AMERICAN MENTAL HEALTH POLICY, PAST AND FUTURE
SEARCH FOR CHANGE KEYNOTE ADDRESS
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Over the past couple of years, the American mental health system has been repeatedly characterized as a "shameful mess"[1], to quote one recent critic. Some critics have gone so far as to claim that the current system is "worse now than ever before".[2]

I, for one, do not agree.[3, 4] America's current mental health system unquestionably needs improvement, but it is a far better mental health system now than it used to be.[5]

I remember what it was like in the early 1970s, when 100s of thousands of people in the U.S. who would have lived in horrible state hospitals were denied admission or discharged into sub-standard housing, adult homes, or back to families totally unprepared to provide the help they needed. At that time there were no community housing programs for them. I remember the tough battles to establish community housing and to gain recognition of the right for people with mental disabilities to live in the community. I remember the vitriolic opposition to housing--NOT ON MY BLOCK. I remember the passage of the Padavan Law[6] here in NYS thanks to the courage and commitment of Senator Frank Padavan. I remember and still admire the courage of a few elected officials such as former Senator Nick Spano, Assemblywoman Betty Connelly, and Governors Hugh Carey and Mario Cuomo, who stood up to the opponents of housing and insisted that people with mental disabilities have the right to live in the mainstream. I remember the early pioneers in community housing in Westchester—Ruth Stern, Gene Aronowitz, Steve Friedman, Gloria Karp, Esther Mallach, and Al Menikoff, the head of Search for Change at the time.

Yes, Search for Change was one of the organizations that had the courage of its convictions and fought community resistance to provide safe and stable housing for people who desperately needed it. Those of you who are associated with Search for Change should take great pride in its achievements.

In fact, all of us who have worked to build a better and better community mental health system over the past 50 years should take pride in what we have accomplished rather than bewailing our failures. We did not accomplish all that is necessary, but we accomplished a lot and laid the groundwork for more to come.

That said, what still needs to be done? Here's what Sherry Glied and I said in a recent OP-ED[7]:

> Today an unacceptably high [proportion] of people with serious and persistent mental illness (SPMI) … live in totally disgraceful conditions in jails and prisons or homeless on the streets or in shelters. In addition, [too many] people with SPMI who might have been in mental hospitals/asylums have simply been transferred to [adult homes], nursing homes or similar facilities, many of which provide inadequate care. Many of these people could live in the community if adequate housing were available. And too many people with serious illness in the community receive very little or inadequate treatment.

We added:

> Our nation clearly needs to address the enduring problems of our mental health system. How? We know there is need for more stable housing. We know there is a need for more "assertive" community services, to reach out to people who do not benefit from the current system where they are rather than waiting for them -- or forcing them -- to come to the mental health system on their own. We know

there is a need for higher quality care and treatment. We know that there is a need for more mental health services with better access.

But there are many disagreements about how to make America's mental health system better. Today, I will comment very briefly—and superficially—about six (overlapping) conceptual approaches for an improved mental health system. As will be clear, I have abstracted my descriptions of these approaches from far more complex views. I hope that in the process I did not misrepresent actual views too badly.

(1) The first thrust to improve the American mental health system focuses on several recent, terrible tragedies in which a person with a mental disorder (or assumed to have a mental disorder) has committed mass murder. In truth, this call for change has come largely from opponents of gun control who want to distract the nation from the dangers of firearms. The problem isn't guns, they say; it's people with mental illness.[8] Nonsense! People with mental illness are responsible for a very small proportion of murders. This approach ought to be a non-starter. But it plays well politically, and we have to guard against it.

(2) A second approach to improved mental health policy bemoans the loss of hospital beds and long-term inpatient treatment and calls for new, less restrictive standards for involuntary in-and-outpatient treatment.[9] It nostalgically recalls a time when hundreds of thousands of people with serious mental illness were housed in state mental institutions, claiming that they were better off in those days than they are now because they have been transinstitutionalized to jails and prisons and to adult and nursing homes, and left homeless on the streets.

These advocates are right, of course, about how terrible it is that so many people with serious mental illness are now in jails and prisons and in institutions where they do not get adequate care. Getting people with mental illness out of places where they do not belong has got to be one of the highest priorities of American mental health policy.

These advocates for more restrictive care may even be right that we've gone too far in reducing hospital beds and lengths of stay and too far in respecting the rights of some people with mental illness who are exposed to great risk.

But these advocates also purvey a totally unrealistic view of the good old days when people with mental illness were in hospitals rather than in prisons. Snake pits and warehouses were not the good old days. Neglect of the vast majority of people with serious mental illness who lived in dire, and dangerous, poverty before the expansion of income supports and community services was not the good old days. And forcing people into care may be helpful for some people some of the time, but it has terrible consequences for many people much of the time.

These critics of our community mental health system also mostly ignore the hope that has been engendered by focusing on the development of what is called a "recovery-oriented" system. Yes, serious mental illness is persistent or recurrent for many people. But despite its persistence, people with serious mental illness can, and do discover lives that they find satisfying and meaningful. They can, and do, contribute to the development and provision of better and more effective services and supports for their peers. They can, and do, become productive citizens.

(3) A third approach to improving the American mental health system broadens the concern about violence to include concern about suicide as well as homicide and generally focuses on risk reduction.[10] 39,000 people took their own lives in 2011, more than half with guns[11]. Most are people with mental illness. Depression is usually cited, of course, but it is important to note that people with schizophrenia are at very high risk of suicide; at least 1 in 20 and perhaps as many as 1 in 7 will take their own lives.[12,13] That is one of the reasons why people with serious mental illness die at least eight and perhaps as many as 25 years younger than people without mental illness.[14]

This approach to improving the American mental health system focuses on building a system to respond to the risks of serious mental illness including suicide, premature mortality, poor physical health, substance abuse, criminalization of mental illness, and violence (little though it is).

This approach has much to recommend it, especially because it captures the attention of American policy makers and it sharpens priorities. But it troubles me because it focuses on a limited group of people with mental illness, those who are potentially dangerous to self or others. By doing so:

- It does not focus enough attention on the majority of people with mental disorders, who are not dangerous,
- It fuels stigma, and
- It gives credence to the view that individuals' rights to liberty, privacy, and to refuse treatment should be far more limited than they currently are.

Danger is not, in my view, the essence of mental illness; and American mental health policy should not be built on the view that it is.

(4) The fourth approach to improving the American mental health system focuses on expanding, and improving access to, mental health and substance abuse services.[15] Advocates of this approach generally note that about 25% of the American population have a diagnosable mental and/or substance use disorder in any given year (50% over a lifetime)[16] and that fewer than half of them get mental health services[17]. With an abundance of evidence that people cannot find or afford services when they need them, these advocates make a strong case that there just aren't enough accessible and affordable mental health services available.

I don't argue the need for more, but for more of what? Does our nation need more use of psychiatric medications? Psychotherapy in private offices? Mental health clinics? Housing? Psychiatric rehabilitation? Outreach and engagement services? Specialized services for people with serious and persistent mental illness? Services tailored to veterans and their families?

Do we really want more of what we have, to expand the system like blowing more air into a balloon? I don't think so. We need to be selective about the services we increase, with particular concern about those who are most in need of help.

We also need to keep in mind that about 40% of the people who get mental health services at any point in time do not have a diagnosable mental disorder.[18] While there may be very good reasons why some of them get mental health services, it is a troublesome fact at a time when there just aren't enough resources to serve everyone in need.

Finally, we need to be concerned about the quality of the services we expand.[19] According, to the National Comorbidity Survey Replication (NCS-R), most mental health services are provided by non-mental health professionals—especially primary care doctors, and it is minimally adequate less than 15% of the time. Mental health professionals do better, providing minimally adequate care about 50% of the time[20].

And should we really be satisfied with "minimally adequate" services? We certainly are not when it comes to ourselves, our families, and our friends. I bet everyone in this audience has struggled at some point to find not just a qualified provider but a good one.

In addition, there is good reason to call into question the vast influence of drug companies that now consume nearly 30% of all spending on behavioral health services[21] and which use advertising and questionable relationships with doctors to encourage the use medications even when their value is in significant doubt. For example, recent research appears to show that anti-depressant medications are not effective for people who have mild or moderate depressive disorders while confirming their effectiveness with serious depressive disorders.[22] But, this discovery does not appear to have slowed the use of anti-depressants.

Are psychiatric medications important for the treatment of serious mental illness? No doubt. Are they overused? Little doubt.

So—I'm very sad to say—rapid expansion in the absence of major efforts to build a more competent mental health workforce is likely to result in rapid expansion of services of very uneven quality.

Does all this mean that behavioral health services should not be expanded? Of course, not. But it should be selective expansion with regard to who gets service, what services are provided, and what the quality of the services will be.

(5) Health care reform drives a fifth major approach to developing a better mental health system. In addition to more insurance coverage of mental health services for many, many more people and generally equal coverage with that for physical health services, health care reform sets ambitious goals for the American health system. Known as the "triple aim", it seeks better health, better "patient experience", and reduced growth of health care costs.[23] And health care reform efforts are betting that the development of very complex forms of integrated treatment will foster these goals. New forms of service delivery, organization, and finance include patient-centered medical homes, health homes (which are not the same as medical homes), accountable care organizations, and a variety of forms of care management, which are not quite the same as managed care, on which these new systems rely.

Many of you here this morning are living with New York State's variation on this major theme with FIDA, HARPs, DSRIP, RIOs, etc. etc. etc.

I am not an expert on these new forms of finance and organization, so take my comments for what they are worth. I am skeptical about the outcome. These are very complicated adventures, designed by geniuses to be implemented by more ordinary mortals. They call for very high levels of communication, cooperation, and coordination. It may be that computerization will facilitate all of this, though some problems are emerging with this, particularly with regard to communication between diverse systems.[24] This does not surprise me. I worked in this field for forty years

before I retired, and I remain convinced that “collaboration is an unnatural act committed by non-consenting adults.” Human beings—men and women—with big egos build the empires that dominate health care. Hard to believe that they will be able to work together—though maybe the current competition to be designated one or another of the new organizing entities will lead to consolidation of competitive groups, leaving just a few standing and thus reducing the need for communication.

We will have to see whether this very complicated adventure works or not. I hope it does, but frankly I am happy to be retired and not to have to cope with it.

(6) Finally, I want to note that there is much talk these days about improving the mental health system by emphasizing prevention and early intervention. Two major research findings have revitalized the hope of prevention, which has ebbed and flowed over the past 100 years or more. One is the finding that the average age of onset of a persistent or recurrent mental illness is 14 and that there is a nine year delay between onset and treatment. [25,26] The other is the outcome of a major study of the long-term consequences of “adverse childhood events”.[27] It’s not surprising, of course, but it is important, that the more traumatic events, such as abuse, in a child’s life, the more likely that child is to grow into a dysfunctional and mentally and physically ill adult. The conclusion rightly reached: the mental health system should connect better with children and adolescents experiencing emotional problems, and the American society as a whole should do more to protect children from trauma and abuse.

Who can argue? But this is complicated. It is often not easy to distinguish between normal adolescent struggles and a mental disorder that will persist over

time. It is not clear what interventions are most useful for those with youthful mental health problems. And protection from abuse and trauma—particularly of children who grow up in poverty—is a societal goal that has proved significantly elusive in America.

In addition, pursuing a preventive agenda will not look much like an expansion of the mental health system—which is fundamentally about the delivery of services of a certain form and not about the alleviation of the social determinants of poor physical and mental health.

Conclusion: I am skeptical—perhaps cynical—about the outcome of current efforts to improve the mental health system. Maybe I'm just a grumpy old man. I do like the energy of the more serious efforts. And I hope that my reservations are misplaced.

And I am painfully aware that I have not suggested solutions today. A bit ashamed actually. But I will say to you what I say to my students. Solutions are for the young. My generation accomplished more than a little. Your generation can too. And please do it fast enough for me to live to see it.

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[1] Harris, Leah. "Don't Coerce The Mentally Ill Into Treatment". *Pittsburgh Post-Gazette,* September 10, 2014

[2] Frances, Allen. "Is This The Worst Time Ever To Have A Severe Mental Illness" *The Huffington Post*, August 6, 2014

[3] Glied, Sherry and Friedman, Michael. "Improving The American Mental Health System Requires Accurate History". *The Huffington Post*, August 20, 2014.
[4] Friedman, Michael. "America's Mental Health System Needs Improvement, But Gains of Past Give Hope for the Future". *The Huffington Post*, March 18, 2013.
[5] Frank, Richard and Glied, Sherry. *Better But Not Well: Mental Health Policy in the United States Since 1950.* Johns Hopkins University Press, 2006.
[6] Winerip, Michael. "Group Homes: A Law Works Ever So Quietly". *The New York Times*, November 4, 1988.
[7] Glied, Sherry and Friedman, Michael. "Improving The American Mental Health System Requires Accurate History". *The Huffington Post*, August 20, 2014.
[8] National Rifle Association. "Mental Health and Firearms". January 24, 2013.
[9] Treatment Advocacy Center. "Eliminating Barriers To The Treatment of Mental Illness" on TAC's website.
[10] Sederer Lloyd and Sharfstein, Steven. "Fixing The Troubled Mental Health System" in *The Journal of the American Medical Association*, September 24, 2014.
[11] Centers for Disease Control. "Suicide And Self-Inflicted Injury" in *Fast Stats*.
[12] Pompili, Maurizio, et al. "Suicide Risk in Schizophrenia: Learning From The Past To Change The Future" in *Annals of General Psychiatry*, March 2007.
[13] Hor, Kahyee and Taylor, Mark. "Suicide and Schizophrenia: A Systematic Review of Rates and Risk Factors" in *Journal of Psychopharmacology*, November 2010
[14] Druss, B. et al. "Understanding Excess Mortality In Persons With Mental Illness: 17-year Follow-Up Of A Nationally Representative US Survey" in *Medical Care*, June 2011.
[15] Lerner-Wren, Ginger. "The Time Has Come To End Stigma and Fund Mental Health Care In America" in *The Huffington Post*, September 17, 2014.
[16] Kessler, Ronald et al. "Prevalence, Severity, and Co-Morbidity of DSM IV Psychiatric Disorders in the National Comorbidity Survey Replication" in Archives of General Psychiatry, June 2005.
[17] Wang Phillip et al. "Twelve-Month Use of Mental Health Services In The United States" in *Archives of General Psychiatry*, June 2005.
[18] Kessler, Ronald et al. "US Prevalence and Treatment of Mental Disorders 1990-2003" in *New England Journal of Medicine*, June 16, 2005.
[19] Mechanic, David. "More People Than Ever Are Receiving Mental Health Services, But Gaps And Challenges Remain." in *Health Affairs*, August 2014.
[20] Wang Phillip et al. "Twelve-Month Use of Mental Health Services In The United States" in *Archives of General Psychiatry*, June 2005.
[21] Mark Tami et al. "Spending on Mental and Substance Use Disorders Projected to Grow More Slowly Than All Health Spending Through 2020" in *Health Affairs* August 2014
[22] Fournier, J. et al. "Antidepressant Drug Effects and Depression Severity: A Patient-Level Meta-Analysis" in *Journal of the American Medical Association*, January 6 2010
[23] Berwick, Donald. "The Triple Aim: Care, Health, And Cost" in *Health Affairs*, May 2008.
[24] Creswell, J. "Doctors Find Barriers to Sharing Digital Medical Records". *New York Times*, September 30, 2014.
[25] Kessler, Ronald et al. "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication" in *Archives of General Psychiatry*, June 2005.
[26] Wang, Phillip et al. "Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication" in *Archives of General Psychiatry*, June 2005.
[27] Chapman Daniel et al. "Adverse Childhood Events As Risk Factors For Negative Mental Health Outcomes" in *Psychiatric Annals*, May 2007.