MENTAL HEALTH POLICY IN THE UNITED STATES

THE ROLES OF GOVERNMENT IN BEHAVIORAL HEALTH

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Abstract: This lecture provides an overview of ten vital roles of government in behavioral health—policy vision, service provision, finance, planning, quality assurance, workforce development, research, protection of rights, public assistance, and criminal justice. Significant policy issues are identified in each of these areas. The lecture concludes with a brief discussion of the governmental structures through which policy is made, implemented, and enforced.

That government needs to play a part in our society's efforts to address issues of mental illness and substance abuse is clear and generally accepted. But there are debates about:

- How extensive the role of government should be
- What roles government should play
- Which levels of government (federal, state, county, and municipal) should take responsibility for what.

Keep in mind that other social institutions also play important roles in the response to social problems—the family, community organizations, organized religion, the workplace, commercial health insurance, philanthropy, private practitioners, etc.

Keep in mind, too, that that there is an ongoing debate between conservatives and liberals about how extensive the role of government should be.

Conservatives generally believe that government should be as limited as possible and that as many functions as possible should be left to the family and the private sector.[*]

[*] There are a variety of conservative views. Libertarians generally subscribe to the view that Robert Nozick referred to as a "night watchman" government. For him individual rights take priority over the public good. L*aissez-faire* conservatives believe that government intervention should be held to a minimum so as to promote economic growth. Traditionalist conservatives argue that social engineering with the best of intentions usually has unintended consequences and that, therefore, activist social policy can be dangerous.

Liberals generally believe that government should actively pursue the well-being of the people it governs.[†]

Conservatives and liberals also generally disagree about the autonomy and responsibility of state and local governments. Conservatives usually argue for "states' rights" and against extensive federal control. They also often argue for local "home rule" and limited authority of the states vis a vis local government. Liberals have tended to look to the federal government to provide progressive policy development, though they sometimes prefer state or local policies to federal policies. For example, the distribution and use of marijuana is still a federal crime while many states have legalized it for medical and/or recreational use.

In this lecture I explore the fundamental roles that government plays with regard to behavioral health and touch on some of the live debates about what it should do and how it should do it. I address ten governmental roles:

- Policy vision
- Service provision
- Finance
- Planning
- Quality assurance
- Workforce Development
- Research
- Determination and protection of rights
- Public assistance
- Criminal justice

This lecture ends with a brief discussion of the governmental structure through which policy is made, implemented, and enforced.

Policy Vision

The scope and nature of governmental responsibility for mental health has changed dramatically over the course of American history. Gerald Grob provides a brilliant account of those changes from colonial times to the end of the 20th century in "Government and Mental Health Policy".[1]

The current vision is that federal, state, and local governments have a shared responsibility (1) to help people with serious mental illness to live freely in the community (rather than in institutions) (2) to provide care and

[†] I have traced the history of American liberalism in an article called "In Praise of Liberalism". http://michaelbfriedman.com/mbf/images/In_Praise_of_Liberalism.pdf In this article I argue that the core of liberalism is the progressive effort to improve the economic lot and the power of those who are the most disadvantaged, using government as a primary instrument of social improvement.

treatment for them mostly in the community and using hospitals for as short a period of time as possible and only as a last resort, (3) to provide some help to people with a diagnosable behavioral health disorder to get the treatment that they need even if their disorder is not disabling, and (4) to make some efforts at "prevention" of mental disorders and at the promotion of psychological well-being.

This vision has been called into doubt for several different reasons. Many mental health advocates, as I've said in prior lectures, are very distressed that there are hundreds of thousands of people with serious mental illness who are homeless and/or incarcerated in jails and prisons and believe that deinstitutionalization went too far. They tend to call for greater use of hospitals or even asylums to protect people with serious mental illness.[2] They also generally support increased use of coercive interventions, especially involuntary outpatient commitment, which they usually call "assisted outpatient treatment".

Other advocates stress the rights of people with serious mental illness and call for expansion of supportive housing and other community-based services instead of hospitals to get people off the streets and out of jails and prisons.[3] They also argue for increased efforts at outreach and engagement rather than for involuntary outpatient commitment.

This dispute began in the 1970s and continues unabated today. Unfortunately, as I've also said in prior lectures, this debate engenders dysfunctional division in the mental health advocacy community.[4]

There is another fundamental dispute about the current policy vision that seems to be less common than it was at the end of the last century, but still rises to the surface from time-to-time in debates about what mental health services government should fund. It centers on the question of the extent of governmental responsibility for people who have mental disorders that do not threaten their basic well-being or survival.

Should governmental resources be spent on "the worried well" as they are sometimes disparagingly called? Some advocates believe that government should not use the limited resources available for mental health for people who have diagnosable disorders that are not disabling and especially for people who do not have a diagnosable disorder at all. Other advocates believe that psychological interventions can be extremely helpful to people suffering mild mental disorders or from emotional distress that does not meet diagnostic criteria for a mental disorder such as the typical emotional challenges of psychological development or the ordinary vicissitudes of life, which are sometimes referred to as "problems of living". These advocates believe that governmental resources should be invested in helping people in distress to have psychologically satisfying lives. For example, in my

experience students here at Columbia have tended to believe that they should be able to get psychotherapeutic help at no cost to themselves.

Currently American mental health policy includes support for services for people with mild, diagnosable disorders that don't interfere with fundamental functioning or threaten survival but does not support government funding for behavioral health services for people who do not have diagnosable disorders but do suffer from emotional distress.

There is a governmental responsibility to the population of people with non-disabling mental disorders—to some extent. Through Medicare, the federal government provides some funding for services for older people with diagnosable behavioral health disorders with or without disabilities. Through Medicaid, federal, state, and occasionally local governments provide funding for people with diagnosable disorders who are poor. Federal, state, and local governments provide some additional funding for them via block grants, demonstration grants, contracts for services, and more.

As I've said, in theory, American governments do not have any responsibility to fund or provide services for people experiencing emotional distress that does not meet criteria for diagnosis as an illness. One exception is during disasters when federal emergency efforts include some funding for crisis counseling.[5]

In reality, however, it is exceedingly hard to distinguish between emotional upheaval and diagnosable disorders; and the major epidemiological survey of this century (done in 2000) revealed that 40% or so of people who get treatment for mental illness do not have conditions that meet diagnostic criteria as mental disorders.[6]

Should this be so? What populations should be the responsibility of government is a fundamental policy question.

Another fundamental question is whether behavioral health services should be **merged into mainstream healthcare** or whether there should continue to be separate structures through which behavioral health conditions are addressed? [7]

The argument for merger is that it would promote integration of physical and behavioral health service delivery. The argument against it is that an integrated system would inevitably be dominated by physical health care professionals, who have very little understanding of behavioral health, especially of the special needs of people with serious mental illness, who need much more than traditional treatment.

Another major fundamental issue is prevention.[8] Currently, government does relatively little to prevent mental and substance use disorders. Some advocates are horrified and argue that an ounce of prevention is worth a pound of treatment. They often point to studies about "adverse childhood experiences"[9] that show that kids with such experiences are more likely to develop behavioral and physical health problems when they become adults. They call for various measures to reduce troubling experiences in childhood, especially abusive experiences in the home, and to help children to learn how to deal with stress before it becomes "toxic".[10]

Those who make a strong case for investing in prevention also tend to emphasize the so-called "**social determinants**" of mental health[11,12] and call for government to do more to address poverty, racism, violence, and the like so as to reduce the incidence and prevalence of mental illness and substance misuse. Others argue that it is not the role of behavioral health policy to overcome such huge social issues. That's way beyond the capability of the fields of mental health and substance use.

Some advocates, such as myself, believe that prevention is the right ideal but that we don't know enough about the prevention of illness to be effective. Earlier intervention, yes. Limiting disability, yes. Preventing relapse, yes. Preventing institutionalization, yes. Preventing mental illness altogether? Not given the current limits of our knowledge and power to change society.

In addition to the question of how extensively the field of mental health should involve itself with major social determinants, there is also a question of how extensively the field should focus on **public policy matters** that are not explicitly about mental health but **which** do very much **affect people with behavioral health problems**. For example, should the system of cash bail for people awaiting trial be reformed? Should substance abuse should be decriminalized/legalized? I will discuss a number of issues like these in subsequent lectures.

Direct Service Provision

As I noted in a previous lecture, over the course of the 20th century the fundamental role of government shifted from direct service provision primarily via the state hospitals, to funding and regulation of behavioral health services.

Nevertheless, governments have also continued to be direct service providers. For example, the federal government provides treatment for veterans through the Veterans' Administration and treatment for active military personnel through the medical system operated by the armed forces. The states continue to operate state hospitals, albeit with vastly

reduced populations. And the state hospitals have expanded to provide services in the community—outpatient facilities, housing, case management, etc. And some local governments provide direct services. In NYS, for example, it is common for there to be county operated clinics. Sometimes these are operated by county government itself; sometimes—as in NYC—they are operated by quasi-governmental entities known as "public benefit corporations".

Should governments continue to provide direct services, or should they divest and focus on their responsibilities to fund and oversee service provision? The answer to this question will vary from situation to situation.

Behavioral Health Finance

Funding in my view is the single most important role of government with regard to behavioral health. No money, no policy; just rhetoric.

There are a great many questions regarding governmental funding for behavioral health, starting with what and how much should be funded privately and what and how much should be funded by federal, state, and local governments?

Currently 35-40% of funding for behavioral health comes from the private sector, much of it from employer-based health insurance but a significant portion of it from people getting treatment and/or their families.[13]

Many progressives, of course, argue for replacing employer-based insurance with government-based universal coverage, which in theory would cover behavioral health as well as physical health services. But this is open to some doubt. Canada, for example, which provides government-based universal coverage, has poor coverage for outpatient mental health services.[14,15] And, in the United States, Medicare provides limited coverage of behavioral health services. It does not cover all needed services, and it charges insurance premiums and hefty co-pays that require individuals and families to pick up a significant portion of the cost. It is theoretically possible, as proponents of "Medicare-for-all" have promised, to change Medicare so that health care would be free and mental health and substance use treatment would be completely funded. Whether that is a real possibility given the political realities in the United States is open to question.

Whether governments should pick up a larger share of behavioral health spending is a key question for the future. Should Medicare coverage be expanded? Should Medicaid (which provides far better mental health coverage than Medicare) expand to cover more people? If so, should the federal government pick up a larger share of Medicaid as it has through the Affordable Care Act? Should there be larger mental health and substance

abuse block grants to the states? Should Medicaid—an entitlement program—be replaced by block grants? (I address the difference between entitlements and block grants in the lecture on behavioral health finance.)

For both Medicare and Medicaid, fundamental and ongoing questions include who should be eligible, what services should be covered, how much should they pay for services, how should they pay—with cost-based fee-for-service, with case rates, with capitation, or with value-based contracting—and what controls should they put in place to limit utilization and cost of treatment? (I also address these differences in the lecture on behavioral health finance.)

Although Medicare and especially Medicaid are the largest sources of governmental funding there are many other federal, state, and local sources of funding. Other federal funding streams include:

- Block grants for mental health and for substance abuse
- Research grants (NIH, SAMHSA, HRSA, CDC, etc.)
- Demonstration grants
- Training and technical assistance grants
- Workforce development grants
- Grants to fund specific populations and programs such as systems of care for children and adolescents and suicide prevention.

State and local funding streams include

- Funds for state service programs such as state hospitals
- State aid to localities to provide or to fund local services
- Special grants for priority populations, demonstration programs, research, workforce development, and technical assistance.

Each of this multitude of funding streams is open to constant review. Should it be continued? How much should be spent?

In addition to the questions about spending noted above, there are fundamental questions of accountability and responsible spending. These questions include:

- How to keep costs from becoming unnecessarily high ("cost containment").
    - What funding mechanisms provide the right incentives to encourage provision of needed treatment and to prohibit unnecessary treatment?
    - Should governmental payers use managed care? For services? For medications? Should there be governmental regulation of managed care in the private sector?
    - What works better? Government rate setting or market-based rates?

- How much new program development should be permitted? (The process to answer this question is called "certification of need".)

- How to defend against the misuse of public funds and/or fraud?

- How to use the power of the purse to assure adequate quality of care?

Questions about accountability ultimately become remarkably specific and detailed. What should the reporting requirements be? How should providers be audited? Who should audit—government or private accrediting organizations or both? Etc.

At the beginning of this section, I noted that about 35-40% of behavioral health spending is non-governmental. Should this spending be free from governmental regulation? Or should there be mandates for employers to provide behavioral health benefits? Should employer-based health plans have to meet minimum standards? What should those standards be?

Perhaps the most prominent issue about behavioral health finance for the past several decades has been **whether parity of physical and behavioral health coverage should be required**? That is, should payments for behavioral health services be equal to payments for physical health services? Equal co-pays? Equal maximum fees? Equal total spending per year and/or per lifetime? Federal parity legislation and The Affordable Care Act (Obamacare) established such requirements—to some extent. How to assure that the parity requirements are met is currently a challenge to the states.[16]

I will talk about these issues in more detail in the lecture on behavioral health finance.

Quality Assurance

There is, of course, a fundamental expectation that government will play a significant role in assuring that behavioral health services are of adequate quality. And, despite some concern about over-regulation, everyone expects government to set standards for (1) professionals and for (2) facilities and programs. This is usually done via licensing.

There are, however, some fundamental questions about licensing standards. Should government insist on high quality or just on meeting bare minimums? Who should decide what the standards should be—employees of the government or professional organizations?

At the moment, licensing is mostly done by the states, rather than by federal or local government, using minimum standards. The argument is that

government should avoid disputes with professionals about what constitutes good practice as much as possible. And private professional accrediting organizations, such as the Joint Commission,[17] have emerged that establish professional standards. In fact, there is overlap between the two. Medicaid, for example, requires that some providers be both licensed and accredited as do some other payers.

Some advocates are less than enthused about this arrangement because private accrediting organizations generally are the children of the trade associations that represent provider interests. Can the mental health professions and organizations really police themselves?

Since licensing and/or accreditation are generally preconditions for getting funding, debates about what professions and what types of organizations should be licensed are no small matter. There are frequent battles among the mental health professions—psychiatry, psychology, social work, nursing, and counseling. Should psychologists be permitted to prescribe medications? Psychiatrists don't think so. Should social workers be eligible to be paid for clinical services they provide without supervision from a psychiatrist? Psychiatrists have done what they can to make this difficult. These are known as "**scope of practice**" issues.

There are also very important questions about how to assure the safety and effectiveness of medications. For the most part this is the province of the federal Food and Drug Administration (FDA), about which many reservations have arisen regarding how long approvals take, about the use of emergency provisions, and recently about standards of effectiveness. For example, a new drug to treat Alzheimer's Disease has become a major controversy because there is no evidence that it works, though there is marginal evidence that it affects the brain in ways that in theory should reduce the occurrence of Alzheimer's dementia. Some argue that it should be made available to anyone seeking hope for a cure. Others argue that it should be available only as an experimental drug in controlled studies.

Whatever decisions are made about the reach of government and what the standards should be in order to assure adequate quality, there are then a host of very concrete questions about how to oversee quality. Record keeping? Audits? Surprise visits? Etc.

Planning

Planning is one of the key roles of government. To some extent this is done very broadly through the determination of fundamental policy. The shift to community mental health policy, the inclusion of behavioral health in Medicaid and Medicare, and the funding of housing for people with mental illness are examples.

But there are also formal planning processes carried out by federal, state, and local governmental agencies. These usually result in the development of documents called "plans". Some are "strategic" plans, which identify long-term directions to pursue, and some are long-term or short-term action plans that specify particular actions to be undertaken at particular times. (Take a look at SAMHSA's strategic plan[18] and/or New York State's Comprehensive Plan.[19])

Most governmental planning processes include opportunities for public comment. In addition, most have formal advisory committees and councils, which offer good opportunities for advocacy.

Governmental **budgets**, which are done by all levels of government, **are *de facto* plans**. In my view, they are more important than formal plans because they put the government's money where its mouth is.

There has been a major debate about how extensive healthcare planning should be. Democrats have usually favored the use of extensive governmental planning to guide the development of the healthcare system including behavioral health. Republicans, however, have usually tilted towards a market-based approach, allowing hospitals and other healthcare providers some leeway to decide for themselves how extensive their services should be rather than requiring them to prove need and viability before getting approval to develop new services. This debate is similar to the broader debate about whether planned, regulated economies or laissez-faire economies have better outcomes.

Workforce Development

The behavioral health workforce is inadequate both in quantity and quality. From time to time, a workforce crisis is announced and there is a flurry of activity to enlarge and improve the workforce.[20] Workforce "crises" vary over time. Today the shortage of non-white professionals, especially those who are bilingual, is a major concern. When I began in the field in the 1970s, a core problem was the shortage of psychiatrists who spoke English.

Is it the job of the government to play a leading role in addressing workforce needs? Or is this a job that should be largely left to the private sector, especially to universities and perhaps to the organizations—such as pharmaceutical companies and health systems—that gain economically from having an adequate workforce?

Fortunately, governments do play a role in building the workforce. The federal government funds training programs, provides grants to universities,

and provides scholarships and loan forgiveness to some people who become mental health professionals.

These efforts have helped. Since the middle of the 20th century, there has been growth and improvement. Not nearly enough, however.

And our society is at a particularly challenging moment in its history. It is an aging society without a geriatrically competent workforce in behavioral health or in long-term care. It is a society that is increasingly composed of people of color, with the largest growth among Latinos; but culturally competent, especially bilingual, professionals are in short supply.

We are also at a crossroads with regard to immigrants—who have been the backbone of the paraprofessional workforce. Policy changes during the Trump administration that have yet to be reversed by the Biden administration choke off the supply of new immigrants. If these policies continue, I fear for the supply of direct care workers.

Should the government redouble its efforts to enhance the workforce or lumber along as it has for many years? It's a key question about the responsibility of government in behavioral health.

Research

The federal government has accepted a major responsibility to conduct and fund behavioral health research—largely through the National Institute**S** of Health (NIH), which include:

- The National Institute of Mental Health (NIMH)[‡]
- The National Institute of Drug Abuse (NIDA)
- The National Institute of Alcohol Abuse and Alcoholism (NIAAA).

The Substance Abuse and Mental Health Services Administration (SAMHSA) also funds some research, as do The Health Resources and Services Administration (HRSA), The Centers for Disease Control (CDC), and several other federal agencies.

NYS, unlike other states, operates research facilities (The Psychiatric Institute and The Nathan Kline Institute), which are funded primarily with federal grants but also have state funding.

[‡] From its inception after WWII until the 1992, NIMH was **the** federal agency for both mental health research and mental health services. At that time, The Substance Abuse and Mental Health Services Administration (SAMHSA) was created and became the federal agency for mental health services and NIMH became purely a research agency.

Government funded research is subject to tremendous controversy. There are several fundamental forms of research—biomedical, clinical, services, epidemiological, preventive interventions, etc. Which should get the bulk of the funding? Should behavioral health research focus on the underlying organic roots of mental and substance use disorders? Should it focus on developing medications to prevent or to cure these illnesses? Should it explore how services should be delivered and organized? Should it pay greater attention to issues of prevalence, incidence, utilization, and outcomes? Should it place more emphasis on the psychosocial dimensions of behavioral disorders? Etc.

Since the last decade of the 20th century, there has been increasing attention to the organic roots of mental illness and addictions in the brain. This began in the 1990s with great optimism that there would be a breakthrough in a short period of time—like investment in space travel in the 1960s. But there has been no breakthrough. New drugs are marginally better than the older ones, mostly with regard to side effects. There have been no cures.

So, some mental health advocates are critical of current research priorities, calling for more psychosocial research and more attention to the needs of people who are suffering now rather than investing so much in hopes for an elusive future cure.

It is also clear that better data are needed to inform policy making and planning. How many people are affected by mental and substance use disorders? How does that vary by age, race, and socio-economic status (SES)? How many people get treatment? Adequate treatment? Does it vary from one part of the country to another as well as by age, race, and SES? Given revived concern about behavioral health disparities, answers to these questions are critical to pursuing equity in behavioral health?

It is also of great concern at this moment in history that research has had a distinctly White tilt. There has been too little research regarding mental illness and people of color; and, needless to say, there have been too few qualified researchers who are not White or Asian.

Some advocates are also concerned about how decisions are made about what research to fund. On the one hand, NIMH and others have done an excellent job of insulating the choice of grantees from politics. Senators do not get to decide that a university in their state will get the grant. But that is accomplished by using "experts" working in panels to rate grant applications. The experts are generally people who also seek grants, creating a subtle conflict of interest, and they are also the people whose ideas dominate current scientific thinking. People pursuing novel lines of thought are at a distinct disadvantage.

Pharmaceutical companies also conduct and fund research. Without doubt their research has contributed to the development of psychotropic medications. But advocates and policy makers in government have a deeply ambivalent relation with PHARMA. On the one hand, medications have helped a great many people. On the other hand, medications are almost certainly overused. In addition, the inventiveness of pharmaceutical research is often spent on creating drugs that are different enough from existing drugs to qualify for patents that free them from competition and allow them to charge very high prices without any significant improvement in clinical outcomes compared to earlier drugs with expired patents and much lower costs.

Pharmaceutical companies also provide funds for research, for training and education, and even for advocacy. Does this create conflicts of interest for professionals who, for example, get free trips to conferences in great locations where they tout or just are identified with certain drugs or drug companies? Does it create conflicts of interest for universities that accept funding for training programs, conferences, faculty, etc.? Does it create conflicts of interest for advocates—like myself—who are offered contributions with the unstated expectation that we will support PHARMA on such issues as preferred drug programs? You bet!

All this has led to requirements to reveal conflicts or potential conflicts when publishing or presenting research findings. Is this enough to prevent the perversion of opinion for personal gain? Hmm.

In addition to conducting and funding research itself, government needs to play a powerful role in assuring that human subjects are adequately protected. Informed consent is the current standard. It also needs to ensure that research uses reliable methods, is rigorously analyzed, and is not fraudulent.

Rights

Determination and protection of the rights of people with mental illness are major responsibilities of government. Federal laws such as the Fair Housing Act and the Americans with Disabilities Act (ADA) have created important rights of non-discrimination, to live in the community, etc. Court decisions over the years have also created protections specifically for people with mental disabilities. This includes:

- "Right to treatment" decisions
- Establishment of a right to refuse treatment even if one is mentally ill
- The establishment of a standard of dangerousness for involuntary inpatient admissions and treatment

- The establishment of procedural protections
- Etc.

The Olmstead Decision of the Supreme Court, which was based on the ADA, offered great promise because it requires states to provide community support services for people with mental disabilities if they can leave or avoid institutions by getting such services—**as long as states can afford to provide the needed services**. Quite a proviso! States are permitted to decide how much community housing they can afford to provide for people who are, or will otherwise be, institutionalized. Perhaps that's the reason there has been so little growth in community housing and related services in the aftermath of Olmstead.

Currently, there are a number of highly controversial issues regarding the rights of people with mental illness. These include:

- Does the criterion of dangerousness to self or others for involuntary inpatient commitment result in people "dying with their rights on"? [21]

- What should the criteria be for involuntary outpatient commitment (often called euphemistically "assisted" outpatient treatment)?

- What should the limits be on the right of people with serious mental illness to refuse treatment?

- What are the appropriate limits on a mentally ill person's right to confidentiality due to potential danger to self or others or due to the conflicting rights of parents or other caregivers?

- Do people with histories of mental illness have the right to own guns if they are not currently dangerous?

Public Assistance Benefits

For adults with serious, long-term mental disorders who are unable to work and do not have other sources of income, survival in the community is made possible by the provision of governmental income supports. This is often not noted in discussions about mental health policy,[§] but I would argue that it is absolutely fundamental and should always be at the top of advocacy agendas. Without social welfare benefits, community mental health is simply not possible.

Public assistance benefits that are critical to people with psychiatric disabilities include income supports through Social Security Disability Income

[§] To their credit, Frank and Glied in their book *Better But Not Well*, place heavy emphasis on public benefits as a major source of improvement in the mental health system.

(SSDI), Supplemental Security Income (SSI), and general welfare as well as food stamps and housing subsidies such as "Section 8".

The first key question with regard to these benefits is whether they are adequate to live on. Adequate, of course, is to some extent subjective, and it varies from place to place. But what is the goal? Should government provide benefits that are barely enough for subsistence, or should it enable people with psychiatric disabilities to live a bit more comfortably? Tough questions, which actually have to be answered every year.

A second key question is who is eligible for public assistance and how is eligibility determined? Changes in the determination of eligibility for disability benefits early in the Reagan administration was one of the driving forces of the rise of homelessness in the United States. (The other was gentrification.)[22] Even today half or more of people who apply for disability benefits are denied and have to appeal. Most win their appeals. Surely, there could be a better way.

There is a constant threat that eligibility criteria and determinations will be made more stringent and result again in an explosion of homelessness. This was an important issue during the Trump administration, and it probably will be an issue again if conservatives regain control of the federal government.

This, I'm afraid, is not an easy issue because government certainly needs to make an effort to prevent and root out fraud at the same time that it is helping people get the benefits they need. It's a tough balance even in the hands of humane people.

Another key issue is the impact of public benefits on the willingness of people to work and support themselves. Do requirements related to inability to work create disincentives to take jobs? Does the potential loss of health coverage create a disincentive to accept work?

There are a number of measures currently in place to remove disincentives. These include allowing people to work for pay up to a certain level of income and still retain financial benefits and/or health coverage. Have these very inventive measures worked? Should they be revised? Should the entire issue be finessed by guaranteeing a minimum income to all Americans without regard to the ability to work?

Criminal Justice

Criminal justice policy in my opinion is also a core element of mental health policy, and in recent years criminal justice reform has been a major goal of mental health advocates.

Elements of reform include:

- Improved police intervention on the streets
- Improved pre-trial procedures such as court diversion programs and changes of the bail system
- Use of mental health and substance abuse courts as alternatives to criminal court
- Availability of services for people whose cases are on adjournment in contemplation of dismissal (ACD) or who are on probation or parole
- Adequate mental health services in jails and prisons
- Outlawing solitary confinement
- Appropriate release planning.

In addition, there are occasional reconsiderations of the plea of "not-guilty by reason of insanity".

I will discuss this in more detail in future lectures on mental health and the law.

Mental Health Policy Issues in Other Service Systems

In addition to policy issues regarding people with mental illness in the social welfare and criminal justice systems, there are several other systems that provide services for people with mental and/or substance use disorders. These include: child welfare, education, and aging services. I will touch on some of the issues related to these systems in subsequent lectures.

GOVERNMENTAL STRUCTURE

Governments carry out their responsibilities through unbelievably complicated structures. At the federal level, the Government Accountability Office (GAO) found in a 2014 study that multiple federal agencies manage over 100 programs related to mental health. Not surprisingly, the GAO called for improved coordination.[23] (There was a similar report in 1977 that identified over 135 programs in eleven federal agencies.[24] This report also called for greater coordination and contributed to the passage of The Mental Health Systems Act of 1979.)

The Cures Act of 2016 established an Office of Behavioral Health headed by an Assistant Secretary of The Department of Health and Human Services (HHS) to oversee federal behavioral health programs across multiple agencies. It also established a coordinating council. Will this result in improvement of behavioral health services in the United States?

Frankly, I am doubtful. Calls to address fragmentation of efforts to help people with mental illness go back to at least the 1960s. Progress has been very limited.

This is a fundamental issue in the effort to improve public mental health policy. In order to address important concerns, government generally organizes departments or programs specific to those concerns. Inevitably these separate entities develop priorities and initiatives that may or may not be consistent with the priorities and initiatives of other specialized entities. Of course, they should communicate and coordinate. But that is very time consuming and usually frustrating. After some years of experience trying to build working relationships across systems, I put a sign over my desk that said, "Collaboration is an unnatural act committed by non-consenting adults." Too pessimistic? Probably, but it was comforting in the face of the difficulty getting people to work together.

Here are a few specifics about how government functions. (See pp. 42-45 of my mental health advocacy manual for more detail.[25])

There are four levels of government—federal, state, county, and municipal. They all play roles in the determination and implementation of behavioral health policy. Also, local Boards of Education, which are often independent of local government, play a very significant role with regard to child and adolescent mental health.

All three branches of government—legislative, executive, and judicial also play roles.

Legislatures work through committees. Some of the committees that handle mental health issues are called mental health/developmental disabilities/substance abuse committees; others have broader scope, such as health and/or social service committees that include mental health. For example, the US House of Representatives Committee responsible for mental health is the Health Subcommittee of the Committee on Energy and Commerce. For the US. Senate it is the Committee on Health, Education, Labor, and Pensions.

Legislative determinations about mental health policy are also made by fiscal and budget committees as well as by the heads of legislatures, who effectively control what issues come up for votes and what is included in federal, state, and local budgets.

The executive branch, headed by a Chief Executive Officer such as the President, a Governor, a county executive, or a mayor, functions through agencies or departments that may be headed by a "Secretary", a "Commissioner", a "Director", etc. Key federal agencies include: NIMH,

SAMHSA, The Center for Medicare and Medicaid Services (CMS), The Social Security Department, The Department of Justice, The Department of Education, The Health Resources and Services Administration (HRSA), and more. States and localities also have a complex array of relevant departments.

The judicial branch is hugely complex. There are federal, state, county, and municipal courts. And there are multiple types of courts—criminal; civil; mental health, substance abuse, and veterans courts; appeals courts, etc.

Courts make mental health policy through precedent setting interpretations of law, findings of class action lawsuits, structuring settlements requiring government action, and rulings on Constitutionality.

Complicated? You bet. Too complicated? I think so.

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