

## **ACMHA ARM CHAIR REFLECTIONS**

### **Welcome to the Mainstream**

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Welcome to the mainstream!

As the great health reform convulsion of 2009/10 has played out, everyone with an interest in it has experienced far too many surprises. As of this writing, it is impossible to say with any certainty what many happen to the legislation in Congress or to know how the energy of reform will be directed in the states.

We in the mental health and addictions communities do know, however, that the reform effort has been both an affirmation of what we stand for and a broad policy victory. We've found we have friends many of us never before knew existed – at least for the time being. We have seen that our narrow interests in the debate have largely been addressed, even though most of us never deluded ourselves into believing that what mattered to us was going to influence the course of events one way or the other. Despite the nail-biting and ample unpleasantness that has marked the health reform effort in general, we in the mental health community can take a moment to pinch ourselves and reflect on this as the time when we have finally been accepted into the mainstream of American health care.

Our success in health reform has been achieved for several reasons, chief among them that the time was simply right! It's a measure of the changes that have occurred in our field and in society since the Clinton health reform push of 1993/94. Mental health is talked about much more openly, especially in recent years, as awareness of mental health needs in the military has grown. And perhaps the biggest change since the Clinton years came with passage of the Wellstone/Domenici Parity legislation late in 2008; the timing of which really was a major contributor to our later health reform success.

Truth be told, the annual parity push had begun to wear on many advocates. Despite polls showing public support and tallies showing sufficient Congressional support, the legislation each year was a victim of political horse-trading and effective lobbying by the bill's opponents. We all know that the combination of sentiment for retiring Senator Pete Domenici and ill Senator Ted Kennedy and the tireless effort of Representatives Patrick Kennedy and Jim Ramstad might not have carried the day if the need for rapid passage of the stimulus package had not come into play mere weeks before the 2008 election. Regardless, passage of the parity bill provided needed insurance for the inclusion of mental health and substance abuse treatment in the health reform legislation then under development and may yet be the key guarantor of comprehensive behavioral healthcare in a world that will only grow in complexity, regardless of what finally comes of health reform.

It can be argued, however, that full inclusion of mental health and substance abuse treatment in health reform had been guaranteed not by any earlier legislative victory but by the process itself. It turns out, in fact, that the long, slow road to parity was a very effective way to gather adherents to the proposition that “mental health is essential to health,” in the words of the President’s New Freedom Commission on Mental Health. Year in and year out for 15 years, advocates trooped up to Capitol Hill with their simple request that Congress put an end to the blatant discrimination practiced by insurers and the businesses to which they sold policies. It is safe to say that few if any Congressional offices escaped a visit from consumers, family members, psychiatrists, psychologists, social workers, addictions treatment providers, or others in the coalition that formed around the legislation.

Along the way, new support for the concept of parity emerged in the form of the Surgeon General’s Report (1999), the President’s New Freedom Commission on Mental Health recommendations (2003), and the Institute of Medicine’s Crossing the Quality Chasm Report on Improving the Quality of Health Care for Mental and Substance-Use Conditions (2006). In 2005, the National Business Group on Health, while not endorsing legislation, issued a how-to guide to help its members provide appropriate behavioral health coverage. In a vote that could be seen as a harbinger of the later action on insurance parity, in the summer of 2008 Congress passed the Medicare Improvements for Patients and Providers Act (MIPPA), including an often overlooked provision correcting longstanding inequity in Medicare coverage for mental health treatment. By the time Congress was considering health reform language, a raft of data had been accumulated to show that it was actually more costly to overlook behavioral health coverage than to include it.

The long slog to achieve parity had another beneficial effect and it is up to us to ensure that it lasts. At its outset, the push for parity came mainly from the mental health community, members of which conceived of it as guaranteeing a mental health benefit. The title of the bill ultimately passed by Congress, however, included the term “addiction equity” alongside “mental health parity,” and the legislation’s provisions ensured coverage for treatment of both addictions and mental health disorders. In the successful legislative effort, the mental health and substance abuse communities discovered they could achieve more by putting their differences aside than they could by defending their narrow interests.

This parity lesson is one we took to heart in our advocacy on health reform. Early on, with encouragement from the Hill and the administration, leaders of the mental health and addictions communities agreed to work together towards full inclusion of mental health and substance abuse benefits in health reform legislation. Members of Congress and their staffs made note of this turn. It’s important that we who purport to speak for the two communities not forget what can be achieved working in unison.

As a result of health reform and the process leading up to it, the environment in which advocates work has been changed tremendously. Yes, health reform is a great accomplishment, but we all recognize that its passage unleashes a time of great uncertainty, not for the behavioral health community alone, but for the healthcare community at large and, by extension, for society. We will find ourselves playing by new rules that have yet to be written. The good news for us is that we have made it across the threshold laid down by legislation, but the challenge is that we now have to find our way in a densely packed room, many of whose occupants are people we don’t know.

More than ever before, the future of behavioral health services in this country will depend on our field's ability to work with others whose interests we share, often people who recognize that their professional lives are helped by the availability of effective behavioral health services. We have seen such alliances develop over the past decade as we've worked with judges, law enforcement officers, and the corrections community in an effort to develop and strengthen treatment options that will help people with mental health and addictions disorders to avoid the criminal justice system.

Now, the growing relationship between our field and primary care practitioners is one to nurture. Thanks to the 2006 NASMHPD Medical Directors' report on Morbidity and Mortality, the mental health community belatedly focused on the general health needs of people with mental illnesses. More recently, the National Council for Community Behavioral Healthcare has been helping its members and the field to understand how the integration of behavioral health and primary care can best be accomplished. And a very gratifying part of the health reform experience for advocates inside the Beltway has been the uptake by Congressional staff and their bosses of the mantra that there is no health without mental health.

It would be presumptuous at this point to claim any insight on where health reform is headed, although not particularly reckless to predict a few more surprises before attention turns elsewhere. Regardless of what happens, I believe that we in the behavioral health community have two separate but intertwined tasks for the foreseeable future. First, we must continue to work hard to bring sense and order to the overall healthcare system. We have become too familiar with the consequences an unjust, dysfunctional system holds for people with mental illness and addictions disorders and we can see the promise of better lives for many if coverage is made universal and reimbursement and financing are based on outcomes.

And while pursuing that goal, we must do all we can to ensure it comes with full integration of health and behavioral health. We know there is a role for the specialty services now provided by the public systems and they must be preserved. But we also know that fragmented services and gaps in care cost lives, as well as dollars. Integration won't be done right unless we succeed in demonstrating to the broader medical community that we can bring as much to the partnership as we take from it. We have to admit that we are in the early stages of integration and have a long way to go before we can claim understanding of all that goes into it. For now, the most important thing is to keep the opportunities alive. Health reform legislation will soon become yesterday's news, but new platforms will emerge. Efforts already underway to define Comparative Effectiveness Research and the meaningful use of health information technology are two that spring immediately to mind. Another is the oft-delayed reauthorization of the Substance Abuse and Mental Health Services Administration, which can be used to promote development of a less fragmented, more comprehensive approach to mental health and addiction service delivery. All we have achieved in recent years brings us to this point; now we must start working in the mainstream as if we belong there.