



THE COMPLEXITY OF AMERICAN MENTAL HEALTH POLICY: IMPLICATIONS FOR SYSTEMS IMPROVEMENT

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ABSTRACT. This article explores the complexity of American mental health policy, noting that it results in a wide range of challenging and contentious policy questions that go beyond health policy and involve social welfare policy, disability policy, criminal justice policy, and more. The complexity arises from the heterogeneity of populations with mental and/or substance use disorders; the range of potentially useful interventions (including but not limited to treatment services); the diverse mix of public and private providers and funding sources; shifting responsibilities among federal, state, county, and municipal governments; and vituperatively competitive ideologies. The author maintains that even though the complexity makes it unlikely that there can be extensive transformation of mental health policy at this time, there are many ways in which the mental health system can be made better incrementally. He urges mental health advocates to unite to pursue an agenda of achievable improvements that they are *all* willing to support.

Keywords: American mental health policy; systems improvement

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Fueled in large part by rare but highly publicized acts of violence by people believed to have serious mental disorders, a consensus has emerged that the American mental health system is “broken” and must be fixed. This is not a good metaphor. Broken implies that it used to work but that lately it doesn’t. The truth is that the so-called mental health “system” has always been far from what it should be, that it is better now than it used to be, but that it remains imperfect in a host of complicated ways.^{1,2,3} There has been progress, but for the past 35 years it has been incremental rather than transformational.

One major reason that transformation has proved an elusive goal is that mental health policy is far more complex than is generally recognized. Properly understood it is not just a subset of health policy. It is, and must be, an amalgam of health policy, social welfare policy, criminal justice policy, substance abuse policy, disability policy, education policy, child welfare policy, and more.

That is to say, in order to meet the needs of people with mental and/or substance use problems, we need to address not only their needs for treatment and rehabilitation, but also how they will survive if they are unable to work, how they will be treated if they commit or are accused of committing crimes, what rights they have to liberty and to non-discrimination, how the schools will educate children with psychological problems, how society will respond to children who have traumatic experiences; and so forth.

A Heterogeneous Population

Mental health policy is unavoidably complex primarily because people with mental and/or substance use disorders are a heterogeneous population, including:

- Adults disabled by severe, long-term mental and/or substance use disorders (<2%⁴—<3%⁵ of the adult population) some of whom are homeless⁶ or incarcerated in jails and prisons,⁷ many of whom have co-occurring substance use disorders,⁸ and most of whom will die 10–25 years prematurely;⁹
- Adults with diagnosable mental and/or substance use disorders (22–24% of the adult population in any given year),¹⁰ who experience considerable emotional pain and some dysfunction, but do not live with severe, long-term disability;
- Those who will take their own lives (now over 40,000 people per year and rising);¹¹
- Those who commit very rare acts of violence towards others;¹²
- Special populations, such as veterans and military personnel who have a high prevalence of depression, post-traumatic stress disorder, substance abuse, and suicide;¹³
- Children and adolescents with “serious emotional disturbances” that interfere with their education and relationships and sometimes contribute to run-ins with the law;¹⁴
- Children and adolescents who have diagnosable disorders that cause significant emotional pain and family conflict, but do not cause severe functional impairment;
- Children and adolescents who are victims of abuse or other trauma that puts them at risk for mental and physical disorders both now and later in life;¹⁵

- The rapidly growing minority population, for which there are critical issues of access, cultural competence, and discrimination;¹⁶
- The elder-boomers, a population that will soon be as large as the population of children¹⁷ and for whom there are critical issues of access, generational competence,¹⁸ and co-occurring cognitive, mental, and physical disorders – including dementia;
- And more.

Given the heterogeneity of the population in need, mental health policy cannot be as simple as providing more services to more people. *Services and supports must be responsive to the specific needs of specific populations.*

Not Just Treatment

Meeting the needs of these diverse populations is not just a matter of providing an array of *treatment* services. Despite the almost irresistible logic of the idea that people with mental and/or substance use disorders need treatment, in fact some do not benefit from treatment at all, and many need additional or alternative services such as rehabilitation, housing, case and care management, outreach, peer supports, advocacy, social supports, family support, accommodations for disabilities, protection of rights, court diversion, income supports, preventive interventions, and more.

As a result, expansion of mental health services is an extremely complex matter contributing to any number of tough policy questions. What forms of intervention should be emphasized or de-emphasized in the course of building a better mental health service system? Treatment? If so, what forms of treatment? Inpatient? Outpatient? In-home? Crisis? Verbal? Psychiatric medications? ECT? Involuntary treatment? Outreach and engagement? Early intervention? Evidence-based practices?

Or should a reformed system emphasize recovery-oriented rehabilitation above all else?

What about creating the kinds of social conditions that are necessary to help people with psychiatric disabilities lead satisfactory lives in the community? Shouldn't housing be at the center of all mental health policy development? How should the criminal justice system be changed? What about income supports? What about supports for families that provide housing and other care for disabled family members?

And what about preventive interventions? Early intervention and preventing the development of a mental or substance use disorder completely seem like obvious goals of a better system, but each raises thorny policy questions. Should we intervene at the first signs of mental disorders or will that result in unnecessary treatment and overuse of medication? Should we intervene

extensively after a first psychotic break rather than hoping that this person will be one of those having a transient episode that will never return?

Primary prevention is particularly challenging because it largely depends on identifying the social determinants of mental and substance use disorders and intervening in the social conditions that contribute to later problems in life. Social determinants include family violence, living in dangerous communities, poor early childhood education, poverty, and more. Real prevention calls for extensive changes in the American society. Is that possible? What role should the mental health system play in bringing about social change?

Better Quality of Care

It appears that most Americans who get mental health services get inadequate treatment. According to the National Comorbidity Survey Replication (NCSR), most people initially get treatment from primary care physical health providers, who provide “minimally adequate care” less than 15% of the time. Mental health professionals do better, providing “minimally adequate care” almost 50% of the time.¹⁹ But that means that far less than half of people who get treatment get even marginally adequate treatment. In addition, underutilization of “evidence-based practices” has been and may still be a significant problem.²⁰

There are also considerable shortages of personnel trained to meet the needs of specific populations including children and adolescents, older adults, and cultural minorities.²¹

Many Providers, Many Perspectives, Many Interests

Policy questions are made particularly complex because of the incredible range of behavioral health providers in the United States.

This includes an array of mental health professions: psychiatry; psychology; social work; nursing; school, mental health, substance abuse, and family counseling; mental health management; health economics; and more. Increasingly, primary care physicians are the major providers of mental health services, relying on medications as the treatment of choice.²²

In addition, there are both public and private sectors of providers. The public sector includes mental health and substance abuse services of many kinds that are run by states, local governments, community agencies, and general hospitals. The Veterans’ Administration and the military are major providers of mental health and substance abuse services. In addition, many schools, child welfare organizations, supported housing programs, nursing

homes, and even jails and prisons provide clinical services. Very importantly, over the past decade or so, more and more mental health services are being provided by community health centers.

The private sector, which is probably the source of behavioral health services for most people who get such services, includes behavioral health and physical health care professionals in solo private practice or in small groups. There is now a trend to establish large, group medical practices, which increasingly provide some behavioral health services including screening, diagnosis, treatment, follow up care management, and behavioral counseling to promote “wellness.”

In addition, many employers, especially large employers, provide services to address the personal needs of their employees and their families. This includes employee assistance, disability management, and wellness programs addressing stress and depression in the workplace. In addition, employers design the mental health benefits in the health plans that they fund, which cover more than half of all Americans.^{24,25}

The extent of the responsibility of the workplace for the mental health of workers and their families has been a matter of considerable controversy, which may or may not be resolved as the rules of the Affordable Care Act are fully implemented.

The private sector also includes the pharmaceutical industry. About 30% of current behavioral health spending in the United States is for psychiatric medications.²⁶ Most prescriptions are written by primary care physicians, most, of whom are not well-trained regarding mental and/or substance use disorders.

This raises a host of important policy questions about controlling the potential overuse, misuse, and abuse of psychiatric medications; about the profit margins of pharmaceutical companies in the United States, about advertising; about the scope of lobbying by big pharma; etc.

The multiplicity of providers leads to a host of policy issues including the appropriate scope of practice of different professions, appropriate roles of governmental and non-governmental providers, the legitimacy of profiting on human suffering, the likely overuse of medication, conflicts of interest, and many more.

Multiple Funding Sources²⁷

Improving the American mental health system depends to a large extent on both the amount and structure of available funding.

Although the Affordable Care Act (ACA) promises to increase access to behavioral health services and promote integrated service delivery, current funding structures often don't align well with service goals and need to be

restructured so that they support higher quality and more appropriate services, as well as increased access and integration.

Given the number of funding sources and their specific goals, this is far easier said than done. Medicaid, Medicare, and private insurance are designed to fund treatment and some rehabilitation services that are “medically necessary.”^{28,29} State governments and, to some extent, local governments also provide funds for mental health services that can go beyond medical models of care. But over the years, states have increasingly transferred financial responsibility to the federal government by relying more and more on Medicaid.³⁰ This has resulted in substantial increases in total funding for behavioral health services (estimated to have been \$240 billion in 2014),³¹ but it has vastly limited flexibility to use non-medical services that can make life better for people with serious mental illness.

Currently, a number of major experiments are underway using managed care both to contain costs and to increase the flexibility to use Medicaid funds in ways that improve overall care for people with serious mental illness and avoid unnecessary hospitalization. These new models are also designed to integrate mental health, substance abuse, and physical health services. The hope is to keep people with serious mental illness healthier and ultimately to increase their life expectancy, which currently is much lower than the general population. We do not yet know whether these new forms of mental health management will result in slowed cost growth and better care – a promise that has been made, but not been kept, at every stage of major change in mental health policy since Dorothea Dix pressed for asylums in the mid-19th century.

The Federal Government and others also provide funds for research, demonstrations, and workforce development.

A host of policy issues related to funding emerge from all of this. Should government and private health insurers move beyond the medical model? Will the complex models of managed care actually benefit people with behavioral health problems? Will the ACA effectively achieve parity and integration between behavioral and physical health coverage? What sort of research should government fund – mostly biomedical or also substantial epidemiological, psychosocial, clinical, and services research? Etc.

Multiple Levels of Government

Improving mental health policy in America is further complicated by the fact that federal, state, county, and municipal governments “share” responsibility for mental health policy.³² Although all these levels of government do in fact take on a variety of tasks related to mental health, they also engage in constant efforts to transfer funding responsibility to other levels of government.

This results in frequent debates about which level of government should be responsible for what.

There are also frequent debates regarding restructuring the relationships among different levels of government and about restructuring at each level of government. Should there be an Assistant Secretary for behavioral health in HHS?³³ Should States merge mental health and substance abuse departments?³⁴ Should state and local mental health departments be merged into their health departments? Should local schools become service centers for families and children experiencing emotional problems? Etc.

Competitive Ideologies

Compounding the complexities already noted are vituperative differences in ideologies.

Some people who care about mental health have a libertarian bent; some have a protective bent. Those who are more or less libertarian want to protect the rights of people said to be “mentally ill.” They are willing to accept some of the inevitable hazards of liberty for the sake of avoiding unjust incarceration and loss of personal privacy.³⁵ Those who tilt towards protection believe that we should change the criteria for involuntary inpatient and outpatient commitment so as to reduce risks of harm to self or others. They also believe that we should change the rules of confidentiality so as to be able to share information more easily with families.³⁶ Some – but not all – also believe that America has gone too far in reducing inpatient utilization and insist that more people should be admitted to hospitals and stay there longer.^{37,38} A few call for a return to asylums.^{39,40}

Is it possible to bridge these ideological differences? The heated exchanges that take place between those with different perspectives certainly makes it seem unlikely that agreements can be reached. But if nations that despise each other can find ways to deal with each other pragmatically, as they often do, surely people of good will who care about the well-being of those with behavioral health disorders can also find middle ground.⁴¹

It Can Be Better

The incredible complexity of American mental health policy, the conflicting interests that arise from it, and the range of ideologies that drive it make it unlikely, I believe, that there can be extensive transformation of mental health system at this point in history.

What bold stroke or strokes would leverage vast change that would help the diverse populations of people with mental and/or substance use disorders?

More coercive interventions and more long-term inpatient care, as some suggest, could conceivably benefit a very few people with severe, unrelenting disorders and might infinitesimally reduce violence in America, but what about everyone else with behavioral disorders? Development of a “recovery orientation” throughout the system is the right thing to do for people with psychiatric disabilities but is mostly meaningless to people with transient disorders that are not disabling. Integration of behavioral health services into primary physical health care unquestionably could result in more identification and treatment of mental and/or substance use problems, but it does not address a host of issues in the lives of people with severe and persistent disorders. Innovative managed care enterprises integrating behavioral and physical health care may or may not improve care for people with co-occurring chronic conditions who are eligible for Medicaid, but the impact on other populations will be limited at best. Assuring that everyone has full coverage of mental health services equal to the coverage provided for physical health services may result in a modest increase in access to, and utilization of, treatment,⁴² but it will not result in higher quality treatment, better living conditions, a fairer criminal justice system, more effective preventive interventions, etc.

So far as I can tell, there is no bold stroke on the horizon that would revolutionize the mental health system.

Does that mean that improving the mental health system is impossible? Not at all. The complexity actually means that there is a host of ways in which the mental health system can be made better, just not all at once. We should take steps to make treatment more accessible and of much higher quality. We should promote integration. We should work to reduce suicide, to build a bigger and more competent workforce, to overcome stigma, to reform the criminal justice system, to re-evaluate America’s income supports, to follow through on the requirements of the Americans with Disabilities Act, to prepare for demographic changes, to meet the mental health needs of veterans and military personnel, to change social conditions so as to reduce the risks that contribute to growing up with mental and physical disorders, and on and on and on.

The key question, I believe, is not what needs to be done to improve American mental health policy (although there are tough questions that need to be answered). The key question is how to succeed in bringing about changes that would be beneficial. That will require building unity across the behavioral health “community.” It’s a cliché but an important truth that “united we stand, divided we fall.” We are divided now.

I confess that I do not know what specifically will unite us. I know what I think is most important, but so what? That’s just one man’s opinion. What

matters is what a group of advocates agrees is important and will work together to achieve.

With persistent, unified advocacy much has been accomplished since the advent of community mental health policy but not nearly enough. We can do better if we keep at it.

NOTE

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