MENTAL HEALTH POLICY

MENTAL HEALTH POLICY TODAY: THE MAJOR ISSUES IN 2022

Welcome to the world of mental health policy. I've been part of it for nearly 50 years, first by trying to win community support for a psychiatric rehabilitation program on the West Side of Manhattan, later as the person responsible for government relations for the Jewish Board of Family and Children's Services, and then as an advocate for improved mental health policy as both a member and organizer of a number of advocacy organizations including The Coalition For Behavioral Health of NYC, the Greater NY Hospital Association, The Mental Health Action Network of New York, The Children's Mental Health Action Network, The Geriatric Mental Health Alliance of New York, The Veterans' Mental Health Coalition of NYC, and most recently the Cognitive and Behavioral Health Advocacy Team of AARP Maryland, among others.

Although I have also been a direct service provider, an administrator, a public official, and a teacher, advocacy for improved mental health policy has been the core of my career. It may or not be for you; but if you choose to work in the field of mental health, you would be wise to learn about and advocate for mental health policy. Since you chose to take this course, I assume you know that. Hopefully, the course will help you incorporate advocacy into your career.

Let me say at the outset that mental health policy in America is remarkably complex.[1] There's layer upon layer of detail, and even after nearly 50 years I don't come close to knowing it all. In this course we will get a bit past the headlines of some policy issues, but we will leave a lot untouched.

Let me also note that by its nature advocacy is frustrating. Year after year we deal with many of the same fundamental issues in climates of political division and of competition among mental health interest groups. But with perseverance, progressive change is possible. Indeed, progressive change has taken place.

Since the mid-1950's when a shift from an institution-based to a community-based mental health system began, the proportion of people with serious mental illness getting treatment has increased from about 1/3 to about 2/3, and their lives have gotten better.

When I began in the field in the late 1960s, deinstitutionalization was at its peak, and people coming out of state hospitals often lived in squalid, dangerous conditions without access to decent care and treatment. Since

then—notwithstanding the advent of homelessness and the growth of the number of people with serious mental illness in jails and prisons—there has been significant improvement including:

- Hundreds of thousands of units of supportive housing
- More uniform and stable public assistance for people with disabilities
- Legal rights preventing discrimination against people with disabilities, including mental disabilities
- A significant increase in outpatient treatment
- Creation of community supports for people who even 50 years ago would have been warehoused in state hospitals or abandoned without care or treatment.

Of course, there is far more that needs to be done, but we have made progress.

In what follows I will share with you a number of perspectives on what the most important mental health policy issues are at the moment. I start with President Biden's declaration of a mental health crisis in America. Then I add observations about the politically powerful, false linkage of mass murder with mental illness. I will also make a few observations about lessons of the pandemic and about work to restructure mental health finance and service delivery that has been going on for several decades but does not make headlines. Finally, I'll comment on the inherent relationship between policy and money such that without money there is no real policy, just empty promises.

President Biden Announces A Mental Health Crisis in America

In his State of the Union Address in January, President Biden announced a mental health crisis in America and called for a bipartisan effort to confront it.[2] Music to the ears of a mental health advocate like myself, who has spent much of his career frustrated by lack of interest in the widespread mental health problems of the American people. For years, I and other advocates, have called for major efforts to address the shame of homelessness and of the incarceration of large numbers of people with mental illness in jails and prisons; the low life expectancy of people with serious mental illness; the hard poverty they live in; the bigotry that bars people with serious mental illness from full participation in mainstream society; the burden created for caring families; the shortage of mental health services and a workforce to provide them; the difficulties getting access to services; the uneven—a polite way of saying often poor—quality of mental health services; the chaotic fragmentation of the mental health system; the division of mental needs into silent silos of mental illness, substance misuse, and cognitive impairment despite the fact of the co-occurrence of these disorders; the disparities—the unjust inequities—that affect people with mental illness and, even more, people of color with mental illness; the persistent misinformation

and stigma about mental illness, particularly the stubborn, false view that mental illness is the cause of mass murder; the failure to fully face the special mental health challenges of children, adolescents, and older adults; the recent surge in suicide and drug overdoses; the disparity in funding for mental vs. physical illness; the inadequacy of funding generally and the failure to devise funding structures that are responsive to the realities of mental illness and substance use disorders; and the jockeying of federal, state, and local levels of government to avoid responsibility for meeting the mental health needs of the people they are supposed to serve.

What a relief to have a President who wants to confront the "crisis" of mental health in America and who presents this not as an opportunity to gain partisan political advantage for his party but as an opportunity to make progress despite the current, vituperative political divide in America. It is an opportunity, he believes, to build unity.

What is the crisis, as the President sees it? First, it is important to note that the current perception of mental illness as a crisis in large part reflects the widespread psychological fallout of the pandemic. Suddenly people who never put much stock in the importance of mental health have been emotionally shaken themselves. Fear of death from COVID, grief in response to the deaths of over one million Americans, the daily confrontation with the risk of COVID by people working on the frontlines of health care and those providing vital services that cannot be done via Zoom, economic desperation among millions of people who lost their livelihoods, the stress of juggling work and homelife while sheltering in place, the growth of social isolation, the disruption of the lives of children and adolescents missing the normality of school and friendships—all of this made the importance of mental health clear in a way that it had not been before.

In addition, the pandemic shone a spotlight on huge economic and racial disparities in America, because people who were economically insecure and especially people of color have borne a disproportionate burden of illness and death.

During this time, substance misuse increased, undoubtedly as a way of masking personal distress; and overdose deaths from drugs have increased dramatically. And even though it appears that so far suicide rates have not increased during the pandemic, the news broke into public consciousness that suicide is up 35% or more since the turn of the 21st century.

In addition, while the pandemic was raging in America, there were several prominent murders of Black people by the police. In addition, to highlighting racism in America, these incidents led to widespread recognition that using the police to intervene in psychiatric crisis sometimes results in avoidable injuries or deaths of people with mental illness by some police officers who are racist or simply are unprepared to deal compassionately with menacing

or disobedient people. A call arose to use mental health professionals to respond to psychiatric crisis and to create a new system of crisis response.

Emotional distress, drug overdoses, suicide, a failure of compassionate response in times of great need—indeed, there is a mental health crisis in America.

To confront it, the President has created a remarkably ambitious agenda for action that calls for:

- Building the capacity of the behavioral health* system
- Expanding and improving the quality of the mental health workforce through training and through diversification to include more people of color and people with histories of mental illness (peers)
- Addressing racial inequities in the mental health system
- Establishing a comprehensive initiative to reduce drug overdose deaths
- Increasing efforts to reduce the incidence of suicide
- Addressing the long-term psychological fallout of the pandemic for children and adolescents
- Addressing the potentially harmful impact of social media on the mental health of children and adolescents
- Expanding school-based mental health services
- Providing permanent funding for certified community behavioral health clinics, which use a model of coordinated care that will gradually replace the traditional and antiquated clinic model
- Embedding and co-locating behavioral health services in community settings
- Creating a new system of response to psychiatric crises, starting with the introduction of 988 as the one telephone number to call for help with a crisis in the United States
- Enhancing the integration of treatment for mental and substance use disorders into primary health care
- Expanding access to tele-behavioral health care
- Improving coverage of mental health and substance use services by insurance companies and enforcing requirements of parity between physical and behavioral health funding
- Investing in more research and in the translation of research into evidence-based practice
- Addressing social determinants of behavioral health and illness by creating healthy environments.

What an ambitious agenda! Achievable? Some of it, such as the national roll out of 988, is in motion already. But much more needs doing. It will be complex and costly in a nation beset by sharp political division and in a mental health community that is often divided against itself as providers,

* "Behavioral health" is a term that has emerged over the past few decades to refer to both mental and substance use disorders. See Behavioral Health--what_A_Difference_A_Word_Makes.pdf (michaelbfriedman.com)

professions, and interest groups of various kinds pursue what they need to survive and thrive without much regard for the overall needs of people with mental and/or substance use disorders—a mental health community that is also ideologically divided between those who believe there's a need for more long-term hospitalization and those who believe that that need is an illusion that can be addressed by expanding community services.

And remember, this is an agenda for the federal government. Thoroughgoing change depends as well on state and local governments and on the private sector, which provides a large portion of mental health funding and service in the United States.

So, there's reason for skepticism about the fate of the Biden agenda. But recognition of the importance of mental health is a very positive development, and the details of the Biden agenda define some key issues in mental health policy at this moment in history.

Mass Murder and Mental Illness

However, in the six months following President Biden's announcement of a mental health crisis in America and his plan to confront it, several prominent mass murders—especially several in schools—and the consequent political faceoff of advocates for gun control with advocates for the right to possess guns re-awakened the perception that mass murder is a mental health problem. Democrats by and large reject this view; Republicans by and large insist on it. And in the popular mind—given widespread fear of violence by people with mental illness—it is hard to resist the idea that a young man who mows down children and teachers in a school with an automatic weapon is anything but a lunatic.

So, the conviction that mass murder is a mental health problem has once again become politically powerful.[3] It will undoubtedly fuel calls for more forced treatment and hospitalization of people with serious mental illness. Debate about that I'm sure will once again be a major element of attention to mental health policy.

In fact, the perception that mental illness rather than the existence of guns is the cause of mass murder has made its way into federal gun control legislation. The much ballyhooed gun safety law[4] that was enacted in June of this year includes, at the insistence of Republicans, new funding for the expansion of mental health services.

Should mental health advocates celebrate much needed service growth or rue giving credibility to the false link between mass murder and mental illness? According to Victoria Knight of Kaiser Health News, "While mental health advocates are happy that Congress is authorizing new funds for their cause, they also express concern that it would continue to perpetuate the

idea that people with mental health disorders are largely responsible for gun violence, although research shows that's not the case. Only 3%-5% of violent acts are committed by individuals with a serious mental illness…. People with mental illness are more likely to be victims of violence than are members of the general population." [5]

As I've said, I'm quite sure that the issue of mental illness and violence will be prominent in discussions of mental health policy this year. We will devote one of our classes to it, although in that class we will discuss suicide as well as homicide since it is quite clear that suicide not homicide is the major problem of violence among people with mental illness.[6]

Learning the Lessons of the Pandemic

This year is also a time for learning the lessons of the psychological fallout of the pandemic, as is partially reflected in the Biden agenda.

This includes the realization that the human mind reacts to social circumstances and that healing reactive emotional distress depends on addressing those circumstances as well as making more treatment available. Both the Trump and the Biden administrations and the Congress of the United States moved remarkably rapidly to make economic supports and medical care available to people who became ill and to those who lost their livelihoods due to tough public health measures that led to the closure of businesses.

Mental illness clearly is not a condition that exists independently of the environment in which people live. This, of course, is not news to social workers who draw from a bio-psycho-social model of psychological distress. But it has been an important awakening for many mental health professionals who have become devoted to the view that mental and substance use disorders are brain diseases.

The power of social isolation has been another critical lesson of the pandemic. Loneliness, especially of older adults cut off from their usual social, recreational, and spiritual lives, became an obvious source of distress. And this happened on the heels of an important report from the National Academies of Science, Engineering, and Medicine that documented widespread social isolation and loneliness even in the best of times as well as the consequent negative impact on physical and mental health and on disability and mortality.[7] Some argue that social isolation is as harmful to people's health as smoking.

During the pandemic there have been some remarkable efforts, often using volunteers, to help people in isolation to connect with other people. Whether these kinds of efforts will continue to be part of the repertoire of mental health services and supports is an open question.

The pandemic also led to a remarkably rapid change of laws and regulations to facilitate the use of tele-technology to provide treatment and support. The need for tele-health had long been known and was met to some extent for people living in areas with scarce or non-existent mental health resources. But insurance carriers, both commercial and governmental, had long resisted paying for tele-health services except in dire circumstances. Now the value of such services has been demonstrated and has opened the door to a new era of mental health treatment using technology to replace face-to-face contact. To many people in my generation, this seems strange—a deeply personal relationship without in-person contact. Those of you who have meaningful relationships through social media all the time probably don't find it strange at all. In any event, the debate about whether to make tele-health available as a routine matter rather than just in a crisis, is likely to be a major issue in the coming years.

Finally, I want to note that a truly critical lesson of the pandemic has been the rediscovery of systemic racism. People of color have been disproportionately victims of COVID and of death and disability due to COVID. In part, of course, this reflects the fact that people of color are generally at the bottom of the economic ladder. They do jobs that are essential for the survival of our society that cannot be done virtually. And they often live in shabby and dangerous environments where the spread of disease is hard to prevent. But disparities during the pandemic also appear reflect the racism ingrained in the medical and mental health systems. Psychiatry, psychology, social work and other professions have issued public apologies for bigotry, neglect, and abuse over the course of their histories. All are working to build equity. Such efforts to address disparities in medicine and mental health are not new, as I point out in a lecture on race and mental health later in this course; but the full realization that prior efforts have been inadequate is new and will hopefully drive significant efforts to improve mental health policy in this regard.

Systems Change

While the headlines and politics of mental health policy focus on mass murder, suicide, drug overdoses, homelessness, incarceration in jails and prisons, systemic racism, shortages of services, back-ups for admission to inpatient treatment, the post-pandemic fate of children who suffered developmental disruption, the dangers of social media, and other matters of great alarm, much work is going on off the front pages to transform the mental health system from a costly, fragmented, chaotic hodge-podge of services, systems, and financing to integrated systems of care that hold down costs while improving services and their outcomes.

These efforts to improve the systems go back several decades beginning with the introduction of managed behavioral health care by commercial

health insurance carriers in the early 1980s and spreading rapidly to the introduction of managed care techniques into Medicaid, the largest source of funding for behavioral health services in the United States.

As it became clear that the drivers of high costs were people with multiple chronic physical and behavioral health conditions who did not get routine treatment for their conditions, the focus of these efforts became outreach to, and engagement with, this population wherever they were in the community rather than waiting for them to appear in emergency rooms in need of lengthy, expensive inpatient treatment. For this population, managed care moved from mere price and utilization control to aggressive efforts to make sure they had stable housing and access to the services they needed in their homes and in community settings if they would not or could not come to places where mental health services were provided formally.

For others—for the vast majority of people with mental or substance use disorders that are not severe and persistent—as well as for people with multiple chronic conditions, the focus of change became "value", defined as getting good outcomes. Payers for services, both governments and employers, no longer want to pay just for numbers of services; they want the services to actually result in clinical improvements and better quality of life.

In general, systems reform has several core goals—(1) to control the growth of costs (called "cost containment"); (2) to assure that people with mental and/or substance use disorders get the care and treatment that they need and that they are not provided with care they do not need, especially unnecessary inpatient treatment; (3) to coordinate the care and treatment that they get from diverse providers; and (4) to improve clinical condition and quality of life.

To achieve these goals various more or less experimental changes have been made in the structure of financing and service delivery. This includes the replacement of fee-for-service funding with forms of payment that create incentives to hold down costs and provide effective treatment. It also includes a variety of ways to integrate treatment for mental and/or substance use disorders and/or to integrate treatment of physical and behavioral health conditions. The new structures go by such names as "patient-centered medical homes", "accountable care organizations", "value-based treatment", "coordinated care management", "community behavioral health clinics", and quite a few more.

I don't expect that you will have understood much of what I just said. We will tackle the some of the complexities of behavioral health finance in a subsequent lecture. At this point I simply want you to be very clear that in addition to the mental health policy issues that make the headlines, there are active efforts going on to remake the financing and structure of mental

health systems. These efforts ultimately may have profound impact on the lives of people with behavioral disorders, whether for better or worse, in my view, has yet to be seen.

Money and Policy

The advocacy goals that I have sketched out in this lecture are, frankly, terrifyingly numerous and complex. But if you take a quick look at the advocacy agendas of just a few of the advocacy organizations that are actively working for change, you will find even more issues that are priorities for advocates. I am not going to try to list them here.

Except for one—**inflation**. Policy and funding are intimately linked. I frequently argue that if you really want to know the policy, look at budgets. Policy statements without financial backing are just rhetoric, just political diversions from the true state of affairs. So, the state of the economy matters greatly to the state of mental health policy. Our economy may be entering a recession during which funding for mental health will become increasingly difficult to come by. We may also be moving to a shift in national leadership from relatively liberal to conservative with consequent reluctance to spend tax dollars to meet social needs. And we are already in a period of inflation, which—if it continues—will make the provision of mental health services increasingly difficult.

I lived through the last such period 40 years ago when I was the Chief Operating Officer of the Jewish Board of Family and Children's Services. We had to raise an additional 8% or more every year for about 5 years just to maintain our current level of service. Not easy. And I'm afraid that we are entering such a severely challenging period again. If we do, I guarantee that the hope of unifying the mental health community around a shared agenda for change will fall by the wayside as fights break out over the bones of fiscal constraint. Let's hope that the economy remains strong enough for substantial investment in an improved mental health system.

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[1] Improving_American_Mental_Health_Policy--HHPR.pdf (michaelbfriedman.com)

[2] FACT SHEET: President Biden to Announce Strategy to Address Our National Mental Health Crisis, As Part of Unity Agenda in his First State of the Union | The White House

[3] Stigma_As_A_Political_Weapon.pdf (michaelbfriedman.com)

[4] Text - H.R.7910 - 117th Congress (2021-2022): Protecting Our Kids Act | Congress.gov | Library of Congress

[5] Knight, V. (2022). "Gun Safety 'Wrapped in a Mental Health Bill': A Look at Health Provisions in the New Gun Law" in *Kaiser Health News*, July 7,2022.

[6] Friedman, M. and Nestadt, P (2015). "Violence and Mental Illness: Suicide, Not Homicide, Is the Major Problem" in *The Huffington Post*, 11/1/2015.

[7] Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System |The National Academies Press