MENTAL HEALTH POLICY IN THE UNITED STATES

ADULT MENTAL HEALTH POLICY

By
Michael B. Friedman, LMSW
Adjunct Associate Professor
Columbia University School of Social Work

Abstract: This lecture focuses on adults with diagnosable (but not necessarily diagnosed) mental disorders who do not develop long-term disability as a result. I provide an overview of the prevalence of these disorders and of the extent to which people with them do or do not use mental health services. According to the National Co-Morbidity Survey Replication, fewer than 50% of people with diagnosable disorders get treatment, while about 40% of the people who get treatment do not have a diagnosable disorder. I review the reasons for underutilization and propose policy changes to increase service use. I also provide an overview of the problem of poor quality of available services and propose possible policy solutions.

There are two ways in which I could have approached this lecture on adult mental health policy, from the standpoint of epidemiology or from the standpoint of adult psychology. With much ambivalence I have chosen to do this lecture from the standpoint of epidemiology.

Epidemiology

Adults with mental illness include those who are seriously and persistently mentally ill and are disabled (discussed last week) and those who have a diagnosable disorder but do not have a long-term psychiatric disability. This lecture focuses on the population with mental disorders who are not disabled.

To say that someone has a "diagnosable" disorder is not to say that they have been diagnosed. A great many—perhaps **most—people who have or have had a diagnosable mental disorder are never actually diagnosed**.

How do we know how many? From household surveys—either in-person or on the telephone—in which interviewers ask questions the answers to which

are tabulated in such a way as to reveal whether and how a person would be diagnosed if they were seen by a competent psychiatrist.*

The findings of epidemiological surveys vary from survey to survey.[1,2,3,4,5] (I've included a few examples in the endnotes.) Roughly speaking what they reveal is that about **25% of American adults experience a diagnosable mental and/or substance use disorder in any given year, 50% in their lifetimes**. Anxiety disorders are the most prevalent mental illnesses, experienced by about 15% of American adults per year. Mood disorders—mostly depression—affect about 10%, and substance use disorders about 5%. The estimates for psychotic conditions are quite variable ranging from about 1-3%. There is considerable **co-occurrence of mental disorders and of mental and substance use disorders**. Annual co-occurrence is about 4%.[6,7] Lifetime co-occurrence is about 50%.[8]

The vast majority (about 75%) of people with a diagnosable disorder **have "mild" or "moderate"**, rather than "serious" or "serious and persistent" **disorders**. So, most people with a diagnosable mental disorder are not disabled by it, although they must have some functional impairment to meet diagnostic criteria. Of course, everyone with a diagnosable disorder has some negative experiences—sadness, fear, inability to manage stress, frustrated ambitions, troubled relationships, etc.

Epidemiological surveys also reveal that **most adults with a diagnosable mental illness—about 55%—do not get treatment**, especially if they have a mild mental illness. 65% of people with serious mental illness get treatment.[9] Women with mental illness are more likely than men to receive mental health services. **People of Color are less likely to receive treatment than Whites**.[10]

The National Co-Morbidity Study Replication (NCS-R),[11] which, from my point of view, is still the best source of epidemiological information even though it was done in 2000, also tells us that **about 40% of people who get treatment do not have a diagnosable disorder at the time.[12]** This has led some to argue that we are wasting resources on the "worried well" while others argue that most of this population are in treatment for good reason.[13]

Despite this controversy there is overwhelming agreement that the **American mental health system does not serve a huge portion of**

* Some surveys do not use diagnoses from the DSM but instead use such categories as "serious psychological distress", which is not quite the same thing as a serious mental disorder. Many surveys report "symptoms of" a mental disorder such as depression or anxiety. This is very different from reporting about the presence of a disorder.

people with diagnosable mental disorders, who might benefit from treatment.

In addition to lack of treatment for people who might benefit from it, there is a **major problem with the quality of treatment** in the United States. According to the NCS-R, many people get treatment from primary care physicians, who provide minimally adequate treatment less than 15% of the time. And even those who get treatment from mental health professionals get minimally adequate treatment less than half of the time.[14] There are other studies that show that many providers do not use evidence-based practices.[15]

THE PROBLEM OF LOW UTILIZATION

There are four major reasons why there so much unmet mental health need in America—**inadequate capacity**, **problems of access**, **choice not to seek mental health care**, and **cost**.

1. CAPACITY

Even in NYC and other urban communities with sophisticated health systems, it is difficult to find and get a rapid appointment to see a mental health professional in whom you can have confidence. There are often substantial waits to be seen either by clinicians in private practice (other than those just starting out) or by clinics. According to the National Council on Mental Well-Being, the average wait for outpatient mental health services is 48 days.[16]

Workforce Shortage: A fundamental problem is the overall shortage of qualified mental health professionals. This problem is exacerbated because mental health professionals tend to cluster in urban areas with medical schools. In many parts of the U.S., especially in rural areas, mental health professionals either in private practice or in outpatient programs are quite scarce.[17] There are parts of the country in which there are no psychiatrists at all.

Inadequate Funding of Outpatient Services: Much mental health service is provided by clinics that rely on public funding above and beyond Medicaid and Medicare to be able to operate. Non-profit clinics usually get some philanthropic support to fill the gaps in income—but not nearly enough. For-profit clinics tend to cut costs by using staff paid on an hourly basis, without paid time for supervision, and often without benefits, raising questions about quality. Some argue that non-profit clinics should use these management methods to hold down costs. But those of us who believe that it is important to provide a living wage and basic benefits to the mental health professionals who staff clinics (primarily social workers) advocate for public

sector funding to increase so as to keep pace with inflation, to increase capacity, and to improve quality of care.

Reliance on Primary Care Physicians: In part because of shortages of mental health providers and in part because routine visits to primary care physicians are the norm in the U.S., diagnosis and treatment of behavioral health conditions by primary care physicians have been on the rise.[18] Today, many, if not most, people with mental health problems get diagnosed and treated first by a primary care professional, who usually prescribes medication because s/he does not have the training or the time to provide psychotherapy. This adds to the overall capacity of our society to provide treatment for mental illness, but at a significant loss of quality.

Happily, some large primary care practices—especially those that have become "medical homes"—have behavioral health professionals in their facilities, which makes competent care more likely. In addition, there has been some expansion of the use of the "collaborative care" model, which makes successful outcomes about 50% more likely [19] as well as other models of integration that also improve outcomes.[20]

Inpatient Services: There may also be a shortage of inpatient services both for adults with serious and persistent mental illness and for those who have occasional, relatively brief acute psychotic episodes. This is highly controversial. Some argue that the apparent need for inpatient care is linked to the lack of adequate community-based services, and others argue that a great many people with mental illness would benefit from inpatient services that would protect them from the consequences of acute psychotic episodes and would protect others in their families and communities as well.

Unfortunately, there is no empirically sound method for estimating inpatient (or outpatient) need.[21]

Policy Changes To Address The Problem Of Capacity.

There is clearly a need to build capacity in the mental health system. How?

- **Improve geographic distribution of mental health professionals** and programs around the country. This requires (1) inducing some states to fund more mental health services and (2) providing incentives for mental health professionals, who are usually trained in relatively service rich areas such as Boston, New York City, Baltimore, Chicago, and Los Angeles to relocate elsewhere. Loan forgiveness is one such incentive.

- **Increase the number of people who choose to become mental health professionals** including--psychiatrists, psychologists, clinical social workers, psychiatric nurses, mental health counselors, etc. How to

do this problematic. It requires efforts as far back as high school to interest kids in mental health. It requires better public relations—such as good TV shows—about the mental health professions. It requires changes in college and medical school curricula. It requires changes in income for professionals. Etc.

At best, a full-scale effort to attract people into the mental health professions would pay off in the next generation, leaving a major shortage for the time-being.

- **Reduce the need for mental health professionals**. There are a number of ways to do this—(1) less frequent visits, (2) shorter visits, (3) use group rather than individual therapies, (4) re-assign professional roles, e.g. use nurse practitioners, para-professionals, peers, etc.

- Perhaps **ease licensing requirements** so that more people can qualify as mental health professionals—especially people who speak foreign languages, some of whom have credentials in their home countries but not in the US. (This, of course, raises issues of competence and quality.)

- Provide **more funding** for mental health services so as to keep pace with inflation and population growth and to be able to serve a larger portion of the population.

- **Develop a meaningful method to identify unmet need**, including need for inpatient as well as outpatient services.

- **Reduce the demand** for mental health services by weeding out patients who do not have a diagnosable mental disorder.

- **Expand mental health services in the workplace**. This is a hard sell for the most part, but some large corporations are convinced that depression interferes with productivity and have made some efforts to assure that treatment is provided. Giving tax benefits to employers might lead them to provide more mental health services in the workplace.

2. ACCESS

Even in areas of the country where mental health services are available, there are often problems getting access to services including:

- Cost to people receiving help (see page 8)
- Long waiting lists and treatment delays
- Difficult locations of services and lack of transportation

- Inconvenient hours of service, especially for working people and people with childcare responsibilities
- Language barriers and lack of cultural competence
- Bureaucratic and economic barriers to providing off-site services.

Policy Changes To Address Problems of Access

- Permanently remove financial and regulatory barriers to the use of **tele-mental health**. During the pandemic, emergency legal and regulatory changes have been made to permit and pay for tele-mental health services. This appears to have been, on balance, quite successful. There is a major push by providers and advocates to make this permanent. Insurance companies are reluctant.

- **Improve geographic distribution** of mental health services. There clearly needs to be national redistribution focused on areas that are officially short of mental health professionals. But even in relatively service rich areas such as NYC, there are problems of distribution because service providers tend to be located more in White, affluent, or middle-class neighborhoods than in poor neighborhoods where many people of color live. This can be addressed through the relocation of clinics and/or a **shift from licensing specific places where services are provided to licensing service capacity that is not bound to a location**.

- **Modify licensing and funding regulations** to require publicly licensed and funded clinics:

  - To see new patients within a few days of their first call.
  - To have adequate evening and weekend hours
  - To be multi-lingual
  - To permit licensed programs to provide services off-site in people's homes and in community settings such as houses of worship.

3. PROBLEMS DUE TO PERSONAL CHOICE

Many people who might benefit from mental health services do not seek and/or do not want them.

Why? **Stigma** is the most common answer. And embarrassment or shame about needing psychological help is certainly one reason why people avoid mental health services, especially when they are provided in locations identified as places that provide mental health services.

But there are other important reasons why people do not want mental health services, such as **bad experiences with the mental health system**, **fear**

of psychiatric medication, **lack of confidence in confidentiality**, and **concerns about quality**.

Of course, many people simply **lack knowledge about mental illness and where to turn for help**. For example, many people think of mental illness as psychosis; they do not know that there are less severe forms of mental illness such as mild or moderate mood or anxiety disorders for which effective treatment may be available.

Even people who know that there are non-psychotic mental disorders may not know that certain physical symptoms such as gastro-intestinal distress, headaches, fatigue, etc. may be symptoms of emotional distress and therefore seek help from their primary care physician rather than from a mental health professional.

In addition, there are **some cultures in which the concept of mental illness is alien** and in which there are pathways to help[22] outside the mental health system. There are also cultures, such as the military culture, in which asking for help is perceived as a weakness, which can affect peer relationships and opportunities for career advancement.

Policy Changes To Encourage The Choice To Use Mental Health Services

- **Develop anti-stigma campaigns**. This is more complex than it sounds because changing attitudes is very difficult and because changing attitudes does not necessarily result in behavior change.

- **Provide services in locations not labeled as a mental health program**. For many people this is critical. They may be willing to meet with a mental health professional in their homes or in community settings such as houses of worship but unwilling to walk through a door marked "mental health clinic". Unfortunately, there are significant regulatory obstacles to providing off-site services or establishing satellites, etc.

- **Provide public education**: It is frequently argued that there needs to be widespread public education about mental disorders and their treatment. This is probably true. But there's frequently an underlying assumption that people choose not to go for mental health services because they are ignorant about how valuable treatment can be. That is not necessarily the case. Some people don't need education so much as they need confidence in the treatment they would get.

- **Improve the experience of getting services:** Some people who don't want mental health services have had experiences with the mental health system that were very troubling, and they don't want to go back. For them, and the people they tell about their experiences, the most important effort is to improve the experience of the recipient of services.

- **Expand outreach and engagement** efforts: Having mental health professionals go into community settings such as houses of worship, local community centers, etc. can result in developing connections with people who don't know about or don't trust mental health providers but who will often accept mental health services when effectively engaged.

- **Information and referral services:** For people who don't know where to go for help, it can be very valuable to have a telephone number to call or a website to go to that can help them find mental health services. There are many such services around the country—warm lines, hot lines, some with volunteer staff, some with professional staff, etc.

  There is also a National Suicide Prevention Lifeline, which helps people who are not suicidal as well as those who are. **988** is the number to call.

  There is a very sophisticated service in NYC called NYC Well. **1-888-NYCWELL**.

  One of the shortcomings of information and referral services, in my opinion, is that they usually do not refer to private practitioners or even to community health centers that offer mental health services unless they are licensed mental health programs. I&R needs to become more comprehensive.

4. <u>The Problem of Excessive Cost to Consumers</u> [23]

Mental health services can be much too costly. Some psychiatrists in private practice charge $400 per visit or more and do not accept insurance. This is obviously beyond the capacity of most people. And psychologists and clinical social workers in private practice can also be quite expensive. Even with insurance coverage, deductibles and co-pays can be unaffordable.

In addition, most private practitioners do not take Medicaid clients because rates are so low and paperwork requirements are so extensive. Some private practitioners will not take Medicare clients, not because their rates are as terrible as Medicaid but because they can charge more for patients who do not have Medicare. And some clinicians will not accept any insurance because they don't want to compromise on rates or be second-guessed by managed care. Apparently, there are enough people who can afford to pay out-of-pocket to fill the practices of many private practitioners.

Mental health clinics with public support pick up some of the slack. Generally, they have sliding fee scales and accept all forms of insurance, including Medicaid, which generally pays clinics much higher rates than it pays clinicians in private practice. But clinics that have many low fee clients

without insurance coverage often need additional public funding to survive financially.

Policy Changes to Make Mental Health Services Affordable

- **Universal behavioral health coverage:** Health coverage for all Americans, similar to, but more extensive than, that provided under the Affordable Care Act, is key to making mental health services affordable for consumers. Such coverage must, as in the ACA, include behavioral health services as an "essential benefit."

- **Deficit contracts and sliding fee scales**: At one time it was commonplace for governments to enter into contracts with licensed mental health programs such as clinics through which the government paid for care that was not paid for by clients or health insurance. This made it possible for programs to use sliding fee scales that made treatment affordable. This type of contract has become extremely unpopular—a mistake in my view even though some states, such as NY, have found ways to build deficits into Medicaid rates.

- **Parity:** In addition to coverage, insurance must limit co-pay requirements. For several decades, this goal has been referred to as "parity" of coverage for physical and mental health benefits. Much progress has been made, but parity has still not been fully achieved. And parity does not assure that co-payments are affordable, especially for people who need more than a few outpatient sessions per year.

- **Reasonable Payment:** Medicaid and Medicare and private insurance companies should provide reasonable fees both to mental health provider organizations and to private practitioners. This would help to reduce the incentive to accept only patients who can pay high fees without using insurance.

- **Mandated Acceptance of Insurance:** It would also be useful if providers were required to accept reasonable fees from public and private insurance plans, although I'm not at all sure how that would be enforced. It would also be helpful if disincentives to accept insurance, such as paperwork, were reduced.

THE PROBLEM OF "UNEVEN" QUALITY

Much mental health service is of poor quality. The polite way of saying this is that quality of care in the mental health system is "uneven".

Poor quality is due to:

- Over-reliance on primary care physicians
- Over-reliance on and mismanagement of psychiatric medications
- Lack of integrated treatment
- Failure to use evidence-based treatments
- Inadequate education and training
- **STRUCTURAL INADEQUACIES**
    - Reliance on the medical model
    - Immobility of providers
    - Lack of outreach and engagement
    - Lack of home and community-based services
    - Limited hours of availability
    - Lack of intensive services in times of crisis
    - Etc.

Policy Changes To Enhance Quality

- Integrated Treatment: The fundamental push these days is to end the schism between the physical and behavioral health fields and develop ways to integrate treatment. Many experiments are underway. Whether they will result in improved clinical outcomes is an open question.

- Coordinated care management[24]: Adding mental health professionals, primarily nurses and social workers, to primary care practices to follow up on treatment decisions made by a physician has worked well to enhance clinical outcomes, especially in the treatment of depression. The mental health professionals serve as care managers and sometimes as psychotherapists while the doctors prescribe and monitor medication. As there are more and more large group medical practices, this approach should become more feasible and needs to be encouraged by assuring funding for care management and by establishing relevant licensing and accreditation standards.

- On-site psychiatry in health practices and centers: Some primary care practices go beyond care management by having mental health professions on site to provide needed treatment. This includes psychiatrists as well as clinical social workers and other trained clinicians. This model provides for integration of physical and mental health staff. But being on site does not guarantee coordination of care.

- On-site physical health care in mental health and substance abuse treatment programs: Another way to provide integration is to have physical health care staff on site in mental health programs. There can

be satellite clinics or staff from local hospitals and community health centers who make regular visits to the program. If they can afford it, mental health programs can also hire primary care providers. Some substance abuse agencies and some mental health/developmental disabilities agencies establish separate health clinics to serve their own clients or people with similar characteristics.

- Enhanced professional education regarding mental illness: Medical and nursing schools notoriously provide little education about mental disorders and their treatment. While those who go on to specialize in matters of mental health get substantial additional training, primary care physicians and those who go into other specialties have to rely on the inadequate education they got in school. There's little doubt that more needs to be done in school, but how much more is possible is an open question given how much doctors and nurses need to know.

- Enhanced training after professional school: The usual suggestion for primary care providers is that they be required to get additional training in matters of mental health and substance abuse once they are in practice. It is not clear, however, how realistic this is. Yes, doctors and nurses are required to get continuing education, which could include mental health; but there is so much they need to know in other areas as well. Can they do it all? In addition, there are studies that indicate that not much knowledge is retained from typical training experiences. A review of three decades of studies about training in mental health concluded, "… a high degree of involvement by the physicians learning psychiatry is necessary for change. One-day conferences that feature long lectures with little opportunity to interact or practice reenforcing strategies have little or no impact on practice patterns or patient outcome." [25] Research regarding the effectiveness of courses taken for CMEs on-line is apparently inconclusive at this point. Based on personal experience I am skeptical whether such courses when taken to comply with CME requirements produce lasting knowledge and changes in practice. What works best with doctors, apparently, is the "detailing" approach used by drug companies—one-to-one discussions, preferably over lunch. Do doctors need more training? Certainly. Is it realistic? A critical question.

- Revised requirements for professional licensure: Another suggestion is to build more requirements into professional licensure both for primary care providers and for mental health professionals. Again, there is a question of how realistic this is.

- Research and translation of research into practice: One of the fundamental problems with mental health services is how frequently they are based on traditional practice of questionable effectiveness rather than

on evidence from research. What is needed is (1) more clinical and services research so that more evidence-based practices are developed and (2) processes to encourage the use of these practices. Again, easier said than done.

FUNDAMENTAL STRUCTURAL CHANGE

In addition to the suggestions I have already made about how to increase utilization and improve quality, there is a need for fundamental structural change in the mental health system. Below are several areas in which major change is needed.

Crisis intervention:

There is widespread agreement that psychiatric crisis intervention services fall short; improving them is a major goal of mental health policy today.

One change, just recently implemented, is the creation of 988, a number that can be called anywhere in the United States for help with a psychiatric crisis, for help coping with emotional distress, and for help finding mental health services.

Current plans call for much more than a number to call. Major efforts are underway to reduce reliance on the police to respond to psychiatric crises. This involves the creation of mobile crisis teams of mental health professionals who can rapidly respond to a crisis on site, reserving use of the police for situations in which violence is threatened. Unfortunately, current mobile crisis teams are often not able to respond rapidly, i.e., within a few minutes, 24 hours a day, seven days a week. Whether new teams will be able to do this nationwide is yet to be seen.

Another current goal is to reduce reliance on generic emergency rooms, which—especially in urban areas—are often chaotic and frightening. And, in suburban and rural areas, often no mental health professionals are in the emergency room; sometimes none are available to be called in from the community.

In some places psychiatric emergency rooms with appropriate ambiance, appropriate staffing, and holding beds for overnight stays without admission to inpatient treatment have been created. These generally improve on the gruesome experience of ordinary emergency rooms, but to be financially viable they require a large number of patients. So, they are generally not available in suburban or rural areas.

Remaking psychiatric crisis services also includes the development of "crisis centers", which can be either non-residential alternatives to emergency

rooms or residential alternatives to inpatient care. I.e., some crisis centers are residences where people can stay and get treatment for short periods of time in more humane settings and at far lower cost than most hospitals. NYS, for example, has recently released regulations for such programs.[26]

Among the people who experience psychiatric crises are people who are in treatment with a private practitioner or clinic or other outpatient program. Many of these providers refer their patients to 911 (now maybe to 988) or an emergency room when they have crises outside of regular office hours. Some of us have advocated for **requirements that providers be available in some more responsible way for their own clients/patients when they have emergencies.**

Inpatient Services

As I have said repeatedly, there is widespread disagreement about the need for increased inpatient services for people with acute or chronic mental health conditions. There are many reports from emergency rooms and from mental health providers that often no beds are available for people in extreme psychiatric distress and that frequently hospital stays are cut prematurely short to make room for admission of people in acute need. This, as well as the shameful number of people with serious mental illness who are homeless or incarcerated in jails or prisons, leads to the impression that more psychiatric hospital beds are desperately needed.[27]

That impression, however, does not take into account the possibility of developing community-based alternatives to hospitals such as crisis centers, emergency mental health housing facilities, day programs, etc. Many advocates maintain that there would be no apparent need for greater inpatient capacity if there were more community-based alternatives available.[28]

A more fundamental question is whether inpatient services in hospitals are needed at all. Could hospital-based inpatient services for people with acute mental conditions but without co-occurring serious physical conditions be replaced by crisis-oriented community residences? This could vastly reduce costs because the staffing requirements and overhead charges of hospitals are extremely high. Sadly, there is, as far as I know, little serious discussion of this possibility.* And, in my opinion, there should be. Inpatient psychiatry serves many purposes, and it is possible that these purposes could be achieved in other settings. For example, hospitals are sometimes used for people who have no place to sleep, who

* The Soteria Model has been proposed as an alternative to the use of hospital emergency rooms and inpatient treatment. But it's a fringe idea that loses credibility because it combines providing a residential alternative to hospitals with a commitment not to use anti-psychotic medications.

could be just as well-served in a hotel or a "foster home" or a humanely designed and managed shelter. Sometimes people need to be in a locked residential setting with onsite observation and supervision. That does not have to be in a hospital. Sometimes people need residential care and on-site treatment, but it is certainly possible for psychiatrists and others to come to a residential setting without it being a hospital. Etc.

Why does it matter? Hospitals frequently have very unpleasant living spaces. Long hallways the colors of cheap paints, sterile dining and recreation areas, large living units, not uncommonly for 30 patients. Residences are typically no more than 16 patients/residents and are homelike by design. In addition, hospitals have prescribed staffing patterns and other standards with which they have to comply whether their patients need them or not. Is it really necessary to have RNs on-site and awake 24 hours a day? How many? Do physicians really have to be the treatment team leaders or to sign-off on process notes. For that matter is it really necessary for there to be frequent, voluminous notes? It is likely that residences could have more than adequate staffing patterns with fewer professionals and more and better trained paraprofessionals, including peers, at considerably lower cost. Not to mention the fact that hospitals have huge overhead costs that generally are much, much lower for non-hospital residential care.

<u>Home and community-based services</u>

All mental health advocates agree that there is a need for more and better community-based services.

Recently, more attention has been brought to bear on the fact that the mental health system is built on the assumption that people in need of services will come to places, such as clinics, where they can get treatment. This, of course, creates a major barrier to services because many people who could benefit from care are not able, or willing, to go to a mental health place for treatment.[29] Alternatives exist to some extent, but more are needed. Alternatives include **tele-mental health, mobile outreach and engagement services, and mental health services in community settings such as senior centers, schools, and houses of worship**.

Should the place-bound program model and the clinic model, which is basically unchanged since it was developed about a century ago, be replaced with approaches that make community-based services more accessible? Alternative models such as Certified Community Behavioral Health Clinics (CCBHC)[30] have begun to emerge that provide more flexibility regarding eligible populations, services provided, accessibility, coordinated care, etc. But perhaps a more radical shift is called for. For example, **instead of licensing places where services are provided,** calling for special

arrangements to provide offsite services, perhaps **service capacity could be licensed** with permission to serve people wherever they are and to be paid a bonus for doing so.

Workforce:

Problems with the size and quality of the workforce call for substantial re-thinking of who should be providers of mental health services. It simply seems unlikely, despite decades of talk about inadequacies of the workforce, that the problems with be substantially overcome using current proposals.

There are significant changes that have already taken place. Notably, non-physicians are now used to provide treatment. Social workers already provide 70% of mental health care. Nurse practitioners play some of the roles of physicians. Etc.

Most important, in my view, is the **use of peers** to provide services.

But more can be done by **reconceptualizing mental health needs not in terms of what treatment they need but in terms of what can be done to make lives more satisfying**. For example, it is not at all clear that lonely people need treatment so much as they need companionship. Etc. Volunteers can be called into play, as they have been during the pandemic. Houses of worship can do more. I'm confident that innovative solutions can be created.

My generation of mental health advocates and providers, it seems to me, have been much too tied to traditional models with a few innovations here and there. Hopefully, your generation will break free from the old ways and find new ways to help adults with mental disorders.

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[1] NIMH » Mental Illness (nih.gov)

[2] Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication | Anxiety Disorders | JAMA Psychiatry | JAMA Network

[3] Mental Health | Healthy People 2020

[4] 2019 National Survey of Drug Use and Health (NSDUH) Releases | CBHSQ Data (samhsa.gov)

[5] Mental Illness Surveillance Among Adults in the United States (cdc.gov)

[6] Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (samhsa.gov)

[7] Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R) - PMC (nih.gov)

[8] NIMH » Substance Use and Co-Occurring Mental Disorders (nih.gov)

[9] Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (samhsa.gov)

[10] Mental Health Disparities: Diverse Populations (psychiatry.org)

[11] The National Comorbidity Survey Replication (NCS-R): background and aims - PubMed (nih.gov)

[12] Twelve-Month Use of Mental Health Services in the United States: Results From the National Comorbidity Survey Replication | Psychiatry and Behavioral Health | JAMA Psychiatry | JAMA Network

[13] Druss, BG et al (2007). Understanding mental health treatment in persons without mental diagnoses: results from the National Comorbidity Survey Replication - PubMed (nih.gov)

[14] Wang, PS et al (2005). Op Cit.

[15] Mechanic, D et al (2014). Chapter 6 (page 144) of *Mental Health and Social Policy: Beyond Managed Care*. PEARSON.

[16] New Data Shows CCBHCs Improve Behavioral Health Access, Reduce Wait Times - Behavioral Health Business (bhbusiness.com)

[17] Over one-third of Americans live in areas lacking mental health professionals - USAFacts

[18] Wang, PS et al 2006. "Changing Profiles of Service Sectors Used for Mental Health Care in the United States" in *The American Journal of Psychiatry*, July 2006.

[19] Goodrich, DE (2013). "Mental Health Collaborative Care And Its Role In Primary Care" in *Current Psychiatry Reports*, August 2013.

[20] Integrating Health and Mental Health Services: A Past and Future History | American Journal of Psychiatry (psychiatryonline.org)

[21] McBain, R. et al (2022). "Estimating Psychiatric Bed Shortages in the U.S." in *JAMA*, February 16, 2022. Estimating Psychiatric Bed Shortages in the US | Psychiatry and Behavioral Health | JAMA Psychiatry | JAMA Network

[22] Rogler, LH and Cortes, DE (1993). "Help-Seeking Pathways: A Unifying Concept in Mental Health Care" in *American Journal of Psychiatry*, April 1993.

[23] Petersen, A. (2021). Why It's So Hard to Find a Therapist Who Takes Insurance - WSJ

[24] Goodrich, DE (2013). Op. Cit.

[25] Hodges, B. et al (2001). Improving the Psychiatric Knowledge, Skills, and Attitudes of Primary Care Physicians, 1950–2000: A Review | American Journal of Psychiatry (psychiatryonline.org)

[26] Crisis Residence Program Guidance - 6/2/2021 (ny.gov)

[27] Estimating Psychiatric Bed Shortages in the US | Psychiatry and Behavioral Health | JAMA Psychiatry | JAMA Network

[28] Community alternatives to inpatient admissions in psychiatry - PMC (nih.gov)

[29] Alegria, M et al (2021). "Transforming Mental Health Addiction Services" in *Health Affairs*, February, 2021.https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01472

[30] Certified Community Behavioral Health Clinics (CCBHCs) | SAMHSA