavioral health issues.

Mental Health America has an internet screening self- evaluation tool. Data from its first four months of use show 100,000 users with 75% female and the majority between the ages of 18 and 24.

Reachout.com is a website for youth facing “tough times” that was started in Australia and within a few years reported that one third of all “transition age youth” (ages 16-25) in Australia had been on their site. It is now available in the US with headquarters in San Francisco and funding support from CalMHSA through Inspire USA.

Beating the Blues, Cobalt, and Big White Wall are internet based therapy programs that provide evidence based therapy offered through computers without a live therapist which have been funded as part of health care in the United Kingdom and are now being launched in the US. For people with some mild to moderate conditions they appear to be sufficiently therapeutic to eliminate the need to ever see a live therapist.

These programs and Reachout can connect people to chat rooms for peer support which is monitored by mental health professionals.

These are just a few examples and there are no doubt hundreds of programs and even more being created constantly.

What is not known is what is their relative value and which ones are worthy of more investment of public mental health system and private health system funding as well as

higher education and employer support. A group of experts should be funded to study these programs and develop recommendations.

A special focus should be on transition age youth. This is the age group most likely to use the internet, and least likely to seek care for mental or physical health through primary care. Moreover, if they are university students neither school programs nor workplace programs can reach them very often so that the internet is most vital. In addition they have the highest unemployment rate.

Special projects led by youth in partnership with mental health professionals should evaluate these programs and promote the most promising practices. These practices should include prevention and social connection supports as well as evaluation and information that provides therapeutic value and guidance to getting more help than is available online. There probably need to be special programs for different age groups and settings focusing on high school students, college students in commuter schools, college students in residential schools, youth who have dropped out of school and are struggling to make ends meet, veterans and other special populations of transition age youth and others likely to use the internet to address their mental health needs.

Once the best practices have been identified there should be outreach to make sure that people will be led to these sites instead of others that might have more commercial appeal, including some that may be damaging to one's behavioral health. In addition they should include local resource links and guidelines for the process to access behavioral health care through county networks for MediCal recipients and through health plan networks for others. In addition, there should be linked resources identifying the parity benefits and rights of everyone to get all of their Medically necessary care and the state agencies and outside groups that can offer assistance if they encounter delays or denials in accessing all levels of necessary care.

GETTING FROM HERE TO THERE

Most of getting from here to there involves statewide strategies, in collaboration with counties and communities, to be determined.

Much of the existing PEI programs are expended on where high risk populations may go for help of any kind or to just talk about problems. Existing approaches such as religious leaders, other spiritual and personal supports, mental health first aid, youth drop in centers, and community centers will still be needed. For now counties and other funders will need to engage in a balancing act to use sufficient funds to facilitate full scale development of these recommended priority core programs while recognizing that until they are more widely utilized they won't meet the needs of much of the population.

WHO WILL WE STILL MISS

As these four priority core programs expand, each county will need to assess its existing programs to determine whether the populations that it serves will still need these outreach efforts or whether they will be eclipsed by some of the pathways programs as they get implemented.

Some populations such as recent immigrants are less likely to be reached by any of the primary pathways. Some programs such as early psychosis programs, support for religious and spiritual leaders, training in Mental Health First Aid for “first responders” teachers, clergy, health care workers and other special populations and drop in centers for transition age youth who are not working or full time students will likely still be needed. That is probably true of other specific populations and programs.

However, just as the expanded health care coverage from the Affordable Care Act reduces the need for PEI funds to be spent on direct services, these four priority core programs create proactive strategies that can reduce the need for some of the other strategies now being implemented.

Work groups of counties and stakeholders should be established over time to evaluate and develop recommendations.