Healing the Broken Mind

Transforming America's Failed Mental Health System

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> A nation's greatness is measured by how it treats its weakest members.
>
> Mahatma Gandhi

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>
> The President's New Freedom Commission on Mental Health, *Interim Report to the President* (2002)

MENTAL ILLNESS CAN be frightening both for those who experience it and for their family and friends, who may try in vain to somehow just make it all go away. It strikes young and old, rich and poor, Democrat and Republican alike. Some of our greatest leaders have experienced it, such as President Lincoln, who struggled with depression. Some of the most talented artists have experienced it, such as Mozart, who is likely to have had bipolar disorder. Some of our most brilliant scientists have experienced it, such as Dr. John Nash, the "Beautiful Mind" mathematician. Nobody is exempt, nobody is somehow "above" being able to become mentally ill. That may be scary, but it should not keep us from figuring out what to do about it.

Mental disorders are the leading cause of disability in the United States and Canada for ages fifteen to forty-four (World Health Organization 2004). Untreated, mental illness can lead to self-destructive impulses or even death by suicide. Mental illness can be both frightening and debilitating and thus warrants all the help that can reasonably be given so that those struggling with it may recover (to the extent possible) and take their place in the home community. Everyone so affected deserves our deepest

sympathy, as well as the most effective treatment society can realistically provide. Even treated and well managed, mental illness is a burden unlike any other. Unlike physical illness or injury it is unseen, yet it mercilessly affects the lives of those who have it in untold ways. Perhaps this is why society has had such difficulty understanding or even recognizing this traumatic reality, much less embracing those so affected. And perhaps this is why policy makers are quick to point out that there are no "votes" to be had in mental health policy, no careers to be made. Thus mental health tends to be the stepchild in policy deliberations—the last to be funded, the first to be passed over. We would rather focus on simpler problems with ready solutions. Simply put, mental illness scares us, so we avoid the topic altogether.

Yet on a deeper level we know (or should know) better. We know that all our neighbors—our fellow citizens—deserve to be treated well, and all the more so when struggling with disabling challenges. We know that there is no such thing as a "throwaway" person. We know that American society will be judged not only by our economic and military might but also by how we treat our most vulnerable members. Accordingly, this book is about recognizing and welcoming our neighbors with mental illness, about understanding their plight and their needs, about what we can do as a nation to make their lives markedly better. It's actually not all that hard to do, except for the resistance to change that is built into all status quo structures. That, of course, is a critical topic and is addressed in the book's last chapter.

I have had the privilege of working in the field of mental health services for over a third of a century in clinical, academic, and governmental positions. From 1994 to 1997 I was appointed by Governor George Allen to serve as commissioner for Virginia's Department of Mental Health, Mental Retardation, and Substance Abuse Services (Kelly 1997), and I have served on various mental health commissions and boards. My experiences as psychologist, as professor, and as commissioner have all led me to the same conclusion: it is time for dramatic change (e.g., Kelly 1997, 2003b, 2007b).[1] It is time to transform the mental health system of care so that persons with even the most serious mental illnesses can regain their place in the home community—so that they can have real homes, fulfilling jobs, and deep relationships.

Others have come to this conclusion as well, and thankfully efforts are being made in that direction. However, resistance to chance is fierce, and it is not yet clear whether America's mental health system will indeed

be transformed into an effective and innovative system of care or whether the inevitable pull toward the status quo will win out. This book lays out a road map for achieving lasting transformation. The following are five interrelated recommendations for creating a truly effective mental health system of care:

1. Use results-oriented clinical outcome measures and "evidence-based practices" so as to improve quality of care and accountability.[2]
2. Open the monopolistic state mental health care system to competition and innovation so as to improve treatment choice and effectiveness.
3. Implement "parity" coverage for mental health treatment so as to increase access to care and coverage, per the 2008 parity law.
4. Empower persons with mental illness and their families to have a voice in mental health policy and service delivery so as to ensure consumer input and satisfaction.
5. Win over (or work around) the keepers of the status quo who resist change so as to move ahead toward transformation with all parties at the table.

These five recommendations must be implemented together, as they overlap and interact to create one whole effect—transformation of America's broken mental health care system. The following pages explore and explain each of these recommendations in detail.

Men in Diapers

I was only twelve years old, and Kennedy was president, when I first experienced the state mental health care system. The year was 1963, the place was the Lynchburg Training Center in Virginia, and I was one of dozens of Boy Scouts who were parading through the grounds during the hot summer as a tribute to those unfortunate souls who lived their troubled lives confined there. The training center was practically a city in its own right, located across the river from downtown Lynchburg, housing over five thousand men, women, and children, most with severe and disabling mental retardation. The large brick buildings covering many acres had been built long before air conditioning was available, and most opened

onto courtyards surrounded by twelve-foot chain-link fencing that looked very much like a prison's. Our parade route took us along an access road that ran alongside the fenced courtyards.

We marched by the buildings in formation behind each troop's flag, proud to be in uniform and glad to be doing something that was supposed to be good for others. But as we marched on, the chatter and laughter of the scouts slowly died away. There behind the large fences were dozens of men in diapers—in diapers! Many of them had nothing else on, and they hung onto the fence with strange looks as they watched us pass by. Now and again there would be a ruckus of some sort, with yells and grunts and vain attempts to scale the fence, and people in white would rush over to wrestle the diapered men to the ground. Like the other scouts, I knew absolutely nothing about mental retardation or the horrible conditions of places like the Lynchburg Training Center—including the then-current practice of eugenics. But I knew something was terribly wrong with the men behind the tall fences and with the way they were being treated. And I never forgot the sight of grown men in diapers.

Thirty-one years later, in 1994, I entered the grounds of the training center (now renamed the Central Virginia Training Center) for a second time. But this time I was arriving in a state car driven by my staff, and I was there to assess the quality of the treatment program. I had been appointed by the governor to serve as commissioner of Virginia's Department of Mental Health, Mental Retardation, and Substance Abuse Services. And I was eager to see whether the horrors of 1963 had been corrected. The buildings looked much the same, but thankfully the fences had been removed and air conditioning installed. Around the grounds could be seen small groups of "residents" walking from building to building accompanied by their caretakers. Everyone was fully clothed. By outward appearances, life was much improved at the training center.

As commissioner, I was given the red carpet treatment—staff presentations, tours, greeting selected residents, a nice lunch. I was impressed by the dedication of the staff, many of whom worked long hours for low pay in a discouraging environment. I was also impressed by the improvements since 1963. Most of the residents seemed reasonably well cared for, some were productively employed, and none were left to wander untended. But I was troubled by the suspicion that much of what I saw was scripted for me and not necessarily representative of daily life at the training center.

So I came back several weeks later, alone in my state car and completely unannounced.

This time I did not park in a space specially prepared for the commissioner. Instead, I simply picked a building at random, parked nearby, and walked in. What I saw confirmed my suspicions. I could see two rooms with six or seven residents in each and two staff chatting amiably together in an adjoining hallway. There was a distinct odor of urine and unwashed clothes and a general unkempt/lazy atmosphere, as if there were nothing to do and nobody cared. No one recognized me or made any effort to "get busy," probably assuming I was just another parent stopping by for a brief visit. As I spoke with the staff and residents, it became clear that this particular building was intended to deal with behavioral problems—residents who had been out of control. That should have meant that these residents would be offered intensive behavior modification treatment until they learned how to appropriately manage anger, frustration, grief, and so on. Instead, they were offered "custodial care," a fancy term for babysitting. I was seething but kept my thoughts to myself.

In subsequent surprise visits to Virginia's fifteen psychiatric facilities I had many such encounters. Once I even walked unannounced into a facility director's office only to find him with his feet literally on the desk, kicking back for a restful afternoon in his comfortable air-conditioned office. (He almost fell over backwards when he saw me.) Worse, I found that custodial care was the norm, not the exception. Time and again I walked unannounced onto a locked psychiatric unit to find the patients overmedicated, slouched on couches, and watching daytime TV together with the staff. This was not just a waste of time and resources, it was unethical and inexcusable. How dare we restrict persons with serious mental illness to locked units only to ignore their pressing need for effective treatment? How dare we offer only custodial care to patients who are vulnerable and completely dependent on whatever is provided? No wonder the mental health care system is described as in a shambles—broken.

This tragic state of affairs was highlighted by a federal commission five years ago. The President's New Freedom Commission on Mental Health issued its interim report in 2002 and its final report in 2003. Here's what they found:

> America's mental health service delivery system is in shambles, . . . [and] needs dramatic reform. (2002, i)

> For too many Americans with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities. The time has long since passed for yet another piecemeal approach to mental health reform. Instead, the Commission recommends a fundamental transformation of the nation's approach to mental health care. (2003, 1)

These are stunning admissions for a federal mental health commission to make, and they cry out for a response. Other mental health policy analysts are reaching similar conclusions: that the current system is failing and in need of dramatic overhaul (e.g., Mechanic 2008; Olson 2006). It is time to do the right thing—it is time to transform America's broken mental health system.

Transformation and recovery are what this book is all about—the actions and policies needed to transform mental health services so that persons with mental illness can actually recover and take their place in the home community.[3] There are times when sweeping public policy changes become critical for the welfare of the people, and this is one of those times. It is not an exaggeration to say that the quality of life for millions of Americans suffering from serious mental illness depends upon what our nation does in response to the call for transforming mental health services so as to facilitate recovery. Will there be the usual short-lived fanfare of impressive-sounding state and federal proposals, followed by a few half-hearted initiatives, only to end up with the eventual return to the status quo? Or will this nation roll up its sleeves and do the right thing for the sake of those among us who suffer from the most debilitating of illnesses—mental illness?

The following chapters not only make an appeal for taking up this charge but also present a road map for getting there. Strategic policy proposals are offered for state and federal policy makers, mental health providers, consumers and their family members, and third-party payers (public- and private-sector insurers).[4] For those who are satisfied with the status quo, this book will be of little value. But for those who want to make a difference in the lives of persons with serious mental illness, who want to seize the opportunity afforded by a startlingly honest commission and a time that is ripe for action, read on.

How Bad Is It?

Mental illness is one of the most complex and frustrating health care issues facing society today, and its toll is widespread. Tens of millions of Americans will experience depression, panic attacks, or some other form of mental illness this year. It is estimated that in any given year 26.2 percent of America's adult population (57.7 million people) meet the criteria for a diagnosable mental disorder (Kessler, Chiu, et al. 2005).[5] Countless jobs will be lost and lives put "on hold" as individuals and their families struggle to cope with the chaos and heartbreak of mental illness. Some of those with mental illness will attempt suicide, and, tragically, many of those attempts will be successful. In 2003, 340,000 Americans visited emergency rooms as a result of suicide attempts; over 30,000 of those who attempted suicide died (Substance Abuse and Mental Health Services Administration [SAMHSA] 2006).

Ten years ago, the surgeon general found that over $69 billion was being spent annually in direct costs for mental health services, yet often without the results hoped for (Office of the Surgeon General 1999). Today that figure is much higher, but still results are lacking. America enjoys tremendous prosperity and power, but these have not provided a buffer from mental illness and suicide. How did we get here, and what can be done about it?

A Brief History of Mental Health Treatment

Historically, mental illness has often been misunderstood and feared, and those suffering from it have been stigmatized. In colonial America, persons with mental illness were called lunatics, and their families simply cared for them at home as best they could. Often this meant consigning the suffering individual to a basement or attic or some form of restraint for long periods of time until abnormal behavior subsided. (Unfortunately, this is still the case in many countries throughout the world.) "Professional" treatment consisted of humane custodial care at best, quackery or cruelty at worst. By the nineteenth century, "asylums" were built so that those with mental illness could be cared for outside the home community. The various treatments prescribed in those asylums were largely ineffective. In some cases care was provided by well-meaning staff who treated their patients with compassion and dignity, but in too many other cases poorly

trained providers took advantage of their position and cruelly mistreated the patients who were at their mercy. For instance, patients were sometimes found virtually abandoned and chained to walls in small rooms filled with human excrement (Goodwin 1999).

Asylums became known as "mental hospitals" in the early twentieth century, and the numbers of Americans committed within their walls grew substantially, reaching a high of nearly 560,000 in 1955. This rise in demand for inpatient care was driven by several factors, including an aging psychiatric population with nowhere else to go. There were also many World War I and World War II veterans whose combat experiences had triggered chronic mental illness, including what is now referred to as posttraumatic stress disorder (PTSD). Many of those hospitalized suffered from a psychotic disorder: they had lost touch with reality and, in most cases, experienced delusions and/or hallucinations.

In the mid-1950s, the discovery of antipsychotic medications such as Thorazine and Haldol sparked a revolution in inpatient mental health care. These new medications at least partially controlled psychotic symptoms so that, for the first time, persons with schizophrenia and other psychotic disorders were able to be discharged and returned to their home communities. Consequently the population in mental hospitals began to drop dramatically, a movement that continues to this day. The average daily census in America's psychiatric hospitals stood at just over fifty-four thousand in 2000 (SAMHSA 2003). This movement away from hospital care became known as "deinstitutionalization," since hundreds of thousands of people who would otherwise have lived much of their lives in psychiatric institutions were able to return to their home communities. The initial hope was that antipsychotic medication would do for mental illness what penicillin did for infections—provide a cure. Unfortunately, pharmaceutical treatment and deinstitutionalization, while helpful, also elicited a new set of problems. The medications controlled psychotic symptoms to some extent, and for some patients the results were wonderful. But many others found that they triggered severe side effects such as tardive dyskinesia (unstoppable and often embarrassing repetitive motions) and left the patient feeling overtranquilized, emotionally stunted, and interpersonally dysfunctional.

Moreover, deinstitutionalization led to a predictable need to provide effective outpatient treatment and services so that the many patients discharged from psychiatric facilities could find the support and services required to succeed in their home communities. In response to this need,

a complementary revolution in community mental health care soon developed—the community mental health center (CMHC) movement. The laudable goal was to provide outpatient services so that persons with serious mental illness (including those discharged from hospitals) could receive the care needed to live successfully in their home communities. CMHCs were launched with federal funding in the 1960s, and currently many dedicated and talented providers offer excellent care in today's CMHCs. However, the CMHC system is now too often functioning as a dispenser of ineffective or insufficient status quo services, without the full range of community supports and innovative treatments needed to provide effective care. Consequently it is not unusual for a person with serious mental illness to be discharged from a psychiatric hospital, return to his or her local CMHC, get rapidly worse because of ineffective care, and eventually end up rehospitalized. This vicious cycle is emblematic of a broken system of care and serves the best interests of no one.

The vicious cycle also contributes to a rising population of the "homeless mentally ill" and seems to provide evidence for the claim that deinstitutionalization has failed. In fact both revolutions, deinstitutionalization and community mental health care, are examples of well-intentioned public policy poorly implemented. Most persons with serious mental illness need not live their lives institutionalized and can recover enough to live successfully in their home community. So the goal of discharging patients as soon as possible from inpatient care is appropriate and ethical. However, for that to work, a whole new array of home- and community-based services must be put in place. Otherwise, patients are sent home to predictable deterioration and, eventually, to readmission. The vicious cycle exists not because deinstitutionalization is the wrong policy but because sufficient and effective community services are not available. The one without the other is a recipe for disaster. The mental health care system is well intentioned but broken and must be transformed.

What Is Mental Illness?

It is important to clarify terms before proceeding, yet mental illness is surprisingly difficult to define. Unlike communicable physical illness, there is no pathogen—no viral or bacterial infection—that can be readily identified and treated. The affected organ is, of course, the brain, and many mental illnesses are associated with changes in brain chemistry. But the

etiology, or cause, of mental illness remains largely unknown and there are many competing definitions of the term. To clarify the definition, it is helpful to appeal to the "biopsychosocial" model used by social scientists, as well as two other well-regarded definitions.

Most behavioral scientists embrace the biopsychosocial model (Engel 1977), which means that a given mental illness (such as schizophrenia or depression) may have several components—biological, psychological, and social. The biological component refers to the fact that some persons are born with a vulnerability to specific illnesses (both physical and mental). Such persons are "genetically predisposed," meaning that statistically they are more likely to develop a given illness than the average person. So, for instance, the child of a person with schizophrenia is more likely than others to have inherited the genetic structure that is associated with this disorder. That does not mean for certain that the child will develop schizophrenia, but it does mean that he or she is more at risk biologically. Likewise, a child may inherit a genetically driven tendency to withdraw from others socially, which makes him or her more likely to experience depression later in life (Tan and Ortberg 2004).

The psychological component refers to the fact that certain patterns of thinking or feeling are associated with mental illness. For instance, a person who tends to draw negative conclusions about self despite positive evidence to the contrary is more likely to experience depression (J. Beck 1995; Tan and Ortberg 2004). The social component refers to the stressful or traumatic experience that often triggers mental illness. For instance, depression can be triggered by a significant loss such as the breakup of a long-standing relationship or the loss of a job (Tan and Ortberg 2004). The biopsychosocial model of mental illness has proven helpful for research and treatment and provides a useful conceptual framework for defining mental illness as well.

The surgeon general's well-regarded report on mental health defines mental illness as "diagnosable mental disorders . . . characterized by alterations in thinking, mood, or behavior . . . associated with distress and/or impaired functioning" (Office of the Surgeon General 1999). In this definition, *diagnosable* is the operative word, and it is what distinguishes mental illness from other, less serious problems such as adjustment to life difficulties. Saying that mental illness is "diagnosable" means that a person's symptoms meet the criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR;* American Psychiatric Association 2000). The *DSM-IV,* published by the

American Psychiatric Association, lists observable or reportable criteria for every recognized classification of mental illness. For instance, to be diagnosed as having depression an individual would have to have experienced, for a period of time, at least five of nine specific symptoms (e.g., sad mood, sleep disturbance, low energy, difficulty concentrating, and thoughts of self-harm). Since both public and private health insurers typically require *DSM-IV* diagnoses to cover treatment for mental illness, this manual has come to play a critical role in mental health care treatment and policy.

The second well-regarded definition comes from the National Alliance for the Mentally Ill (NAMI). NAMI is the nation's largest mental health advocacy organization, with chapters in every state, and exists to support individuals and families struggling with mental illness.[6] This organization is very active in the arena of mental health policy at both the state and federal levels, correctly recognizing that such policies greatly affect the quality of life of those with mental illness. NAMI tends to focus on "serious mental illness" and works from the premise that persons with serious mental illnesses require a combination of medication, psychotherapy, and community support services in order to recover. NAMI (2008) defines mental illnesses as "a disorder of the brain that disrupts a person's thinking, feeling, moods, ability to relate to others, and daily functioning . . . [and] often result in a diminished capacity for coping with the ordinary demands of life."

I believe that these two definitions are complementary and fit well within the framework of the biopsychosocial model. Consequently, throughout this book, I will use the following definition of mental illness, which draws on all three perspectives: "Mental illness is a biopsychosocial brain disorder characterized by dysfunctional thoughts, feelings, and/or behaviors that meet *DSM-IV* diagnostic criteria."

What Is Serious Mental Illness?

A working definition of mental illness provides at least a starting point for developing mental health policy. For instance, it clarifies the difference between genuine mental illness and general "life difficulties," such as feeling stressed out or somewhat down, since mental illness must be formally diagnosable by the *DSM-IV.* But that leads logically to an important question: Is every diagnostic category listed in the *DSM-IV* equally burdensome to the individual and thus equally deserving of priority attention? Some would argue yes and feel that to leave out any category of mental

illness in policy discussions is a great mistake. Others (such as NAMI) argue that it makes more sense to focus attention and resources on a priority basis on "serious mental illness," which by definition is more debilitating than the milder forms of mental illness included in the *DSM-IV.*

The trouble is that the *DSM-IV* is like a dictionary, intended to be broad and comprehensive and thus inclusive of every possible category of mental illness regardless of severity. It is an attempt to catalog and classify *all* pathological psychological experiences outside the "norm." Accordingly, it includes forms of mental illness that do not warrant the same level of attention as, say, schizophrenia or major depression. Pathological deviations from the norm included in the *DSM-IV* range from mild cases of simple caffeine intoxication to potentially suicidal cases of chronic major depression. This poses a challenge for insurers, whether private or governmental, who must set parameters for coverage eligibility. Should all 297 categories of mental illness listed in the *DSM-IV* be equally covered, or should some be prioritized over others?

To answer the question, consider the contrast mentioned above—caffeine intoxication versus chronic major depression. Not surprisingly, caffeine intoxication is caused by the ingestion of excessive amounts of caffeine, which results in symptoms such as restlessness, insomnia, and nervousness. Although many a college student has experienced the results of a caffeine overdose while studying for exams, it is unlikely that this form of mental illness is serious enough to warrant priority treatment. Chronic major depression, on the other hand, can be debilitating in the extreme and frequently includes suicidal thoughts or actions. Untreated, it can literally end in death. More often, it leads to a life of increasing dysfunction at home, at school, or in the workplace. It is clear that this form of mental illness is indeed serious enough to warrant priority treatment and that effective care should be made available through private insurance, the public mental health care system, or both.

Mental health researchers and policy makers have labored for some time to define serious mental illness in order to distinguish it from less severe forms of dysfunction. Serious mental illness is based on two factors—diagnosis (severe categories) and level of functioning (highly debilitating). A consensus definition has yet to emerge, but the surgeon general's mental health report states that "this category includes schizophrenia, bipolar disorder, other severe forms of depression, panic disorder, and obsessive-compulsive disorder" (Office of the Surgeon General 1999, 46).[7] The report's definition provides a useful starting point since it includes psychotic

disorders, which are the most severe mental illnesses, and mood and anxiety disorders, which are the most common mental illnesses. However, it leaves out childhood disorders such as attention deficit disorder, eating disorders, and substance use disorders. Disorders in these categories are also common and debilitating. In fact, many who suffer from a mental illness also struggle with substance use disorders. Accordingly, I believe that serious mental illness should include six categories of mental disorders:

1. Psychotic disorders (e.g., schizophrenia)
2. Mood disorders (e.g., bipolar disorder, major depression)
3. Anxiety disorders (e.g., panic disorder)
4. Childhood disorders (e.g., attention deficit/hyperactivity disorder)
5. Eating disorders (e.g., anorexia)
6. Substance use disorders (e.g., alcohol dependence)

Insurance coverage should vary for specific mental disorders according to the severity of the illness. For instance, under "childhood disorders" Tourette's disorder (uncontrollable and highly disruptive tics) should be included in every plan given its severity. But mathematics disorder (lower than expected mathematical ability) could be in the "uncovered" category, except perhaps for the most extensive and expensive coverage packages intended to include all possible diagnoses.

As mentioned above, serious mental illness is based not only on diagnosis but also on level of functioning. In other words, a person experiencing a serious mental illness not only will meet the criteria for a disorder in one of the six categories listed but also will have significant difficulty in functioning at home, work, or school. For example, this may involve weeping uncontrollably throughout the day (depression), experiencing heart attack–simulating panic when with others (agoraphobia), or hearing viciously accusing voices that are not there (schizophrenia). Such experiences make it impossible to function well, which is part of the grim reality of serious mental illness. In sum, the most serious mental disorders are recognized by a combination of diagnosis and functionality. Such disorders will always involve a severe diagnosis and a significantly compromised level of functioning.

Although the prevalence of serious mental illness is hard to determine, especially since there is no consensus on which diagnoses to include, it is estimated that about 6 percent of the U.S. adult population (13.2 million people) suffer from a serious mental disorder (Kessler, Chiu, et al. 2005).

Serious Mental Illness: Symptoms and Treatment

As described above, serious mental illness involves six categories of mental disorders, including schizophrenia and major depression. Unfortunately, there is much confusion both about mental illness in general and about specific disorders, as indicated by questions such as "Is mental illness caused by poor parenting?" or "Can mental illness be caught by spending time with a person suffering from serious mental illness?" The answer to both questions is "no." Although poor parenting can, of course, contribute to a child's problems, the biopsychosocial model is based on the premise that mental illness is caused by multiple factors. Many people from good families become mentally ill, and many of those from dysfunctional families do not. And, of course, since mental illness does not involve a viral or bacterial infection it cannot be "caught."

Anyone experiencing serious mental illness without the benefit of effective treatment can easily get to the point where he or she is simply unable to function in society. The sadness, anxiety, and uncontrollable behaviors that are part of serious mental illness—and, in the case of schizophrenia or other psychotic disorders, the delusions and hallucinations—can easily become too much for a person to bear. However, when provided with effective treatment, the majority of persons with serious mental illness can live a healthy, productive life in their home community. Thus effective care benefits not only the individual in need but the community as well, which would otherwise lose a valuable member.

Even from a purely pragmatic and financial perspective it makes sense to help persons with serious mental illness early on, before a crisis point is reached. Prevention and early intervention programs, such as support groups and counseling offered in schools, are much less expensive than the types of services provided post crisis—such as hospitalization and incarceration.

It is important to understand something of what a person with serious mental illness experiences so as to fully appreciate the imperative to transform America's broken mental health care system. The reader who is already familiar with the clinical aspects of mental illness and its treatment may want to skip the following sections. But for the sake of those not familiar with the realities of serious mental illness, what follows is a brief profile of some of the major disorders. The reader should remember that this sketch is simply a snapshot of some of the more common disorders in the six categories defined as constituting serious mental illness. For a

more complete overview of emotional disorders, see *Psychopathology: History, Diagnosis, and Empirical Foundations* (Craighead, Miklowitz, and Craighead 2008).

Schizophrenia: A Psychotic Disorder

Schizophrenia is perhaps both the most debilitating and most misunderstood of the serious mental illnesses. The misuse of the term *schizophrenic* to apply to a Jekyll-and-Hyde personality just adds to the confusion. Schizophrenia does *not* mean "split personality" or "multiple personality," even though the term, coined by Swiss psychiatrist Eugen Bleuler in 1911, does literally mean "split mind." The "split" referenced by Bleuler is a division between experiences and feelings, or between thoughts and reality. Persons with schizophrenia may react in a bizarre manner to a normal social situation because their thoughts or feelings are not corresponding to what is actually happening around them. Individuals with schizophrenia are considered psychotic, meaning that they have lost touch with reality. They may see and hear things that are not there, or they may have bizarre delusions that seem absolutely real to them.

Schizophrenia seems to strike out of the blue, typically in late adolescence or early adulthood. It can affect the best and brightest and often lasts a lifetime. It is not possible to describe schizophrenia without recognizing the heartbreak that this disorder entails. The tragedy of schizophrenia was well portrayed in *A Beautiful Mind*, a movie about the life of Nobel Prize winner John Nash Jr. As demonstrated in Nash's case, some persons are born with a genetic vulnerability to this disorder. (Nash's son also has schizophrenia.) Approximately 1.1 percent of the population (2.4 million adults) develops schizophrenia, a percentage that is fairly stable across cultures (Gottesman 1991).

There are five types of this disorder, but perhaps the best known is paranoid schizophrenia. This often involves unrelenting and extreme delusions of persecution or threat and the belief that others are "out to get you." Those who are actively experiencing paranoid schizophrenia are at greater risk of hurting themselves or others if they do not receive treatment. However, with effective treatment, with symptoms under control, and with good social support the risk for harm is typically no greater or less than for anyone else.

The symptoms of schizophrenia vary greatly but can involve auditory or even visual hallucinations that are often threatening and frightening, such as hearing voices or seeing demonic figures. Bizarre delusions and

peculiar behavior are common experiences for persons with schizophrenia, who may believe, for example, that they are receiving messages from a dead person or from the CIA. The emotional response of persons with schizophrenia is often completely unrelated to their actual situation. For example, one may laugh after hearing of the death of a loved one, while another may show no feelings at all. Of course, these symptoms result in dramatic dysfunction at work, home, or school. The tragedy of this disorder is compounded by the fact that a person with schizophrenia may have times of normality interspersed with periods of delusion or hallucination. This often confuses and gives false hope to the individual, as well as to friends and family.

Until the 1990s, treatment for schizophrenia relied almost solely on conventional antipsychotic medication that decreased delusions and hallucinations to the point where a person with schizophrenia could again function at home and at work. However, these medications (e.g., Thorazine and Haldol) came with the risk of serious side effects such as tardive dyskinesia.[8] Additionally, heavy dosages of these medications often left the patient feeling overmedicated, as if even normal thoughts and feelings were restricted by an invisible barrier. Consequently, a person with schizophrenia had to make the difficult choice between continuing to endure psychosis or risking the downside of conventional antipsychotic medications.

More recently, new "atypical" antipsychotic medications (e.g., Clozaril, Risperdal, Zyprexa, Seroquel, Abilify, and Invega) were developed that seemed capable of reducing the effects of psychosis with minimal risk of serious side effects (Comer 2004, 473). However, research has determined that these medications also come with significant risk of unintended side effects, such as obesity, diabetes, or, in the case of Clozaril, agranulocytosis (decreased white blood cell count). Additionally, there is some indication that conventional antipsychotic medications can be equally effective, and less likely to trigger side effects, if dosage is kept to a minimum and patients' reactions are carefully monitored (McEvoy et al. 2006; Stroup et al. 2006).

Antipsychotic medications, carefully matched to the patient and properly dosed, can accomplish wonders. In fact, as commissioner I personally witnessed many "Clozaril miracles"—patients who had not responded to any of the traditional medications for many years, yet "came back" to reality and eventually to their home community through the use of Clozaril.

Medication alone is not sufficient, however. Once medication has taken effect, treatment should expand to include supportive therapy for

the individual and his or her family, as well as vocational and psychosocial rehabilitation if needed. Even with effective treatment, schizophrenia is a heavy burden to bear. The individual, and often family members as well, need help managing the challenges posed by ongoing medication, by symptoms when they appear, or by misunderstanding in the home or workplace. With effective treatment and rehabilitative supports in place, a person with schizophrenia can do well at home and at work and move toward recovery. Thankfully there are many cases demonstrating just that—yet there need to be more.

Mood Disorders: Major Depressive Disorder and Bipolar Disorder

Mood disorder is the term used in the *DSM-IV* for mental disorders characterized by depression, mania, or both. Major depression and bipolar (manic-depressive) disorder involve much more than simple mood swings from sadness to elation, which are simply part of normal experiences.

Major Depressive Disorder

Major depressive disorder is the most common mental health diagnosis and is the leading cause of disability in the United States for ages fifteen to forty-four (World Health Organization 2004). Worldwide, it ranks among the top ten causes of all disabilities (Murray and Lopez 1996). Major depressive disorder affects approximately 6.7 percent of adults (14.74 million) in a given year (Kessler, Chiu, et al. 2005), and affects a significant portion of America's children and adolescents as well (SAMHSA 2007). A person with depression experiences, for a sustained period, symptoms such as sadness and crying, sleep disturbance, loss of energy and interest, loss of appetite, difficulty concentrating, and thoughts of self-harm. Depression can be triggered by a psychosocial stressor such as a loss (e.g., the end of a relationship, death of a spouse, or loss of a job) that constitutes the social component in the biopsychosocial model. In addition, depression often involves changes in brain chemistry (the biological component) and negative thought patterns (the psychological component). The difference between diagnosable depression and "feeling down" is a matter of severity, duration, and impairment. Anyone can feel down for a day or so, but depression can last months, immobilize a person, and lead to suicide. Tragically, about 10 percent of persons with the most serious forms of depression (those who typically seek hospitalization) eventually attempt suicide (SAMHSA 2006).

Depression can be effectively treated with psychotherapy, antidepressants, or a combination of both. There are three major classes of

antidepressants, but the most frequently used are known as the "SSRI" (selective serotonin reuptake inhibitor) antidepressants, which include Prozac and Zoloft (Comer 2004). The primary function of these medications is to increase the active amount of a brain neurotransmitter, serotonin, which in turn elevates an individual's mood. With fewer side effects and greater effectiveness than the older antidepressants, these medications have become common. Currently, tens of millions of Americans are taking antidepressants, most of which are prescribed (and too often overprescribed) by a general practitioner rather than by a psychiatrist.

Although these medications are useful in many cases, there is a tendency for both patients and providers to see them as a quick fix—the solution to depression in a pill. Consequently we as a society have become overdependent on antidepressants, often prescribing or renewing them without question when a careful assessment would suggest otherwise. As a practicing psychologist I have seen many patients take SSRI antidepressants for years, assuming it will brighten their mood and ward off depression indefinitely. In reality, many medications when overused tend to lose their effectiveness as tolerance develops. Further, for some persons SSRI antidepressants can increase the likelihood of self-harm by providing energy for action before the depression has lifted. Such medications are best used cautiously and in moderation, as an adjunct to other treatment (Healy 2004: Miranda, Chung, and Green 2003).

Several mainstream psychotherapies have been shown to be as effective in treating depression as SSRI medications and in some cases longer-lasting (Comer 2004). Of these, cognitive-behavioral psychotherapy (which deals with negative thought patterns) and interpersonal psychotherapy (which focuses on relationships) have been shown to be particularly helpful. In some cases, a combination of psychotherapy and a course of medication constitutes the most effective treatment approach. Thankfully, the majority of persons suffering from major depression, about 60 percent, respond well to appropriate treatment (Comer 2004).

Bipolar Disorder

Bipolar disorder, formerly called manic-depressive disorder, involves experiencing a manic episode (an abnormally elevated, expansive, or irritable mood) as well as depression. The manic mood is accompanied by symptoms that could include grandiosity, decreased need for sleep, flight of ideas, pressured speech (speaking rapidly and excitedly without pause),

and, in some cases, self-destructive activities such as sexual indiscretions or buying sprees. Extreme cases can include psychotic symptoms, such as delusions or auditory hallucinations. Like depression, a manic episode can be triggered by a psychosocial stressor. The manic episode can last for minutes or for days and often either follows or precedes a depressive episode. The cycle from depression to mania and back can occur rapidly within a day or slowly over weeks. Approximately 2.6 percent of adults (5.7 million) and 1.1 percent of children and adolescents (275,000) suffer from bipolar disorder (Kessler, Chiu, et al. 2005; Office of the Surgeon General 1999). Untreated, this disorder can quickly ruin lives, as a person experiencing mania may behave in such a way as to hurt family, property, employment, or self. Self-destructive behaviors, including suicide attempts, are not uncommon.

Treatment for bipolar disorder usually begins with medication to stabilize the manic mood swings. Throughout the years, lithium has been the most frequently prescribed and most effective medication for this disorder, with minimal side effects for many. Recently, new medications that were originally developed as anticonvulsants (e.g., Tegretol and Depakote) have been found to be particularly effective in treating bipolar disorder, especially for those who do not respond to lithium (National Institute of Mental Health 2000). In my clinical experience, I have found that it is not unusual for a person with severe bipolar disorder to be taking a number of medications—for example, one for mania, another for depression, and perhaps a third to control side effects from the first two. Appropriate medication is of course critical, but there seems to be a tendency to overmedicate and to ignore the need for adjunctive psychotherapy. Supportive, practical psychotherapy is usually necessary to help a person cope with this disorder, including learning new strategies for managing bipolar experiences.

Anxiety Disorders: Panic Attacks, Obsessive-Compulsive Disorder, and Post-traumatic Stress Disorder

Anxiety disorders involve extreme experiences of anxiety that can debilitate an individual. These disorders are very different from experiencing fear in the face of danger, worrying about life's concerns, or feeling stress under pressure—all of which are part of the normal human experience. An anxiety disorder can lead to wild panic, bizarre obsessive/compulsive behaviors (e.g., washing one's hands hourly or constantly checking locked doors), or terrifying reexperiences of a trauma such as rape.

Panic Disorder

Panic attacks usually involve a gut-wrenching, overwhelming sense of fear—often including the belief that one is "going crazy" or about to die. Accompanying this fear are symptoms that may include a racing heart rate, sweating and trembling, shortness of breath, or hot flashes. The attack usually comes on suddenly and builds to a crescendo within ten to fifteen minutes. By then, it is not unusual for the person who is having the attack to lose control (e.g., to run out of a building, to scream, or to cry hysterically). All of this is very costly on the individual, both physically and emotionally. Panic attacks are associated with other anxiety disorders such as phobias (an inordinate fear of an object or situation) and agoraphobia (fear of public settings). In both cases the person engages in avoidant behavior—either of objects or of being in public—to keep from having a panic attack. A person struggling with agoraphobia, for example, may stay at home because that's the only way to ensure that he or she will not end up having a panic attack. Needless to say, these attacks and the behaviors they elicit can be highly disruptive at home, at school, or on the job. Approximately 2.7 percent of adults (6 million) currently experience severe panic attacks and their associated disorders (National Institute of Mental Health 2007). About 13 percent of children and adolescents (3.25 million) experience some level of anxiety-related difficulty or disorder (SAMHSA 2003a).

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) consists of two components: obsessive thoughts and compulsive behaviors. An obsessive thought is an abhorrent thought, image, or impulse that invades a person's consciousness and cannot be "turned off." A compulsive behavior is a repetitive, unwanted action that cannot be resisted. The two usually go hand in hand. For instance, Howard Hughes, the billionaire, who suffered from obsessive-compulsive disorder during the last half of his life, was irrationally concerned about germs. He could not stop thinking about infection, so he developed elaborate and bizarre routines such as opening doors with his feet to avoid germs. This was depicted well in the movie *The Aviator* (2004), which showed how a person such as Hughes can be very accomplished and intelligent and still suffer greatly from OCD. Severe OCD, untreated, can be quite debilitating, as individuals may spend much of their time pursuing compulsive, irrational behaviors. Approximately 1.0 percent of adults (2.2 million) experience some level of OCD (Kessler, Chiu, et al.

2005). It is estimated that between 0.2 and 0.8 percent of children, and up to 2 percent of adolescents suffer from some level of OCD-related difficulty or disorder (Office of the Surgeon General 1999).

Post-traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) was officially recognized as a mental disorder in 1980, largely in response to Vietnam War veterans who were experiencing debilitating symptoms. Formerly, similar symptoms that affected World War II veterans were diagnosed as "combat fatigue," and World War I veterans were declared to be suffering from "shell shock." But PTSD is not limited to war trauma. It can be caused by exposure to any horrifying, traumatic stressor, including combat, violent assault (e.g., rape), kidnapping, torture, a severe auto accident, or a major natural disaster. Symptoms include reexperiencing the trauma in nightmares or flashbacks, sometimes many years after its original occurrence. Because these experiences are often triggered by something reminiscent of the initial event, persons with PTSD may go to great lengths to avoid places or reminders of their trauma. If despite their best efforts the trauma is invoked, they may suddenly and unexpectedly reexperience the full anxiety and horror of the original event through a flashback. Such experiences can be truly debilitating and unnerving. This mental disorder is somewhat unique in that its cause (the trauma) is known. What is not known is why some individuals develop PTSD while others who experienced the same trauma do not. About 19 percent of Vietnam War veterans experienced PTSD at some point after the war (Dohrenwend et al. 2006), although one study found the rate for those exposed to heavy combat much higher (36 percent; Kulka et al. 1988). There is no reason to believe that veterans returning from Iraq and Afghanistan will not suffer similar rates. Overall, 3.5 percent of America's adult population (7.7 million) have PTSD in a given year (Kessler, Chiu, et al. 2005).

Treatment for anxiety disorders often involves both medication and psychotherapy. Some SSRI antidepressants have proven to be helpful in some cases for both OCD and panic attacks. Panic attacks are also treated with antianxiety medication known as benzodiazepines (e.g., Klonopin and Valium), though these can become addictive. A newer medication, BuSpar, may be helpful in some cases in providing a nonaddictive alternative for reducing general anxiety (Comer 2004). Many persons who are dealing with a severe anxiety disorder benefit not only from medication but also from psychotherapy. Psychotherapy may be supportive and

practical, focusing on strategies for managing anxiety such as relaxation techniques: it may be cognitive-behavioral, focusing on replacing anxious thought patterns, or it may be insight oriented, helping an individual to work through his or her feelings and defuse the impact of the initial trauma. A more recently developed form of brief psychotherapy, eye movement desensitization and reprocessing (EMDR), has demonstrated notable effectiveness in treating PTSD (Craighead, Miklowitz, and Craighead 2008). This involves triggering left-right eye movement, or tapping left-right on shoulders, while the patient recounts and reprocesses the trauma experience and its meaning.

A large number of military personnel returning from the wars in Iraq and Afghanistan suffer from PTSD or other stress-related disorders. For that reason, the Pentagon announced in August 2008 a $300 million program on research and treatment for PTSD and traumatic brain injury. This unprecedented effort will likely revolutionize our understanding of how PTSD works (etiology and course) and lead to new and more effective treatments for veterans and civilians alike suffering from anxiety disorders. Although anxiety disorders rarely disappear altogether, with effective evidence-based treatment those suffering from them can usually minimize and manage their symptoms and return to a fully functioning lifestyle.[9]

Attention Deficit/Hyperactivity Disorder: Typically, a Childhood Disorder

Attention deficit/hyperactivity disorder (ADHD) is the most commonly diagnosed behavioral disorder of childhood, although it can also be found among adults. Research shows that it is four times more common among boys than girls and that it affects approximately 5 percent of the child and adolescent population (1.25 million) (Office of the Surgeon General 1999). ADHD has generated a good deal of controversy—especially among parents who feel that the diagnosis and medication are too readily given in order to calm disruptive children. There is, in fact, evidence to warrant more research on whether the diagnosis may at times be given too freely to children who meet only some of the actual criteria for ADHD in an effort to control poor behavior (Office of the Surgeon General 1999). Mild ADHD symptoms in children who are somewhat prone to disruptive behavior or inattention may often best be dealt with through parental/teacher attention and special tutoring rather than medication. However, severe ADHD involves measurable dysfunction in the brain's ability

to process information and cannot be addressed with tutoring alone. Children suffering from severe ADHD are simply unable to perform at home or at school and are very much in need of effective treatment, which may include medication.

While children tend to be the subject of most discussions of ADHD, it is important to recognize that the malady also affects many adults, who often suffer more damaging effects than children. ADHD affects an estimated 4.1 percent of those aged eighteen to forty-four (Kessler, Chiu, et al. 2005). Adults with ADHD may have trouble holding down a job or managing their finances. Forming and maintaining relationships can also be difficult, leading to increased loss and stress in their lives. Both adolescents and adults with untreated ADHD are at increased risk for substance abuse and dangerous impulsivity, a combination that sometimes results in tragedies such as automobile accidents and acts of violence (SAMHSA 2003a). ADHD is characterized by two sets of symptoms: inattention and hyperactivity. Although any child can, of course, be inattentive and hyperactive at times—especially when upset—the cluster of symptoms for ADHD goes far beyond the normal range of behavior. For instance, a child with severe ADHD may be always talking and moving around, unorganized, inattentive, and unable to focus in on or complete tasks at school or home. Whereas a few of these behaviors are to be expected from any child now and again, it is the sum of all these behaviors exhibited most of the time that marks severe ADHD.

Treatment for ADHD usually involves both medication and behavioral therapy. The medications—"psychostimulants" including Ritalin and Adderall—arouse or stimulate brain regions that are responsible for directing attention and inhibiting impulses. While it may seem counterintuitive that an energizing medication would help to treat a hyperactive disorder, the results have clearly been positive. At least 80 percent of children with ADHD respond well to psychostimulants (Comer 2004). Although the actual mechanism of improvement is not known, it has been hypothesized that a stimulant may improve the ability of a child with ADHD to focus more effectively on one thing at a time by "arousing" his or her interest level. Behavioral therapy is often required as a complement to medication to help parents and teachers establish structure in the child's life and reinforce rewards and consequences for actions. Otherwise, dysfunctional learned behaviors (bad habits) can deter improvement, even with successful medication.

Anorexia Nervosa: An Eating Disorder

Anorexia nervosa is an eating disorder characterized by refusal to eat what is required to maintain a minimally normal body weight. Those suffering from this disorder are inordinately afraid of gaining weight and exhibit a significant disturbance in perception of the shape or size of their body. For instance, an individual may be emaciated, yet see an overweight body in the mirror. Females account for more than 90 percent of all cases. Anorexia nervosa is a potentially life-threatening disorder, since those who experience it are in jeopardy of literally starving themselves to death. They may also die from suicide or from starvation complications such as electrolyte imbalance. Tragically, the long-term mortality rate among persons with the most severe cases of anorexia (i.e., those who are hospitalized at some point) is over 10 percent. Treatment for anorexia nervosa can involve medication, psychotherapy, or both. Psychotherapy can be essential, given the "therapeutic relationship" in which a caring professional helps monitor and work against starvation. Unfortunately, to date, this disorder has proven to be particularly difficult to treat effectively. Many who suffer from anorexia find themselves going from treatment to treatment without recovering their ability to function well on a daily basis. This is one example of a mental disorder that cries out for innovative treatments to be developed and tested.

Substance Use Disorders

There is a good deal of discussion among third-party payers as to whether substance abuse disorders should be covered with other mental illnesses such as depression or schizophrenia. Is substance abuse truly a mental disorder, or is it simply a chosen behavior—such as smoking (which also can be argued both ways)? Arguments can be made on both sides of this debate, but from the public policy perspective there is a more basic point to be made. Regardless of how responsible or irresponsible those struggling with substance use disorders may or may not have been at one point, it is clear that once addicted they need help. It is also obvious that to not provide help is to leave such a person in a state that is dangerous for self and costly for society. So from both an ethical and a pragmatic point of view, it makes good sense to offer effective substance abuse treatment along with other mental health services.

Substance abuse frequently co-occurs with serious mental illness, meaning that many who struggle with addictions also meet the criteria for

a mental disorder and vice versa. These are sometimes referred to as "dual diagnosis" patients. Treatment is much more difficult if only part of a person's medical needs are covered by insurers. So for instance, currently a person struggling with both major depression and alcohol addiction may find that treatment is covered for depression but that any services for alcoholism must be paid for out of pocket. As a result, the depression is treated but not the accompanying addiction, making it likely that the patient will eventually relapse on both counts. Further, even when two relevant treatment programs are available, one for substance abuse and one for serious mental illness, they are often not coordinated or compatible. This means that the patient may receive care from two sources that is significantly mismatched (e.g., one calling for more independent living and the other calling for more group accountability). What is needed? A unified, transformed system of care consisting of evidence-based home and community services.

The substance that leads to addiction can be legal (e.g., alcohol), illegal (e.g., cocaine), or a prescription medication (e.g., painkillers). Once the person is addicted, a strong physiological component driving usage makes it almost impossible for the user to stop on his or her own. Epidemiological research shows that approximately 22.2 million people aged twelve and above are struggling with substance use disorders (SAMHSA 2006). One consequence of this is, of course, the illegal drug trade, which is driven by strong market demand and seems impervious to interdiction. Thus a side benefit to offering effective treatment for substance abuse is reduction in demand for illegal drugs.

Several treatment approaches are available for substance use disorders, including cognitive-behavioral therapy that deals with the automatic thoughts and underlying beliefs that drive addictive behavior. Different people respond well to different treatment programs, so it is important to have more than one type available if possible. At the same time, since many programs have not been demonstrated to be effective, it is easy to waste a good deal of time and money in search of help. The best-known treatment program is probably still the most effective for the largest numbers of those seeking help. Alcoholics Anonymous (with its related spinoffs such as Narcotics Anonymous) has been in existence since 1935 (Comer 2004). There are chapters in every major city, many hosted or run by churches or community organizations such as the Salvation Army. Research shows that faith-based organizations can be particularly effective with substance abuse treatment (Swora 2001, cited in Comer 2004).

However, the success rate of any treatment for substance use disorders is highly variable, with relapse as a frequent outcome. Here too there is a need for innovative treatment programs to be developed and tested. Furthermore, effective follow-up care in the home community is sorely lacking, which makes deterioration and relapse all the more likely.

Psychiatric Facility Care

Having glimpsed something of how difficult it is to manage a serious mental illness, the reader is now ready to appreciate how critical it is that effective and timely treatment be made available for all in need. This is nowhere more pressing than in psychiatric hospitals/facilities. Many of those confined there are committed against their will on the basis of judicial review that has found them to be mentally ill and a threat to self or others. This is one of the few cases in which a law-abiding citizen's basic right to freedom (to not be confined against one's will) is overruled by society. Once committed, an individual is completely at the mercy of those who staff the hospital. In some cases, the staff consists of warm-hearted, dedicated, and talented professionals who serve their patients tirelessly and make sure that time in the hospital is well spent. But in too many other cases, the committed patient is left in the care of those more focused on avoiding difficulties than treating patients. Such providers may be tempted to overmedicate psychiatric patients and turn on the TV to avoid the hassle of trying to improve life for someone with serious mental illness.

Unannounced Visits

I had only been commissioner of Virginia's Department of Mental Health, Mental Retardation, and Substance Abuse Services for about a year, but I had already become known as Commissioner "System Reform" Kelly, since my main message was that the mental health system was broken and in need of dramatic reforms. This was a welcome message to many of those receiving care, to many providers who knew we could do better, and to some of the department's administrators. But to many others, especially those comfortable with a status quo that provides good salary and benefits and doesn't ask too much in return, my message was anathema. For that reason, it was impossible to get an unbiased assessment of the quality of care in Virginia's psychiatric hospitals—called psychiatric "facilities." As

with my first visit to the Lynchburg Training Center, whenever I officially planned and visited a facility I saw a carefully orchestrated show designed to say that all was well, and I knew it.

Virginia has sixteen psychiatric facilities originally built to house over fifteen thousand patients. Today there are fewer than three thousand hospitalized patients in Virginia, yet not one of the facilities has been closed. Why? Because each one is protected by a "patron saint" —its state legislator, who sees the facility as a critical source of jobs and votes in his or her district. Never mind that it takes more than $500 million a year to fund the facilities, or that those monies could be better spent on community services designed to help persons with serious mental illness succeed in their home community. My promotion, throughout my tenure, of the need to close one or more of Virginia's facilities and reinvest those funds in community mental health care did not endear me to the facility directors or their patron saints.[10]

Not surprisingly, I had found that unannounced visits were the only way to see what was really going on in the department's many psychiatric facilities. So at one point I found myself on the road, driving alone (to avoid tip-off) to drop in unannounced on a facility a few hours away from the Mental Health Department's central office in Richmond. I arrived late morning, went straight to the stunned director's office, declined his polite invitation to organize a staff meeting, and asked for an escort to get me onto the locked wards immediately—before news of my arrival spread. Sure enough, as I walked the halls of the locked units, this is what I found:

- The central assembly room was filled with staff and patients lounging together—sitting on couches or standing—and watching daytime TV.
- There was an overall "lazy" atmosphere—both staff and patients moving slowly and seemingly with little to do.
- Several patients were left alone in their rooms down the hall—unattended and seemingly overmedicated.
- A program of activities was posted on the wall, showing hour by hour what each patient was supposed to be doing (group therapy, art therapy, social skills training, etc.). But when I asked where these activities were taking place I found most had been cancelled for various reasons (staff not in that day, difficulties with patients, etc.).

Once again my suspicion had been confirmed. During a previous, official visit to this facility my staff and I had been proudly shown the list of program activities and had even (with patients' permission) sat in briefly on a group therapy session. Now I discovered to my dismay that programming was often the exception, not the rule—despite the daily posting of planned activities. The facility director "moved on" shortly thereafter, and the department's staff and I searched far and wide until we found a new person who specialized in hospital "turnarounds" to head up the facility. This got the attention of leadership throughout the Department of Mental Health and led to a new openness to innovation. Shortly thereafter, several of the facility directors collaborated to implement an innovative and newly developed concept—the "treatment mall."

A mental health treatment mall is designed to provide a selection of needed services and supports each day in a central place so that patients can go easily from area to area to find the treatment they need. This might involve training in social skills or hygiene, help in picking out new clothes and managing one's wardrobe, work with an anger management group, individual psychotherapy, or vocational training. Each morning the patients come to the treatment mall and are helped to select whatever is most appropriate for them, which varies depending on each person's progress. So for instance, a patient might end up working on social skills and hygiene and clothing, then on anger management, and then on vocational training before being discharged. The various programs are offered by staff trained in that area, with sensitivity to individualizing the training to meet each person's need. After the allotted block of time has been used, the patients move on to their next "appointment." Although this may require more staffing or new skills compared with custodial care, it is not inordinately expensive, since most staff can be easily retrained in these areas. The goal is for hospitalization to be marked by intensive and effective treatment, which also makes it more likely that the patient may be successfully discharged after a shorter-than-average stay. Thankfully, the average length of stay in psychiatric hospitals is decreasing and is now typically measured in days or weeks rather than months or years.

Treatment malls are not the solution to every facility problem, but they go a long way toward filling the void of use of time that is too often met with overmedication and TV. Nobody is left behind in his or her room, and nobody wastes the day away with television. Instead, everybody who is physically and emotionally capable joins in the treatment

mall experience each day. In this way, daily programming is not just a theoretical list of activities on the wall. It is built into the facility's daily structure—both physical and programmatic. It should be noted that for hospitalization to succeed, planning for rehabilitation and recovery in the home community must begin long before discharge. There should be a smooth transition from brief hospitalization to intensive community care, which requires careful preparation and ongoing liaison with community services.

Persons with serious mental illness who are hospitalized against their will have the right to receive effective treatment, not just custodial care while medications are stabilizing, and to be returned to their home communities for effective follow-up care as soon as possible. Anything less is unethical, risky for the patient, unnecessarily burdensome on their family, and costly for the community that is deprived of a functioning citizen. It is time to transform America's broken system of mental health care.

Less Severe Mental Health Needs and Community Resources

Before proceeding, it is necessary to take a look at how less severe mental health needs should be met. If they are not to be included in the same category as serious mental illness, must they then be ignored altogether? Although the needs of individuals with serious mental illness should be met on a priority basis, those who suffer less severe needs must by no means be ignored. A compassionate society must assist all of those in need and should provide timely resources that can prevent less severe mental health problems from spiraling out of control. Without social support, for example, a person suffering bereavement is all the more vulnerable for a major depressive episode. Put another way, if a person's support network is not adequate, that could constitute the social component of the biopsychosocial model and thus trigger mental illness. Likewise, a person dealing with persistent sad feelings needs someone to offer support and a listening ear. Such imperatives are best understood as "mental health needs," and they can often be addressed by family, friends, church/synagogue/mosque counselors, school counselors, employee assistance personnel, or social service nonprofit organizations. It would be a mistake for public and private insurers to conclude that all mental health matters must be addressed with the same urgency as serious mental illness, thereby reducing

the prioritization of services for those with the greatest needs. Indigenous community resources can effectively address many mental health needs by offering the sensitive and personal care and support that they alone can provide. This allows insurers to focus all the more on addressing serious mental illness with well-funded, effective, innovative, community-based treatments.[11]

Community Resources

Needless to say, the most important community resource for dealing with mental health problems is one's own family and friends. A timely word of encouragement, practical help with a problem, and the support of loved ones who believe in us and walk with us through hard times are priceless resources for dealing with the storm and stress of life, and this support can help prevent the development of more serious mental health problems. In addition, other resources within the community can play a valuable role in preventing and addressing mental health needs.

- *Employers*. Large organizations often offer their workers Employee Assistance Programs (EAPs) that provide resources for managing stress, anxiety, anger, and grief. The EAP may provide gym privileges, yoga sessions, support groups, short-term counseling, or other sources of help. Access to these resources, for example, could help prevent an employee who is feeling overwhelmed with personal and professional stressors from experiencing a debilitating panic attack. Or they might help an employee work through the grief of a personal loss and thus avoid experiencing a major depression. Since serious mental illness is costly to both the employee and the employer, it is not only compassionate but also good fiscal policy for companies to provide effective EAPs.
- *Schools*. Schools can provide timely evaluation and appropriate support for children whose conduct is problematic, even while maintaining the importance of personal responsibility and parental involvement. Such support could be as simple as changing a child's classes to reduce academic or social frustration. Or it might involve working with the child's parents to explore opportunities for tutoring, mentoring, or sports activities. With parental approval, the child might also be referred to the school psychologist to provide counseling and guidance for dealing with stress, or perhaps to have

the child tested for attention deficit disorder or other emotional needs. It is important to deal with such needs as soon as possible, given that today's frustrated student could become tomorrow's dropout headed for even greater problems such as depression, substance abuse, or gang involvement.

- *Religious Institutions*. Churches, synagogues, and mosques can play a critical role in ministering to members who are struggling with mental health needs. Family members who are grieving over the loss of a loved one, older persons who are experiencing isolation and sadness, and couples having marital difficulties can all benefit from the support of their faith community. Many churches, for example, offer support groups and personal/pastoral counseling for those in need as well as twelve-step programs, which have proven to be very effective for many in dealing with addictions. Such support provides important resources for men and women of faith who are experiencing mental health needs and can help avert the development of major depression or other serious mental illnesses.[12]
- *Nonprofit Community Organizations*. Nonprofits such as the Boy Scouts and Girl Scouts, sports clubs, community centers, and other community-based organizations often play an important role in the lives of those who are faced with mental health needs. For instance, in scouting a boy or girl from a dysfunctional family may find the acceptance, camaraderie, and mentoring that is lacking at home. This support and sense of belonging can help protect youths from low self-esteem, depression, and self-destructive behaviors. It can also keep them from looking to gangs as a sort of surrogate family.

In these and other ways, resources within communities can help address the mental health needs of their residents and prevent them from spiraling into serious mental illness. Although individuals whose community offers few of these resources are at greater risk than those who have strong community support, the family or community must not be blamed for the emergence of serious mental illness. The biopsychosocial model makes it clear that mental illness is the result of a variety of factors—a "perfect storm" of contributing vulnerabilities and stressors. Thus it is far more appropriate to focus on providing effective resources for those who are suffering from mental health needs than it is to waste time and energy on pointing the finger of blame.

Transformation: The Road Map

The chapters that follow provide a road map for the transformation of America's mental health system of care. As noted earlier, five critical and interrelated topic areas are covered, since the new system of care must be

- *Results oriented:* Using results-oriented outcome measures and "evidence-based practices," which have been proven effective by empirical studies, so as to improve quality of care and system accountability.
- *Innovative:* Opening the monopolistic state mental health system to competition and innovation so as to improve effectiveness and increase treatment choices.
- *Adequately funded:* Implementing "parity" so that mental health treatment coverage matches physical health coverage.
- *Consumer friendly:* Empowering persons with serious mental illness—giving them and their families a real voice in policy development and service evaluation.
- *Committed to change:* Overcoming resistance to change from forces wed to the status quo.

A mental health system of care that is results oriented, innovative, consumer friendly, well funded, and committed to change cannot avoid transformation. These five key areas constitute a whole that, if implemented, will bring the service system into a time of dramatic and much-needed reform.

It is not surprising that various parties would like to move ahead in some but not all of these areas. Many mental health advocates support full parity between mental health and physical health coverage. But if this is accomplished without putting new evidence-based services in place, it will serve only to expand the status quo of ineffective care. Many insurers are calling for greater innovation and outcome-oriented accountability from providers but are not willing to pay the price for reform, including parity coverage and outcome data administrative costs. Many consumers are asking to be at the table for policy and treatment decisions, yet are hesitant to embrace outcome measures for fear these could be used to terminate treatment prematurely. For mental health reform to occur, it is clear that all parties must be willing to engage in the give-and-take of public discourse and negotiation. If one or more of these five key areas is not

addressed because of resistance, there can be no comprehensive, enduring system transformation. Some brief changes may occur like a flash in the pan, as has happened many times on both state and federal levels. But genuine and lasting transformation requires sustained forward movement in all five areas, as will be shown in the following chapters.