Using Evidence to Inform Public Policy in Behavioral Health

Amy T. Campbell, JD, MBE
ASU Summer Institute * Sedona AZ
July 20, 2012
Today’s Objectives

• Identify important policy considerations in behavioral health debates.
• Describe ways evidence may be translated into health policy, and limits of such use
• Recognize how to bring an evidence-based message to policymakers
• Discuss! Apply! Discuss!
Today’s Case Studies
Defining the Context
Our Examples Today

Cases
1. Mental Health Screening in Schools
2. Homelessness and Behavioral Health
3. Military Suicides

Will Address:
• Stats
• Evidence (Interventions)
• Policy Issues (including barriers & opportunities)
Behavioral Health: The Evidence

Context & Our Cases
Case Study #1: Mental Health Screening in Schools
Case Study #1

• JFK High School in Phoenix, Arizona
  – Bullying; nearby school w/ rash of suicides
  – Administrators want to do > education.
  – Collaborate with local academic psych, SW, and local adolescent med clinicians to come up with intervention
  – Screening tool recommended.
  – Choose ScreenRTeens program: parental consent & student assent; opt in; two step process (screen, assess); target all incoming 10th graders.

• Qs: Is this a good model to implement by school and best policy approach?

(Case adapted from Campbell 2010)
Adol MH: Stats

• Prevalence of MH issues in adolescence
  – #s affected, treated, originating in adol

• Concerns over undiagnosed problems
  – Health issues
  – Education
  – Employment
  – Justice involvement
  – Costs
Adol MH: Evidence

• Early intervention
• MH screening
  – Generally
  – Adol – recommendations
  – Adol – tools
School-Based Interventions

• Why schools for screening?
• What issues for schools to do?
  – Resources
  – Legal issues
  – Costs/benefits
CONSENT

• When does “adolescent” become legal “adult”?
• Who provides consent for a pre-adult adolescent (i.e., “minor”; prior to age of majority)?
• Can a minor ever provide own consent to health care?
  – When?
  – How?
CONFIDENTIALITY, PRIVACY, SCREENING

- HIPAA (confidentiality in health care)
- FERPA (privacy of educational records)
- PPRA (limits on screening of students)
Case Study #2:
Homelessness and Behavioral Health
Case Study #2

• Tampa, FL Task Force on Homelessness
  – City of Tampa witnessing increase in homeless population, and when examines numbers, identifies @ 10% are chronically homeless, but 50% of costs
  – Chronic homeless includes many adult males with co-occurring disorders, but some families too.
  – Calls together Task Force to identify ways to address human and cost burdens from problem
  – Recommends adding 100 permanent supportive housing units using *Housing First* model.

• Qs: How can the Task Force present findings to make strong policy case? Obstacles to address?
Homelessness & BH: Stats

• Homeless #s
  – How defined / estimated
  – “Hot Spots” & trends

• Chronic Homeless: Prevalence of MH / Co-occurring issues
  – #s affected, population characteristics

• Where found?

• What systems are impacted / involved?
Homelessness & BH: Evidence

Full-Service Partnerships
• Permanent Supportive Housing
• Housing First philosophy

Evaluations:
• “1811 Eastlake” Seattle Study  (Larimer et al 2009)
• San Diego FSP study  (Gilmer et al 2010)
• New York City CASAHOPE study  (National Center)
Homelessness & BH: Policy

At federal, state, local levels …

• What policymakers/influencers are involved?
• Who addresses housing and how?
• Who addresses services and how?
• Is there policy support for supportive housing? If yes, What? How? Who?
Case Study #3: Military MH & Suicides
Case Study #3

• Governor’s Special Advisory Committee to Address Texas National Guard Suicides
  – Marked increase in # of suicides among military personnel, esp. those after one deployment
  – Collaborate with state VAs, clinical and research suicide experts to develop educational tools to address concerns.
  – A public health approach is recommended.
  – Initial efforts look to inform media so “appropriately” cover suicides

• Qs: Does evidence support public health approach to make it a policy goal? If so, how would policy best support?
Military Suicides: Stats

• #s of active duty & veteran suicide attempts and completions

• Characteristics & Risk factors
  – Mental health, SA
  – VHA utilizer or not; MH system contact?
  – Gender, family situation, job situation, geographic region
  – Deployment, branch affiliation, “dwell” time
Military Suicides: Evidence

• Public health approach
  – Preventive (e.g., proactively address risk factors)
  – Universal (e.g., screening)
  – Targeted (e.g., crisis lines, limit gun access)

• DoD Surveillance System (Gahm et al 2012)

• Post-deployment screening (McCarthy et al 2012)

• National Suicide Hotline (Knox et al 2012)
Military Suicides: Policy

• What national efforts have (are) addressed (ing) suicide rates & risks?
• Who are key policymakers/influencers involved in addressing the issues?
• What seem to be the policy priorities?
Evidence to Inform Policy

Tying Evidence to Policy
### “Rational” Policymaking Process

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify a Policy Problem</td>
<td>- Set out policy goals and objectives; relevant values.</td>
</tr>
<tr>
<td>List Alternatives</td>
<td>- Strategies, Actions, Policies to meet Policy Goals/Objectives</td>
</tr>
<tr>
<td>Predicted Consequences of Alternatives</td>
<td>- Estimate Probabilities of Happening</td>
</tr>
<tr>
<td>Compare Consequences with Policy Goals/Objectives</td>
<td></td>
</tr>
<tr>
<td>Select Alternative</td>
<td>- Consequences closes to Policy Goals/Objectives or Closest to Solving Problem</td>
</tr>
</tbody>
</table>

*Adapted from: Nutley and Webb, 25-26.*
The Policy Cycle

Identify Issues → Policy Analysis → Policy Instruments

Evaluation → Implementation → Decision → Coordination → Consultation

Source: Huw et al. at 26.
The Evidence-Informed Policy and Practice Pathway

From: Bowen S, Zwi AB at e166 (fig. 1)
Policy Factors & the Evidence Base

- How define issue?
- How deal with “tangle” of government stakeholders involved?
  - Braided funding
  - “System of care” / Continuum of care
  - Accountability, Addressing gaps
- Getting data straight, right (address “study-ese”)
- Understanding what study says (and does not)
- Does data support working hypothesis of issue, and how policy may be addressing?
- Unintended Policy Consequences
  - E.g., stigma reduction @ PTSD (Nash et al 2009)
Being an Effective Advocate

A Few Skills to Bear in Mind
“Advocacy is a matter of giving the right person the right information at the right time.”

Types of Advocacy

1. Case Advocacy
2. Administrative Advocacy
3. Legislative Advocacy
4. Media Advocacy
5. Public Education
2. ADMINISTRATIVE ADVOCACY

- Implementing agencies of laws, e.g., executive branches
- Seeks to change rules/regulations (e.g., regulations implementing ADA).
- Example: Ask AZ state board of education to develop and implement plan to incorporate social and emotional development standards to help with academic success.
3. LEGISLATIVE ADVOCACY

- Mid-to-upper-level policy changes.
- Propose new law or changes to existing law (e.g. seek new appropriations for programs).
- Example: Ask local Congressional rep to support President’s budgetary request of $2.23B for HUD McKinney-Vento Homeless Assistance Grants to support new supportive housing production.
4. MEDIA ADVOCACY

• Draw attention to an issue. Use the power of anecdote.

• Includes editorials, letters to the editor, news interviews.

• Example: Join coalition press conference on Austin TX Capitol steps promoting national suicide hotline targeted to vets.
5. PUBLIC EDUCATION

• Build foundation for other types of advocacy by informing public – and policy-makers – about key issues facing populations of interest.

• Information flow helps you connect with community supporters and build relationships with policy-makers who need this information/expertise.

• Examples: Go to PTA meeting to discuss issues @ adol MH; Contribute to annual “state of adolescent health” reports in city, county, state. (Include positive actions, not just obstacles, especially if positive actions taken by your local reps.)
What might you bring to the table??

- Your behavioral health expertise, front line experience, administrative perspective …

- You can illuminate:
  - The evidence base and how applies in real world.
  - If policy-supported program is working effectively.
  - If changes might help enhance effectiveness.
  - Any unanticipated consequences of policy.
Simple Steps You Can Take

1. **Use your direct contact with populations of interest.** Be prepared to share these stories.

2. **Track problems** in accessing/delivering services among your patients/clients.

3. **Foster communication.** Join/help build coalitions, advisory committees.

4. **Educate the public.** Raise awareness.
Simple Steps You Can Take

5. **Identify trends in the environment.** Pay heed to the “politics” of policy.

6. **Build relationships.** Learn the art of listening.

7. **Learn basics of policy-making process.** This includes the legislative and budget cycles.

8. **Be persistent, consistent, and patient.**
Legislative Advocacy Basics

• Aim is to convince lawmakers to support your idea or oppose something you see as harmful.
TIPS for successful legislative advocacy

1. Research the Issue:
   - Know your “case”
   - Be a source of facts/compelling info based on your “cases”
   - Combine “hard” data with “personal stories” (anecdotes).
TIPS for successful legislative advocacy

2. Build Coalitions:

- Consider other groups who might also be interested in your chosen issue. Be creative – involve untapped voices:
  - clinicians?
  - administrators?
  - researchers?
  - educators?
  - law enforcement?
  - faith-based organizations?
- Develop grassroots support. Build consensus around a realistic agenda.
TIPS for successful legislative advocacy

3. Ask for More

– ...but be willing to settle for less.

– Be prepared to compromise: it is the rare bill that makes it to enactment without some sort of amendment.
TIPS for successful legislative advocacy

4. Keep Information to One Page:
   - Prepare one-page, concise fact sheets.
   - Include: contact information, the relevant bill # and name, sponsor(s), your name and the organization you represent (if acting on behalf of), your reasons for supporting or opposing the bill, and your chosen solution.
   - End by requesting the legislator’s support (either of the bill or in your opposition to the bill).
Ways to Advocate

1. In Person
2. By Phone
3. By Testimony
4. In Writing
Some Final Thoughts on Evidence-Informed Health Policymaking and the Therapeutic Role…
What You (w/Evidence) Should Do

• Relationship
  – Be a good source of information
  – Be reliable
  – Be discreet
  – Be flexible
  – Be appreciative of time you get

• Education
  – Help explain, on-going
  – Be open to learning about policy process
What Policymaker Should Do

• Be open
• Enable access
• Listen & learn
• Educate about process
• Be transparent about process and competing goals
• Apply reasoning / have justification
• Be willing to make mistakes, admit mistakes, course correct
Defining TJ

- TJ explores the therapeutic or countertherapeutic consequences of the law on the individuals involved … perhaps even the community. TJ recognizes that the law is a social force with negative and positive emotional consequences for all of the people involved in a particular legal matter. It seeks to identify those emotional consequences; assess whether they are therapeutic or countertherapeutic; and then ask whether the law can be changed, applied, interpreted, or enforced in ways that can maximize its therapeutic effects. It is explicitly interdisciplinary and offers a fresh perspective.

From Daicoff S, at 813 (emphasis added).
Can policy address a health problem, and promote psychological well-being?

Does policy-making/implementation create psycho-policy soft spots?

Is policy (potentially) anti-therapeutic, but can we mitigate negative consequences?

Is policy (potentially) anti-therapeutic, but do other values trump?

Is no policy best (at this time)?
## Evidence Use in Health Policy

<table>
<thead>
<tr>
<th>Evidence Use</th>
<th>Evidence Based Health Policy</th>
<th>Evidence Informed Health Policy</th>
<th>Therapeutic Jurisprudence Framed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence Application</td>
<td>Direct</td>
<td>Enlightening / Interactive</td>
<td>Health-Promoting (Enlight./Interactive)</td>
</tr>
<tr>
<td>Evidence Defined</td>
<td>Mechanistic</td>
<td>Complex</td>
<td>Complex</td>
</tr>
<tr>
<td>Driver of Evidence Use (In Prioritization and Application)</td>
<td>Hierarchy: Scientific method at top</td>
<td>Hierarchy: Broader base</td>
<td>Take existing evidence and add/weight: Behavioral+Social science; interdisciplinary</td>
</tr>
<tr>
<td>Context based</td>
<td>Research to Application</td>
<td>Research to Discussion to Potential Application</td>
<td></td>
</tr>
<tr>
<td>Preeminent Value</td>
<td>Limited</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Descriptive</td>
<td>What works (we can determine)</td>
<td>What works (to inform)</td>
<td>What promotes health (to inform)</td>
</tr>
<tr>
<td>Normative</td>
<td>What works (by top level in hierarchy of evidence)</td>
<td>What works (less certainty, broader base informing)</td>
<td>What promotes therapeutic and mitigates antitherapeutic health consequences</td>
</tr>
</tbody>
</table>

*Preeminent Value:
- **Rational policymaking process is possible.**
- **Rational (scientific) process is the best way to make policy**

*Descriptive:
- **-Rational policymaking process is not possible.**
- **-Research evidence is an important tool to spur discussion at policy level and question assumptions.**

*Normative:
- **-Promoting health via health policy is possible.**
- **-Promoting health via health policy is an important policy goal.**
- **-Health-related research evidence is an important tool to spur discussion at policy level and question assumptions.**

*Expert: The policymaker and/or researcher; **Participatory: The policymaker, researcher, and/or “consumer” of evidence (e.g., clinician, individual, target population), and/or community.*
Thank You! -- Amy
Contact: campbela@upstate.edu
Advocating for Evidence-Informed Behavioral Health Policy

Useful Websites
&
Presentation References
Federal Government

- [www.usa.gov](http://www.usa.gov) (Federal Government’s official portal)
- [www.house.gov](http://www.house.gov) (US House gateway)
- [www.senate.gov](http://www.senate.gov) (US Senate gateway)
- [http://thomas.loc.gov/home/thomas.php](http://thomas.loc.gov/home/thomas.php) (bill search; committee information)
State Government (Generally)

- [http://www.nga.org/cms/home.html](http://www.nga.org/cms/home.html) (governors’ association)
- [www.nashp.org/](http://www.nashp.org/) (state policy clearinghouse)
Advocacy Resources (Generally)

- [http://www.apha.org/advocacy/tips/](http://www.apha.org/advocacy/tips/) (APHA’s advocacy tips)
- [http://www.childwelfare.gov/famcentered/casework/advocation.cfm](http://www.childwelfare.gov/famcentered/casework/advocation.cfm) (info on advocating for families)
- [http://www.advocacyresource.org.uk/What-is-Advocacy](http://www.advocacyresource.org.uk/What-is-Advocacy) (advocacy info from UK org; disability focus)
- [http://www.bazelon.org/](http://www.bazelon.org/) (Bazelon Center for Mental Health Law)
Professional Society Policy & Advocacy Resources

- [http://www.nursingworld.org/gova/](http://www.nursingworld.org/gova/) (ANA Gov’t Affairs)
- [http://www.nasmhpdp.org/policy.cfm](http://www.nasmhpdp.org/policy.cfm) (NASMHPD (state MH directors) policy site)
Policy & Evidence Use Resources

- [http://ushealthpolicygateway.wordpress.com/](http://ushealthpolicygateway.wordpress.com/) (US Health Policy gateway – a great vehicle for finding policy issues, profiles, contacts, etc. at the federal, state, and local level)
- [http://coalition4evidence.org/wordpress/](http://coalition4evidence.org/wordpress/) (Coalition for Evidence-Based Policy, in DC)
PPT Citations

• Gilmer TP et al, Effect of full-service partnerships on homelessness, use and costs of mental health services, and quality of life among adults with serious mental illness. Arch Gen Psych 2010;67(6):645-652.
PPT Citations


Additional References

Adolescent MH


Homelessness:


Military Mental Health: