A Public Policymaker's Response: Weisleder and Meyer on Legislator Decision-Making

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J Am Acad Psychiatry Law 36:10–12, 2008

Mental health care advocates, like most public policy advocates, love to muster clinical evidence. With utmost rationality, we demonstrate that mental illness affects 1 in 4 American adults and 1 in 10 children in any given year. In nearly six percent of all Americans, mental illness will be serious. We routinely assure the public and policymakers that treatment works. Yet Americans continue to pay close to $600 billion annually for the costs of untreated mental illness. Add to that the considerable cost of extraordinarily expensive emergency medical care and nursing home care in the absence of appropriate treatment. So why isn't there more mainstream outrage and demand for changes in public policy?

Part of the answer, of course, is the power of stigma. In countless ways, popular culture stereotypes and denigrates mental illness to a degree no longer tolerated with respect to other conditions of disability or difference. In addition, American politics, public policy, and public opinion tend to have a short-term focus on symptoms rather than a longer term investment in treating underlying causes. This is especially true of our failure to engage meaningfully in systemic health care reform. Mental health care reform, of course, is a distant echo of even that muted debate.

The rest of the answer may be just about us as mental health care advocates. We fight and sometimes win legal challenges but fail to see that changing the law in terms of personal rights does not mean changing the world in terms of public obligation or investment. We also tend to celebrate small victories because experience teaches us the therapeutic value of low expectations. Unfortunately, this often means we aim too low or settle for too little, even when we might do better.

For example, despite the final outcome, 2007 was a banner year for advancing mental health parity at the federal level. Yet, with early sign-on from virtually all the national mental health care advocates, we either did not read the fine print in the federal legislation or were simply so eager for some victory that we actually considered making a Faustian bargain. Rather than a new national floor that would protect stronger state parity laws, advocates were ready to settle for a national ceiling and federal preemption. As usual, something was better than nothing. Yet, when told not to rock the boat, we made waves instead and got the best possible bill out of the U. S. Senate on unanimous consent.

The pervasiveness of the problem of ineffective representation led me to develop a training program that I call *Why Bad Government Happens to Good People*. What we get, or do not get, from government has everything to do with how we approach the institutional, political, and personal processes involved. "[P]eople who are trying to advocate change are like surfers waiting for the big wave. You get out there, you have to be ready to go for the big wave. If you're not ready to paddle when the big wave comes along, you're not going to ride it in" (Ref. 1, p 165). As surfers, we need experience, the right equipment, the ability to tell the small wave from the big one, and the fortitude to wait for it when it means letting a lot

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of other waves go by or even sometimes missing it. We cannot be afraid to get in the water and we have to keep our balance while riding the wave as far as it takes us toward the shore. One difference, of course, is that effective policy surfers also have to know how to make waves.

Policy waves may come unpredictably when there is a perceived crisis or other external urgency. In this respect, the media are our friends, and we really need to spend much more time communicating about mental health concerns to those who cue the public and policymakers as to what matters. Other policy waves are quite predictable, as when there is a change in leadership or the beginning of a new legislative session. National election years are one of those big, predictable policy waves.

In the words of Angela Kimball, NAMI Director of State Policy, "The 2008 Presidential election may be a year away, but there has never been a better time than now for Americans to be heard by our nation's next leader. And there has never been a more opportune time to raise issues of mental health care" (Ref. 2, p 4). Add to that all the elections for Congress, governors, and state legislatures, and it is hard not to notice that the surf's up. Campaigns and elections are crash courses for elected officials. If we do not ask questions and provide information about mental health care, those we elect will never have the policy answers we advocate or feel the right political obligation to us. Worse still, if we are unprepared, unfocused, unmessaged, disconnected, uncommunicative, and less than insistent, the wave may pass us by.

Whether speaking to the public, media, or policymakers, we also need to be more aware of how the brain processes political information. As Emory University clinical, personality, and political psychologist Dr. Drew Westen writes, "The political brain is an emotional brain. It is not a dispassionate calculating machine, objectively searching for the right facts, and policies to make a reasoned decision" (Ref. 3, p xv). Yet, in trying to make the case for comprehensive mental health care reform, we advocates continue to offer all the right facts and all the reasoned arguments, only to come up short in the competition for the political resonance that drives public opinion and official policy. Reason and logic alone seldom win out in public life any more often than in our own daily lives. Words, images, emotions, personalities, and transactional power drive public policy debate.

Thus, when Weisleder[4] recently examined how state legislators as deciders actually decided one significant issue of mental health care policy, he was "surprised and not happily." It was evident that neither science nor clinical practice was a "significant consideration." In response to Weisleder and to Meyer,[5] I must emphasize that lawmakers, and this includes executive and judicial authorities, are less policymakers than they are policy diagnosticians and policy deciders. In other words, they make imperfect choices among imperfect options based on imperfect information under imperfect circumstances. Sometimes they fit solutions to problems; other times they fit problems to "solutions"; and always they do so in a mostly *ad hoc* and short-term way.

What does all of this mean for mental health care advocates? Clearly, we need to talk less about problems (illness) and more about opportunities (wellness). Policy-deciders want to "fix" more than they want to treat, while the public has an even more limited policy focus and a much shorter attention span. We need to choose carefully the face we put on mental illness. However important, putting issues of juvenile detention, adult incarceration, policing, and interdiction up front only tends to compound stigma, convey social marginality, and touch more on fear than on compassion. Similarly, even the most compelling clinical arguments can all too easily get lost in professionalese or trigger the popular image of never-ending psychoanalysis.

Changing public policy is also at least as much about building bridges as it is about building arguments. Surfers usually do not go in the water just once or go out alone. Although there are no permanent friends or permanent enemies in politics, we need to build ongoing relationships. Good policy entrepreneurs are not dilettantes, alarmists, or strangers. Similarly, there is no substitute for building relationships through broader coalitions of immediate or ongoing interest. Coalitions add mass and volume that add up to greater political weight and are harder to ignore. Relationships are also about who knows whom, who talks to whom, and who listens to whom. Sending the right message with the wrong person is worse than sending no message at all.

Relationships are ultimately personal rather than intellectual, institutional, or political. Finding and building connections with what is already there in the hearts, minds, and souls of policymakers really makes a difference. Indeed, wherever there is a strong

mental health advocate in government, I can predict with near certainty that mental illness has somehow been experienced, directly or indirectly, in the life of that person.

Finally, it is all about message. A good message is focused, consistent, emotionally compelling and resonates with what people already feel, believe, and think. Policymakers are still people, and people respond best to the rhetoric of fairness, opportunity, and personal responsibility embedded in our political culture. In this context, we can easily make the case against discrimination as well as the case for personal independence. Similarly, we can use powerful, common assumptions about big government and wasteful government to argue for reinvesting in less expensive and more effective community-based prevention, treatment, and supportive services. Above all, people actually dealing with and in recovery from mental illness have compelling personal stories to tell. Emotional framing goes a long way in moving the media, public, and policymakers.

To put mental health care more into play in the run-up to the 2008 elections, we have to get into the political water, watch for the big waves and make some too. We have to tell our story in ways that create moving mental pictures and emotional responses. We need to simplify and frame our message in ways that resonate with the broadest possible public and offer political cover for those who support us. We must be much more a part of the broader coalition for overall health care reform, lest mental health once again be carved out when federal and policymakers finally come to the table. Above all, we have to show that mental illness is not the face of a stranger. It is the face of our friends and neighbors, our families, and sometimes ourselves.

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