

Using Evidence to Inform Public Policy in Behavioral Health

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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

Adol MH: Law & Policy

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?

Adol MH: Law & Policy

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

Identify a Policy Problem

-Set out policy goals and objectives; relevant values.

List Alternatives

-Strategies, Actions, Policies to meet Policy Goals/Objectives

Predicted Consequences of Alternatives

-Estimate Probabilities of Happening

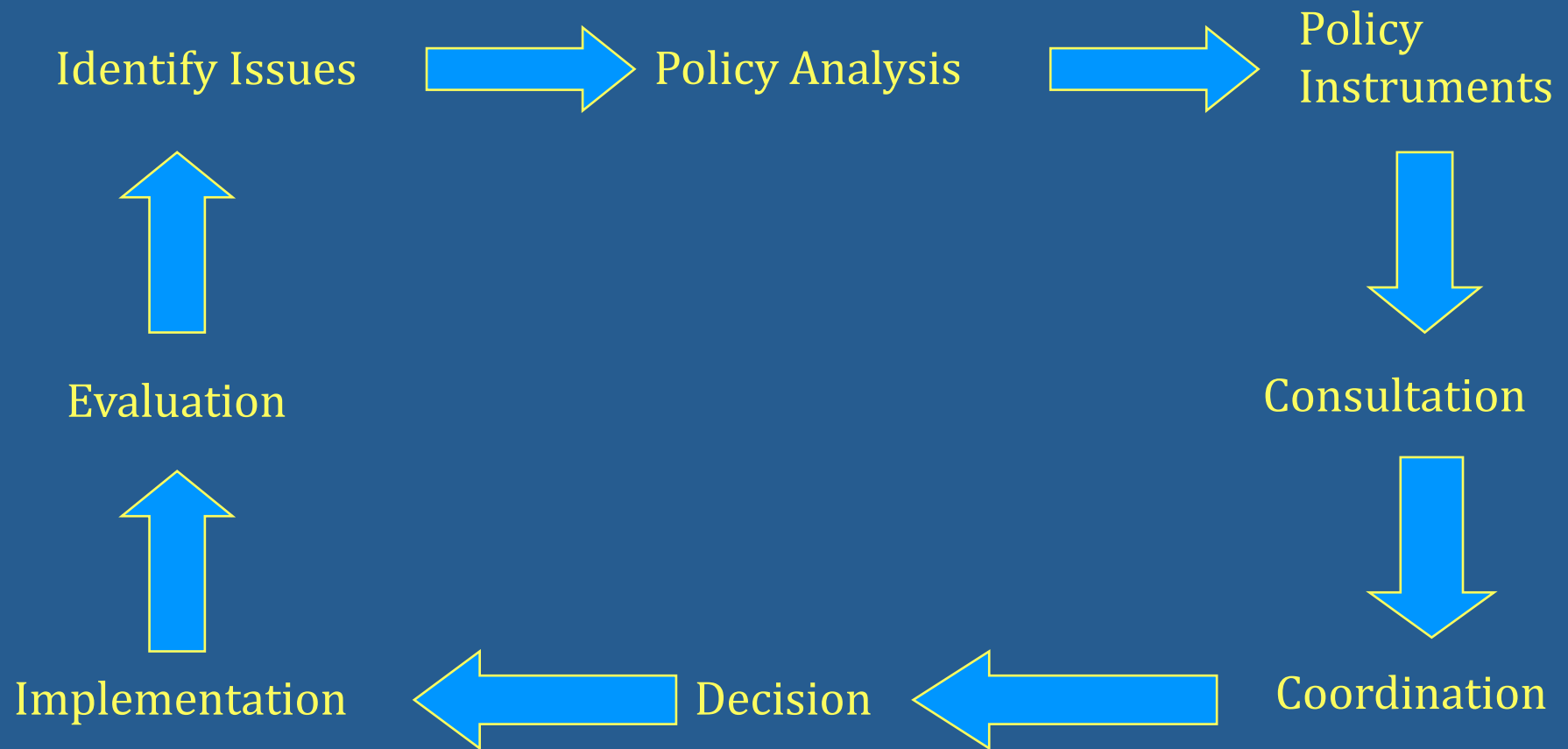
Compare Consequences with Policy Goals/Objectives

Select Alternative

-Consequences closes to Policy Goals/Objectives or Closest to Solving Problem

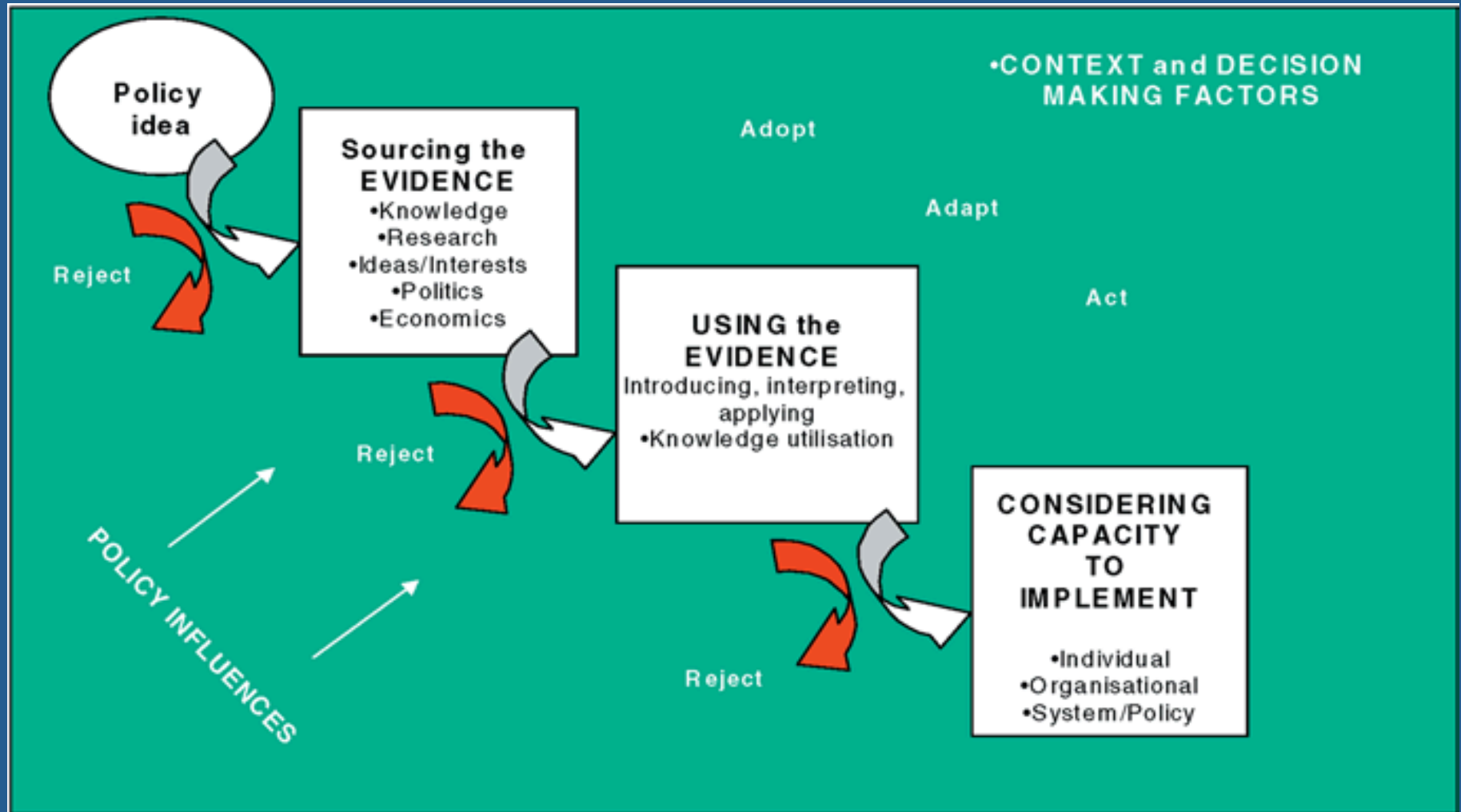
*Adapted from: Nutley and Webb, 25-26.

The Policy Cycle



Source: Huw et al. at 26.

The Evidence-Informed Policy and Practice Pathway



From: Bowen S, Zwi AB at e166 (fig. 1).B

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.”

-A. Kirwan, “The Art of the
Possible” (2001)

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

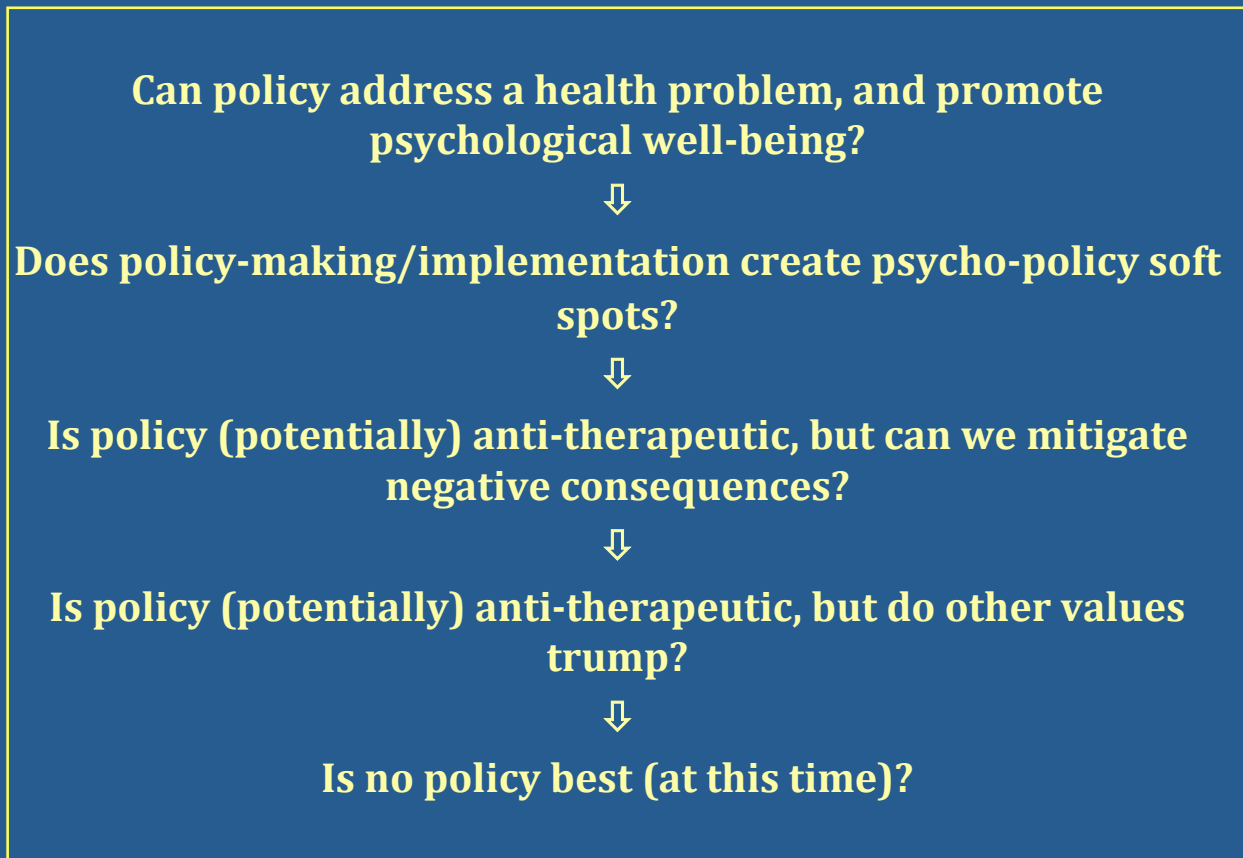
Defining TJ

- 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).

Therapeutic Jurisprudence/Evidence Informed Health Policy Framework [Framing Questions]

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Evidence Use in Health Policy

	Evidence Based Health Policy	Evidence Informed Health Policy	Therapeutic Jurisprudence Framed
Evidence Use	Direct	Enlightening / Interactive	Health-Promoting (Enlight./Interactive)
Evidence Application	Mechanistic	Complex	Complex
Evidence Defined	Hierarchy: Scientific method at top	Hierarchy: Broader base	Take existing evidence and add/weight: Behavioral+Social science; interdisciplinary
Driver of Evidence Use (In Prioritization and Application)	Prioritization: Expert* / Application: Expert	Prioritization: Expert / Application: Participatory**	Prioritization: Participatory / Application: Participatory
Evidence Use Process	Research to Application	Research to Discussion to Potential Application	Research to Discussion to Potential Application
Context based	Limited	Yes	Yes
Preeminent Value	What works (we can determine)	What works (to inform)	What promotes health (to inform)
Descriptive	What works (by top level in hierarchy of evidence)	What works (less certainty, broader base informing)	What promotes therapeutic and mitigates antitherapeutic health consequences
Normative	-Rational policymaking process is possible. -Rational (scientific) process is the best way to make policy	-Rational policymaking process is not possible. -Research evidence is an important tool to spur discussion at policy level and question assumptions.	-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.

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 *Expert: The policymaker and/or researcher; **Participatory: The policymaker, researcher, end “consumer” of evidence (e.g., clinician, individual, target population), and/or community.
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Thank You! -- Amy

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Advocating for Evidence-Informed Behavioral Health Policy

Useful Websites
&
Presentation References

Federal Government

- www.usa.gov (Federal Government's official portal)
- www.house.gov (US House gateway)
- www.senate.gov (US Senate gateway)
- <http://thomas.loc.gov/home/thomas.php> (bill search; committee information)

State Government (Generally)

- <http://www.nga.org/cms/home.html> (governors' association)
- www.nashp.org/ (state policy clearinghouse)
- www.ncsl.org/ (state legislatures' national organization)

Advocacy Resources (Generally)

- <http://www.apha.org/advocacy/tips/> (APHA's advocacy tips)
- <http://www.childwelfare.gov/famcentered/casework/advocation.cfm> (info on advocating for families)
- <http://www.advocacyresource.org.uk/What-is-Advocacy> (advocacy info from UK org; disability focus)
- <http://www.bazelon.org/> (Bazelon Center for Mental Health Law)
- <http://www.cthealthpolicy.org/toolbox/Default.htm> (health advocacy toolbox)

Professional Society Policy & Advocacy Resources

- <http://www.aap.org/en-us/advocacy-and-policy/Pages/Advocacy-and-Policy.aspx> (AAP Advocacy & Policy clearinghouse)
- <http://www.apa.org/ppo/pi/> (APA Public Policy)
- <http://www.naswdc.org/advocacy/default.asp> (NASW Advocacy)
- <http://www.nursingworld.org/gova/> (ANA Gov't Affairs)
- http://www.thenationalcouncil.org/cs/public_policy (National Council for Community Behavioral Healthcare; Policy gateway)
- <http://www.nasmhpd.org/policy.cfm> (NASMHPD (state MH directors) policy site)

Policy & Evidence Use Resources

- <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://www.who.int/evidence/en/> (WHO's Evidence-Informed Policy-Making)
- <http://coalition4evidence.org/wordpress/> (Coalition for Evidence-Based Policy, in DC)
- <http://www.ohsu.edu/xd/research/centers-institutes/evidence-based-policy-center/index.cfm/>
(Center for Evidence-based Policy in OR)

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Homelessness:

- Department of Housing and Urban Development. *The 2011 Point-in-Time Estimates of Homelessness: Supplement to the Annual Homeless Assessment Report*. December 2011. Available at: www.hudhre.info.

Military Mental Health:

- *See series of articles in American Journal of Public Health, Supplement 1, 2012, Vol. 102, No. S1.*
- American Foundation for Suicide Prevention. *Military Personnel and Veteran Suicide Prevention. Fact Sheet & Policy Statement*. Available at: www.afsp.org.