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CONGRESSIONAL MENTAL HEALTH POLICY REFORM: HOPE OR HYPE?

By
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Since the tragic killings in Newtown, CT in 2013, most politicians have mistakenly maintained that mass murder is largely a consequence of a "broken" mental health system. In Washington, and elsewhere, elected officials have been promising to "fix" the system, and to their credit they have enacted a number of important incremental improvements into law. But so-called "comprehensive mental health reform" has not moved, probably because comprehensive reform bills have included highly controversial proposals to limit rights to refuse treatment and to privacy. This year modified versions of previous bills have been introduced in the House of Representatives[1] and the Senate[2] that claim to address the controversies while also keeping the promise of comprehensive reform.

Good news? Not very. The ideological controversies, as important as they are, have been a distraction from the fact that these legislative proposals are not really comprehensive. They are just a few more incremental changes, some of which may be worthwhile but which certainly don't live up to the promise of major reform.

The core problems with the American mental health system are pretty clear. A great many people with mental and/or substance abuse disorders who might benefit from mental health or substance abuse services cannot get services at all, and the services that people do get are often of poor quality. According to the National Comorbidity Study Replication (NCS-R), nearly 60% of people with diagnosable mental and/or substance use disorders do not get treatment. And most people who get treatment, get it initially from primary care physicians, who provide "minimally adequate care" less than 15% of the time. The chances for getting minimally adequate care (which is not necessarily high quality) are better with mental health professionals, who provide it almost 50% of the time, but hardly what one would hope for.[3]

So the key questions to ask about the so-called "comprehensive mental health reform" bills in Congress are: (1) what do they do to increase mental health and substance abuse service capacity and (2) what do they do to improve quality of care? Let's see.

A fundamental premise of the current legislative proposals is that the bureaucracy in Washington needs to be re-organized. The bills call for a new position in The Department of Health and Human Services (HHS)—an Assistant Secretary for Mental Health and Substance Abuse. The Office of the Assistant Secretary would oversee (or replace depending on the bill) the Substance Abuse and Mental Health Services Administration (SAMHSA). It would also have authority to coordinate the 112 federal programs that the Government Accounting Office (GAO) recently identified as involved

in behavioral health.[4] These agencies are loosely linked at best, and this is perceived as a major cause of the fragmentation that plagues the American mental health system.

But is it really clear that poor communication and coordination among public officials in Washington are a major cause of fragmentation on the ground, where services are delivered? And, more importantly, what will improved coordination at the level of federal agencies contribute to the development of more and better services? Lots of meetings in Washington and lots of E-mails (monitored by the Office of the Assistant Secretary?) will do what to increase service capacity and quality? It's far from clear to me.*

Don't get me wrong. I don't oppose the creation of a new Assistant Secretary, and I support the idea of a Coordinating Council and a Mental Health Services Laboratory, which are also built into the re-organization proposals. Maybe they will help a little. But reorganization is usually an illusory solution and rarely results in major improvements in caring for people who need care.

Of course, the bills now being considered do propose to increase service, but not nearly on the necessary scale. Let's think about it. If more than half of people with behavioral health disorders do not get treatment now, it may be necessary to double services in the United States. OK, that's probably more than needed since not everyone with an untreated mental disorder needs or would be benefit from treatment. So let's guess that the system needs to grow about half that, say 50%. It is currently projected that in 2014 the nation spent over $210 billion on behavioral health services (about 63% public and 37% private)[6]. Does that mean we would need to spend more than an additional $100 billion **per year** overall, about $63 billion by the government and $37 billion by the private sector, in order to bring the mental health system to scale? Is there any chance at all that the Congress would authorize or mandate spending of this magnitude?

The bills under consideration do propose what at first appears to be a significant increase in Medicaid spending for inpatient treatment in hospitals. They call for elimination of the exclusion of Medicaid coverage for mental health services in psychiatric hospitals ("institutions for the mentally diseased") for adults aged 22-64. According to the Congressional Budget Office (CBO), this could cost as much as $66 billion **over 10 years**.[7]

There is, of course, an important question about whether it is sensible to make a major financial investment in acute (these bills limit coverage to an average of less than 30 days) inpatient treatment rather than long-term care or investing instead in community-based services and housing. And there is also a significant question about why it is necessary to lift the exclusion on psychiatric hospitals since there is no exclusion on Medicaid coverage of inpatient psychiatric services in general hospitals. Why invest in state and private, mostly for-profit, psychiatric hospitals rather than creating incentives for general hospitals to expand psychiatric inpatient services, especially in the context of the call for increased integration of behavioral and physical health care services that is an essential element of these bills?

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* The observation that there are a great many federal mental health programs is not new. For example, in 1977 the GAO issued a report that identified 135 such federal programs and called for consolidation and improved coordination.[5] Obviously, in the following years little progress has been made. Will the call for coordination succeed this time?

That aside, one has to wonder about the reality of this call for increased inpatient services when these bills authorize expansion only if the actuary of CMS certifies that more inpatient services will not result in an overall increase in Medicaid expenditures. In its estimate of the costs of this section of the main House bill, the CBO states that it is highly unlikely that CMS would find the new spending to be budget neutral, and that, therefore, it is highly unlikely that these new inpatient services will ever take place.

What about expansion of community services? These bills do call for re-authorizations of some community service demonstrations, for expansions of others, and for some new ones. For example, the primary House bill calls for expansion of the Federal mental health block grant by 2% for states that have "assisted outpatient" programs. If all states qualify, that would amount to an increase of $10 million nationwide, not very much in the context of over $210 billion of annual spending on behavioral health. Altogether, proposed community service expansions come nowhere close to a meaningful increase in federal spending.

The point is simple. There is not nearly enough money in these "comprehensive reform" proposals to pay for a major growth in service capacity. Without such growth, what will be different for the vast number of Americans who don't get behavioral health services when they need it?

To be fair, this legislation does try to address the shortage of personnel trained to provide behavioral health services. If successful—i.e. if the number of well-trained behavioral health professionals increases at greater than the rate of population growth—it would then be possible to serve a greater portion of the population than is now served. Much to be hoped for, but I'm not at all sure we should count on it.

What about quality, the other major problem with the American behavioral health system? Proposed legislation does recognize and try to address the uneven quality of behavioral health services in the United States. It calls for, and provides some funding for, more research. It calls for, and provides some funding for, better translation of research into practice. It calls for, and would fund some training for, greater use of evidence-based practices. It calls for more attention to the mental health needs of children. Etc.

Will this help? Probably some, and it should certainly be supported. But I remain concerned that these proposals will not address a number of core issues of quality including:

- Lack of interest in the fact that America is aging and needs a "generationally competent" behavioral health system
- Lack of attention to the divide in America between a public and a private mental health system and the reliance on trainees and freshly minted professionals in the public system
- Lack of attention to the failure to reach and appropriately serve people for whom the tradition of office-based treatment is a problem

- Lack of attention to the social determinants of behavioral health and to the kinds of societal level interventions necessary to address them
- And more.

Comprehensive mental health reform? That would be great. Maybe someday a proposal will emerge in Congress that gets beyond rhetoric and really makes more and better behavioral health services available to people who need them. But we are not there yet. The comprehensive reform bills in Congress are, I'm afraid, far more hype than hope.

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