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Jonathan Delman

University of Massachusetts Medical School

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Consumer Quality Initiatives, Inc.

132 Kemble St.
Roxbury, MA 02119
Phone (617) 427-0505
www.cqi-mass.org

A Public Health Framework for the State Mental Health Authority: A Call for Action by Massachusetts Consumers and Family Members

INTRODUCTION

During the Spring of 2006, Consumer Quality Initiatives (CQI) conducted 20 focus groups across the state, 12 with adults with mental illness, 3 with parents of youth with serious emotional disorder, 2 with youth with SED, 1 with family members of adult consumers, and 2 with youth in transition. Supported by a contract with Massachusetts Department of Mental Health (DMH), the goal was to assist DMH in framing the criteria for its upcoming reprocurement.

Our findings reveal a frustration with an approach to health care delivery that focuses primarily on the provision of psychiatric care (egs, medication, therapy, hospitalization). These findings are consistent with those of the 2003 President's New Freedom Commission report¹ which stated that *"Too often, today's system simply manages symptoms and accepts long-term disability."* They are also consistent with the 1999 Surgeon General's report on Mental Health² which called for a mental health system that is based on a public health framework.

FROM FINDINGS TO A CONCEPTUAL FRAMEWORK

We reviewed the focus group reports to identify the most significant themes, which clustered within eight broad categories³. Since we could examine only a limited number of topics in depth, these themes and categories are not meant to be definitive in considering the construction of a mental health system. They do however illustrate the participants' desire for a "system of care," with a broad array of components that would help them and others avoid, deal with, and/or recover from mental distress/illness.

¹ New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care: Final Report*. (2003). Rockville, MD: Department of Health and Human Services Pub. No. SMA-03-3832.

² United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S Public Health Service.

³ The focus group reports are not yet posted on the web. In the mean time, they can be obtained by emailing jdelman@cqi-mass.org.

The eight categories are listed below. In some cases, we provide examples of significant subthemes that fall in the category:

- 1) Access to Care/Help
- 2) Coordination of Services
- 3) Consumer/Family-driven Care: (individualized care, consumer involvement, informed consent, rigid rules, peer-operated services)
- 4) Staff (provider and school) competencies
- 5) Basic Needs: (housing, transportation, dental, medical, eye care)
- 6) Prevention: (crisis planning, respite services, wellness activities, stigma reduction activities, information about mental illness, services and supports)
- 7) Self-determining: (skills training, vocational support, rights, advocacy)
- 8) Social Support and Activities: (peer support, supported social and physical activities).

Based on this list of categories, there is no question that participants wanted good psychiatric care from high quality staff, both consumer-driven and reasonably accessible. However, participants saw psychiatric/psychological care as only a part of the equation for addressing the communities' mental health wellness needs. (While the first four categories have a direct relation to provision of psychiatric services, the second four in general do not.) Thus, participants felt it was critical that their basic needs be met, wanted to be self-determining, and wanted to have social outlets. Finally, there was a major emphasis on prevention, not only of relapse, but also of an initial mental breakdown.

In essence, and without using this terminology, participants embraced the public health model.

THE PUBLIC HEALTH MODEL

The public health model is characterized by a focus on the health of the entire population, the inclusion of preventative care, and the promotion of social supports. According to the Surgeon General's report on Mental Health (1999):

“The public health model is characterized by concern for the health of a population in its entirety and by awareness of the linkage between health and the physical and psychosocial environment. Public health focuses not only on traditional areas of diagnosis, treatment, and etiology, but also on epidemiologic surveillance of the health of the population at large, health promotion, disease prevention, and access to and evaluation of services (Last & Wallace, 1992)....”

Implicit in this definition is the concept of enhancing the **quality of life** of individuals and the public at large. The mission of public health, as defined by the Institute of Medicine (IOM), is to assure *“the conditions for people to be healthy,”* as pursued by governmental agencies, public and private health care organizations, academic institutions, and community-based organizations.

A public health framework is community and culturally driven. Again from the Surgeon General's report:

“In the words of a distinguished leader in the field of mental health prevention, ‘... built into any definition of wellness . . . are overt and covert expressions of values. Because values differ across cultures as well as among subgroups (and indeed individuals) within a culture, the ideal of a uniformly acceptable definition of the constructs is illusory’ (Cowen, 1994). In other words, what it means to be mentally healthy is subject to many different interpretations that are rooted in value judgments that may vary across cultures. The challenge of defining mental health has stalled the development of programs to foster mental health (Secker, 1998), although strides have been made with wellness programs for older people.”

The American Public Health Association (APHA) has developed 10 performance standards for states to be judged on their public health approach⁴:

1. Inform, educate, and empower people about health issues.
2. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
3. Assure a competent public health and personal healthcare workforce.
4. Enforce laws and regulations that protect health and ensure safety.
5. Develop policies and plans that support individual and community health efforts.
6. Diagnose and investigate health problems and health hazards in the community.
7. Mobilize community partnerships to identify and solve health problems.
8. Monitor health status to identify community health problems.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

In addition, the Center for Disease Control (CDC) is in the process of developing a logic-model for a public mental health framework⁵.

SOME CRUCIAL ASPECTS OF PUBLIC MENTAL HEALTH

In the sections below, we discuss some of the key aspects of mental health services and supports that exist within a public health framework. These are key areas that we've noted based on consumer/family views, academic and governmental reports, and research reports. We realize that these are only some of the categories.

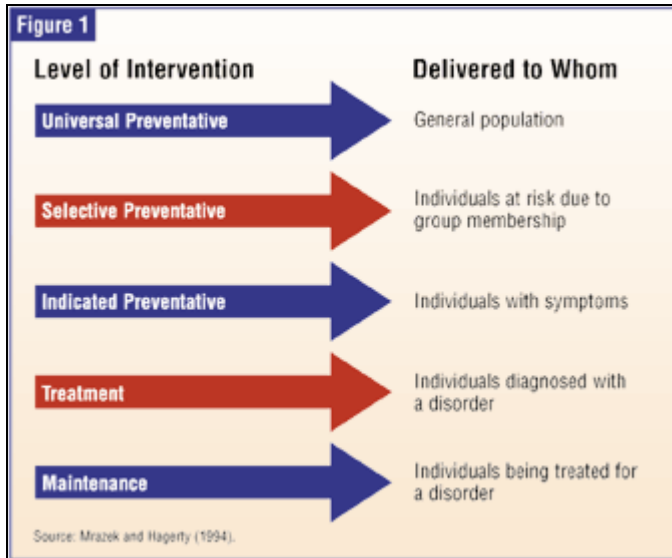
Multiple levels of intervention

The 1994 Institute of Medicine report *Reducing Risks for Mental Disorders* (Mrazek and

⁴ <http://www.apha.org/ppp/hipmain/statefinal.pdf>

⁵ Lando J, Williams SM, Williams B, Sturgis S. A logic model for the integration of mental health into chronic disease prevention and health promotion. *Prev Chronic Dis* 2006 Apr. Available from: URL: http://www.cdc.gov/pcd/issues/2006/apr/05_0215.htm.

Haggerty, 1994) defined five levels of public mental health (Figure 1). Traditional psychiatric systems usually have two levels: inpatient and outpatient. If an individual is not a "patient," then there is no place for him/her in the system. The public health model adds three levels: universal preventative, selective preventative, and indicated preventative.



(In applying this framework to mental health I would change the Maintenance stage to Recovery/Rehabilitation. JD)

Universal preventative interventions are delivered to an entire population. For example, an anti-stigma campaign (eg., consumer/family discussions with religious institutions) would reduce institutional fear and discrimination, and the resultant loss of social status often experienced by people with mental illness. Another example: DMH could effectively publicize community services that offer treatment, support, or advocacy, such as support groups, legal aid, and local counselors (eg., social workers, psychologists, and psychiatrists).

Selective interventions are offered to those adults/children who are at a high risk of developing mental health problems due to group characteristics. An example is DMH's setting up mental health assistance centers in places where homeless people congregate. Jail diversion programs, such as the Framingham model, offer mental health assistance to people with mental illness who are at risk for jail.

Indicated interventions are offered to adults/children who have an individual risk of developing a disorder and are manifesting symptoms at low but noticeable levels. Respite is an excellent example of this. For many consumers, it's a caring place to spend a few nights with peers, and with access to a psychiatrist as they need one, but without being locked up in an expensive hospital unit. For parents of youth with a serious emotional disorder, it's having as little as a few hours without their children in order to regroup. Another example is assisting a consumer with difficult vocational or housing situations (eg, reasonable accommodation requests).

Health promotion, Disease Prevention

Psychiatry has often focused on the treatment of mental illness symptoms, often to the exclusion of the patient's physical health status. For example, psychiatrists may prescribe medications that alleviate psychiatric symptoms, but contribute to short-term physical distress and/or long term chronic physical illness.

In a recent article, Hutchinson et al discuss the importance of the mental health system's embracing "health promotions models relevant to people with psychiatric disabilities."⁶ They note that, in "contrast to the field of mental health, the field of public health has long embraced a holistic, multidimensional, future-oriented view of health as vital not only to individuals but also to groups and communities."

Their article reports on numerous examples of health promoting activities and policies that will improve wellness, including nurse practitioners stationed at mental health centers, more opportunities for self-directed care (where a consumer might spend money on a health club), and educating consumers on "positive self-care behaviors and self-promotion strategies" at their programs⁷.

Disease prevention also requires a more holistic view of the person. While people with schizophrenia already have very high rates of type 2 diabetes, 50% to 75% of them are being prescribed second generation antipsychotic medications (SGAs), which increase the risk of both obesity and acquiring or exacerbating diabetes. Although physicians could screen for diabetes risk (eg., family history), consider alternative medications, and/or advise on wellness activities (eg., exercise, diet), studies show that they rarely do. One reason is that physicians are loath to change practice patterns. Another reason is that clinical guidelines (which have been endorsed by respected medical bodies) are usually disseminated through written materials, which rarely influence physician practice.

A disease prevention strategy would have the guidelines summarized in a visually attractive manner, endorsed by local opinion leaders, and disseminated through interactive educational seminars and meetings devoted exclusively to the guidelines. One such method of dissemination is called "academic detailing," pre-arranged face-to-face discussions between "opinion leaders" and a clinician in the latter's office, with the aim of persuading the practitioner to change behavior through information, evidence, and financial supports.

Competent Workforce

There has been a significant amount of writing recently on mental health workforce issues, in particular by the Annapolis coalition (<http://www.annapoliscoalition.org/>). We

⁶ Dori S. Hutchinson , Cheryl Gagne , Alexandra Bowers , Zlatka Russinova , Gary S. Skrinar , William A. Anthony. "A framework for health promotion services for people with psychiatric disabilities." *Psychiatric Rehabilitation Journal*, Volume 29, Number 4, Spring 2006, pgs. 241 – 250.

⁷ In addition, the article mentions the use of medical identification cards (which identify their care choices and reduce tendency to treat all sickness as psychiatric symptoms), addressing polypharmacy, physical fitness implementation guidelines.

are in agreement with coalition leaders that much of health care quality is related to the provider personnel competencies.

We wish to emphasize, primarily based on our observations of PACT teams, that if we are to transform systems, we need both job descriptions that contain the truly essential job competencies, and CEOs, supervisors and team leaders who are flexible, good teachers/coaches, and take their accountability role seriously. The job description should make clear the essential functions and behaviors upon which the job holder will be guided and assessed.

Necessary staff qualities are based in part on training and education, but more so on personality and overall experience. Unfortunately, job descriptions we've seen tend to either leave out or deemphasize the latter. Thus, we are attaching a job description we developed for a PACT team leader that emphasizes the personal qualities and experience necessary for that job. We would recommend job descriptions include "critical skills and attributes," such as the ones we drafted for PACT team leaders:

- *Able to offer ongoing encouragement to clients and staff in the client-centered treatment planning process.*
- *Excellent advocacy and communication skills.*
- *Courage and creativity in group facilitation and team building.*
- *Values the experience of all staff and clients and takes appropriate responsibility for her/his own behavior.*
- *Optimistic, confidant, curious, compassionate, has stamina.*
- *Safe and approachable under pressure.*
- *Respectful of other people's thoughts, behaviors, and interactions.*

Multicultural

The 1999 Surgeon General's report on Mental Health was followed up by a supplemental report on "Culture, Race and Ethnicity."⁸ According to that report, a public health model has "*culturally competent*" services, which incorporate understanding of racial and ethnic groups, their histories, traditions, beliefs, and value systems." The report notes that consumers may desire treatment from someone of their own race/ethnicity, so that more training and opportunities for people of variety of cultural and ethnic background is important.

The report further notes that to achieve culturally competent care, programming should include:

1. "language access for persons with limited English proficiency;
2. services provided in a manner that is congruent, rather than conflicting, with cultural norms; and
3. the capacity of the provider to convey understanding and respect for the client's worldview and experiences."

⁸ <http://www.surgeongeneral.gov/library/mentalhealth/cre/>

Our focus group with Cambodian-American consumers provided CQI with a window into their needs and desires, but only a window. Thus, we recommend further information gathering on the needs of people of particular racial-ethnic communities. The Surgeon General's report notes that it is important to have representative (of the racial/ethnic group) consumers involved in designing the studies. Focus groups with different racial/ethnic groups are very effective here.

In addition, we have identified several research centers (Cambridge Health Alliance Center for Multicultural Mental Health Research⁹ and the Center for Multicultural Mental Health¹⁰ (associated with Boston University)) and projects that should be adding to the knowledge base of Massachusetts policy makers.

Wraparound approach

Our focus group participants emphasized that they found the current system disorganized and sometimes disorienting. This is particularly true for the youth system, where services may be delivered by schools, juvenile justice, child welfare, and public and private health and mental health practitioners. Parents often do not feel that their family is the focus of attention.

The wraparound approach has been described as a response to the coordination and access issues (emphasis added):

Wraparound efforts occur in the community, where services are individualized to meet children's and families' needs. Parents are included in every stage of the process and the approach must be culturally sensitive to the unique racial, ethnic, geographical and social makeup of children and their families. The process of wraparound is designed and implemented on an interagency basis using an interdisciplinary approach in which providers have access to flexible, noncategorical funding. Wraparound services must be delivered on an unconditional basis where the nature of support changes to meet changes in families and their situations. Finally, wraparound involves the measurement of child and family outcomes to determine the effectiveness of services that ensure that appropriate populations are being served.¹¹

This approach is consistent with a public health model that aims to keep a family intact, while reducing the amount of care that takes place away from the family. Massachusetts has wraparound services, but we would recommend that it become an overarching philosophy of how youth dollars are spent.

Recovery-oriented

The World Health Organization has stated that "health" is "a state of complete physical, mental, and social well being and not merely the absence of disease."¹² This view

⁹ <http://www.multiculturalmentalhealth.org/investigators.asp>

¹⁰ <http://www.cmmh-cmtp.com/index.php>

¹¹ VanDenBerg, J.E., & Grealish, E.M. (1996). Individualized services and supports through the wraparound process: Philosophy and procedures. *Journal of Child and Family Studies*, 5(1), 7-22.

¹² <http://www.who.int/about/en/>.

emphasizes the target outcome for psychiatric patients should not simply be symptom reduction, but should instead be increased **Quality of Life**. The consumer community at large has had this focus for many years. National policy makers have recently accepted this point of view, and now have joined consumers in championing the development of “recovery-oriented” systems.” Recovery oriented systems have been discussed by many groups, from consumer researchers¹³ to academics¹⁴ to community psychiatrists¹⁵. CQI’s focus groups identified the following key elements of recovery-oriented system:

- 1) Prevention through education and outreach
- 2) Consumer-centered, strength-based care planning
- 3) Significant involvement of consumer in treatment planning
- 4) Respect
- 5) Self-determination
- 6) Qualified staff
- 7) Peer/social support
- 8) Advocacy assistance

The American Association of Community Psychiatrists took a different but worthy approach, with their key elements being:

- 1) Hope and faith
- 2) Personal responsibility and productivity
- 3) Self-management and autonomy
- 4) Peer support and community life
- 5) Restoration and personal growth
- 6) Dignity and self-respect
- 7) Tolerance and forgiveness
- 8) Acceptance and self awareness
- 9) Adaptability and capacity to change

Integrating these approaches would provide a worthy framework for service delivery and supports.

Building the Science base

The Surgeon General’s report emphasizes the need for research that drives policy and practices. At one end of the spectrum, the report recommends genetic research as a way to create new treatment options and to battle stigma. At the other end of the spectrum, the report emphasizes the “*urgent need for research evidence that supports strategies for mental health promotion and illness prevention.*”

In either case, the public health model embraces a Community Based Participatory Action Research (CBPR) approach. CBPR is a “collaborative process that equitably

¹³ http://www.nasmhpd.org/spec_e-report_fall04measures.cfm

¹⁴ <http://www.dpw.state.pa.us/Resources/Documents/Pdf/AnnualReports/CountyPlanFY0708/SectionIIIa.pdf>

¹⁵ <http://www.wpic.pitt.edu/AACP/finds/ROSGuidelines.pdf>

involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities”¹⁶. CBPR also addresses the Report’s concern about the length of time it takes to introduce research findings into practice and policy settings. If consumers and family members are involved from the beginning, they are in a better position to introduce findings to their communities.

The Boston University School of Public Health and CQI are co-investigators on a NIMH funded and DMH supported CBPR grant project- the Boston Community Academic Mental Health Partnership (B-CAMHP). Working also with M-POWER, PAL and NAMI, one of the goals is to build capacity for the B-CAMHP to identify research issues that are most important to the community, with the goal of impacting policy and practice. We expect that B-CAMHP will serve as a model for conducting relevant high impact mental health research.

Empowerment

Public health embraces the notion of empowerment. Critical elements are consumer operated services/activities and significant consumer involvement in designing, implementing and evaluating services and systems. Also important are significant consumer involvement in their treatment and service planning and peer support. Consumers can best learn about managing their condition and preventing relapses if they take an active role in their care. Peer services and activities offer “on the job” education and skills training.

A NEW WAY

Moving from where we are now to where we want to be will require a paradigm shift. First, applying a public health approach to mental health service delivery presents a number of challenges to mental health care professionals. Several philosophical shifts are required to build an efficient public mental health care system, including a concern with the total population of a community, a focus on prevention, the systematic utilization of assessments, and a commitment to establishing partnerships with families as well as with other service providers. Collaboration and engagement will require that no one profession be titled THE “expert,” but instead all considered “leaders.”

There is also the issue of provider service codes and billing. A major issue is what is allowable under the Medicaid program.

¹⁶ Minkler, M., Blackwell, A. G., Thompson, M. & Tamir, H. (2003, August). Community-based Participatory Action Research: Implications for Public Health Funding. *Am J of Public Health*, 93(8), 1210-1213.

The following are some of the necessary building blocks for DMH to make that shift to an authentic public health model.

- Significant consumer/family involvement in designing, implementing, evaluating and researching public mental health services. We have found the Community-based Participatory Action Research framework very useful here.
- Quality of life is the focus. This includes services funded by MassHealth.
- Partnering and Teamwork need to be valued. This is especially true within DMH and also with other key state agencies, such as DSS, DYS, DOC, DPH, etc.
- Accountability. This includes providing people/staff with clear responsibilities and providing very good supervision.
- Data needs to be useful and useable. (See J. Delman, Crossing the Mental Health Quality Chasm in Massachusetts, <http://www.cqi-mass.org/quality-chasm.pdf>)

In conclusion, DMH has several broad challenges. As the public mental health authority, it needs to work with the community and other governmental agencies to meet the basic and preventative needs of consumers. Thus, DMH needs to work in a collaborative fashion, particularly with consumers and family members, whose focus is to change the status quo. In addition, DMH must change from within (including providers it oversees), building a culture that fosters a strengths-based approach, significant consumer involvement in their care, and attention to the individualized needs of each consumer.