

MENTAL HEALTH NEWSTM

Fall 2009

WE NEED A SOUND BITE FOR MENTAL HEALTH. PLEASE SEND SUGGESTIONS.

By Michael B. Friedman, LMSW

As health policy reform is unfolding, it has become clearer and clearer that mental health is not much on the minds of health policy makers in Washington—despite the best efforts of national mental health advocacy organizations. The Bazelon Center, Mental Health America, NAMI, the National Council of Community Behavioral Health Organizations, and others have each developed an agenda of mental health issues that should be addressed as part of health policy reform (fortunately with lots of overlap), but they haven't gotten much traction.

The problem, it seems to me, is that the mental health community hasn't come up with a few sound bites that resonate with the American people and their elected representatives.

“Universal health coverage”—everyone gets that, and it is the driving goal of health policy reform even though, I would argue, the driving goal really should be to improve the health of Americans. Health care should be understood as a means, not as an end in itself.

“Contain health care costs”—everyone gets that, too. We have all experienced first hand or heard stories about people who can't afford the health care they need or have even been wiped out by health care costs. And it is striking, to say the least, that the U.S. spends double per capita what the highest rated health care system in the world spends and is ranked only 37th in the world.

“Improve quality of care”—everyone gets that too because we all have personal knowledge of someone who has gotten just awful care. It is entirely believable and horrifying that 100,000 people or thereabouts die from medical mistakes in hospitals each year.

So these three sound bites—health coverage for all, contain costs, and improve quality—work in the political arena.

But what about mental health?

“There is no health without mental health”. Many of us have quoted the Surgeon General's line confident that it is persuasive. But I'm afraid that while it's true, most people don't get it. And, come to think of it, what does it mean? What's the policy goal? It's not clear.

The most effective sound bite for mental health over the past couple of decades has probably been the call for “parity”. It has a strong moral ring to it and also calls for a policy that at least seems clear and—presumably--won’t cost any additional money. Even so it took nearly 20 years to win that issue, and—as Mike Hogan has been asking—what’s next? Been there, done that. What’s beyond “parity?” Implementing parity? Yes, we need that to happen, but it’s just not a compelling policy issue.

The most popular contender for a new central theme, it seems to me, is “Integrate physical and mental health.” It’s a one-liner that covers a lot of territory. We need to focus on the health needs of people with serious and persistent mental illness, who—we now believe—die 25 years younger than the general population largely because of unattended health problems. We need to focus as well on the mental and substance use disorders of people who are not identified when they get primary health care, a very serious failure since 70% of those who complete suicide have seen their primary care provider within 30 days of taking their own lives. Not to mention the unnecessary suffering of people with untreated depression and so forth. We also need to focus on the mental health needs of people with co-occurring mental and chronic physical illnesses; they are at high risk for disability and premature death, and their medical costs are far higher than people without mental illnesses. In addition, we need to focus on the behavioral health problems of people in, or at risk of needing, long-term care. Federal and state governments have made long-term care reform (aka reduced Medicaid expenditures on long-term care) a major goal; but, as we have argued elsewhere, it can’t happen fully without dealing with behavioral health issues.

So, as a sound bite “integrate health and mental health” covers a lot of important ground. But it also leaves out a lot that’s important. As Richard Franks and Sherry Glied point out in their book, *Better But Not Well*, one of the critical mental health policy issues at the moment is whether we should pursue mental health “mainstreaming” or mental health “exceptionalism.” By “mainstreaming” they mean embedding mental health services more and more in the health system. By “exceptionalism” they mean continuing to provide services—especially for people with long-term psychiatric disabilities—outside of the health system in a special mental health system. Their answer—clearly correct—is that we need to do both—more integration of mental health in the health system and continued expansion of a broad range of treatment, rehabilitation, support, and residential services for people with long-term psychiatric disabilities. The sound bite “integrate health and mental health” just doesn’t capture that complexity, I’m afraid.

And, frankly, I don’t think the idea speaks to most of the American people, who still don’t get what mental health is about, still don’t believe it’s all that important, and for whom the idea of integration is very abstract and hard to grasp.

There are some other fundamental organizing principles for mental health policy. Good ideas, but do they work as politically persuasive sound bites?

“Recovery oriented”: It strikes me that people who don’t speak jargon but do speak ordinary English would be astounded to think that mental health care now is not recovery oriented and would be bewildered by what recovery oriented care might be as distinct from ordinary treatment.

“Patient-centered”: Again, in ordinary English it doesn’t make a lot of sense to call for patient-centered care. What are we doing now if we’re not centered on the care of our patients?

“Mental health home”: I’m very taken by the recent suggestion to think about mental health needs via an analogy to the increasingly popular concept of a medical home. But, how many people know what a “medical home” is, let alone get the analogy between it and the provision of a comprehensive array of services for people with serious mental illnesses? A home? Isn’t that either where you live or an institution you go to when you can’t live at home?

So I think the search for a sound bite needs to continue. Preferably we need one that has a clear meaning in ordinary English. (For example, I would not use the term “behavioral health.” No one outside of our field knows what that means.) In addition, the sound bite should implicitly contain a broad agenda including:

- Coverage of behavioral health care in all benefits packages
- Continued incremental improvement of community supports for people with long-term psychiatric disabilities
- Expansion of, and improved access to, mental health and substance use services for the 50% of us who will experience mental and/or substance use problems in our lifetimes
- Pursuit of new opportunities for early intervention and prevention
- Preparation for major demographic changes—the growth of aging and minority populations
- Quality improvement
- Integration of health and behavioral health services in primary, specialty, and long-term care
- Inclusion of mental health in the drive to improve information technology
- Workforce expansion and enhanced competence
- Enhanced research and translation of research into practice.

As I assume is apparent, I haven’t a glimmer what the mental health sound bite should be. So, I am issuing this invitation:

PLEASE SEND ME SUGGESTIONS
center@mhaofnyc.org

I’ll publish the promising ones in my next column.

(Michael B. Friedman, LMSW is the Director of the Center for Policy, Advocacy, and Education of the Mental Health Association of New York City. The opinions in this essay are his own and do not necessarily represent the positions of MHA.)