Mental Health Policy and Services Five Years After the President's Commission Report: An Interview With Michael F. Hogan

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Editor's Note: As the nation awaits a new administration and as states face budget cuts and increasing demand for health and human services, *Psychiatric Services* asked Dr. Hogan to offer his thoughts about the past, present, and future of mental health policy and services through a series of questions posed by Dr. Sederer.—*Howard H. Goldman, M.D., Ph.D.*

Dr. Sederer: I'd like to begin by asking you about the President's New Freedom Commission on Mental Health. It has been five years since the commission's report was published. What were the overarching conclusions of that report?

Dr. Hogan: The report speaks for itself. I would say that the first thing we learned was that mental health is and must be a bipartisan matter. Policy ideas that emerged in the work of the Carter Commission 25 years earlier were implemented incrementally in successive administrations, including the conservative Reagan administration. Our commission, appointed by President Bush, built on work done during the Clinton administration—largely the efforts of Surgeon General David Satcher.

A second lesson is that mental health problems are pervasive and have profound consequences for people's lives and health and often lead to disability. The prevalence of untreated mental health problems leads to enormous economic costs—yet support for mental health care is not commensurate with this impact.

Another fundamental lesson is that recovery from mental illness is a reality and must be a goal of our mental health care system. Although the phenomenon of recovery was mentioned in the Surgeon General's report on mental health in 1999, it was substantially elevated by the work of the New Freedom Commission. In turn, our understanding of the significance of recovery was greatly enhanced by former First Lady Rosalynn Carter. When she met with the commission, Mrs. Carter stated that the greatest change in the field in the 25 years since the Carter Commission "is that we now understand that it is possible for anyone with mental illness to recover." The fundamental conclusion here is one of hope.

LIS: Is there an enduring message from the New Freedom Commission's work?

MFH: Perhaps it is that for us to succeed with our mission of recovery we will need ongoing policy changes and leadership across a spectrum of programs and settings—not just in specialty settings and state mental health systems. We will need to be engaged in health and school reform, disability policy, affordable housing, criminal justice, and all the other places where adults and youths with mental disorders appear in our health and human services systems. And we know that advancing this work by having a commission every 25 years is not going to be sufficient.

Recovery and transformation

LIS: Earlier this year my colleagues and I published in this journal an article that aimed to define recovery (1). How do you understand recovery, and why has it gained the status that it has?

MFH: There are different ways to see recovery. There is the reality now established in long-term studies, from Eugen Bleuler to Courtney Harding, of the outcomes of people with schizophrenia. Good outcomes are far more possible than we had imagined. Following people over decades, not just years, was what proved this point. Recovery is also the appreciation that it is possible to have a good life despite what can often be a crushing and catastrophic illness. This message has been articulated by people who have lived it, like Ed Knight and Pat Deegan. And finally there is the meaning of recovery as hope.

LIS: "Transformation" sounds like a bit of a religious or revolutionary happening. How do you define it? What does it take to make it happen?

MFH: Transformation as a concept emerged organically for the commission. "Reform" seemed like a stale idea. Transformation resonated with members' beliefs that change is deeper than what happens from the "top down" and with structural change. Transformation reflects a more nuanced but also a more realistic view whereby subtle changes in processes can over time deeply affect how people and organizations behave. It is a view of change that can begin anywhere and may initially seem small and incremental but its effects are, well, transformative. Because no one is in charge of the complex and fragmented mental health system, we have no one person or authority to orchestrate change. In this sense, transformation as a process of change is like

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recovery; expert guidance and leadership are required, but lasting change is achieved by the people involved.

LIS: How is it that the United States spends so much money on mental health care and yet it seems as if we have such a low "return on investment" when we consider the suffering, disability, and death (from suicide and physical illnesses) that mental illnesses produce?

MFH: Drs. Richard Frank and Sherry Glied published a remarkable analysis of 50 years of the history of health economics and mental health, *Better but Not Well* (2). They found that although health care spending overall has increased two- to threefold after accounting for inflation, mental health spending as a proportion of the gross domestic product has been essentially flat. Yet access has dramatically increased; quality is much improved, as measured by the proportion of care that is consistent with effectiveness research (though we have still far to go); and the well-being of people with mental illness is generally better. It is important to emphasize that improvements in well-being are largely due to improvements in mainstream programs: Social Security, Medicaid, Medicare, and health insurance. Those with the most severe impairments, however, still face many challenges. But considering that people are in sum better off, while mental health spending is flat, we can say that mental health care is a great buy!

LIS: Can we do better?

MFH: We are faced with the combined challenges of complexity, fragmentation, and absence of a national health care system or set of policies. Responsibility for mental health care has dissipated over time to multiple federal, state, and local settings. This is especially a result of the "Medicaiding" of services. In terms of access to and quality of care, the state Medicaid director is perhaps more important than the state mental health director. But the state Medicaid director may not appreciate the nuances of mental health and mental illness. Thus we face the problem of how to organize and deliver services in a dissipated and fragmented system of care where no one is in charge and complex solutions are not likely to take root.

If we are to meet the needs of our constituents, we will need action at community, state, and national levels. How might we proceed to improve the integration, continuity, and quality of care? At the community level we could adopt the idea of a "clinical home" for people with mental illnesses. This locus of responsibility may be in primary care for some people, especially those with nonpsychotic illnesses such as depression and anxiety disorders, and in the mental health specialty sector (for example, a mental health center) for people with severe and persistent illnesses. Providing a full range of health care services over time in one setting can improve quality, comprehensiveness, continuity, and integration of care. As we know better than ever, cooccurring conditions are the rule, not the exception, so health and mental health services—as well as mental health and chemical dependency services—need to be readily accessible and integrated.

At the state or regional level we need to rediscover the core concept of a system of care. States have lost that concept with the dominance of Medicaid and health maintenance organizations. I don't imagine a singular model for a system of care, but we need leadership to root it in mental health centers, county governments, and primary care plans.

Finally, leadership is dearly needed at the federal level. Although the Center for Mental Health Services [CMHS] of SAMHSA has the point responsibility for programmatic leadership, we have seen the mental health block grant diminish to 1%–2% of state mental health expenditures. CMHS simply does not have enough leverage or clout. Frank and Glied suggested in their book that the President might try appointing a "mental health czar"—someone with a White House office. I don't know what the solution is, but we need a new approach. Perhaps we might achieve this with a new federal administration representing either political party.

Change

LIS: Surgeon General Satcher's work demonstrated that there are highly effective treatments but that the problem is the gap between what we know and what we do. What do we need to do to close that gap?

MFH: We know from the change literature that it takes 15 or more years for new practices to be incorporated into everyday settings. Although we are getting smarter about how to support adoption of evidence-based practices, the message here is to stay with it. We also know that organizations that have experience with change are better able to accommodate new change. We need to help provider organizations achieve some stability and also have some success with change so that they can become self-adapting change organizations.

For change to take root there is a clear need for leadership at the state and federal levels. But most change is change that people initiate themselves. Leaders create the circumstances that allow for communities and providers to do the right thing. Lao Tse, the great Chinese warrior-philosopher, said you can tell a great leader from a good one (and a bad one) because the people say, "We accomplished great things together."

LIS: You have led public services in four states over three decades. What observations do you have about leading processes of change?

MFH: One lesson is to work in places where people are about to do great things. I have been fortunate in that regard. It is also possible to build the capacity of organizations and even systems to be what Margaret Wheatley, an expert on organizational behavior, has termed "leader-ful."

What can we do now?

LIS: You have emphasized that fragmentation of services with too little accountability is at the heart of why good people and the dedication of precious resources do not succeed. Where do we begin?

MFH: As I mentioned earlier, the idea of a clinical home with dedicated clinicians being accountable to a recipient and family is something we can do now. As we try to stabilize, improve, and expand care in mental health clinics in New York State, the quality standards that you developed for the state support this approach. We are also focused on how best to support the adoption of evidence-based practices

and have created child and adult EBP centers at the New York State Psychiatric Institute.

LIS: Our good friend and colleague Dr. Bob Drake has shown that among people with a severe mental illness and a co-occurring substance use disorder, 50% get no care, 45% get poor treatment, and 5% get evidence-based practice. Yet we keep focusing on improving the care of the 5%!

MFH: Exactly. This turns our attention to how we can become more consumer oriented in order to better engage and retain people in care. When people stay with treatment, these treatments have a chance to work. We must make our clinics and programs more receptive in terms of making people feel comfortable, having hours of operation that accommodate their needs, and conveying a sense to the recipient and family that we are here to help, 24 hours a day. Settings that include people in recovery as staff and that offer programs run by consumers also help normalize the experience of coming in for care. We have also learned that sending people with co-occurring disorders to multiple sites of service doesn't work very well—"sequential" care is often futile. If we can engage people and provide integrated mental health and substance use services, a tall order, that is precisely what people need. That is what we are doing here in New York, in conjunction with our sister agency the State Office of Alcoholism and Substance Abuse Services.

LIS: On a related matter regarding integrated treatment, the disturbing eight-state study by National Association of State Mental Health Program Directors [NASMHPD] demonstrated that adults in the public mental health care system get physically ill sooner and more severely and die 25 years earlier than their age counterparts—from chronic diseases like diabetes, heart and lung diseases, and cancer. Where do we start here?

MFH: Everywhere. The SPAN program developed by our agency is an example. It is about health and wellness that is consumer focused and calls for consumers to take responsibility, with our assistance, for S (smoking cessation), P (prevention, including knowing your numbers such as BMI, blood pressure, and glucose), A (activity), and N (nutrition). Doing this in state hospitals will be difficult, but where it really needs to be done (and where it will provide a bigger lift) is throughout community-based services, integrating primary care and mental health services. We are working on that, and it is now a focus for the NASMHPD medical directors. Consumers are our best allies in this endeavor, because they know better that we do that getting better mentally doesn't help that much if your body is falling apart.

LIS: People with mental disorders and substance use disorders can never stabilize or recover without safe and secure housing. Yet there is no way that enough supportive housing can be funded, built, or rented for the numbers of disabled people in need for generations to come. What would an effective housing policy look like at the federal and state levels?

MFH: At the federal level today there is an 80% reduction in investment in affordable housing compared with 30 years ago. It is as if affordable housing has been deleted from the federal agenda. Yet great breakthroughs have occurred, such as the Housing Trust Fund. Maybe we will see some change with the next administration. At the state level, mental health agencies need to partner with other state agencies charged with housing development and promote set-asides, increase attention to people with disabilities, assist provider and development organizations to access capital financing and tax credits, and enlist private-equity developers into the affordable housing market.

Howard Goldman, editor of *Psychiatric Services*, published an article in 2003 in *Health Affairs*—"How Do You Pay Your Rent?" He reminds us of the grassroots effort that is also needed to make housing part of the conversation, since a person's housing status is a critical-path matter, especially for people with serious mental illness.

Closing thoughts

LIS: The economy is tanking, state and federal budgets are in desperate conditions, and too many promises about community mental health have gone unmet. Yet I know you have hope and that we all need hope—our consumers, their families, and we professionals alike. Where do we find hope? How do we nurture it?

MFH: It might be said that we are at the worst of times: fragmentation, stigma, frozen budgets. But there are rational reasons for hope. We are still in the first decade after the Surgeon General's report on mental health. Our scientific understanding of mental illness continues to blossom, and we can claim substantial effectiveness for our treatments—when clients get them. We have cause for rational optimism, and we need to carry it into the next decade.

The next generation of mental health professionals and the services they provide need to move well beyond the confines of mental health. Our field and its leaders and practitioners must embrace many other sectors, such as schools, primary care (for adults and youths), the courts, juvenile and adult correctional systems, and wherever else our clients' paths cross. There is a growing awareness and receptivity in these settings that we are all working with many of the same people, only at different moments in their lives—and that if we work together we will surely do better than we are now. Reflecting this awareness, the *American Journal of Psychiatry* is publishing a series of papers on mental health in the mainstream of public policy.

Rational optimism says that there has not been a better time to be hopeful. Change is occurring. Because we live in the day-to-day we may be among the last to recognize it. The ground is shifting toward a new, more recovery-oriented and integrated approach to mental health care. We are on the right path and need to stay the course.

LIS: Thank you for your insights.

References

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