Three Legged Stools

Last fall I wrote about mental health parity legislation and the positive impact it could have on our behavioral health system. It was legislated to officially begin this October and go into action in January. Among its many benefits would be equal mental health and substance abuse treatment coverage for covered populations comparable to primary healthcare coverage within insurance companies. Well, the implementation has been delayed because of the national healthcare initiative currently underway in Congress. It is expected that parity will fall into the overall package when/if it passes. While this can be beneficial, delays are generally not in the interests of those in need of the types of care we deliver. One of the ultimate goals of substance disorder treatment is the beautifully stated phrase “treatment upon demand” as it is known that the addict is not going to remain in the action phase very long. In general, waiting lists kill the desire to get help and the next time the addicted person shows up he or she may be divorced, in jail, unemployed and homeless, or maybe deceased. It goes without saying that our grossly underfunded system also falls short when it comes to those who need the waiver for intellectual disabilities and the same goes for those with mental health or co-occurring disorders. Many of them will experience the same fate as their brothers and sisters with substance disorders if there isn’t a commitment to provide treatment upon demand. It is time to take the next step in that direction.

When I spoke of the 3 legged stool in the last Newsletter, the Advocacy and Public Policy leg wobbled like a newborn fawn. With the exceptions of the amazing work of VOCAL and PARA, on the local level this leg is as weak and vulnerable as the monitoring and oversight leg. Neither is as strong as the treatment leg, but even that leg cannot provide the service capacity needed by our community. We were forced at Region Ten to get honest about our limitations in October when I sent out a letter to our many community partners letting them know we were restricting services to only our priority populations which includes those with SMI(Serious Mental Illness). The outcry was swift and sharp with calls to me about the great need for our services. It was followed up with meetings by many of the agencies that work with similar populations that we serve. We came together to figure a way out of this dilemma. After several meetings, it is clear we all want to solve the dilemma and avoid the finger pointing that often derails initiatives.

Funding for our system is another 3 legged stool that involves local, state and federal dollars. All three legs have been wobbling since 2007 and will do so for at least the next 2 to 3 years. And brother when they wobble, we all shake and rattle. Funding is reduced or dries up, services are cut and the system cries out in pain. How do we, what can we, when can we do something to get out of this? Waiting for the pain to ease in 3 years won’t do, so we need to address it today and work on it locally. This leg may appear to be the weakest but it may hold the key to getting our system moving again for the advocacy leg may force us to do a better job of fixing the chaotic treatment leg. Our workgroup is already talking about having a forum this winter where we invite local legislators in the room to hear why we/they can’t wait. We have to convince them that the community can’t wait as well, and that they must decide, with no time outs left in the game, where to target their appropriations. The community at large must be better informed as well and invited to participate. We have a lot of work to do prior to that forum as our agencies need to figure out who’s who when it comes to appropriately serving the
diverse populations needing our care. For example, if one provider specializes in care to certain populations of women, then perhaps it’s time to determine how much unmet need there is there and target system resources in their direction. The same goes for others with moderate mental health needs. They are not the priority populations of Region Ten but there is likely a provider or two who could become the primary agencies to serve them. Keeping it simple, some agencies would grow through merging with others of similar mission while a few might not get funded and fold. The dollars currently in the system can’t make those decisions. Neither can the legislators responsibly decide who gets what as they don’t have our knowledge and experience about the various issues people bring to our doors. That will be the work of our workgroup with input from the community stakeholders. We must decide how to take the wobble out of this leg. Reducing the wobble there will help stabilize the other two. We may need more dollars, but first we need more of a system that’s logical, ordered and comprehensive. We don’t have that today but we must have it by tomorrow. It is good that the workgroup is finishing up a survey of needs and will do a point in time survey in January that will give us greater information about the system. Our next step will then be to dialogue how to get from needs to deeds. That will be the next step and will decide our fate. Most communities don’t get that far as doubt; fear and NIMBY usually win the vote. I think we can win in this community. There is a willingness to change the story here and a sense that our season to rise as a locality like few others is upon us. In my view, we need a local system of care with Region Ten playing a key role as the safety net for those most in need of our type of care. We also need private providers who can work alongside us in a strong partnership with communication through data, information sharing and community investment as our common goals. Is it too much to ask for a strong local system of care that is bought into by all, simple to understand and available? It may be the only way to stop the wobbling.