

Testimony of Elizabeth Faust
North Dakota Legislative Management
Human Services Committee
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Madam Chair and committee members, my name is Elizabeth Faust. I am the Senior Medical Director for Behavioral Health for Blue Cross Blue Shield North Dakota (BCBSND). I appreciate the opportunity to speak with you today. As part of your study of behavioral health needs in North Dakota, I have been asked to talk with you about the definition of “behavioral health”. By way of background, I have practiced psychiatry in the Fargo-Moorhead area for 25 years and have worked in public, private and VA settings. I transitioned to the payer side of health care in October 2014.

We are going to talk about elephants and starfish. I am not trivializing the subject matter, but want to provide you with some simple ways to remember what is meaningful and relevant about this.

I. Elephants:

Everyone knows the parable of the blind men asked to touch different parts of an elephant and name the object. One man touches the leg and says it’s a pillar, another touches the tail and says it’s a rope, another touches the trunk and says it’s a tree branch; and so on.

I often wonder what those who don’t work in Behavioral Health must think: we talk about mental health, behavioral health, psychiatry, substance abuse, addiction, nervous disorders,

chemical dependency, alcoholism, “issues” and my personal favorite--“nervous breakdown”. It is no wonder that people sometimes question the legitimacy of this area of healthcare, when we can’t even figure out what to call it. Is it a pillar? A rope? A tree branch? No, it’s the sum of many parts, just like the elephant. We’ll talk more about that in a bit.

This is an expensive elephant I am describing to you. Here is some of what we know about the cost of different parts of this behavioral health elephant:

*The economic burden of depression in the U.S. (2000) was \$83 billion in direct care, mortality and workplace costs. That includes the cost of what we treat, the cost of what we don’t treat and societal impact.

*The economic burden of schizophrenia in the U.S. (2002) was \$62.7 billion in direct care, morbidity and mortality, and workplace costs.

*The economic burden of substance abuse in the U.S. (2002) was \$417 billion in direct care, mortality, crime, and workplace costs.

That is \$562.7 billion worth of elephant. We are truly beyond questioning whether mental health and substance use disorders exist. These are not matters of moral weakness or character flaw. Brain disorders confuse the public, because their symptoms are behaviors and emotions that don’t make sense. We want to believe we are rational, logical and in charge of our choices. We are baffled when people don’t behave in their own best interest and we believe it must just be bad judgment. These are real diseases and serious public health problems, affecting approximately 20% of Americans. Mental health and substance use disorders often occur together and amplify morbidity and mortality. The evidence base for effectiveness of interventions to treat these disorders is sizable. It is as good or better than the evidence for many of our standard treatments for cancers and heart disease, yet no standard system is in place to ensure that people with mental health and substance use disorders receive

effective medical and psychosocial interventions. You will hear more about those gaps in our care delivery system from other speakers today.

II. History of Treatment Systems:

Some history helps us understand why all of this seems so fragmented and confusing. From the beginning, substance use disorder treatment systems and mental health treatment systems were organized and funded separately at the federal, state and local levels. This separation reflects the way we used to view these problems as completely unrelated to one another and to physical health. The separation of funding streams and public agencies has been preserved right down to the level of patient care and has had negative impact on our ability to treat successfully.

A. Evolution of Substance Use Disorder Treatment:

Addiction treatment actually got a head start with the biological model. It didn't start with the scientific and medical community. The Alcoholics Anonymous tradition began in 1935 and defined alcoholism as a disease. But at that time, addiction wasn't considered a disease by the medical community and you could not get hospitalized for withdrawal or complications related to alcohol. AA gradually gained traction because it worked for many people and in 1956 the American Medical Association officially recognized alcoholism as a disease. Hospitals and treatment programs began to develop specific techniques for dealing with addiction, evolving toward treatment services and programs as we know them today. The American Society of Addiction Medicine (ASAM) is a symbol of mainstream medicine embracing substance use disorders as diseases.

B. Evolution of Mental Health Treatment:

Mental health treatment developed along completely separate lines. As AA was just beginning, mentally ill patients were being cared for in state hospitals run by psychiatrists. There were no psychiatric medications as we know them, and psychoanalysis was the dominant theoretical model through the 1940's and 50's.

Mental illness was believed to be caused by environmental and developmental factors; hence the "schizophrenogenic mother" and "refrigerator parents" believed to cause autism.

In the 1960's, antidepressants and lithium came into use and psychiatry broadened its scope to include social and biological treatments of mental illness instead of simply containment.

The 1970's saw great advances in brain research and wider use of effective medications for mental illnesses. Thousands of patients were optimistically deinstitutionalized with minimal community supports. We thought meds were going to cure people. There were mental health funding cuts in the Nixon era coupled with this flood of deinstitutionalized people with no community survival skills, which triggered rising homelessness. At the same time in parallel, there was expanded acceptance and availability of illicit drugs in American culture.

By the 1980's, community mental health centers were flooded with deinstitutionalized patients and young chronic adults who would in the past have gone to institutions. This vulnerable population fell prey to the wide availability of alcohol and drugs, and rates of "dual diagnosis" skyrocketed. It turns out that if you are genetically susceptible to

mental illness, you are also at high risk for being susceptible to substance use disorders and vice versa.

C. Summary: Where did this problem emerge from?

As best we know, mental health and substance use disorders have existed as long as we have. What we are seeing is simply the “perfect storm” of deinstitutionalization, ready availability of abusable substances and unraveling of traditional social supports and fabric.

Not only have the funding and administration of mental health and substance abuse treatment systems evolved very separately from each other, and from mainstream medicine, they have often had competing philosophies concerning the use of medications, the role of self-help supports and the role of various health professionals. Each system has tended to identify the disease it treats as “primary” and symptoms of the other as “secondary” and thus to focus treatment on only one disease. Dually diagnosed patients are often bounced from one system to the other, responding poorly to treatment because their other conditions are not recognized or managed.

III. The 21st Century:

All of the blind men are starting to work together to figure out that the pillar, the rope and the branch are actually parts of a larger whole, the elephant. Mental illness and substance use disorders are understood to be inter-related brain-based diseases we now think of under the umbrella of Behavioral Health conditions. They are increasingly accepted into the mainstream of medical care. The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and the Patient Protection and Affordable Care Act (ACA) of 2010 aim to improve the delivery of and

access to treatments for mental health and substance use disorders. The federal, state and local systems are now moving gradually toward integrated funding streams, research and administration of treatment for behavioral health conditions into blended systems that acknowledge the close relationships and overlap between these conditions and their impact on other medical conditions.

We still have quite a ways to go, however. Evidence-based medication treatment and psychosocial interventions exist but are not available as part of routine clinical care for mental health and substance use disorders. The gap between what is known and what is commonly practiced can be attributed to problems of access, training, insurance coverage, quality measurement, and fragmentation of care, including the separation of primary and specialty care and poor coordination of care.

IV. Starfish:

I am going to turn now to the Starfish Story.

One day a man was walking along the beach when he noticed a boy picking something up and gently throwing it into the ocean. Approaching the boy, he asked, "What are you doing?" The youth replied, "Throwing starfish back into the ocean. The surf is up and the tide is going out. If I don't throw them back, they'll die." "Son", the man said, "don't you realize there are miles and miles of beach and hundreds of starfish? You can't make a difference!" After listening politely, the boy bent down, picked up another starfish, and threw it back into the surf. Then, smiling at the man, he said "I made a difference for that one."

The current quality of care for both physical and mental health and substance use disorders is less than ideal. National studies indicate that among patients with a wide array of physical and mental disorders, somewhere between 30-55% receive recommended care. Think of our population as that whole beach full of starfish to take care of. We spend more money than any other developed nation and are 38th in health outcomes. The answer is not going to be

spending more resource. The answer is going to be spending resource more wisely. We have to take steps to ensure that evidence-based, high-quality care is provided consistently to all. We cannot ignore behavioral health conditions, because that makes care for other conditions more expensive and less effective. Even for those still skeptical about whether behavioral health problems are real disease, this is a \$562.7 billion dollar elephant we cannot afford to ignore.

At the same time, we have to honor that every starfish, every citizen, is special and unique. Every patient with cancer needs an individualized treatment plan according to his or her specific condition and needs. Every patient with behavioral health conditions needs the same thing. The use of medications, psychosocial interventions such as therapy or community supports, the dose and duration of services, the setting of service delivery, etc., all need to be tailored to each individual. Some patients we cure, and for some we manage chronic conditions.

We have hard choices ahead of us in holding health care accountable to refining care and reducing waste. That frustrates people. Sometimes it makes us look for simple answers. In behavioral health, I see that play out as: “Why can’t you just give them a pill?”, or “Why do they keep going back to treatment? Don’t they want to get well?”.

There is a tension between managing the needs of the larger population and the needs of the individual. The starfish story helps me remember that we have to balance wisely spreading

resource to support the needs of all alongside recognizing the unique needs of each individual consumer.

V. Conclusion:

In summary, what I hope you retain is that Behavioral Health is defined as the sum of multiple parts, like the elephant. Mental health and substance use disorders are like the tail and trunk. We no longer look at them as completely separate objects that stand alone, but as integral parts of the whole human disease and wellness.

I also hope you will remember that there is a tension between the needs of the many and the needs of the individual. We must steward resources more wisely and make hard choices, but we cannot lose sight of the fact that every starfish matters and every consumer has individual needs when they require health care, whether it's for cancer or behavioral health.