

# 10

## PRACTICING POLICY ADVOCACY IN THE MENTAL HEALTH AND SUBSTANCE ABUSE SECTOR

### LEARNING OBJECTIVES

**In this chapter you will learn to:**

1. Develop an empowering perspective about mental health and substance abuse
2. Analyze the evolution of the mental health and substance abuse sector in the United States
3. Understand the sheer magnitude of mental and substance abuse disorders in the United States
4. Analyze the effects of income inequality on mental health and substance abuse
5. Analyze the political economy of mental health services and substance abuse
6. Recognize the magnitude of other addictions such as smoking and poor dietary habits
7. Identify ways to engage in micro, mezzo, and macro policy advocacy to redress seven core recurring problems in the mental health and substance abuse sector
8. Apply the eight challenges in the multilevel policy advocacy framework

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*Note:* Judith A. DeBonis and Eri Nakagami made invaluable contributions to this chapter in the first edition of this book.

## DEVELOPING AN EMPOWERING PERSPECTIVE ABOUT MENTAL HEALTH AND SUBSTANCE ABUSE

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Mental illness was a scourge in the United States until relatively recently. Persons with mental problems were often placed in poorhouses and institutions through the 19th century. They encountered stigma and often did not work. Beneficial medications had not been invented. Mental health professionals lacked evidence-based clinical tools. Nor did the nation have evidence-based medications or clinical tools to address alcoholism or drug addictions. Persons with serious mental illness were warehoused in asylums in rural locations.

Considerable progress has been made in the intervening decades. A large number of mental illnesses and drug addictions have been identified, such as those listed in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* of the American Psychiatric Association (2013). Many medications have been developed that help persons with mental problems cope with their conditions, allowing them to live in their communities, have healthy networks, and hold jobs. Evidence-based clinical tools have been developed that support the effectiveness of cognitive therapy, mindfulness, and motivational therapy with specific kinds of persons.

Moreover, social policies have been developed in past decades that have greatly helped persons with mental health problems and addictions. Civil rights laws forbid discrimination against persons with mental health problems and addictions in places of work. Medicare, Medicaid, and private health insurance plans have greatly expanded coverage of services and medications for mental health problems and addictions. Increasing numbers of employers give persons with mental disabilities and substance abuse issues work accommodations, such as reduced hours or different job assignments. The population of mental health practitioners has been greatly expanded to include social workers, psychologists, psychiatrists, and marriage and family counselors.

Even with these advances, the United States has remarkable numbers of persons with mental health and substance abuse problems—and many of them are poorly addressed. Nearly one in five U.S. adults lived with mental illness in 2016, or 44.7 million persons. Their mental illnesses ranged in severity from mild to moderate to severe. Two broad categories exist: any mental illness (AMI) and serious mental illness (SMI). AMI includes all mental, behavioral, or emotional disorders and can vary from no impairment to mild, moderate, and severe impairment. SMI is a “mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities” (National Institute of Mental Health, data from the 2016 National Survey on Drug Use and Health collected by the Substance Abuse and Mental Health Services Administration). The distribution of AMI, overall, was 18.3% (44.7 million adults) with 21.7% for women and 14.5% for men. Roughly 21.5% of persons from 18 to 49 years of age had AMI as compared with only 14.5% of persons over age 50. Across race and ethnicity, 22.8% of American Indians and Alaskan Natives, 19.9% of whites, 15.7% of Hispanics, 16.7% of Native Hawaiians and other Pacific Islanders, and 12.1% of Asian persons had AMI. The prevalence of persons with SMI overall was 4.2% of all U.S. adults with young adults from 18 to 25 having the highest prevalence of SMI (5.9%) compared with 5.3% for persons age 26 to 49 and 2.7% for persons age 50 and older.

The prevalence of mental illness includes 1.1% of American adults living with schizophrenia (2.4 million), 2.6% with bipolar disorder, 6.9% with major depression, and 18.1% with anxiety disorders that include panic disorder, obsessive-compulsive disorder, posttraumatic stress disorder, generalized anxiety disorder, and phobias—or 18.7% of adults (42 million).

About 26% of homeless adults in shelters have serious mental illness. About 24% of state prisoners have a recent history of mental illness (National Alliance on Mental Illness, 2018). Mental illness costs the United States \$132.9 billion in lost wages every year. It disrupts families. Roughly 90% of those who commit suicide—the tenth-leading cause of death—have an underlying mental illness.

Roughly 60% of adults with mental illness did not receive mental health services in the previous year—and nearly 50% of youth age 8 to 15 did not receive them in the previous year (National Alliance on Mental Illness, 2018).

One in eight American adults is alcoholic, rising from roughly 8% of adults over age 18 in 1991–1992 to 12.7% in 2012–2013 (Ingraham, 2017)—or a rise of 49% in the first decade of the 21st century. This includes 10.2 million adults with co-occurring mental health and addiction disorders.

Many problems prevent the United States from empowering tens of millions of its residents who possess mental illness and substance abuse. The Centers for Disease Control and Prevention (CDC, 2018a) says that 50% of Americans experience mental health issues over their lifetimes. About 25% of adults experience mental health issues in a given year, including anxiety and mood disorders such as depression—but less than half receive assistance despite the fact that roughly 85% are treatable (McClain, 2015). It is unacceptable that 9.2 million persons have mostly untreated substance abuse.

Nor has the United States eliminated the stigma that many persons with mental illness and addictions encounter. Persons with mental health and substance abuse problems (MHSAPs) encounter many kinds of stigma. When labeled with terms like “schizophrenia,” “suicidal,” “manic-depressive syndrome,” “neurotic,” “anti-social,” “alcoholic,” or “drug abuser,” people often choose not to receive help for their MHSAPs. People contemplating suicide may not discuss this problem with anyone else or seek help to address it because they are ashamed they have clinical depression as illustrated by suicides of celebrities Anthony Bourdain and Kate Spade in 2018. People who disclose mental health problems fear they will be shunned, not be hired, and even be fired. Persons who admit substance abuse problems may fear they will not be hired or even fired even when they have stellar work records. Many people wrongly believe that persons with psychoses are dangerous even when evidence demonstrates that they commit fewer violent crimes than other persons (Brekke, Prindle, Bae, & Long, 2001).

Stigma leads American policy makers to fund programs that address cancer and many other health programs rather than also funding mental health and substance abuse programs sufficiently. The federal budget devoted only \$1.167 billion to mental health and only \$2.195 billion to substance abuse in 2016. The Trump administration sought cuts in federal mental health spending in 2018 of \$252 million while increasing spending on substance abuse only by roughly \$500 million at a time when 72,000 persons had died in 2017 from poisoning from opioid drugs (U.S. Department of Health and Human Services, 2018).

Many persons with mental illness and addictions cannot afford health services for their problems despite augmentation of insurance coverage in recent years by Medicare, Medicaid, and private insurance plans, as we discuss subsequently.

Many Americans have dual diagnoses of mental illness and chronic diseases because individuals with serious mental illness are more likely to have a chronic medical condition—yet many of them receive care for only one condition (Colton & Manderscheid, 2006). They are likely to have life expectancies that are 25 years shorter than persons without these dual conditions largely because the American medical system fails to address their chronic medical conditions (Manderscheid, Druss, & Freeman, 2008). Males with schizophrenia have life expectancies of roughly 63 years primarily because they receive poor medical care for heart disease and other ailments.

### Why Social Workers Work to Improve Poor Outcomes in This Sector

Social workers can assume a pivotal role in reforming the mental health and substance abuse sector because they have advocacy skills at micro, mezzo, and macro levels. They have a code of ethics that asks them to contest policies and practices that discriminate against vulnerable populations that include persons of color, LGBTQ persons, low-income persons, children, seniors, and many other populations, as we discussed in Chapter 1. All social workers are versed in social justice that mandates them to hew to the ethos of Jane Addams and other social work leaders. They have all taken at least one social policy course.

Let's start at the macro level and then move to mezzo and micro levels. Politicians love to cut funding for mental health institutions while not funding community-based services for people with MHSAPs who have exited these institutions. The Congress and president failed to simplify the maze of insurance, Medicare, and Medicaid programs for persons with MHSAPs—not to mention the complex network of public, not-for-profit, and for-profit institutions that help people with MHSAPs. It is a challenge for consumers of service to find out where to go for which problem, to understand fees, and to determine which professionals have the requisite knowledge about evidence-based treatments. Waits for physicians to obtain medicine for opioids were as much as one year in 2016—and the demand for such medicines has grown exponentially in the succeeding years as deaths from overdoses soared to 72,000 persons in 2017 (Vestal, 2016).

Social workers seek greater resources for programs that help persons with mental health and substance abuse problems. They can ask to view their state's application for federal resources from the Community Mental Health (MHBG) and Substance Abuse Block Grant (SABG), which were enacted in 1981. Each state applies for federal funds for these block grants, including in fiscal years 2018 and 2019, when states were asked for the first time to develop joint applications for mental health and substance abuse. States have to identify in remarkable detail the populations their block grants serve, the kinds of services they provide, and assessments of mental health and substance abuse clients who receive help from these block grants. They discuss the extent they use Medicare, Medicaid, and other resources to fund these services. They describe services provided by public, not-for-profit, and for-profit agencies. (Go to <http://www.samhsa.gov> to view application forms under the title Block Grants, "SABG and MHBG" and examine the application form, including one that asks them to identify "resources." Then contact your state's mental health and substance abuse agencies to view the actual plans they submitted to the federal government for fiscal years 2018 and 2019.)

Because many persons have to wait months to get treatment for their substance abuse problems, macro policy advocates can demand states and the federal government increase access for them. They can demand that the federal government fund and distribute

lifesaving medications to persons with opioid poisoning, which we discuss subsequently. They can mandate the use of evidence-based medications and cognitive therapy for persons with substance abuse issues as compared with 12-step programs, like Alcoholics Anonymous (AA), which are not evidence based. They can seek more funding for primary health clinics in low-income areas that have insufficient services for persons with mental health and substance abuse problems. They can diminish stigma in many ways. They can link clients to advocacy groups that emphasize the strengths of persons with MHSAPs. They can educate employers about the strengths of persons with MHSAPs including how to help them make work adjustments that increase their productivity. They can seek social policies that ban discrimination against persons with MHSAPs in hiring. They can seek better enforcement of the Americans with Disabilities Act (ADA) that prohibits discrimination by employers against persons with MHSAPs during hiring processes.

Social workers can engage in mezzo policy advocacy to improve services for persons with MHSAPs. They can work to increase residential mental health services for persons who languish in emergency rooms and hospitals because professionals are prohibited from discharging them before they are medically stabilized and before they can find licensed residential facilities. They can work to increase staff and clinics in hospitals with expertise in persons with MHSAPs at a time when relatively few hospitals have sufficient numbers of staff with expertise in addictions. They can initiate training sessions with community residents and leaders about specific mental health and substance abuse. They can seek cross-disciplinary teams in primary clinics and hospitals that integrate contributions of physicians, psychologists, and social workers.

Social workers can help persons with MHSAPs through micro policy advocacy in many ways. They can help them navigate the complex funding systems that the United States has developed, including coverage offered by private insurance, Medicare, and Medicaid. They can help them navigate public, not-for-profit, and for-profit providers. They can help them find providers that use evidence-based programs (EBPs). They can help persons with MHSAPs seek and retain employment. They can help them find temporary residential centers where they can recover sufficiently to reenter their communities after they have been discharged from emergency rooms and hospitals. They can help persons with MHSAPs who are often impoverished due to their lack of employment or low wages to find assistance from safety net programs including the Supplemental Nutrition Assistance Program (SNAP), food banks, rent subsidy programs, and other programs discussed in Chapter 9. They can help them find and fund caregivers when they need them, such as tapping into Medicaid funds targeted to persons with MHSAPs. They can help them obtain legal assistance from federal administrative judges when their rights are violated.

### Indicators of Poor Services in Mental Health and Substance Abuse Areas

Several indicators suggest that many Americans receive inadequate care for mental health and substance abuse problems.

1. Primary care physicians deliver most mental health services in the United States, yet most have no or only elementary knowledge of mental health problems. They usually treat patients in a single session during which they prescribe medications rather than referring them to mental health specialists who can diagnose,

give medications, and provide follow-up services. There is an overlap between physical and mental health conditions. Up to 70% of all primary care visits involve a mental health concern—and nearly 68% of people with mental illness have chronic health conditions such as diabetes, hypertension, or heart disease. Integrated care models that coordinate physical and mental health services can improve care, coordinate physical and mental health care, and reduce costs (National Alliance on Mental Health, 2015).

2. Clients often do not have access to an array of interventions because primary care physicians, as well as other helpers, lack knowledge of an array of interventions that include the following (Jansson, 2011):
  - Diagnose biopsychosocial factors that contribute to specific mental and substance abuse problems (*differential assessment*).
  - Identify specific medications that are useful in treating specific mental health and substance abuse problems (*psychiatric or medical interventions*).
  - Help consumers resolve their internal conflicts and uncertainties (*counseling*).
  - Help consumers cope with adverse news (*supportive counseling*).
  - Facilitate the diagnosis of specific mental health conditions that might otherwise not be detected (*screening*).
  - Help consumers resolve familial tensions and conflicts (*family counseling*).
  - Help consumers resolve tensions and conflicts within their social networks (*social network counseling*).
  - Help consumers find meaning and dignity when they confront disabilities, chronic diseases, and terminal illness (*existential counseling*).
  - Help consumers deal with grief, bereavement, and trauma (*grief, bereavement, and trauma counseling*).
  - Help consumers deal with persisting psychological and social effects of trauma (*posttraumatic stress counseling*).
  - Gauge the cognitive competence of specific persons to determine if they can make decisions about their health care—and help find proxies when necessary (*assessing competence*).
  - Diagnose why specific consumers do not adhere to treatment recommendations and develop interventions to improve adherence (*adherence counseling*).
  - Help stabilize persons with psychotic and other disorders who are disruptive in health and other settings (*stabilizing services*).
  - Help consumers deal with specific crises (*crisis intervention services*).



- Help consumers with specific mental health interventions that have proven effectiveness with specific problems (cognitive, motivational, behavioral, psychosocial, and other therapeutic strategies).
- Provide social service and mental health interventions as part of a health care team to achieve specific health objectives like weight loss, including psychosocial and behavioral counseling (*adjunctive counseling in a health team*).
- Educate physicians and other health staff about mental health problems (*mental health education for professionals*).
- Use evidence-based yoga, meditation, biofeedback, and other interventions (*nontraditional interventions, often called mindfulness programs*).
- Help consumers avoid learned helplessness (*empowerment strategies*).
- Help consumers surmount environmental stressors, such as those involving economic problems, housing, and the community (*coping with environmental stressors*).
- Help consumers obtain knowledge about psychological conditions that often accompany physical illness, mental health problems, and substance abuse problems—and how to address them (*psychoeducation*).

Mental health researchers and administrators have to decide which of these interventions are relevant to which clients, for what duration, and at what cost. Acute mental illnesses often can be addressed in less than 10 visits with some follow-up services. Some mental illnesses can be managed with medications and periodic follow-up services. Many substance abuse problems, including addictions that include smoking and drug addictions, may require extended treatment including use of medications, monitoring, and cognitive therapy. Chronic mental health and substance abuse problems may require episodes of treatment coupled with ongoing monitoring as clients contend with these problems. Some clients may need inpatient care in hospitals or in residential facilities for short or longer periods. Many mental health and substance abuse problems recur, requiring clients to resume treatments on some or many occasions.

3. Clients that need access to inpatient care, whether in hospitals or residential facilities, often cannot be placed in them due to a paucity of beds or residential facilities. Some patients remain in emergency rooms or hospital beds for days or weeks because they cannot be discharged when they need residential care (Jansson, 2011).
4. Many patients do not receive evidence-based care for alcoholism or addictions to drugs. They are often referred to 12-step programs developed by AA even though evidence-based data fails to uphold their service. Considerable evidence supports, instead, the coupling of medications with cognitive therapy for varying lengths of time. Relapses are common, so medications and cognitive therapy may need to be used on several or more occasions. Many clients do not receive evidence-based care for substance abuse, such as for opioids or other drugs. They do not receive medications with cognitive therapy. They do not receive medications when

they have overdosed sufficiently that they may lose their lives. They do not have access to emergency medical care due to lack of sufficient emergency room staff and emergency vehicles. Physicians and dentists often perpetuate drug epidemics by over-prescribing addictive drugs and not monitoring patients, even though considerable progress has been made in curtailing prescriptions in some locations. Drug companies often distribute addictive drugs to areas, such as rural towns, where drug epidemics exist (Macy, 2018).

5. The United States lacks universal health insurance so that the nation is divided into different subpopulations with varying levels of insurance coverage for mental health and substance abuse services and medications. Despite federal legislation that requires private insurance companies to cover mental health conditions and substance abuse on equal terms with physical health problems, coverage of mental health and substance abuse services varies. Despite augmentation of coverage for mental health and substance abuse in Medicare and Medicaid programs, certain gaps still exist.
6. Roughly 37% of adults with clinical depression fail to receive medications, as well as therapy, that help patients control this disease (National Institute of Mental Health, 2017). Absent therapy and medications, many depressed persons cannot hold jobs, sustain relationships, or engage in other activities. Some of them commit suicide.
7. Insufficient numbers of halfway houses exist for persons recovering from psychoses or other chronic health conditions—nor are their costs sufficiently covered by some health insurance policies (Jansson, 2019).
8. Large gaps exist in the professions that provide mental health and substance abuse services. Few physicians have expertise in substance abuse treatment out of a workforce of roughly 1 million physicians. Most people who provide help to persons with substance abuse are themselves recovering addicts who lack professional degrees. The nation has a substantial number of social workers, but hospitals vary widely in the number that they hire—and relatively few social workers specialize in addictions.
9. Mental health and substance abuse problems are insufficiently addressed by professionals and other staff in the eight policy sectors discussed in this book including the following:
  - In the education sector many students in middle schools and many students in high schools have mental health problems of varying seriousness. Considerable numbers of students commit suicide. Many students have substance abuse issues with alcohol, smoking, cocaine, heroin, and marijuana. Some students have sexual identity issues. Bullying often takes place. Some students engage in mass shootings of fellow students, teachers, and administrators (see further discussion in Chapter 12 of this book). Many students do not graduate from high school, junior colleges, and colleges because they possess substance abuse and mental



health problems. The National College Health Assessment revealed that the number of students suffering from depression rose from 32.6% in 2013 to 40.2% in 2018—and those attempting suicide from 1.3% to 1.7% (Brody, 2018). Many schools have augmented their mental health and substance abuse staff, but most cannot address students' problems sufficiently. Preschools and schools are ill equipped to provide them with any mental health professional on their premises. The vast majority of students who attend junior colleges do not graduate—and those students on the spectrum or with serious mental problems are often included in their ranks due to the lack of sufficient support services. Nor are most institutions of higher education equipped to provide mental health services to students, leading to high dropout rates of students (Brody, 2018). Youth with other chronic mental illnesses receive inadequate services from preschools or primary and secondary schools. It is not surprising that many of these youth receive inadequate services. Once they graduate from high school, many youth with chronic and serious mental illnesses have no place to live because their parents are unwilling or unable to care for them in their homes. Left to their own devices, these youth often end up on the streets or in jail.

- In the criminal justice sector, roughly 40% of inmates have mental health and substance abuse problems, as we discuss in Chapter 14. Although prison populations have recently declined in some states that have released nonviolent offenders, probation departments contend with high rates of mental illness and substance abuse with insufficient staff.
- The child and family sector possesses populations with high levels of mental illness and substance abuse, yet lacks sufficient staff to give them adequate care. Child welfare departments have insufficient links to health, mental health, and substance abuse services. When youth are emancipated at age 18 in some states, 21 in other states, and even later in other states, they often end up on the streets or in jail because their mental health and substance abuse problems have not been addressed, as we discuss in Chapter 11.
- In the immigration sector adults and youth who are undocumented suffer from anxiety and depression related to the uncertainties of their legal status and from separations from family members. They rarely use existing medical and mental health services because they fear deportation, as we discuss in Chapter 13.
- People in the safety net sector often have serious food, housing, and employment needs. We have already discussed the substance abuse and mental health problems of many homeless people that are often exacerbated by the stress of lacking secure housing, as is discussed in Chapter 9. We can hypothesize that many persons who use food banks and SNAP have mental health and substance abuse issues caused by their poverty and economic uncertainty.

10. Mental health and substance abuse programs often face an ethical dilemma when clients are imminent threats to other people—but who refuse treatment. Mental health personnel are compelled to inform the police when a client threatens to harm or kill another person by a ruling by the U.S Supreme Court. These persons include people who commit violent acts in families, schools, and places of work against other persons or who attempt suicide. They include some homeless persons who refuse to enter government-supplied or financed housing at considerable cost to the broader society. Although this policy alerts police and potential victims of danger, police are often reluctant to provide indefinite protective services to persons in danger. Some states, such as California and New York, allow mental health and substance abuse personnel and/or police officers to seek court orders to require specific persons to take medications and counseling that have been proven to decrease violent actions or even to induce homeless persons to accept housing or residential treatment centers or to accept other forms of protective custody. Such court orders are viewed by some critics as violations of clients' rights to informed consent, but judges have to balance clients' rights with the rights of community members and the community at large. Protective custody might, for example, have averted the massacre at Marjorie Stoneman Douglas High School in Parkland, Florida, in 2018.
11. Funding for mental health services by state governments has decreased from 1980 to the present despite substance abuse epidemics, high levels of suicide, burgeoning homeless populations, high levels of anxiety, high rates of mental illness among secondary and college populations, and many other indicators of unmet mental health and substance abuse diseases (National Alliance for Mental Illness, 2011). However, states that chose to participate in marked increases in the eligibility of Medicaid in the wake of enactment of the Affordable Care Act (ACA) in 2010 gave millions of Americans mental health and substance abuse coverage that they would not otherwise have had. By late 2018, 37 states and the District of Columbia had made this expansion, leaving only 14 states that did not increase Medicaid's eligibility. The federal government paid for this expansion, including for mental health and substance abuse services funded by Medicaid (FamiliesUSA, 2018).
12. The federal MHBG and SABG, enacted in 1981, supplanted many so-called categorical federal grant programs. Governors hoped that the block grant funds would give them more latitude to develop their state mental health and substance abuse programs—but block grants were funded at levels lower than the funds of their prior categorical programs (Jansson, 2019). Nor has funding of the MHBG and the SABG kept up with inflation. For example, the MHBG has received funding of roughly \$1 billion for many years.
13. An unfulfilled promise of parity took place in the wake of federal legislation that required private insurance companies to equalize access to mental health and substance abuse services as compared with their health benefits. Prior to this legislation, many persons found that their private insurance policies failed to cover any mental health services or only meager ones. In a survey conducted in 2015, many persons could not locate mental health providers in their networks, including inpatient care in hospitals and residential services (including social workers and

## POLICY ADVOCACY LEARNING CHALLENGE 10.1

Select one of the 15 indicators of major, unsolved shortcomings in American mental health and substance abuse services. Identify a policy or

policies that might address the shortcoming. Identify whom you might contact at federal, state, or local levels to start the ball rolling.

psychologists), as compared with general or specialty medical care. Only 75% of respondents could find an in-network mental health therapist, for example, as compared with 91% who could find an in-network medical specialist. This meant they had to pay higher costs for out-of-network mental health and substance abuse services. They had to pay higher out-of-pocket costs for these mental health and substance abuse services than for services for their physical health problems. These findings suggest that the federal government has to monitor health systems to upgrade their numbers of mental health professionals and so that consumers of mental health services do not have to pay a higher percentage of these costs than patients using traditional medical care (National Alliance on Mental Illness, 2016). Their out-of-network and out-of-pocket obstacles have proven to be greater for mental health services than when they sought general or specialty medical care from their networks in violation of federal legislation that required parity.

14. Half of all mental illness emerges by the age of 14 and three-quarters by age 24—and early identification has been shown to prevent crises and allow children to avoid serious mental problems. In the United States, however, an average lag of eight to 10 years exists between the onset of a mental health condition and the start of treatment. Although one in five American youth live with a mental health problem, less than half receive treatment. The federal Medicaid law requires mental health screening as part of the Early and Periodic Screening, Diagnostic and Treatment Program, but many states do not comply with this mandate (National Alliance on Mental Health, 2015).
15. Early interventions for persons with first episode psychoses (FEP) dramatically improve outcomes for persons with them—but many of these persons do not receive timely care. Congress has required states to use 5% of the 2015 and 2016 MHBG to encourage FEP programs (National Alliance on Mental Health, 2015).

## ANALYZING THE IMPACT OF INCOME INEQUALITY ON MENTAL HEALTH AND SUBSTANCE ABUSE

All persons, regardless of age, race, religion, or income, are vulnerable to mental illness. The causes of specific mental illness and addiction often include a combination of brain disorders affected by biological and genetic vulnerabilities as well as environmental stressors (National Institute of Mental Health, 2017). Low-income people have markedly higher

rates of anxiety, depression, and many other forms of mental illness than relatively affluent persons. They commit suicide at higher rates than affluent persons. They have far poorer access to mental health services than other persons, whether medications or counseling. They have higher rates of mental illness that stem from multiple causes. Some researchers contend that stress induced by poverty exposes persons to ongoing economic uncertainty as well as a quest for survival (Kolbert, 2018). Psychologist Keith Payne contends that the subjective experience of feeling poor—not limited to persons in the lowest economic quintile—causes substantial stress that can lead to depression, risky behaviors like gambling, feeling inferior, and subscribing to conspiracy theories. A study of British civil servants found that people ranking themselves in terms of status was a better predictor of their health than their education level or their actual income (Payne, 2017). Yet other researchers implicate poverty itself in causing mental health and substance abuse problems. Poor people often have poor nutrition even with assistance from SNAP and food banks. They experience high rates of eviction when they cannot pay their rents—a demeaning process during which police place their possessions on the street (Barr, 2008). They experience uncertainties in their neighborhoods such as gangs, drug dealers, and random shootings. Their mental illness is less likely to be effectively addressed by mental health services than affluent persons because they have poorer access to counseling and to medications due to a paucity of emergency rooms and outpatient mental health and substance abuse clinics. Incomes of low-income persons with mental health and addiction disorders are further diminished by their disorders, making it difficult for them to find and hold employment (Barr, 2008). Access to mental health and substance abuse services is particularly poor in those 17 states that chose not to increase their Medicaid eligibility levels as allowed by the ACA. Recall that the ACA gave states the option of expanding Medicaid eligibility to nearly all low-income persons with incomes at or below 138% of the poverty line and many moderate-income families—or \$28,676 for a family of three in 2018 (Garfield, Damicao, & Orgera, 2018). In states that did not expand coverage, the median income limit for persons seeking care from the ACA's insurance policies is just 43% of poverty. Low-income whites, African Americans, and Latinos in states that did not increase Medicaid eligibility levels, such as Florida, Georgia, and Texas, disproportionately lack access to mental health and substance abuse services that are reimbursed by Medicaid.

Roughly 32% of adults beneath the poverty level smoke, but only 17% of persons twice the level of poverty do. Roughly 28% of persons with less than a high school education smoke cigarettes, but less than 10% of college graduates do. Low-income persons are just as likely as affluent persons to attempt to quit smoking cigarettes but are far less likely to quit. These disparities in smoking levels partly stem from the targeting of low-income areas by tobacco companies and outlets (CDC, 2018b). Opioid consumption is highest in rural areas partly because pharmaceutical companies flooded them with drugs, but the relationship between social class and use of opioids is complex and varying (Macy, 2018). Disparities in alcoholism between low-income and affluent persons is not as discernible as smoking.

## ANALYZING THE POLITICAL ECONOMY OF MENTAL HEALTH AND SUBSTANCE ABUSE

Mental health and substance abuse services have traditionally been viewed as stepchildren of the medical system. Until relatively recently, mental health was given poorer coverage than physical health conditions—and it still lags behind, as we

discuss subsequently. Psychiatrists have lower status in the medical profession than surgeons. Primary care physicians have the lowest status in the medical hierarchy. Moreover, primary care physicians often have little training in counseling, mental health, and substance abuse disorders. They often rely excessively on medications to provide most mental health services within the medical system—with little or no follow-up.

Discussion of the opioid epidemic as well as the epidemic of alcoholism reveal the political economy of the mental health and substance abuse sector.

The opioid tragedy from roughly the mid-1990s to the present is a case study of how political and economic factors impede the development of evidence-based and fully funded interventions in the mental health and substance abuse sector. Large pharmaceutical companies realized that they could flood specific areas of the nation with drugs that are prescribed by physicians and dentists to allay the pain of persons with dental problems, arthritis, injuries from car accidents, workplace injuries, sciatica, and many other illnesses (Macy, 2018). The U.S. Food and Drug Administration (FDA) approved OxyContin's new time-release mechanism on the grounds that it reduced addiction—and sales representatives from drug companies convinced physicians to prescribe many other pain-reducing opioids, including Vicodin, Percocet, Lortab, and immediate-release opioids. Unfortunately, these pain-reducing drugs are highly addictive. Drug companies hired 5,000 doctors, pharmacists, and nurses to give seminars to convince doctors that OxyContin was not addictive. They argued that opioids could be used not just for intense pain but for moderate pain. They gave bonuses to physicians who prescribed large amounts of these drugs, even as high as \$100,000 every three months (Macy, 2018). Dentists joined the fray by prescribing addictive drugs for pain. Opioid distributors spent a billion dollars on political lobbying and campaigns to be certain that Medicaid and physicians would fund and prescribe opioids. The drug company Perdue reformulated opioids in 2010—and inundated small towns with the drug, including 9 million pills to just one town in West Virginia. Drug companies eventually manufactured and widely distributed Fentanyl, another highly addictive painkilling drug because of its small size, its potency at 50 times heroin, and the ease with which it can be mixed with heroin (mostly imported from India and China). They convinced dentists and physicians to prescribe it. When addicts could not obtain Fentanyl, they moved to heroin that they obtained from drug dealers (Macy, 2018). Meanwhile, rehabilitation centers continued to use the ineffective 12-step model, rather than medication-assisted therapies, even though it is effective in preventing deaths only for 11% of patients as compared with roughly 50% for medication-assisted therapies (Macy, 2018).

Other family members and acquaintances soon obtained the drugs, whether by raiding places where parents or relatives stored their drugs or by purchasing drugs from dealers. Drug dealers found ways to find the drugs through underground markets or from smugglers. With a dearth of physicians or other professionals who were versed in addiction science, few addiction clinics, and overtaxed emergency rooms, an addiction epidemic grew from relatively few deaths in 1996 to 72,000 deaths from opioids in 2017 (CDC, 2018a).

Stigma assumed a major role in fueling the drug epidemics. Many persons traveled to other states to secure drugs to hide their addictions from friends and relatives—only often to die in these states. Even well-connected and wealthy people refrained from getting help for substance abuse and mental health problems because of stigma. Congressman Patrick Kennedy, for example, chose not to inform the Mayo Clinic that he had a substance abuse problem because he feared his problem would become public. He finally surmounted his

fears by championing congressional legislation in 2006 and later years that required private insurance companies to cover substance abuse and mental health at levels equivalent to Medicare and Medicaid.

The drug epidemic was so lethal because the health system and residential centers lacked evidence-based treatments. They referred drug addicts to the 12-step program initiated by AA decades earlier. They referred them to residential centers that also used this strategy or other counseling techniques. These strategies were not effective for the vast majority of addicts (Glaser, 2015).

Because the nation's attention was diverted to the epidemic of addictive painkilling drugs, few experts realized that alcoholism rose by 49% from 2000 to 2017. Roughly 12.7% of the American population met the criteria for "alcohol use disorder" in 2017, with annual deaths from it rising to 88,000 per year in 2017 (Ingraham, 2017). These deaths were caused by hypertension, cardiovascular disease, cirrhosis of the liver, and other diseases caused by alcoholism, as well as automobile accidents. Alcoholism rates were 16.7% for men, 16.6% for Native Americans, 14.3% for persons below the poverty line, and 14.8% for people living in the Midwest. Remarkably, 23.4% of adults under age 30 suffer from alcoholism (Ingraham, 2017).

Most physicians and other health professionals in outpatient settings, as well as staff in residential facilities, had long assumed that the 12-step model used by AA was the only effective cure (Coy, 2010; Glaser, 2015). Remarkably, only 582 physicians in the United States out of almost 1 million identified themselves as addiction specialists (Glaser, 2015). Most treatment providers call themselves "addiction counselors" or "substance abuse counselors," which requires only a high school degree or a GED, with many of them also recovering from substance abuse (Glaser, 2015).

Curiously, many physicians in the United States fixated on a single approach to addressing alcoholism for decades rather than exploring alternative approaches that are effective with specific persons (Glaser, 2015; Macy, 2018). That single approach has been the faith-based 12-step program (five of the steps mention God) provided by AA, in which alcoholics and former alcoholics meet in groups to support one another to achieve and retain abstinence. Some people are helped by AA, but others often feel defeated if they relapse because AA's "Big Book" states "those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. These are such unfortunates; they seem to have been born that way" (Glaser, 2015). Critics note that AA's approach has not been verified by scientific studies. The Cochrane Collaboration, a leading health research group, maintained in 2006 that no scientific studies demonstrate that the 12-step method reduces alcohol dependence (Glaser, 2015). A retired psychiatry professor from Harvard estimated from available data that AA's success rates falls between 5% and 8% (Dodes, 2015). Some experts contend that abstinence often causes bingeing, citing animal and human studies (Sinclair, cited by Glaser, 2015).

### **Toward Evidence-Based Treatments for Both Drug Addictions and Alcoholism**

Experts in the fields of drug addiction and alcoholism are moving toward evidence-based treatments. They prefer medications to remove or decrease the urge for addictive substances. They prefer medications to help addicts avert death when near death after taking life-threatening doses or amounts of alcohol and drugs.



Scientists have used disulfiram (Antabuse), which causes persons to have bad reactions when they drink alcohol by blocking its processing in the body. Other medications have appeared more recently, such as naltrexone, that greatly reduces the urge to drink alcohol. John David Sinclair, a clinical psychologist, discovered that patients who coupled naltrexone with cognitive therapy achieved a 75% success rate among 5,000 Finnish alcoholics over 18 years—a treatment costing only \$2,500 compared with tens of thousands of dollars in the United States for each patient placed in rehabilitation units for roughly 30 days (Sinclair, cited by Glaser, 2015). High rates of success were obtained in a dozen clinical trials including one funded by the National Institute on Alcohol Abuse and published by the *Journal of the Medical Association* in 2006 (Glaser, 2015). Other medications became available to patients but were not funded by Medicare or Medicaid.

Although many health professionals seek to terminate intake of alcohol altogether, some experts contend that treatments that help alcoholics control the quantity of alcohol they consume have been shown to be effective (Glaser, 2015). They contend that alcoholism is often not a progressive disease that inevitably worsens. The CDC found that nine out of 10 heavy drinkers are not dependent on alcohol but can change their intake with a brief intervention from a medical professional (Glaser, 2015). The 2015 diagnostic manual of the American Psychiatric Association asserts that only 15% of persons with “alcoholic-use disorder” have a severe problem—although the rest are often ignored by researchers and clinicians and do not receive individualized treatment options (Glaser, 2015).

Yet other research was published in late 2018 that drew upon data of tens of thousands of persons in many nations. It concluded that any use of alcohol has negative health effects on persons who use it (CNN, 2018). Our discussion of alcohol usage suggests that considerable controversy exists even as we move beyond the 12-step model to strategies to control its usage. Although some experts aim for total cessation of drinking, others want merely to control its usage. Still others want to combine cognitive therapy with medications to help persons not to drink to levels that constitute clinical alcoholism.

Similar progress was made with respect to opioid addictions as naltrexone and other medications decreased the urge to take them. Scientists also discovered that naloxone (a drug with the brand name Narcan) reverses drug overdoses from heroin and other painkillers by quickly restoring normal breathing.

Persons addicted to alcohol and opioid drugs often relapse even when they appear to have recovered. Many of them remember the highs they obtained by their addictions and are tempted to return to them. Or they fail to return for prescriptions or cannot afford them. Or they do not engage in cognitive therapy that allows them to realize that addictions have ongoing negative impacts on their lives, including disrupting their families, employment, and education.

Many addicts also recover from their addictions without assistance, even if the process may take decades and despite negative impacts on their lives. These evidence-based approaches provide a superior alternative for most of them because they may save their lives and decrease negative impacts.

Addicts often cannot afford some effective medications that have not been approved by the FDA and that are not funded by Medicaid. To help addicts buy them, some clinics gave them twice the amount they need so they can sell the half they don't need and use the remaining funds to buy their share of the drug (Macy, 2018).

Many physicians have not yet adopted these new approaches. Many physicians shun drug addicts whether because they don't want them in their waiting rooms or because they don't have waivers that allow them to use the medications (Macy, 2018).

Drug courts and law enforcement officers often do not like medication-assisted treatment. They wrongly view the lifesaving medications as addictive. They wrongly subscribe to the 12-step model. They wrongly believe residential centers are effective. They began changing their views only in 2018 (Macy, 2018).

### Three Additional Epidemics: Smoking, Poor Diets, and Unaddressed Mental Health Problems

The United States also has to address three additional major epidemics: smoking, poor diets that lead to obesity, and unaddressed mental health problems. Roughly 480,000 Americans die each year from smoking due to lung cancer and other cancers, heart disease, and many other ailments it causes (CDC, 2018a). Although health and longevity problems from smoking are often viewed as health problems, they also can be viewed as mental health problems. Smoking is an addiction to a drug—nicotine and other chemicals in tobacco products. The United States has, at best, an inadequate method for dealing with this problem. Roughly half of primary physicians do not ask patients if they smoke. Yet smoking is an addiction. Here too, some medications help people curtail smoking when combined with cognitive therapy and regular monitoring by health professionals.

Food is another addiction for tens of millions of Americans. Roughly 35.7% of American adults age 20 to 39 years are obese as well as 42.8% of adults age 40 to 59 years and 41% of adults age 60 and older (CDC, 2018c). Here, too, an epidemic exists with rates of obesity rising from 33.7% in 2007–2008 to 39.6% in 2015–2016—and with rates of severe obesity rising from 5.7% to 7.7% (CDC, 2018c). With respect to obesity, considerable scientific evidence refutes the notion that obese persons need to undergo drastic weight reduction because researchers have discovered that obese persons almost always regain lost weight (Mayo Clinic, 2015).

Persons often have better outcomes when they combine modest weight reduction with regular exercise. Many scientists urge interventions in families that have obese children to modify diets, modify meals at schools, reduce eating sugar and fat content, especially at fast-food outlets, and educate parents about healthy nutrition. Some people with extreme obesity undergo surgery to diminish the size of their stomachs because they cannot otherwise control their weight. They realize that they are otherwise likely to have shortened life expectancy from heart disease and other diseases that are linked to extreme obesity.

The challenge of changing eating habits to include less fat, meat, dairy products, sugar, and salt is formidable, but other nations have succeeded. The Finnish government launched an attack on early deaths in the North Karelia province of Finland in 1972 by attacking high blood pressure, cholesterol, and smoking. They used “media campaigns, community meetings, chats in people’s kitchens, carrots and sticks for farmers and food producers—up to and including village-versus-village competitions over cutting back on smoking or reducing cholesterol counts” (Willingham, 2018). As of 2012, deaths from heart disease plummeted by 82% among middle-age men. When the project was converted into a national one, the death rate of these men plummeted by 80% by 2012. According to Professor Glorian Sorensen at the Harvard T.H. Chan School of Public Health, the project demonstrated “how social factors may really shape health behaviors that are associated with chronic disease” (Willingham, 2018).

Mental health problems can also be viewed as an epidemic. We have already discussed the prevalence of mood disorders such as anxiety and depression as well as the roughly 1% of the American population who have schizophrenia. We have discussed the sheer numbers of persons with serious mental illness who receive no help for their conditions. We view with dismay the sheer number of mass shootings often conducted by persons with serious mental illness. We see many homeless persons on the streets for mental health problems. Many persons fail to graduate from high school, junior colleges, colleges, and universities due to unaddressed mental health problems, as I discuss in Chapter 12. I discuss in prior and ensuing chapters the sheer number of unaddressed or poorly addressed mental health problems in the health, gerontology, safety net, child and family, education, immigration, and criminal justice sectors.

Many persons are members of two or more of these epidemics. A person may be alcoholic and obese. Another person may have a severe mental condition and smoke. Odds of early death likely increase with dual or greater membership in these epidemics.

It is now certain that these epidemics require collaboration among the health, mental health, and substance abuse sectors. Combinations of medications, counseling, and social support systems need to work in tandem to address them, as we have discussed with respect to each of the five epidemics.

A prominent law professor, Elyn Saks, reveals that she could not have had her highly productive career without using medications for her schizophrenia as well as periodic visits with her psychiatrist (Saks, 2007). Persons with these problems need to work with health professionals to determine the dosage levels that relieve symptoms but minimize side effects.

Many difficult issues need to be addressed moving forward. Many experts also contend that children and adolescents are overmedicated in the United States for conditions such as attention deficit hyperactivity disorder. They argue that excessive medications used by children and youth may harm their brains because they are not fully developed. Many adults may be overmedicated for a variety of disorders including sleep problems and anxiety. Unlike many other nations, the United States allows mass media to advertise medications widely to the public rather than relying on health professionals to inform patients about medications that might be useful to them. Nor does the United States allow Medicare and Medicaid officials to bargain with pharmaceutical companies about the cost of medications—or encourage American consumers to shop for medications in Canada, Mexico, and elsewhere.

Considerable prejudice against persons with problems in the five epidemics will slow the progress in addressing them. Many people believe that persons with schizophrenia or autism are inherently dangerous, when in fact, they commit fewer crimes than persons in the broader population (Brekke et al., 2001). Some biologists and geneticists contend that current descriptions of mental illnesses and substance abuse in the *DSM-5*, published by the American Psychiatric Association, lack scientific rigor, even though many clinicians find it to be useful. Its authors, they contend, relied on descriptions of patients' symptoms and behaviors to identify mental health and substance abuse problems rather than seeking their underlying genetic and physiological causes. The National Institute of Mental Health seeks genetic and biological factors that cause mental health and substance abuse problems so that medications and other physiological interventions can be developed to treat them, but its leaders admit that this approach may not yield substantial results for a decade (National Institute of Mental Health, 2017).

## What Will It Take to Curtail the Substance Abuse, Alcohol, Smoking, Obesity, and Mental Health Epidemics?

The nation spends about \$35 billion per year on alcohol and substance abuse treatment (Glaser, 2015). Absent other estimates, assume that at least \$50 billion in additional resources is needed over the next 10 years just to get medication-assisted treatments into the medical system for substance abuse as well as cognitive therapy. Physicians have to be retrained. Thousands of physicians have to be recruited to treat persons with substance abuse. Residential treatment centers have to be banned or not reimbursed if they fail to provide medication-assisted treatment. Primary care physicians need to be informed about evidence-based care so that they can make appropriate referrals. Emergency rooms and ambulances have to be able to administer lifesaving medications that revive persons who are near death from overdosing (CNN, 2018). Support and monitoring systems have to be developed, such as when persons with substance abuse relapse. Everyone needs to view different addictions as diseases rather than as a moral fault. Unfortunately, House Republicans and the Trump administration proposed minuscule resources in 2018, even seeking deep cuts in Medicare and Medicaid, not to mention repealing the ACA (Macy, 2018).

Absent other estimates, let's assume that \$50 billion is needed for each of the other epidemics in the next 10 years because the nation needs similarly to retool its existing non-systems for addressing alcoholism, smoking cessation, and obesity, not to mention mental health problems. That would require at least \$200 billion over 10 years in addition to the new funds allocated to the substance abuse sector—and possibly far more. The nation can afford these expenditures as illustrated by the nearly \$2 trillion in tax cuts in 2018 that mostly benefited corporations and wealthy persons. Otherwise, the nation will needlessly lose hundreds of thousands of lives each year, not to mention diseases, loss of employment, premature deaths, and other problems that compromise the well-being of persons encumbered by any of these five epidemics. These investments would be partially offset by fewer emergency room visits, lower surgical costs, higher tax revenues from increased employment, lower medical costs, and greater productivity of workers.

Primary care doctors need to refer persons in the five epidemics to teams of professionals that develop and monitor treatment rather than assuming the primary role. Community clinics need to be developed to augment access and monitoring. Interdisciplinary teams are needed, as are currently common with respect to chronic diseases like diabetes. Social workers need to be important members of these teams. Sufficient numbers of staff need to be funded to eliminate long waits, such as six-month waits that commonly occur with respect to persons seeking help with substance abuse. Telemedicine should be widely used to allow frequent interactions with patients and to allow fast responses when they relapse. Policy planning at federal and state levels needs to be developed by policy and budget teams vested with each of these epidemics. The teams need to cut across federal agencies, including the FDA for medications, the Department of Health and Human Services for financing of the four initiatives, and the Office of Management and Budget for funding of the initiatives. Funds need to be planned for 10-year periods so that Congress does not frequently cut them. Unlike President Trump, who failed to invest sufficient resources to stem the opioid epidemic,

the nation needs to invest huge resources for a sufficient period to stanch these epidemics. Trump did sign a package of bills to address the opioid crisis but failed to fund a “wide and sustained expansion of addiction treatment” (Lopez, 2018).

## ANALYZING THE EVOLUTION OF THE MENTAL HEALTH AND SUBSTANCE ABUSE SECTORS

Grob (1994, 2008) points out that throughout history, mental health policy goals have been shaped and transformed by the shifting of funding responsibility among the local, state, and federal sectors of government. The following timeline depicts the evolution of the American mental health care system from the colonial era to the present:

- **Mental Illness in Colonial Times.** Low incidence of mental illness reported; not defined as a medical problem or a matter of social concern. There were no effective treatments; families were responsible for providing care to members unable to work (Grob, 1973, 1994; Deutsch, 1937).
- **The Late 17th Century.** As numbers grew, the mentally ill were housed with other dependent populations (the aged, infirm, or criminals) in local workhouses or almshouses (Grob, 1983; Jansson, 2019) or in the basements of early private hospitals (Grob, 1973).
- **The Moral Age.** Progressive communities applied Christian principles and established well-ordered asylums to cure the effects of the outer world (Grob, 1983; Jansson, 2019).
- **The Public Mental Hospital Movement.** In 1848, social reformer Dorothea Dix advocated for more humane treatment and state financing for building 95 asylums (Jansson, 2019).
- **The Late 1800s.** Optimism diminished as state hospitals offered custodial care but little hope of cure; and costs for care became the largest piece of the budget; state regulations pressed for scientific basis for provisions (Grob, 1983; Deutsch, 1937; Mechanic, 1989).
- **The Mental Hygiene Movement to the Progressive Era.** Following institutional care failures, many medical treatments shifted to an outpatient services focus (Grob, 1994). Explorations in neurology and psychiatry, including Freudian insights into the mind, created hope that understanding and cures were possible (Grob, 1983). Treatment innovations became supplements to institutional care rather than a substitute for it; by 1940 admissions to state hospitals increased to 455,000 (Grob, 1973, 1983).
- **Impact of the Great Depression, World War I, and World War II on Psychiatric Care.** There developed increased public awareness that given sufficient stress, anyone could develop psychiatric symptoms (Grob, 1983);

America's involvement in wars exposed the need for crisis-oriented and group treatments (Grob, 1973). New laws and the creation of the National Institute of Mental Health (NIMH) provided the impetus for research to develop preventive and therapeutic services (Grob, 1994).

- **The Deinstitutionalization Movement.** In the early 1940s, public reports of state hospital overcrowding and mistreatment of patients combined with evidence of the debilitating effects of institutionalization (Grob, 1991) made deinstitutionalization an appealing opportunity to shift costs to the federal government (LaFond & Durham, 1992).
- **Development of Antipsychotic Drugs.** The introduction and use of antipsychotic drugs in the treatment of the mentally ill during the late 1950s was credited with the successful release of large numbers of patients from the state hospitals (Grob, 1994; Deutsch, 1937).
- **The Liberal Era: Great Society and Community Mental Health.** In 1963, the federal budget allocation to create community mental health treatment centers (Kennedy, 1990; Koyanagi & Goldman, 1991; Jansson, 2019) resulted in fewer hospitalized patients but failed to produce positive treatment outcomes. By the early 1970s, many former hospital patients were abandoned to psychiatric ghettos, jails, or the ranks of the homeless (Dear & Welch, 1987; LaFond & Durham, 1993).
- **The Carters.** In 1978 the Carter administration increased funding for community-based services and Rosalynn Carter made mental health her major domestic issue (Grob, 2005; Jansson, 2019) in response to sharp criticism of care provided for serious mental illness (Koyanagi & Goldman, 1991). Unfortunately, funding was inadequate to implement real reform.
- **The Neoconservative Era.** Between 1980 and 1993 the Reagan administration relinquished federal responsibility for the mentally ill and slashed state block funding and support of the national institutes (National Institute on Alcohol Abuse and Alcoholism [NIAAA], National Institute on Drug Abuse [NIDA], and NIMH). States were allowed to ignore mental health issues (Mechanic, 1989), and the numbers of mentally ill who became homeless, incarcerated, or confined to nursing homes increased (Jimenez, 2009). Public outcry, grassroots advocacy, and public education efforts were organized by the newly formed National Alliance for the Mentally Ill (NAMI).
- **Social Reform in a Polarized Context: President Bill Clinton and Vice President Al Gore.** By the 1990s Medicaid and Medicare became the source of most mental health funding, helping restore state authority for mental health services policy, whereas the federal government covered more of the costs (Grob, 2008).
- **The Mental Health Parity Act (1996).** This act aimed to improve mental health reimbursement for private insurance recipients (Mental Health America, 2012) but failed to require employers to offer mental health coverage, and many employers dropped coverage completely (Jimenez, 2009).



- **George W. Bush Era.** The New Freedom Commission on Mental Health (2003) committed to early treatment of mental disabilities similar to treatable physical illness and the need to address barriers to reform (stigma, treatment limitations, and delivery system fragmentation).
- **The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act** (2008; Substance Abuse and Mental Health Administration, 2012a). This act required that large insurance plans provide parity of coverage for behavioral health. Plans could be exempt from the law if they excluded mental health and substance health coverage and were allowed to retain higher premiums/co-pays for use of those services (Substance Abuse and Mental Health Services Administration, 2012a).
- **Barack Obama and the Audacity to Hope.** The Affordable Care Act (ACA) was signed into law in 2010, expanding coverage to 32 million uninsured Americans. The ACA reformed the parity law to integrate the care and managing of physical health and mental health conditions and disorders as well as requiring them to be equally funded in the hope of lessening or removing the historic barriers (U.S. Department of Health and Human Services, 2011).
- **The Opioid Crisis During the Obama and Trump Presidencies.** A massive epidemic of addiction to opioid drugs grew rapidly during the presidency of Barack Obama, growing to roughly 72,000 deaths in 2017. President Trump and his administration dealt with the crisis haltingly even though many of these deaths took place in the white blue-collar population in rural and semi-rural areas. Congress enacted the Substance Use-Disorder Prevention Act that was signed by President Trump on October 24, 2018. Critics viewed it as underfunded. See Table 10.1 for advocacy groups serving persons with mental illness and substance abuse.

**TABLE 10.1 ■ Some Advocacy Groups for Mentally Ill Persons and Persons With Substance Abuse**

American Psychiatric Association (APA) is a leading advocate for mental health services: <http://www.psych.org>.

American Psychological Association (APA) adopts a variety of policy statements: <http://www.apa.org>.

National Alliance on Mental Illness (NAMI) mobilizes persons with mental illness to improve mental health services: [www.nami.org](http://www.nami.org).

National Council for Behavioral Healthcare (NCBH) is a leading advocate for improved mental health services: <http://www.thenationalcouncil.org>.

National Association of Social Workers (NASW) injects social workers' policy preferences into public arenas: <http://www.socialworkers.org>.

## ADDRESSING SEVEN CORE PROBLEMS IN THE MENTAL HEALTH SECTOR WITH ADVOCACY

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### Core Problem 1: Engaging in Advocacy to Promote Consumers' Ethical Rights, Human Rights, and Economic Justice—With Some Red Flag Alerts

- **Red Flag Alert 10.1.** Ethical features associated with a patient's care are violated because health care staff may not be aware of the individual's right to confidentiality, self-determination, informed consent to treatments and medication, accurate information, and safety related to being a danger to self or others.
- **Red Flag Alert 10.2.** Patients may experience a lack of empathy from providers because of differences in life experiences, attitudes, personal values, and culture.
- **Red Flag Alert 10.3.** Patients experience provider negative stereotyping, non-therapeutic attitudes, and behavior.
- **Red Flag Alert 10.4.** Patients may be misdiagnosed or experience diminished expectations for improvements due to clinician negative bias or inaccurate stereotypes, such as that individuals with mental illness are not intelligent and cannot change or that older adults are all frail, ill, or inflexible.
- **Red Flag Alert 10.5.** Patients may work with health care providers who are not transparent about their lack of clinical expertise about mental health conditions.
- **Red Flag Alert 10.6.** Some patients do not have conservators appointed through special court proceedings even though they cannot provide for their basic needs, engage in treatment voluntarily, or engage in hostile or disruptive behaviors at a high level.
- **Red Flag Alert 10.7.** Do insufficient numbers of mental health staff exist in specific settings, neighborhoods, regions, or states to help persons with mental problems or substance abuse?

#### Background

According to the National Association of Social Workers (NASW, 2012) Code of Ethics, mental health consumers have the right to have access to services, resources, and other needed information; to be treated with dignity, respect, and worth; as well as to self-determination to refuse treatment. Mental health consumers also have the right to receive care from providers who are competent; are committed to consumers; act respectfully, responsibly, and honestly; acknowledge the importance of human relationships; and act respectfully with regard to lifestyle choices.

Power disparities during treatment can create difficulties for consumers. Mental health providers tend to be placed in the expert role, which creates a power and role imbalance (McCubbin, 1994; Sullivan, 1992; Ware, Tugenberg, & Dickey, 2004). Tarrier and Barrowclough (2003) affirm that “without an equality and collaboration between those who provide and those who use professional mental health services there is always a risk of paternalism, stigmatization, and coercion” (p. 240).

In contrast to the goal of effective patient–provider partnerships, consumers may be undervalued and underestimated in their capacity to think and speak for themselves. These commonly held negative beliefs, perceptions, and attitudes about persons with mental illness can lead providers to a type of “self-fulfilling prophesy” about the potential for the person to participate fully in treatment or to recover (Rosenhan, 1973).

### Resources for Advocates

Mental health advocates can draw upon many existing policies to protect patients’ ethical rights at the micro level. These include professional ethical values and standards of accreditation agencies that license health professionals.

The Patient Self-Determination Act (PSDA) of 1991 mandated that health care facilities receiving Medicare or Medicaid reimbursement inform individuals of their right to engage in treatment decisions (Bradley, Wetle, & Horwitz, 1998). The ability for individuals with mental illness to participate in shared decision-making about treatment choices and goals or to complete advance directives are important matters to clients, families, and their providers.

Each state has a Board of Behavioral Sciences (BBS) that serves as a consumer protection agency with the goal of protecting consumers by determining and upholding standards for competent and ethical behavior by the professionals under its jurisdiction. For example, the BBS in California has adopted guidelines that identify the types of violations and range of penalties or disciplinary actions that may be imposed on practitioners. Detailed information about the violations of statutes and regulations under the jurisdiction of the BBS and the appropriate scope of penalties for each violation can be found at <http://www.bbs.ca.gov/pdf/publications/dispguid.pdf>.

Historically, the lack of mental health awareness and supportive services to the mentally ill has contributed to unnecessary deaths and injuries in hospitals, prisons, and the community (Jansson, 2019). Further, community agencies, services, and other professionals who have interactions with persons who have mental health symptoms or disorders may require additional training and protocol to act in an ethical and safe way.

The *Washington Post* calculated that roughly 500 people with mental illness were fatally shot by police in the United States—or one in four police shootings (Roth, 2018). Although law enforcement agencies typically have provided training to their officers and staff so that they can safely and appropriately communicate with persons who are homeless or mentally ill, training is not as extensive as the training offered to mental health professionals. In addition, staff may not be able to learn and implement specific techniques and approaches for responding to certain populations in particular settings, such as with persons who have psychotic symptoms and are un-medicated and homeless. Many police departments have instituted go-slow and back-off policies to counteract the tendency of many officers to take actions that escalate violence. Many police

departments employ social workers and women to take prominent roles in reducing tension in confrontations between law enforcement and persons with mental problems. Police have increasingly been taught how to differentiate mentally ill persons and persons inebriated or on drug highs from other people in confrontations so that they refrain from shooting at them.

Public officials have historically responded to problems or disruption in the community related to mental health by proposing additional laws to enforce mandatory treatment of individuals with mental disorders, particularly in the wake of publicized violent incidents in which either the victim or perpetrator is mentally ill. For example, Andrew Goldstein, a 29-year-old man with schizophrenia, pushed Kendra Webdale into a subway train, leading to her death. Reports of Mr. Goldstein's refusal of treatment and medicine non-compliance resulted in Kendra's Law in New York State (1999), which gives judges the authority to mandate individuals with severe mental illness to receive outpatient psychiatric treatment or be subjected to involuntary inpatient state hospitalization. Opponents of involuntary treatment argue that the notion that individuals with mental and substance use disorders are "dangerous" is an exaggerated bias and unsubstantiated fact that has influenced public policy (Stuart & Arboleda-Flórez, 2001). Statistics show that only 3% of violent, incarcerated offenders have committed crimes that are attributable to a primary non-substance-use-related disorder (Stuart & Arboleda-Flórez, 2001) and that individuals diagnosed with a serious mental illness are 14 times more likely to be a victim of a violent crime than to be arrested as the perpetrator of one (Brekke et al., 2001).

Conservators are often appointed through special court proceedings for persons with mental illness that lead them to be able to care for their basic needs and not to engage in disruptive behaviors (Jansson, 2011).

## POLICY ADVOCACY LEARNING CHALLENGE 10.2

### CONNECTING ADVOCACY TO PROTECT A PATIENT'S ETHICAL RIGHTS AT MICRO, MEZZO, AND MACRO LEVELS

Josie Mora, a 35-year-old woman, was diagnosed with schizophrenia (disorganized type) at the age of 22. Despite large doses of psychotropic medication, Josie exhibited disruptive and bizarre behavior, disorganized speech, inappropriate affect, and daily auditory hallucinations. For example, she called out to people using derogatory language, often falsely accusing them of trying to harm her. At home, she required constant limit setting as she would drink continuous pots of coffee and large amounts of soft drinks unless stopped. During the night she would get up several times to pace and clang pots and pans

in the kitchen. As a result, she required ongoing supervision and was unable to participate in any psychiatric rehabilitation program activities offered at the mental health center.

The Mora family lived in the same community since they emigrated from Mexico over thirty years ago. The parents preferred to speak in Spanish, although they understood and spoke limited English. Josie preferred English, although Spanish was her first language. Josie lived at home and her parents were her primary caretakers. Several adult siblings and other extended family members lived in the same city and participated

in Josie's care. Mrs. Mora had not worked outside the home since the onset of Josie's illness. During the day while Mr. Mora was at work, Mrs. Mora relied on a network of family and friends to help her with Josie, particularly whenever Mrs. Mora had her own medical appointments or needed to run certain errands. Eventually, Mr. Mora opted for early retirement from his factory job because he wanted to help his wife with Josie's care.

Both parents always accompanied Josie to her medication management appointments and monthly meetings with a social worker. The Moras took turns sharing the highlights of the month regarding Josie's behavioral outbursts involving family members, friends, and neighbors. Often they shared certain successful outcomes, like going to the park for a family gathering where Josie was able to tolerate being around many people without causing much

disruption. Because of her severe impairment and her extensive need for supervision, on several occasions the social worker gently raised the option of board and care or other supervised residential care for Josie. The Moras considered the various options presented, but always expressed their willingness to accept their parental responsibility for Josie's caregiving, and their great hope that Josie would get better. The Mora family wanted to raise enough money for a trip to Mexico City. They hoped to take Josie to a special church to receive a holy blessing that would lead to healing and possibly a miracle. Several years later Josie was prescribed a new atypical anti-psychotic medication and with additional rehabilitation she made a substantial improvement in her social functioning. The Moras expressed that this progress was more than they had hoped Josie would achieve.

*Source:* Barrio, C. & Yamada, A. M. (2005). Serious mental illness among Mexican immigrants: Implications for culturally relevant practice. *Journal of Immigrant & Refugee Services*, 3(1/2), 87–106.

### Learning Exercise

1. How does the social work value of self-determination apply to this case example?
2. Does the social worker respect the values of interdependence and the family's sense of hope?
3. What other advocacy actions could a social worker take to protect the patient's ethical rights on micro, mezzo, and macro levels? For example, do the laws of your state allow judges, under specific circumstances and safeguards, to require specific patients to take anti-psychotic medications—and would you agree that this is ethical in these specified circumstances?

### Core Problem 2: Engaging in Advocacy to Promote Quality Care—With Some Red Flag Alerts

- **Red Flag Alert 10.8.** Clients receive one eclectic or generic treatment from an agency or practitioner that is used for all clients.
- **Red Flag Alert 10.9.** Clients are treated by practitioners who are not fully trained to implement EBPs.
- **Red Flag Alert 10.10.** Clients are offered treatments that are provided by clinicians who do not have access to ongoing supervision or training and are not up-to-date on the empirically supported treatments.

- **Red Flag Alert 10.11.** Clients may be treated by clinical staff or at agencies with negative attitudes about EBPs or new interventions.
- **Red Flag Alert 10.12.** Clients are recommended for treatment interventions without attention to their individual preferences.
- **Red Flag Alert 10.13.** Clients are treated with EBPs that have not been adequately researched, such as with specific ethnic/racial populations.
- **Red Flag Alert 10.14.** Social workers' distinctive focus on diagnoses and treatments based on a biopsychosocial model are not sufficiently recognized in those settings that rely on EBPs. (See Policy Advocacy Learning Challenge 10.3).

### Background

As the emphasis on implementing EBPs and effective empirically supported treatments (ESTs) has gained stronger literature support, mental health providers are expected to choose and implement the best possible services and EBPs that target the client's specific needs and desired health care outcomes. Treatments need to be implemented with fidelity (sometimes called adherence or integrity) to preserve the components that made the original practice effective.

Despite extensive evidence of effectiveness, mental health practitioners and programs often underutilize EBPs with the majority of clients with mental health disorders and in other human services (Kirk, 1990; Brooks, 2016). Professionals often lack training in the EBP process, possess insufficient provider education to implement specific ESTs, have limited resources, and lack ESP in community practice settings (Bellamy et al., 2008; Bledsoe et al., 2007; Brekke, Ell, & Palinkas, 2007). They lack reimbursement from Medicaid and other health insurance for EBP (Ganju, 2003). They face competing organizational demands, insufficient length of client visits or number of sessions, and excessive reliance on existing treatments (Cohen et al., 2008), as well as inadequate preparation to interpret research findings (Bellamy et al., 2008; Murray, 2009).

It must be acknowledged that considerable controversy exists about the science of mental health. Some mental health experts questioned the validity of some diagnostic information provided in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-4)* of the American Psychiatric Association (2003). Bryan King, director of the Seattle Children's Autism Center and who served on the task force of the American Psychiatric Association, influenced the decision in the fifth edition of this manual to eliminate many autism spectrum diagnoses such as Asperger's syndrome, pervasive developmental disorder, and childhood disintegrative disorder and to consolidate them in a single diagnosis of autism spectrum disorder. It must also be acknowledged that some medications produce side effects that offset their positive effects for some patients, including recently developed anti-psychotic medications. It is often difficult to diagnose patients with borderline or multiple conditions. See Table 10.2 for sources that provide EBPs for mental health and substance abuse.



**TABLE 10.2 ■ Sources That Provide EBPs for Mental Health and Substance Abuse**

1. SAMHSA: Evidence-Based Practices (EBPs) Resource Center on the web at <https://www.samhsa.gov/ebp-resource-center>
2. National Guideline Clearinghouse™ (NGC), <http://www.guideline.gov>
3. California Evidence-Based Clearinghouse for Child Welfare (CEBC), <http://www.cachildwelfareclearinghouse.org/>
4. Suicide Prevention Research Center: Best Practice Registry, [http://www.sprc.org/featured\\_resources/bpr/index.asp](http://www.sprc.org/featured_resources/bpr/index.asp)—information about best practices that address the specific objectives of the National Strategy for Suicide Prevention
5. *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*), American Psychiatric Association

### Resources for Advocates

Current Council on Social Work Education (CSWE) Educational Policy and Accreditation Standards (EPAS) (CSWE, 2008) have established 9 professional social work competencies that specify that social workers in accredited MSW programs learn to use research to inform practice and their practice to inform research (e.g., CSWE, 2015). Ones particularly relevant to policy practice include Demonstrate Ethical and Professional Behavior (Competency 1), Engage in Diversity and Difference in Practice (Competency 2), Advance Human Rights and Social, Economic, and Environmental Justice (Competency 3), Engage in Policy Practice (Competency 4), and Engage in Practice-Informed Research and Research-Informed Practice (Competency 5).

## POLICY ADVOCACY LEARNING CHALLENGE 10.3

### CONNECTING MICRO, MEZZO, AND MACRO LEVEL POLICY INTERVENTIONS TO ADVANCE QUALITY CARE

Adams, LeCroy, and Matto (2009) believe that social workers do not share the medical model philosophy of treatment (focusing on symptoms and diseases) that typically underlies an EBP model because it may not adequately reflect sufficient focus on the individual and environmental factors that social workers view as essential to quality care. Consider an example of a discouraged

and caring family who presents in treatment with a family member who has previously been diagnosed and treated for major depressive disorder and, despite treatment motivation and adherence, is currently so seriously depressed that he or she is unable to work or care for personal daily needs. The potential complexity in the case may not fit neatly into an EBP model.

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### Learning Exercise

Discuss the following questions posed by Adams, LeCroy, and Matto (2009):

1. How would a social work frame of reference, which includes the biopsychosocial model; the developmental stage of the person; the cultural, spiritual, and community factors; as well as ecosystems context assess and choose an EBP?
2. What other aspects of the case would the social worker frame suggest as important to the assessment and treatment planning for this case?
3. How does the social work emphasis on alliance or therapeutic relationship get incorporated into the treatment response?
4. What mezzo and macro policy advocacy interventions might social workers consider in these circumstances?

### Core Problem 3: Engaging in Advocacy to Promote Culturally Competent Care—With Some Red Flag Alerts

- **Red Flag Alert 10.15.** A diagnosis is assigned of a mental health disorder based on the presentation of one or more symptoms taken out of context of the person's situation.
- **Red Flag Alert 10.16.** A person is judged as incompetent based on his or her failure to respond in the language and rules of the predominate culture.
- **Red Flag Alert 10.17.** Assumptions are made that a person has certain mental health problems or a diagnosis based on demographic characteristics (education level, age, and gender).
- **Red Flag Alert 10.18.** There is a failure to consider the importance of cultural values and beliefs or include them in the assessment or treatment of the patient's mental health.
- **Red Flag Alert 10.19.** Insufficient numbers of personnel, members of boards of directors, and public officials exist to engender multicultural services in specific programs or agencies.

#### Background

Access to health care is a leading health indicator and barriers to access include cost, language differences, lack of information about mental health services, scarce presence of mental health services in their native country, stigma toward mental health services, and competing cultural practices (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Lack of interpreter services or culturally or linguistically appropriate health education materials is associated with patient dissatisfaction, poor comprehension and compliance, and ineffective or lower quality care. Bureaucratic intake processes

and long waiting times for appointments have also been particularly cited by ethnic minorities as major obstacles to obtain health care (Phillips, Mayer, & Aday, 2000).

### Resources for Advocates

In response to the surgeon general's report, the President's New Freedom Commission on Mental Health (2003) was established in 2002, and a call for the elimination of disparities in health services due to cultural or geographic factors was identified.

The National Center for Cultural Competence (2007) reported that California, New Jersey, and Washington had passed laws mandating the integration of cultural and/or linguistic competence into curricula, continuing education, and licensure requirements for health and mental health care professionals.

## POLICY ADVOCACY LEARNING CHALLENGE 10.4

### CONNECTING MICRO, MEZZO, AND MACRO LEVEL POLICY INTERVENTIONS TO PROMOTE CULTURALLY COMPETENT CARE

#### Ensuring Culturally Competent Care

An 80-year-old Italian immigrant woman named Maria, who had lived in the United States for 60 years, arrived at an emergency room of a local hospital with her Italian friend and neighbor. She had fallen from her chair as she tried to pick up something that she had dropped and as a result cut her eyebrow on the edge of an end table. Her family was called, and when her daughter-in-law and adult granddaughter arrived, the daughter-in-law went with a nurse to fill out some paperwork, and the granddaughter stood in the waiting room anxious to find out where her grandmother was and how she was doing. A resident emerged and told the granddaughter in a matter-of-fact tone that he did not have good news. "Your grandmother has blood collecting in the sinus cavity above her eye, and it will eventually go to her brain and kill her."

"Isn't there anything that can be done?"

"Well, she's very old and likely has a type of dementia so I'm sure your family will not want to put her through surgery. Her quality of life is already poor. What medical conditions does she have? How old is she?"

The granddaughter knew that her grandmother had no medical conditions, had planted

her garden the day before, and had dinner with the family as was usual for a Sunday, and she had seemed fine. "Demented? How did you assess that?"

The resident went on to say that when the patient was first seen in the hospital, she was unable to answer any questions they asked and wasn't making sense.

"Did they have someone speak to her in Italian?" At that moment the woman's son arrived, and the resident repeated to him that he was sorry that there was nothing to be done for his mother. Hearing what had happened, the son requested that before the resident decide that it was his mother's time to die, he tell the family what he would do for this type of problem if his mother was 50 years old instead of 80.

"I'd do a CAT scan to see the full extent of the trouble and then likely surgery to remove the blood and repair the bleed." The son suggested he do the CAT scan. He then went to talk to his mother in her dialect and to ask how she felt. She spoke to him normally, apologizing for taking him away from his workday. Clearly, as the son suggested later to the resident, his assessment was that his mother's mental faculties were working as usual. The resident was surprised to see the

*(Continued)*

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patient was able to respond to her son when he translated questions for her and to laugh when he joked with her; she looked like she had been in a brawl (her eye was swollen from the fall, but this was a very petite and mild-mannered woman who hardly ever raised her voice above a whisper). After the CAT scan, the resident returned in astonishment and reported that the woman had no sinus cavity on the right side of her head (where she had sustained the injury) and therefore the black area that had shown up

on the X-ray that was thought to be blood was really only the absence of the sinus cavity (a condition that the patient was born with but had not caused any problem). The woman received five stitches over her right eye and left the hospital with her family. She lived happily and independently on her own for another 17 years. This was her first and only trip to a hospital in her entire life. A week after her visit, she removed her own stitches, reporting to her son that she was feeling fine and didn't need them anymore.

### Learning Exercise

1. Which of the problems encountered by this patient could benefit from micro, mezzo, and/or macro policy interventions?
2. What assumptions were made by the practitioner? How did those shape the assessment?
3. What advocacy skills do families need when a member of the family is determined to be "incompetent"?

### Core Problem 4: Engaging in Advocacy to Promote Prevention of Mental Distress—With Some Red Flag Alerts

- **Red Flag Alert 10.20.** Prevention screenings are not universal but only offered to persons based on selection criteria in hospitals, schools, places of employment, and elsewhere.
- **Red Flag Alert 10.21.** Clients are not screened for behavioral health risks or problems that were not included as the presenting problem due to practitioner discomfort in medical settings, schools, places of employment, and elsewhere.
- **Red Flag Alert 10.22.** Clients have insufficient insurance coverage for behavioral health screenings.

#### Background

The lack of knowledge about the etiology and causes of mental illness and absence of formalized tests (such as a blood test) to detect or confirm the presence of the illness are serious barriers to preventive services. Although it is currently believed that many genetic and environmental factors contribute to mental health, there is no certainty or understanding as to the exact mechanisms of mental illnesses, and therefore scientific support for the creation of prevention programs is lacking. There has been a lack of funding from

private insurance companies, Medicare, and Medicaid for services intended to prevent an illness. There also has been less money for research to show the efficacy of preventive interventions in part because of the expense of conducting the longitudinal studies necessary to show positive results. Because of this fact, which is inherent in the definition of prevention, research and interventions related to prevention may appear to be more costly in that they do not provide cost savings immediately. Finally, stigma associated with mental illness continues to stand as a barrier to prevention.

### Resources for Advocates

Primary care physicians are often the first point of contact for many people as they enter the health care system. This fact offers primary care physicians an opportunity for the early identification of mental health concerns, to educate individuals and families about behavioral health, and to help facilitate referrals where necessary. There is a recognition of the need for primary care physicians to participate more fully in early screening and intervention aimed at new models of integrated health that focus on the impact of all health conditions on the person. These efforts encourage health care practitioners to view the person as a whole and to consider mental health, physical health, substance use, and behavioral health as essential components of health. Screenings to treat all known risks and manage existing conditions can improve the person's health status, reduce the need for additional health care services, and reduce financial and human costs. It is essential for mental health providers to collaborate and coordinate with primary care providers to screen for physical illness and substance abuse.

As part of the ACA, a new Prevention and Public Health Fund was created to expand the infrastructure needed to prevent disease through early detection and support the management of existing health conditions at the lowest severity level possible. Inclusion of additional prevention measures (the Prevention and Public Health Fund and the National Prevention Strategy) signals a significant shift in the focus of the ACA and movement in our country from a focus on sick care toward a system that advances health and health equity, saving money and lives (Jansson, 2011).

### Core Problem 5: Engaging in Advocacy to Promote Affordable and Accessible Mental Health Services—With Some Red Flag Alerts

- **Red Flag Alert 10.23.** Persons who do not have health insurance cannot get coverage for mental health treatments, including immigrants.
- **Red Flag Alert 10.24.** Persons have health insurance, but their coverage offers inadequate coverage of mental health services, including its amount, length, and coverage of certain types of service.
- **Red Flag Alert 10.25.** Insurance deductibles or co-insurance for mental health services and medications place financial burdens on persons seeking treatment.
- **Red Flag Alert 10.26.** Persons with limited resources (lower socioeconomic status or fixed income) give priority to expenditures for health conditions (such as a life-threatening condition or a chronic medical condition) over treating mental health concerns.

## POLICY ADVOCACY LEARNING CHALLENGE 10.5

### CONNECTING MICRO, MEZZO, AND MACRO LEVEL POLICY INTERVENTIONS FOR PREVENTION IN MENTAL HEALTH

#### Benefits and Risks of Prevention

The *Diagnostic and Statistical Manual (DSM-5)* was currently revised and considered the inclusion of a category or disorder that would reflect a pre-diagnosis risk group, specifically for individuals who present with psychotic-like or attenuated symptoms that may convert and eventually meet the criteria for a DSM disorder. Although supporters of the risk category highlight that “early intervention may help delay or prevent exacerbation into psychosis,” others feel that the evidence to distinguish between “ill and non-ill persons is difficult,” making the likelihood of false positive diagnosis higher (Carpenter, 2009, p. 841).

Given the controversy of screening for psychotic risk and treating individuals before they have a diagnosis, Carpenter (2009) suggests that we consider whether the benefits of early intervention intended to help prevent a psychotic exacerbation outweigh the negative damage of labeling individuals with a mental health disorder when it is not certain that it will develop. Further, Carpenter (2009) asks practitioners to consider whether placing a person in a diagnostic risk category could “do more harm than good

because of stigma or the unwarranted administration of treatment with a poor benefit/risk ratio?” (p. 841). Yet screening for mental health problems is widely practiced in health settings, such as by asking patients to respond to several questions that have proven effectiveness in diagnosing depression.

Recent research suggests, however, that early interventions are effective with persons who have signs and symptoms that place them at high clinical risk of psychosis but who have not yet developed full symptoms. These interventions delay the onset of first-episode psychosis and improve the outcomes of first-episode psychosis. NIMH has required states to allocate a substantial share of their MHBGs to funding early interventions for persons who are at high risk of approaching first-episode psychosis (Fusar-Poli, McGorry, & Kane, 2017). Further evidence may suggest that early intervention may improve subjects’ future health and response to treatment. By using a team approach that gives families supportive assistance, this intervention may reduce family trauma associated with the onset of psychosis of family members.

#### Learning Exercise

1. What are your thoughts about this controversy?
2. As an advocate, what direction would you recommend? Why?
3. Do other efforts to prevent problems associated with mental health serve to educate the public or to reinforce the stigma?
4. If we do not seek early detection in schools, hospitals, and other settings, do we risk increasing unnecessary suicides or outbreaks of violence?
5. Do we need to be attentive to research findings to identify evidence-based findings that do, or do not, support early interventions for specific mental health and substance abuse problems?



- **Red Flag Alert 10.27.** Patients are not compliant with mental health treatment recommendations due to costs rather than personal motivation or health beliefs.

### Background

The financial structure of the health care system in the United States has presented as one of the primary barriers to addressing the health care needs of individuals with mental illness:

- Health care systems lack reimbursement for coordinated care across service systems, health education, and supportive services; inadequate case management services to promote self-management and linkage to services; poor coordination between physical and mental health care systems; and lack of integrated treatment for dual diagnosis disorders.
- Many individuals with mental health problems are uninsured or underinsured, putting them at a disadvantage for receiving integrated health care.
- The majority of individuals who seek services in community mental health centers have health care insurance through Medicaid. To be effective serving patients in the public mental health system, Medicaid and Medicare must become partners in designing and implementing new strategies to improve access to care.
- Community Mental Health Centers (CMHCs) are not nationally required to serve the uninsured. Currently, a state policy mandate is being considered to require CMHCs to treat those who are uninsured. A decrease in non-Medicaid funding to CMHCs at the state level has led to more patients choosing Community Health Centers (CHCs), thereby giving them a lower quality of mental health care.
- Medicare has a large gap between mental health and physical health care coverage. Much larger co-pays are required for mental health visits than physical health visits. These cost differences force many individuals to pay high prices for mental health care or to seek mental health diagnosis and treatment through their physical health providers.

### Resources for Advocates

The 1996 Mental Health Parity Act did not offer coverage for substance use/abuse disorders and increased insurance premiums for some, so California voters enacted Prop 63 (SB1136) to increase resources and access to mental health services to underserved or uninsured persons. Prop 63, or the Mental Health Services Act of 2004, was funded by a 1% tax on those individuals with incomes greater than \$1 million; the associated funding has established full service partnerships across California and allowed for

service expansion, innovation, and outreach programs addressing the concern for the rising numbers of those with mental illness who also are homeless. Similar legislation was not enacted in most other states, however.

Although the federal parity law of 2008 provided necessary coverage to persons with private insurance, millions of Americans remained uninsured and did not qualify for federal Medicaid or Medicare programs. The ACA attempts to close the service gap or the loopholes created under the federal parity law with new rules to the parity law that require that mental health treatment must be treated equally with standard medical and surgical coverage in terms of out-of-pocket costs, benefit limits, and practices such as prior authorization and utilization review. These practices must be based on the same level of scientific evidence used by the insurer for medical and surgical benefits. The ACA's provisions include the following:

- The ACA creates additional incentives to coordinate primary care, mental health, and addiction services.
- Grants and Medicaid reimbursement will be available for the creation of health homes for individuals with chronic health conditions, including mental illness and substance use disorders. Studies demonstrate that integrated and coordinated care is ultimately beneficial as it can help detect health problems before they become more serious concerns. It can also ensure that if a person gets a life-threatening diagnosis, he or she is also seen by a psychiatric professional for emotional health needs.
- The ACA provides improved coverage of mental health and substance abuse conditions.
- Mental health parity law prohibits insurers and/or health care service plans from discriminating between coverage offered for mental illness, serious mental illness, substance abuse, and other physical disorders and diseases. The ACA carries forward and considerably expands the requirements set forth in the parity law.
- The ACA prioritizes services in the home and community instead of within institutions.
- To promote the coordination of care, the ACA provides Medicaid payments for medical homes or health homes that coordinate care for people with chronic physical and/or behavioral health conditions.

### **Core Problem 6: Engaging in Advocacy to Promote Mental Health Services for Underserved Populations—With Some Red Flag Alerts**

We discuss in this section two specific underserved populations: persons in places of employment and current and retired military personnel and their families.

- **Red Flag Alert 10.28.** Employees report that they fear that their mental health problems, if known by colleagues, will lead to adverse repercussions such as termination.

## POLICY ADVOCACY LEARNING CHALLENGE 10.6

### CONNECTING MICRO, MEZZO, AND MACRO LEVEL POLICY INTERVENTIONS TO INCREASE ACCESS

#### The ACA Cuts Consumers' Mental Health Costs

The ACA has greatly decreased disparities between the cost of care to patients of health care and mental health care. For example, a patient who was treated for diabetes and bipolar disorder

prior to its implementation paid a 20% co-pay for diabetes care but a 50% co-pay for bipolar disorder. The new health care law will change this so that there is parity in co-pays. Think about some policy implications of this major shift in policy.

#### Learning Exercise

1. Are patients aware that mental health treatment is now much cheaper—and, if not, what kinds of community outreach and education might be considered?
2. Have health providers added sufficient mental health personnel, including social workers, to their rosters to provide the increased levels

of mental health services needed by patients who will now receive them?

See how one patient advocate sees this issue at the following Internet site: <http://www.npr.org/templates/story/story.php?storyId=92751635>.

- **Red Flag Alert 10.29.** High absenteeism, dropouts, resignations, or discharges stem from untreated mental conditions as well as poor performance.
- **Red Flag Alert 10.30.** Persons currently in military service, as well as veterans, often fail to receive services for posttraumatic stress disorder, traumatic brain injuries, substance abuse, and family violence.

#### Background

Stigma, as well as lack of mental health personnel, interferes with mental health services in many institutional settings, such as schools and universities, military units, prison systems, nursing homes, and workplaces (Carter, Golant, & Kade, 2010). The U.S. National Comorbidity Survey of Americans ages 15 to 54 found that 18% of those who were employed reported that they experienced symptoms of a mental health disorder in the previous month. In 1990, mental health disorders cost the U.S. economy almost \$79 billion in lost productivity (Rice & Miller, 1996, as cited in U.S. Department of Health and Human Services, 1999). Mood disorders cost more than an estimated \$50 billion per year in lost productivity and resulted in 321.2 million lost workdays (Kessler et al., 2006). In addition, serious mental illnesses, which afflict about 6% of American adults, cost society \$193.2 billion in lost earnings per year (Insel, 2008).

The failure of the Veterans Administration to provide timely and effective mental health services to military personnel and veterans has received extraordinary publicity as veterans have returned from the wars in Afghanistan and Iraq during the past 10 years.

The toll on these veterans has been particularly linked to the sheer prevalence of traumatic brain injury from improvised explosive devices in these wars. Veterans from the Korean and Vietnam wars also have complained about lack of treatment for long-standing cases of posttraumatic stress disorder. A new head of the Veterans Administration, Robert McDonald, was appointed in the summer of 2014 with the mandate to cut delays in mental health and medical services that have been experienced by tens of thousands of veterans in recent years.

### Resources for Advocates

We have already discussed augmented health insurance for mental health care by the ACA, but the ACA also benefits veterans' mental health care because the ACA counts Veterans Administration health care as insurance coverage along with TRICARE, other military health plans, Medicaid, and Medicare. President Obama signed an executive order in 2012 authorizing additional funding to improve access to mental health services for veterans, service members, and military families (The White House, 2012), including expansion of crisis services, additional staffing for the Veterans Administration health care system, improved research on posttraumatic stress disorder, and care for traumatic brain injuries (O'Gorman, 2012). These services remained grossly inadequate, however, in 2014 and into 2015. Military personnel and veterans were also underserved in areas of substance abuse and family violence. It remained to be seen if services would be dramatically increased in coming years. Automatic access to medical care is provided to all veterans.

Mental health services are inadequately provided in many places of employment. Some corporations possess relatively large human resource departments with Employee Assistance Programs (EAPs) that offer free or low-cost mental health services. They provide short-term counseling either with their own hired staff or through contracts with external providers. Some employees are reluctant to seek help for mental problems because of stigma or because they fear that their diagnoses will be disclosed to their employers even when EAPs pledge confidentiality.

### Core Problem 7: Engaging in Advocacy to Promote Care Linked to Consumers' Communities—With Some Red Flag Alerts

- **Red Flag Alert 10.31.** A national network of mental health agencies based in communities that help persons with substance abuse does not currently exist. Many patients who are discharged from hospitals, particularly in low-income areas, cannot obtain mental health or substance abuse services because of this problem.

#### Background

Historically, the care for mental illnesses has been offered by separate facilities, programs, and systems of care. Even as there is increasing evidence that a person-centered approach, which integrates services for health, mental health, and substance use disorders, improves health outcomes, the integration and need for more effective and collaborative community-based services, including outreach and transitional

## POLICY ADVOCACY LEARNING CHALLENGE 10.7

### CONNECTING MICRO, MEZZO, AND MACRO LEVEL POLICY ADVOCACY INTERVENTIONS FOR UNDERSERVED POPULATIONS

#### The Impact of Support From Fellow Employees

Without the insistence of her colleagues who knew that this episode of psychotic symptoms was somehow different than previous episodes that they had observed, Elyn Saks, an accomplished law professor at the University of Southern California and recipient of the MacArthur Foundation genius award, might have died of encephalitis. Brought to the emergency room by her colleagues due to worsening psychosis, she was immediately assessed to be psychotic and might have been dismissed by the hospital with additional antipsychotic medications except that her work colleagues advocated strongly that doctors check her for something

other than psychosis. They knew how Dr. Saks looked when her mental illness worsened, and they knew that she was behaving differently. Dr. Saks, whose symptoms and mental illness and treatment resulted in hospitalization, forced treatment, isolation, and restraints (Carter, Golant, & Cade, 2010), has reported that one of the pillars that offered her support was her workplace and doing work that she loved. Saks and other tenured college professors with mental illness, including depression, have spoken openly about their initial fear of disclosing information about their diagnoses due to fear that they might be looked upon as unstable or less competent or be ostracized by peers.

#### Learning Exercise

1. What micro, mezzo, and macro policy level actions would you promote in specific employment settings to address employees' mental health problems, such as help from EAPs? Should social workers be central to EAPs in light of their biopsychosocial orientation?
2. What mezzo and micro policy advocacy initiatives might social workers lead to obtain more responsive care by the Veterans Administration and other health systems for military personnel and veterans?

programs, exists. Different philosophies of care, missions, and mandates that are not complementary and also separate funding sources act as barriers to collaboration.

#### Resources for Advocates

Many common mental illnesses are similar to the common physical chronic illnesses (such as diabetes, asthma, and cardiovascular disease) in that they are less likely to be “cured” but with proper care can effectively be managed over a person’s lifetime. To successfully manage any chronic illness, patients will require treatment that is integrated and collaborative so that all aspects of their health are considered (they are treated as a “whole” person). Members of their health care team would also be able to communicate about ongoing treatment planning and decisions effectively. Access to community care that is integrated and collaborative will allow for smooth transitions from one type of treatment to another, when and if necessary, to manage the person’s

condition. For example, hospitalization to stabilize a person on a new medication may be necessary in a crisis, but having outreach services and an emergency on-call staff available to the person may help him or her return to home sooner with family support. The link between health care institutions and community agencies is essential to provide a continuum of care that can offer the patient the best and safest care in the least restrictive environment, many of which are also cost-effective and more desirable for the patient.

The ACA has begun to implement changes that will promote collaborative care. The ACA provides new flexibility in existing Medicaid state plan options for covering home- and community-based services. Outreach services, which began in 2014, will help enroll vulnerable and underserved populations in Medicaid and will target individuals living with mental illness (Mental Health America, 2012). Unfortunately, many neighborhoods currently lack mental health services that are easily available to many Americans in medically underserved areas. We discuss subsequently a policy initiative (The Excellence in Mental Health Act) that would fund neighborhood centers.

## POLICY ADVOCACY LEARNING CHALLENGE 10.8

### CONNECTING MICRO, MEZZO, AND MACRO LEVEL POLICY INTERVENTIONS TO DECREASE FRAGMENTED CARE IN THE MENTAL HEALTH SECTOR

#### Fragmented Care

The *Los Angeles Times* (Morocco, 2007) reported on a story that highlights the negative impact created by a fragmented system of care. The story tells of the struggle to find a way to respond to the complex needs of a woman who is homeless, 22 weeks pregnant, and mentally ill. Brought to the hospital emergency room by two good Samaritans who found her mumbling and wandering the street naked, her physical exam and lab tests were normal except for her mental status. After hours of trying to locate a place for this unnamed person ("Jane Doe"), she

was unacceptable to the psychiatric unit in the hospital (they don't treat pregnant women who are more than eight weeks pregnant), had no medical reason to be admitted to the hospital, and was refused by a county psychiatric center, which never called back after reading her faxed record. Even after almost a day of effort on the part of the emergency room staff, and locating the name of a brother (who would not take responsibility for his sister), the hospital failed to find any possible support for the woman and started the process of recalling every call they had previously made in hopes of eventually being successful.

#### Learning Exercise

1. What failures in the current health care system are identified in this case?
2. How would you advocate and at what level to assist this woman in getting the help she needs?
3. What would you prioritize as her needs? Are they medical, psychiatric, or situational?



## THINKING BIG AS POLICY ADVOCATES IN THE MENTAL HEALTH AND SUBSTANCE ABUSE SECTOR

We've identified five epidemics that include unaddressed or poorly addressed problems of alcoholism, substance abuse, obesity, smoking, and mental health. Assume the United States enacted Medicare for All that would replace the current Medicare and Medicaid programs. Assume Medicare for All would fund services for each of these epidemics that include cross-disciplinary teams that provide medical, psychological, and social support, outreach services, regional service facilities, and a network of community agencies. Take one of these epidemics. Discuss how social workers might develop and improve services by using micro policy advocacy. Discuss how social workers would build services at the community level (HINT: Reread the Finnish mezzo policy initiatives that led citizens to have better diets and exercise). Discuss how social workers would use macro policy advocacy to convince members of Congress to develop policies to address one of these five epidemics within the Medicare for All program.

### Learning Outcomes

#### You are now equipped to:

- Describe the numbers of Americans with specific mental health and substance abuse problems
- Analyze the impact of poverty and income inequality on mental health and substance abuse
- Analyze flawed policies in the United States with respect to substance abuse and mental health problems as well as promising initiatives
- Identify how mental health and substance abuse policies evolved in the United States
- Identify and analyze seven core problems in the mental health and substance abuse sector
- Think big in the mental health and substance abuse sector by developing initiatives with respect to mental health, alcoholism, substance abuse, obesity, and smoking

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