A **Pathways** Policy Brief

Behavioral Health—Prevention, Early Identification, and Intervention

This policy brief is one of a series from APHSA addressing specific policies and recommendations that support the four outcome impact areas identified under our members' *Pathways* initiative. This brief supports the outcome of **Healthier Families, Adults, and Communities.**

This brief is the first in a series of planned papers covering behavioral health. **Behavioral health,** defined here as including both mental health and substance use, encompasses a continuum of prevention, intervention, treatment, and recovery support services. Since human services is a component of the recovery-oriented systems of care,[1] these briefs will touch on several aspects of behavioral health, including tools and technology; financing; evidence-informed and evidence-based practice; care coordination; access to quality care; supportive housing; employment and supported employment; and workforce capacity.

Introduction

Pathways calls for an integrated, holistic service delivery system addressing prevention, early intervention, bridge supports, capacity building and sustainable strategies. State and local health and human service agencies are achieving better health outcomes through flexible funding, a prepared workforce, modern technology, accountability, and effective engagement of those we serve, blended with simultaneous efforts to enhance organizational effectiveness and leverage the resources of private and community partners.

Prevention, early identification, and intervention of behavioral health strategies are integral components of a holistic health and human service delivery system serving individuals across the lifespan. Early, adverse experiences of children and youth have serious impacts on social, emotional, physical, mental, and behavioral health development and on their later health and quality of life as adults. Other factors, including access, provider shortages, training and development, technological infrastructure, and resource sustainability also affect the provision of preventive behavioral health care for individuals, families, and communities.

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The American Public Human Services Association is a bipartisan, nonprofit membership organization representing state and local human service agencies through their top-level leadership. APHSA's mission is to pursue excellence in health and human services by supporting state and local agencies, informing policymakers, and working with our partners to drive innovative, integrated, and efficient solutions in policy and practice.

Incidence and Risk Factors

According to the U.S. Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) in 2012, one in five adults was living with a mental health condition in the past year.[2] Additionally, and in 2010 and 2008, according to HHS' Centers for Disease Control and Prevention, one in five children had a mental health disorder,[3] and approximately 14 to 20 percent of the nation's elderly population had one or more mental health disorders.[4] The National Institute of Mental Health reports that half of all lifetime cases of mental, emotional, or behavioral disorders were first diagnosed by age 14 and three-fourths were diagnosed by age 24.[5] In addition, the National Council of Community Behavioral Health Care has shown that 50 percent of children and youth in the child welfare system have mental health problems and 67 to 70 percent of youth in the juvenile justice system have a diagnosable mental health disorder.[6] SAMHSA's National Survey on Drug Use and Health (NSDUH) also reported that in 2011, an estimated 22.6 million Americans age 12 and older were using illicit drugs, including 2.5 million youths between the ages of 12–17.[7]

While research has shown that there is a genetic and biological component to both the onset and diagnosis of substance use and mental health-related conditions, there is also a host of other factors that contributes to behavioral health, including physical and social environments, economic stability, education, individual behavior, physical health, and access to physical and behavioral health services.[8] Low income also affects cognitive, emotional, behavioral, and physical development through its frequent association with substandard housing, frequent moves and changes of school, limited access to quality health care, unsafe and stressful environments, and lack of enough food or adequate nutritional intake.[9]

Findings from the Adverse Childhood Experience Survey (ACES)[10] have also shown that certain adverse experiences by children and youth have direct correlations to the well-being of children and families and disease in later adulthood. These adverse experiences include abuse, neglect, and household dysfunction.

The increased use of prevention, early identification, and intervention services to address these behavioral health deficits can mitigate the risk factors correlated with substance use and mental health distress and disorders while strengthening factors that support the development of well-being of children, individuals, and families.

Challenges

Efforts to address prevention, early identification, and interventions targeting the multi-dimensional facets of an individual's development at all stages of life are part of the paradigm shift needed in how we as a nation provide care. This shift requires action at all levels across the public and private sectors. This shift is already under way, and the individual and societal benefits of early prevention pioneers continue to become evident. However, there are glaring challenges that all systems in the public and private sectors must begin to focus on, including expanding access through targeted delivery design; enhancing training of public- and private-sector professionals in behavioral health; utilizing modern technology to assist in the coordination and integration of multi-agency and -sector care; and enabling sustainable resources to continue investments in prevention, early identification, and interventions across the lifespan.

Access

For many infants, school-aged children, adolescents, and youth, child-care facilities or schools are typically the first access points to initial screenings, receipt of service, or at least referrals for follow-up behavioral health care. For many at-risk children and youth, the juvenile justice system or the child welfare system may

also be a first access point for prevention and early identification of behavioral health concerns. It is imperative that these services be located in schools, the places that children and youth frequent most.

For example, several states utilize School-Based Health Center (SBHC) models, which are community-based health centers located within or near schools serving underserved communities funded through private/public partnerships, to provide physical and behavioral health care to youth. Over the past decade, primarily due to the economic recession and the increased numbers of those without health insurance, states have increased their utilization of SBHCs in mostly urban but also rural settings. However, the demand is still high and the primary function of SBHCs is the provision of primary care services. Not all states utilize the models that incorporate behavioral health professionals.[11]

While the intersection of behavioral health and primary care is receiving considerable attention, we must also keep in mind the need for bi-directional care coordination between mental health and substance use providers. In 2008–2009, approximately 8.9 million adults had co-occurring disorders (both a mental health disorder and a substance use disorder), but only 7.4 percent of that group receive treatment for both conditions, and 55.8 percent receive no treatment at all.[12] For many adults living with one or more co-occurring conditions, their primary access points to care may be through a myriad of places: community-based mental health and/or substance use provider, emergency rooms, or judicial systems, among others. For the most effective intervention, screenings and timely, subsequent referrals must be conducted from a system with entrance through any door.

Provider Shortages and Training

There are not enough behavioral health professionals or primary care professionals trained to identify behavioral health concerns of underinsured or uninsured individuals receiving publicly funded care at community-based health centers. This issue is prevalent in both rural and urban areas and across the lifespan.

Professionals working within SBHCs, Federally Qualified Health Centers (FQHCs), Rural Health Centers, and community-based social service organizations, as well as other public and private health and human service professionals, must be equipped with the training and tools to engage in positive youth development and adult recovery and wellness spanning the continuum of care. This continuum ranges from physical to behavioral health (including mental health and substance abuse) to social services.

Technological Infrastructure

State behavioral health systems typically are not interoperable with other public health or education systems. Even though they may have interoperable quality reporting mechanisms, they usually cannot share platforms for cross-system data exchange and utilization. Efforts are currently being made to increase accessibility to these types of shared services (e.g., data warehouses) for behavioral health systems and providers and to allow multiple behavioral health professionals and facilities to utilize electronic health records.

Changes to Enable Information Sharing

Restrictions on information sharing also continue to be a significant barrier for educational, health, and social service professionals to exchange information needed to more holistically serve a given individual. There is a great deal of confusion over what information can legally be exchanged among multiple parties in light of the multitude of federal privacy laws. These include the Health Insurance Portability and Accountability Act

(HIPAA), the Family Educational Rights and Privacy Act (FERPA), and others such as those found at 42 CFR Part 2 regulating the confidentiality and privacy of individual information of those receiving substance use treatment. There have also been multiple interpretations of information-sharing policies at the state and local levels.

The Uninterrupted Scholars Act, discussed later in this paper, is an encouraging example of legislation that can begin to address this challenge. APHSA has urged federal agency officials to delineate the exact requirements of federal law for the full range of information-sharing situations, and has encouraged its member agencies to carefully review whether restrictions they themselves have added in the past may now be counterproductive. The most effective prevention, early identification, and treatment are possible only if all relevant information is available.

Financing

Over the past several years, the funding that state and local behavioral health agencies and other agencies bring together for preventive and early identification services has been continuously decreasing. While many states are already designing or implementing new initiatives designed to bend the cost curve and improve health outcomes, they must do so in piecemeal fashion due to a perfect storm of factors—outdated information technology, funding cuts, lack of providers, and professionals untrained in behavioral health and use of available information technology. All these deficits affect the ability of individuals and communities to achieve behavioral wellness.

Again, SBHCs provide an example of the typical way state behavioral services are funded. They are dependent on several sources of funding, both federal (e.g., the Temporary Assistance for Needy Families program and the Social Services Block Grant) and state (mostly through state public health departments and human service agencies). About half are reimbursed by managed care organizations and half are not, frequently depending on whether a primary care physician works there. Many SBHCs have only a nurse practitioner or other primary care professional.

Many situations also exist that are not reimbursable through regular funding avenues and for which alternative funding has to be found—which may also mean through uncompensated care funding or state and local general dollars. These include SBHCs that are not in the Medicaid network of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) plan providers in the state, carved out for managed care or not; states in which the CHIP program is a stand-alone plan (which may or may not require EPSDT coverage at state option); and children who do not receive Medicaid.

Prevention and early identification in adult Medicaid beneficiaries and adults coming into the new insurance marketplaces with behavioral health concerns will also be a high priority for state health and human service administrators and policymakers. If prevention and early identification do not receive adequate investment, the probability of increases in incarceration and emergency room utilization is high. Such results are costly forms of mental health and/or substance use "care" that are pushed off onto the state and, ultimately, to taxpayers.

Promising Practices

Across the country, new tools are providing states, localities, and community-based providers with opportunities to develop policies and preventive interventions designed to meet individuals in their environment and attend to

the socio-economic factors putting them at risk prior to the onset of a mental health or substance use condition. These include SAMHSA's developmental framework [13] and systems of care initiatives; methods like population health management; [14] and information technology in the form of geographic information systems and other electronic information systems utilized by the public and private health and human service field. Some state agencies have tailored preventive, trauma-informed services to children and families based on data collected from the Adverse Childhood Experiences Survey. [15]

The Uninterrupted Scholars Act (P.L. 112-278), enacted on January 14, 2013, is designed to help alleviate information-sharing barriers for child welfare and educational professionals, particularly where the child welfare agency is legally responsible for the child. The act amends FERPA [16] to permit educational agencies and institutions to disclose a student's education records, without parental consent, to an authorized state, local, or tribal child welfare agency or organization, or the judicial system, to access a student's education plan. [17] This is one example where action has been taken to overcome such impediments to information sharing and comprehensive service. Additional research and federal guidance on information-sharing for health and human service agencies serving the same populations are required for agencies to comprehensively serve children and youth while maintaining privacy and confidentiality.

The Centers for Medicare and Medicaid Services (CMS) and SAMHSA have begun to look at care coordination models that will reduce the cost of care while targeting care coordination received by older adults, disabled adults, and adults with chronic conditions receiving both Medicare and Medicaid (known as dual eligibles). Some of these options incorporate addressing the social determinants of health in a team approach to care (e.g., Medicaid's health home option) for individuals with chronic conditions. Mental health and substance use disorders are included within that definition. Through referrals to social service providers, health provider teams are able to wrap around and coordinate care for individuals needing more intensive services to enhance their overall health and wellness. Other options include the utilization of home- and community-based care, which allows services to be tailored to the individual and provided where the person resides. Some of these options are also being utilized for children and youth services.

These types of coordinated (and in some cases preventive) care contribute to cost containment in other systems. Reinvestments or redistribution of dollars in preventive and early identification services must occur so those across the lifespan may have a chance to achieve wellness while also reducing costs. In 2004 the Washington State Institute for Public Policy, for example, conducted an analysis showing that reinvestments in evidence-based, preschool-based programs supporting healthy social development and cognitive abilities led to net savings of $10,000 per child. [18] The prevention programs studied ranged from ones beginning in the 1970s to some that were two or three years old at the time of the publication.

Summary

We believe a focus on prevention and intervention will greatly enhance the human service system's ability to deliver person- and family-centered services in a holistic and cost-effective manner. Increasing evidence shows that prevention can reduce costs and alleviate dysfunction that hampers healthy outcomes. The potential benefits for the health of citizens, communities, and the economy are both achievable and necessary investments. Public and private systems of care, administrators, and policymakers must prioritize resources to institutionalize prevention

and early identification practices of behavioral health across populations. This will require a greater focus on increasing access, providing training and infrastructure, testing new funding models, and consistently championing the value of prevention and early intervention.

Recommendations

- Promote public and private collaboration between public agencies at all levels and the community as a way to create social and physical environments that enable good health through prevention for all age groups. This includes placing an emphasis on the training of professionals in all settings to be able to identify and screen for mental health and substance use conditions.
- Support collaboration across state and local health and human service agencies to identify where investments can be made that can prevent the social, emotional, and cognitive impairments that, in turn, contribute to at-risk behaviors leading to disease, disability, social problems, and early morbidity.
- Promote utilization of integrated service delivery options (e.g., health homes) that blend new payment methodologies like value-based purchasing with holistic care coordination for all populations with chronic conditions.
- Support public and private research to examine the systematic return on investment (ROI) received through holistic preventive services as well as the ROI on more costly forms of care (e.g., increased utilization of emergency rooms for primary and behavioral health treatment).
- Support efforts to enable information to be shared across agencies and programs that will more effectively coordinate care, and achieve better outcomes among those serving the same individuals and families.

Endnotes

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