

# BEHAVIORAL HEALTH NEWS

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## **IMPROVING AMERICAN MENTAL HEALTH POLICY**

By

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We mental health advocates all agree that America's mental health system should be better. We do not all agree about how to make it better. That's a problem. Our differences have contributed to a political standoff in Washington where efforts to bring about major changes in the nation's mental health system have been stymied as much by disagreements among mental health advocates as by the inability of Democrats and Republicans to work together on a vast number of important issues. We are a house divided against itself.

As always, our differences are rooted in competing interests, ideologies, and egos. I'll leave egos out of this discussion.

America spends over \$200 billion per year on mental health and substance abuse services. That's a lot of money. It supports powerful vested interests and drives tremendous competition. Hospitals, community providers, private practitioners, drug companies, universities, governments, insurance and managed care companies, and others each have a piece of the action. Each believes that what it provides is essential and that some of what others provide is not only not essential but wasteful. The call to take from them and "reinvest" in us is widespread among mental health advocates.

In addition, 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. Those who tilt towards protection worry that people with mental illness (and others) are "dying with their rights on." We should, they believe, change the criteria for involuntary inpatient and outpatient commitment and should also change the rules of confidentiality so as to be able to share information more easily among providers and with families. Some also believe that America has gone too far in reducing inpatient utilization. More people, they insist, should be admitted to hospitals, and they should stay there longer.

There are also major disputes about the hegemony of psychiatry and its system of diagnosis. Some people who care about mental health believe that scientific psychiatry, with its heavy reliance on medication (to which America now commits 30% of behavioral health resources), should be the dominant force in the field of mental health. Some people believe that medication is overused, that the hope for a biomedical breakthrough is sadly unrealistic, and that the dominance of the mental health system by the

profession of psychiatry is a mistake. They tend to see most of what is now labeled as mental illness as part of the human condition and to believe that it can better be addressed with humane, or even spiritual, interventions and with efforts to overcome societal problems such as violence and poverty.

I do not believe that we can overcome these deep ideological divisions, nor do I believe that we can find a singular common cause. But I do believe that we can work together to achieve some of what most of us agree about.

I have identified 15 areas of agreement. There are probably more. They include:

1. More and easier access to mental health services
2. Improved quality of services
3. More stable housing for people with serious, disabling mental disorders
4. More outreach to engage people with serious mental illness who reject or fail to go for mental health services
5. More “rehabilitation” services to promote recovery
6. Improved integration so as to overcome fragmentation within the mental health system, between mental health and substance abuse services, and between behavioral and physical health services.
7. More support for families caring for family members with psychiatric disabilities
8. Reduction of the mortality gap—i.e. the difference in life expectancy—between people with serious behavioral health conditions and the general population.
9. Reduction of the rate of suicide
10. Reform of the criminal justice system
11. Enhanced mental health services for specific populations such as children and youth, veterans, minorities, and older adults.
12. Enhanced prevention and early intervention
13. Reduction of stigma
14. Enhanced research
15. Adequate funding to support all of the above.

Fifteen areas of agreement! This is very hopeful, no?

Some advocates will certainly say that the list is overwhelming. They will argue that we need a lever not a laundry list. That is, we need to identify a point of intervention that will set many changes in motion and rapidly produce major change.

Maybe, but what would the lever be?

Our government seems to be betting that health care reform, driven by the Affordable Care Act, will do much to improve the system. Providing more people with health insurance and the inclusion of a requirement that health insurance cover mental and physical health services equally should result in more people having access to treatment for mental and substance use disorders. In addition, health care reform includes a variety of measures to improve integration of behavioral and physical health

care and to prevent people in need from “falling through the cracks.” The expansion of managed care through complex organizational structures such as health homes and accountable care organizations is, of course, aimed at holding down costs; but it is also intended to engage people in serious need and assure they get the care they need. Improved coverage and improved integration taken together should result in better identification of behavioral health disorders, more treatment, and better physical and mental health outcomes, including longer life expectancy.

Can we achieve a consensus to pursue this health care reform agenda? Partially, yes. I think that we can all agree to work to defend The Affordable Care Act, as it faces a challenge in the Supreme Court and vituperative rhetoric and legislation from a Republican Congress. But I don't think we can all agree on the reorganization of the mental health system being pursued with the creation of accountable care organizations and the like. Many providers are threatened by these experiments, and some of us who are not providers think that the goals are laudable but that the vast complex organizations being created are impractical. Time will tell.

In my experience over 40 years of mental health advocacy it is occasionally possible to rally the mental health community around a single organizing idea, but more often a laundry list, like the one above, has greater unifying power than a silver bullet.

Not that I think it would be possible at this time to rally around **all** of the fifteen areas of agreement that I've identified.

For example, there's real tension between the goal of expanding the mental health system and the goal of improving the quality of the system. Can we do both at the same time and hold a coalition of diverse interests together?

Generally speaking, coalitions do best when there's more for everyone. But addressing the quality of the current system leads to great doubts about doing that. Do we really want to expand the mental health system like blowing up a balloon—more of everything? Does our nation need more use of psychiatric medications, which very clearly are already overused? Do we need more psychotherapy in private offices or in clinics for people who have minor disorders (if any disorders at all)? Or should we give priority to expanding services for people with serious, disabling disorders for whom housing, rehabilitation, outreach and engagement, and improved physical health care are critical? Should we focus on expanding behavioral health services in physical health settings, particularly for people with mild mental disorders, or should we focus on beefing up physical health services in mental health settings for people with serious and disabling mental disorders?

Pretty clearly we ought to be selective about the services we increase. In the process, someone's ox will be gored, and whoever that is will not happily participate in a coalition.

So, I don't believe it's possible to rally around all fifteen of the areas of agreement I've identified. But I do believe that there will be opportunities to achieve some of them, and I think we should take advantage of those opportunities as they arise. We should, that is, go after more incremental improvement of the kind we have had for much of the past 45 years. It will not satisfy our hopes for an extensive transformation of the mental health system, but it is likely to be the best we can achieve, so long as the mental health community remains a house divided against itself.

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