VIEWS FROM THE FIELD
MARCH 16, 2015
GRANT MAKERS IN HEALTH

Behavioral Health for All

JONI SCHWAGER
Executive Director, Staunton Farm Foundation

Behavioral health conditions, which include both mental health and substance-use disorders, are among the biggest health problems our country faces. Roughly 50 percent of the population will be affected by these conditions at some point in their lives (American Hospital Association 2012). Mental illness, in particular, often co-occurs with chronic physical health diseases (APA 2012). The situation is even more extreme in prisons, for at least 75 percent of the incarcerated population suffers from either a mental health illness or substance-use disorder (American Hospital Association 2007).

In addition to the many people who have behavioral health problems, millions more are personally affected by a loved one's mental health or substance-use condition. It has been estimated that behavioral health expenditures reached $239 billion in 2004 (Levit et al. 2008). Integrated care—combining physical and behavioral health care—can help reduce that burden.

THE PROBLEM

Our behavioral health system is a maze of siloed and fragmented services that provide almost no coordinated care. In addition, solutions and treatments are often undermined by problems related to the stigma associated with mental illness. As a result, many people suffer from unidentified and/or untreated behavioral health conditions that incur enormous costs, ranging from reduced business productivity to prison costs, homelessness, poverty, spousal abuse, teen suicide, alcoholism, drug overdoses, and marital conflict.

As a country, we are finally moving away from damaging stereotypes of mental illness. These images haunt us, though, and most American communities are far from a place where it is truly accepted to be open about behavioral health conditions. There is still too much shame, humiliation, and disrespect associated with a diagnosis of a mental issue. Despite society's evolution, the stigma remains pervasive, and it prevents us from taking action. Behavioral health conditions are frequently the underlying cause of many of our society's greatest problems; at a minimum, they can be like gasoline added to the fire of other serious concerns.

It is time to stop discussing behavioral health in simplistic terms. Only 5 percent to 7 percent of people with a behavioral health illness have extreme, or severe and persistent cases. Most fall in the many, many shades of grey along a continuum. Thus, behavioral health conditions are rarely as clear-cut as terms such as "mental health" or "mental illness" imply. Both of these terms are limited: "mental illness" can evoke stereotypical images of a hysterical person sobbing on a chaise lounge, or a wildly distressed inmate fighting against a straightjacket, while "mental health" excludes some of the most common behavioral problems, such as alcoholism and drug addiction. The concept of behavioral health is comprehensive. It includes a range of mental and behavioral conditions that affect how we engage with the world, and it avoids dated thinking and stereotypes. Using the framework of behavioral health helps us mark a turning point in talking about mental health, shifting the conversation to the continuum of experiences.

BEHAVIORAL HEALTH POLICY IN 2015

According to the National Council for Behavioral Health's January 2015 *Capitol Connector*, which represents over 2,000 mental and substance-use treatment organizations, there are five health policy issues to watch in 2015:

- **Recurrent threats to Medicaid and other entitlement programs**, through budget reconciliations, would allow Congress to enact policies that affect national spending and revenues such as converting Medicaid to a block grant program or imposing a per capita cap on spending for Medicaid enrollees. Both of these have been previously introduced into Congress and defeated so far, but these types of bills need only a majority of votes in each chamber to pass.
- **Expiration of the current Medicare physician pay fix**, which, if left to expire in March, will reduce reimbursement to physicians who accept Medicare. A framework for permanent reform was introduced in 2013-2014 but did not get the votes needed before the deadline.
- **Movement towards a balanced budget constitutional amendment**, which could hinder the ability of the federal government to respond to increased needs for social and health programs by requiring that costs be offset somewhere

else in the budget.

- **A Supreme Court decision on federal exchange subsidies** that could limit the number of people eligible to receive subsidies.
- **Piecemeal attacks on the Affordable Care Act**, such as the definition of the work week and how it is tied to employee benefits. All of these policies affect both physical and behavioral health.

These issues and others will continue to impact access to behavioral health care in our country, and the quality of services. Most people are treated for depression and anxiety by their primary care doctors, yet we are experiencing a shortage of health care providers, which is more extreme with our behavioral workforce (Kessler 2003). At the same time, there is a steady increase in the number of older adults nationwide, as well as 7.8 million people newly entering the health care marketplace this year. New payment policies and workforce strategies, such as the use of physician extenders, can help increase the number of medical and health-related degree programs, attract more people who want to work in primary care, and help strengthen the workforce. Adding behavioral health staff into treatment teams and delivering appropriate evidence-based screenings, interventions, and treatments have been shown to greatly improve outcomes and save money; for instance, one research study reported a 6:1 ratio return-on-investment over four years (Unutzer et al. 2008).

IMPLICATIONS FOR GRANTMAKERS

Think about your mission statements and your funding budgets. What kinds of programs are you encouraged or allowed to fund within your mission? There is probably not an explicit mention of behavioral health. Yet behavioral health is probably connected in some way to much of your programming. For example, in early childhood programs we have figured out that children cannot learn if they are hungry, but we are just beginning to understand that trauma can interfere with their daily lives and development. Consider integrating a self-esteem component into physical education programs, or including behavioral health as part of grants to eliminate health disparities.

Recovery principles that are self-directed, holistic, and empowering, and that address discrimination and shame should be included in policy considerations, as well as the proper use of health data. Health literacy, which teaches people to understand basic health information and services, can also help people make their own sound health decisions. Finally, researchers are making new discoveries related to behavioral health every day, and there is an opportunity for funders to support the application of this knowledge into practice.

We know the brain is integral to every part of the body, and when something bad happens to the brain, it affects our entire bodies. Knowing this, we pass laws and enact policies ensuring the use of helmets, hardhats, and seatbelts to protect the brain. We need to add behavioral health to the equation. Without a healthy, versatile mind, the body loses. Behavioral health should and can be completely integrated not only with public health policy but also with public education policy. It is time to lead by example: change your language, incorporate behavioral health into your daily dialogue, and raise awareness. The scope of behavioral health is huge, and it can be included in virtually every funding decision you make. The local and national choices you make as funders can be translated into the policy shifts we need to reduce stigma so behavioral health treatment can be as acceptable as treatment for diabetes or cancer. There is no health without mental health. Behavioral health is essential to overall health and wellness, and health funders can help lead this change.

SOURCES

American Hospital Association. *TrendWatch*. February 2007.

American Hospital Association. *TrendWatch*. January 2012.

American Psychological Association. *Data on Behavioral Health in the United States*. January 2012.

Kessler, Ronald C., Patricia Berglund, Olga Demler, Robert Jin, Doreen Koretz, Kathleen R. Merikangas, A. John Rush, Ellen E. Walters, and Philip S. Wang. "The Epidemiology of Major Depressive Disorder." *The Journal of the American Medical Association*. 289, 23 (2003): 3905-3105.

Levit, Katharine R., Cheryl A. Kassed, Rosanna M. Coffey, Tami L. Mark, David R. McKusick, Edward C. King, Rita Vandivort-Warren, Jeffrey A. Buck, Katheryn Ryan, and Elizabeth Stranges. *Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment, 2004– 2014*. SAMHSA Publication No. SMA 08-4326. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008.

Unützer, Jürgen, Wayne J. Katon, Ming-Yu Fan, Michael C. Schoenbaum, Elizabeth H. B. Lin, Richard D. Della Penna, and Diane Powers. "Long-term Cost Effects of Collaborative Care for Late-life Depression." *American Journal of Managed Care*. 14, 2 (2008):95-100.

VIEWS FROM THE FIELD *is offered by GIH as a forum for health grantmakers to share insights and experiences. If you are interested in participating, please contact Osula Rushing at 202.452.8331 or orushing@gih.org.*