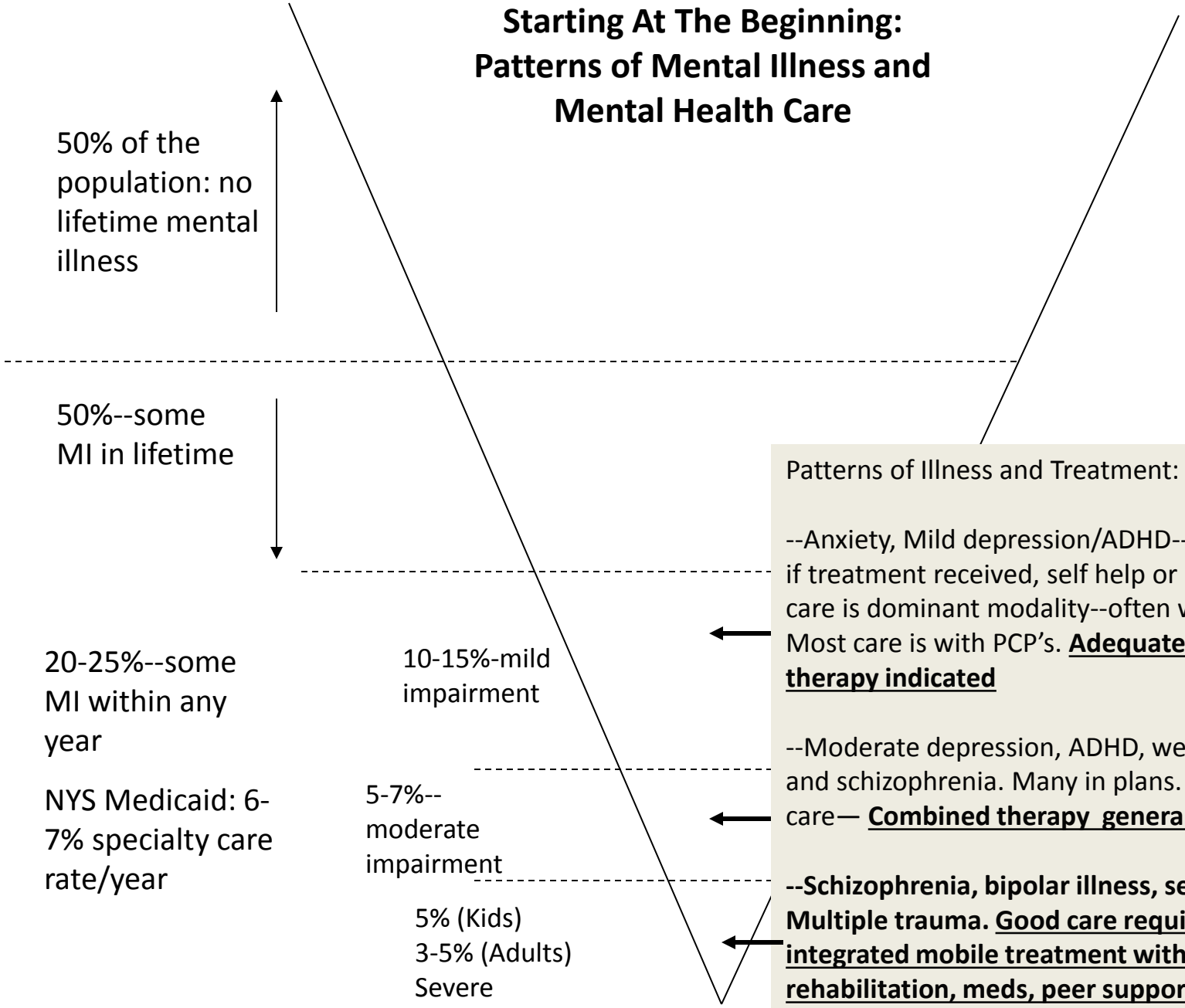
Restructuring Behavioral Healthcare:

The Basics: What's Known About Adult Mental Illness and Good Care

Mike Hogan, Ph.D.
Commissioner, OMH
June 2011

Starting At The Beginning: Patterns of Mental Illness and Mental Health Care



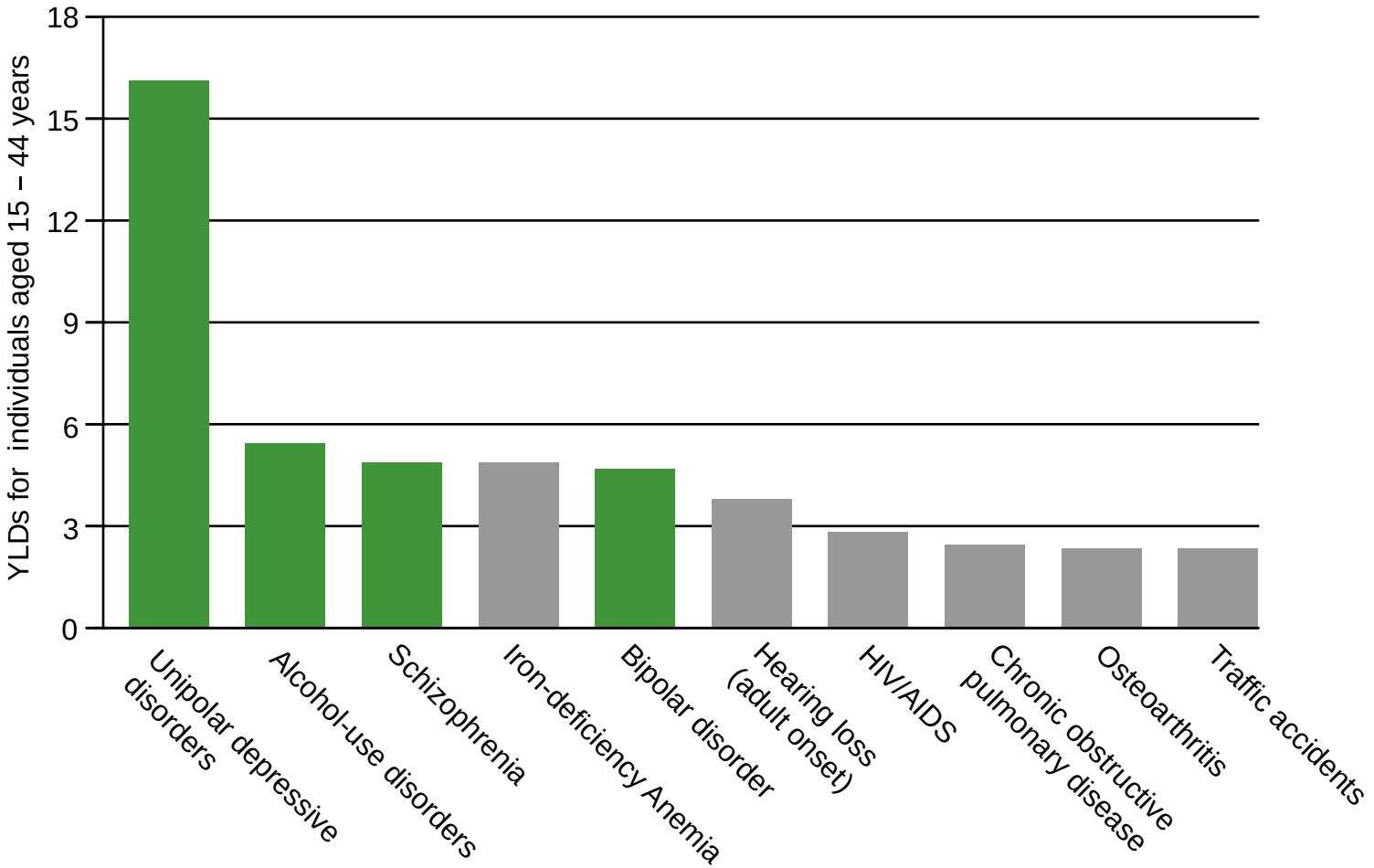
Patterns of Illness and Treatment:

--Anxiety, Mild depression/ADHD-----Most get no care; if treatment received, self help or meds-only in primary care is dominant modality--often with moderate relief. Most care is with PCP's. **<u>Adequate "dose" of (brief) therapy indicated</u>**

--Moderate depression, ADHD, well controlled bipolar and schizophrenia. Many in plans. About half get any care— **<u>Combined therapy generally indicated.</u>**

--Schizophrenia, bipolar illness, serious PTSD, OCD, Multiple trauma. <u>Good care requires continuous integrated mobile treatment with engagement and rehabilitation, meds, peer support</u>. Most treatment in public system.

Neuropsychiatric diseases are among the top 10 causes of disability worldwide (ages 15-44)



Depression:

The Most Common Complication of Childbearing

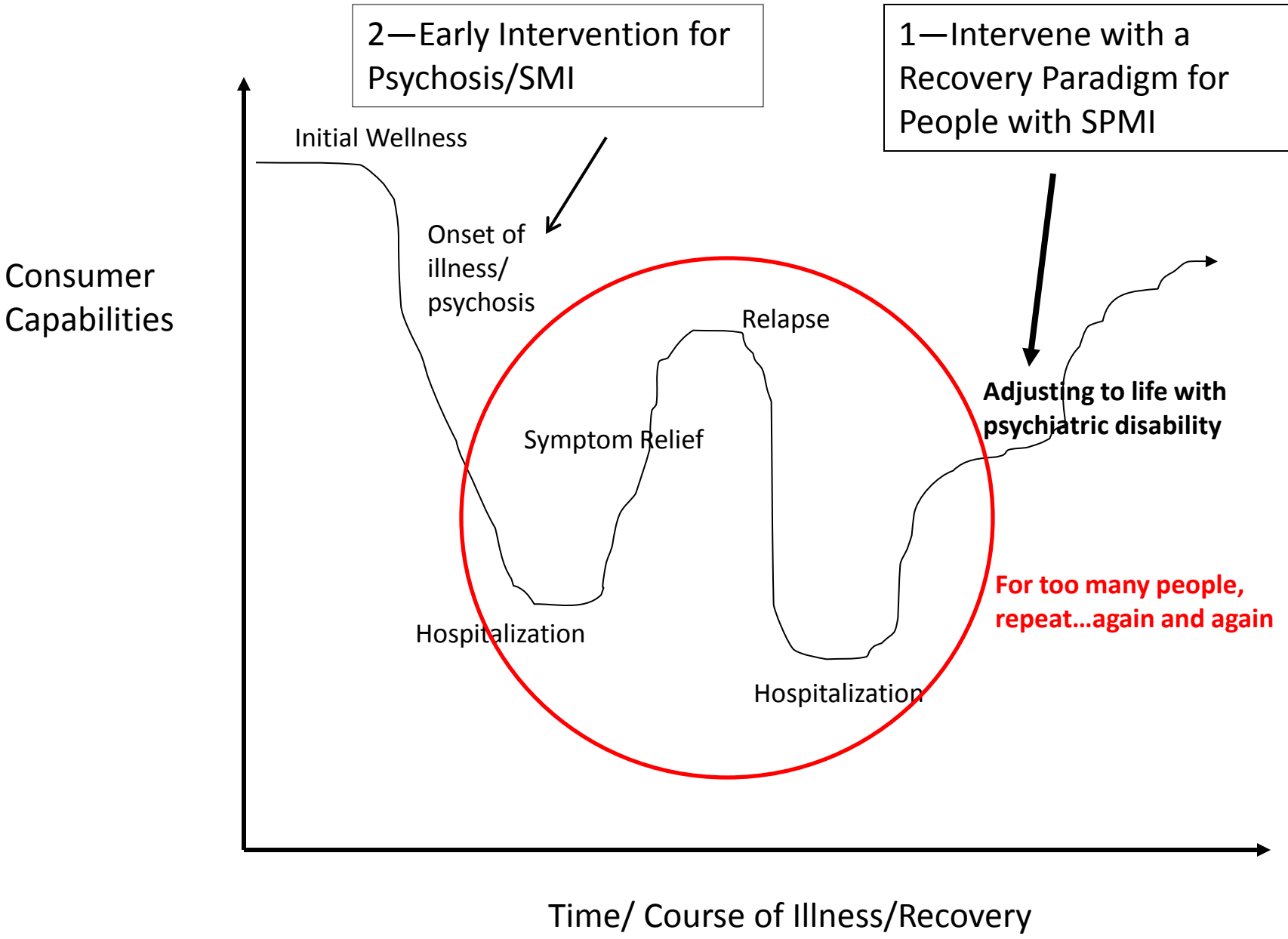
- Incidence: ~10-15% of women develop depressive episodes (7-10% MDD) during pregnancy and ~ 15% in the first 3 months postpartum[1]
  - 22% in the first year post-partum
  - Rates greater in TANF population
- A *majority* of children of depressed moms have mental health problems. 50% resolved if parent's depression is treated
- Up to 2/3s of episodes are not recognized by a provider and less than 1/3 receive treatment[2,3]

1.Gaynes BN et al.2005 Agency for Healthcare Research and Quality
2.Kelly RH et al 2001 Am J Psychiatry 158:213-219
3.Spitzer RL et al 2000;183:759-769

The Basics/Essentials of "Primary Mental Health Care" For Adults

- Reach all individuals with mental illness/impairment
  - Kaiser: 10% in employed population use care/quarter
  - Prevalence of depression in TANF population: 30-50%
- Collaborative Care model at all group clinic sites
  - Universal screening for mental illness (PHQ 2/9)
  - Mental health clinician available on-site
    - Warm Hand-offs
    - Coaching/care management
  - Stepped/measured care (embedded in EMR)
- Structured/manualized approaches to (usually brief) psychotherapy e.g. CBT/DBT/IPT

The Course of Serious Mental Illness: What Must Be Done and Can Be Done



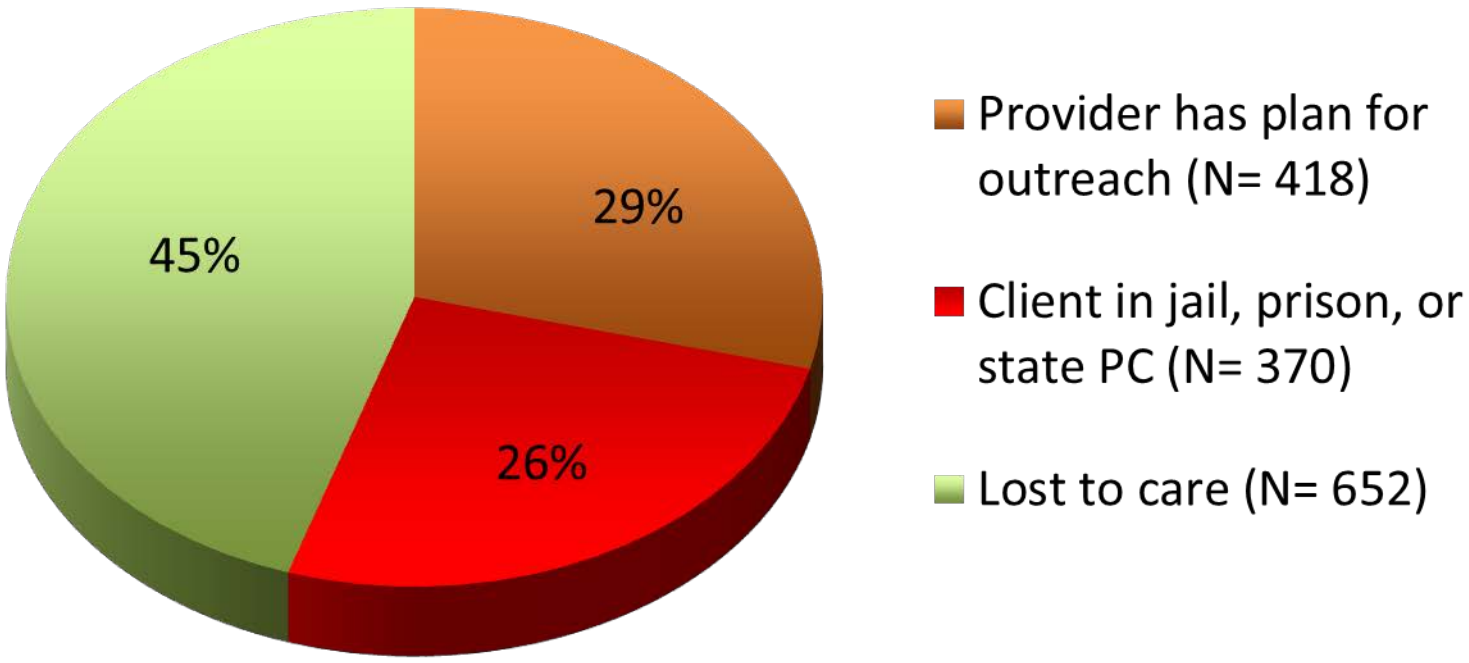
What Must be Done: Recovery Focused Care for People with SPMI

- Team Based, Continuous and Titered
- Integrated:
  - A single master care plan: integrated HIT, care management
  - Medication treatment usually core to symptom management
  - Relevant psychosocial support: wellness management
  - Substance abuse treatment if indicated
  - Assured:
    - Stable Housing
    - Benefits/benefits counseling
    - Employment/education
    - Medical care

Deficits to Address in Current Care

- Most care is discontinuous
- Most care is not integrated
  - Mental health care itself fragmented: meds, therapies, rehabilitation, addiction treatment may be in different locations by different providers, with HIT that does not communicate
  - Education, employment, housing supports available to only a minority
  - Medical care is casual, not connected
- Orientation to symptom management not wellness management (changing significantly)
- Potential of Health/Mental Health Homes

A Symptom of Discontinuous Care: High Risk People are Commonly are Lost to Care (Brooklyn Data)



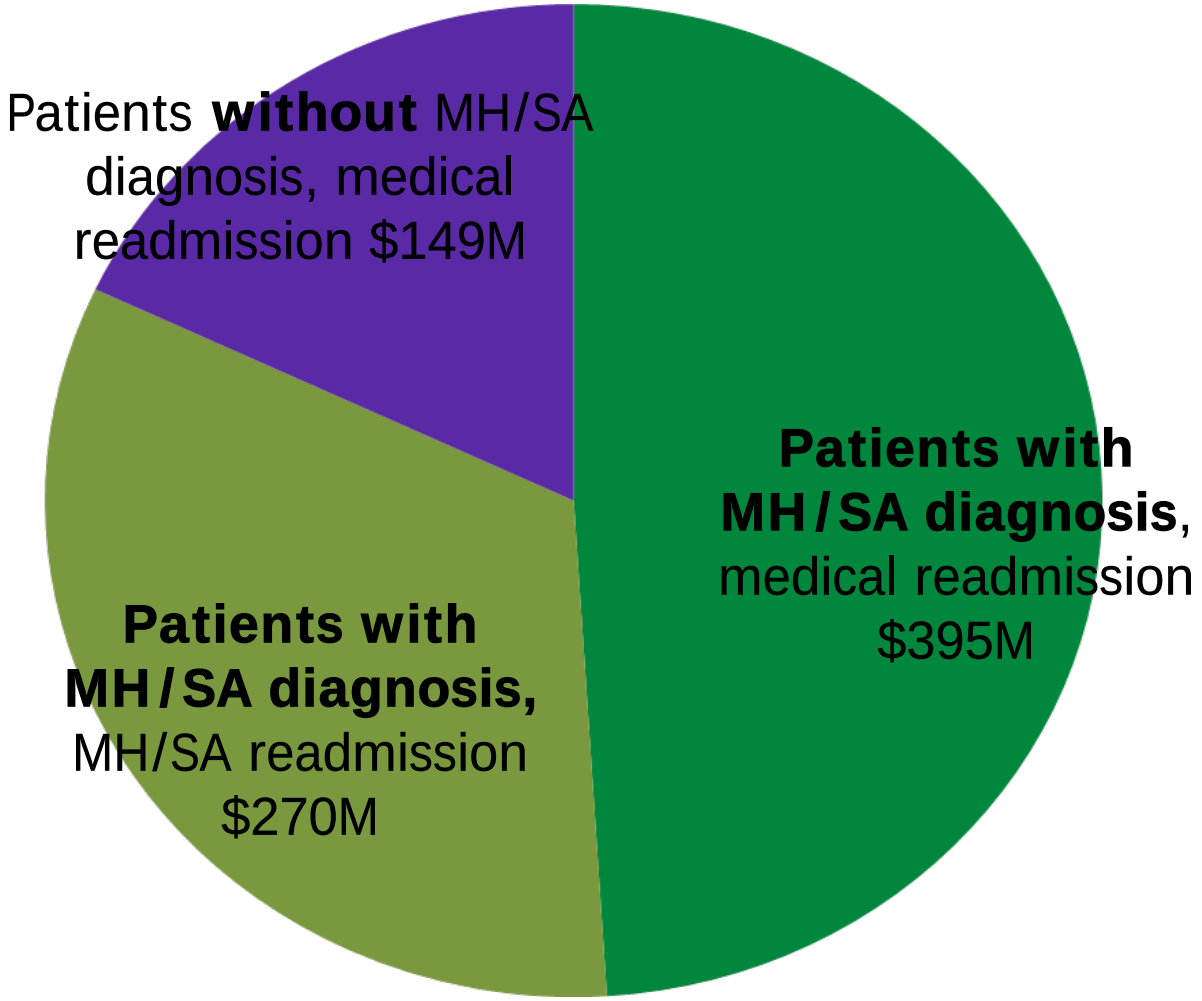
Care for People with SPMI: Special Considerations

- People with serious mental illness usually experience intermittent mental wellness and illness; challenges of disordered thinking and behaviors can occur when people most need care.
- These challenges can result in difficulty following through with critical tasks such as taking medication and attending medical appointments.
  - HIT informed care management is essential
  - Face-to-face case managers needed to coach, facilitate care
  - Role for peers
- People with SMI at highest risk for suicide: monitoring and treatment a core component of care, especially following ED/inpatient

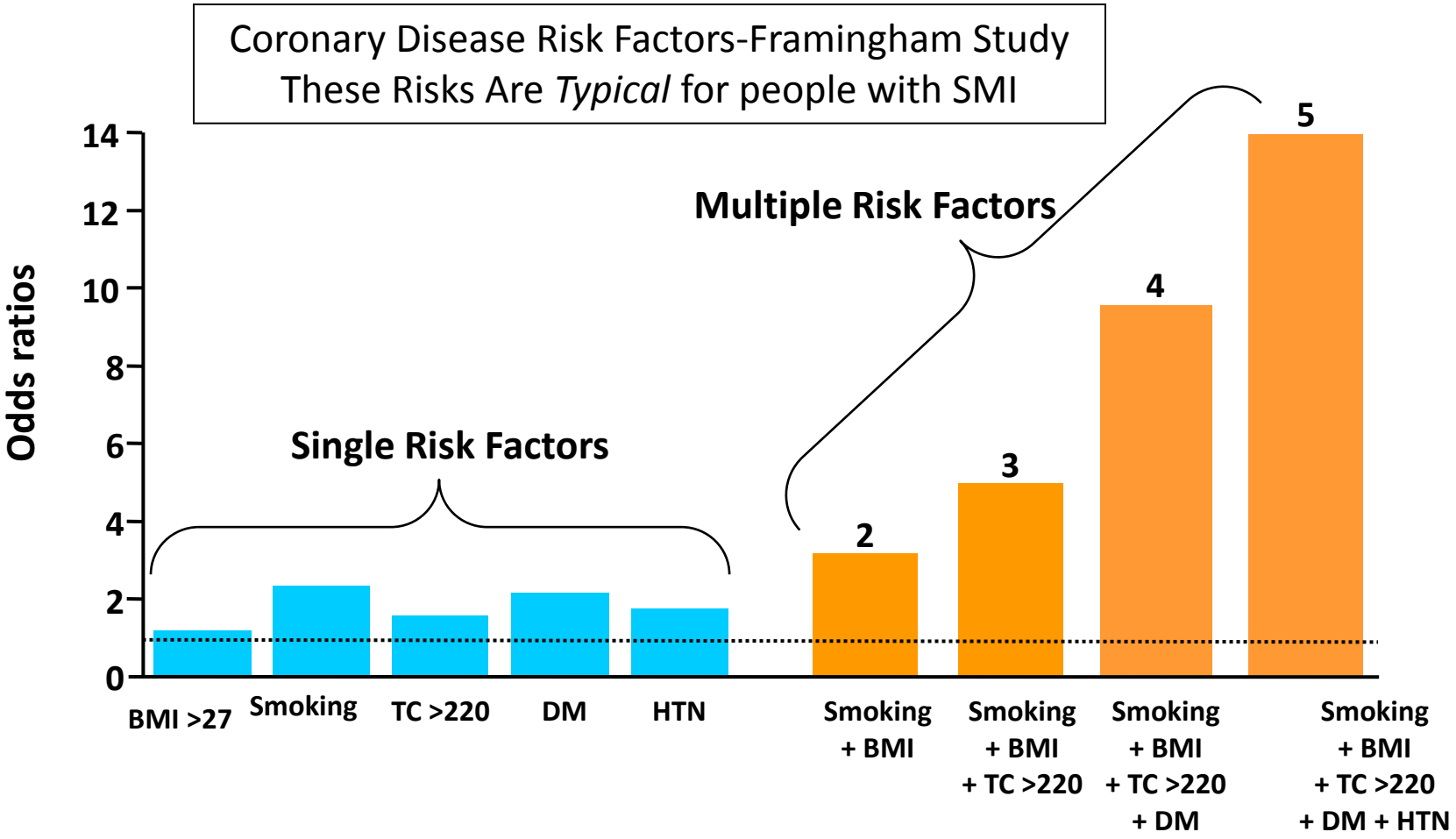
The Need for Integrated Care:

Potentially Preventable Readmissions (PPR's)

NYS Costs $814M (2007)



The Need for Integrating Primary Care in SMI Treatment



Despite Poor Health, People with SMI Have Reduced Utilization of Medical Services

- Fewer routine preventive services (Druss 2002)
- Worse diabetes care (Desai 2002, Frayne 2006)
- Lower rates of cardiovascular procedures (Druss 2000)
- The barriers are obvious:
  - Low presence of competent medical care and inattention to wellness in ambulatory specialty behavioral health settings
  - Poor access for people with SMI to mainstream health settings; inattentive care in these settings
    - Convenience e.g. transportation barriers
    - Psycho-social and cultural barriers, stigma

Evidence Based/Informed Modalities Essential to Care for People with SPMI

- Treatment that facilitates self management (WSM)
- Integrated attention to mental illness/ substance use disorders e.g. IDDT
- Assertive Community Treatment (for people with SPMI who are unstable, can't/don't self monitor, won't come in for care)
- Critical Time Intervention (CTI) as a tool to titrate care
- Access to non-medical/Medicaid supports
  - Tailored Supported Employment (IPS)
  - Supported Housing/Housing First for people who are homeless
  - Benefit counseling
  - Accomodations in Criminal Justice (diversion, reentry)
- *All EBP's for people with SPMI are Team Interventions*

The Next Frontier In Care:
Early, Continuous, Recovery Oriented Care

- Earlier (“First Episode”) treatment produces better outcomes:
  - Better response to antipsychotic medications
  - Better outcomes for social and vocational rehabilitation
  - Greater impact for psychological therapies that target residual symptoms, behavioral adaptation, and quality of life
- The norm for entry into care after psychotic symptoms is 2 years

First Episode Team

- Multi-disciplinary (core members are psychiatrist, “recovery specialist”)
- Multi-element (e.g., psychiatric care and medications, supported education/ employment, skills and substance abuse treatment, family support, suicide prevention)
- Community-based
- Individualized approach
- Developmentally flexible