

# Rapprochement and Reform: Overcoming Factionalism in Policy Making for Serious Mental Illness

William R. Smith, M.D., Ph.D., and Dominic A. Sisti, Ph.D.

This article traces the history of factionalism in policy making and advocacy for persons with serious mental illness from deinstitutionalization to the present. The authors draw on deliberative democratic theory to illustrate how factionalist advocacy causes advocates and policy makers to fail in their duties to represent and develop policy in support of people with serious mental illness. The authors discuss how this factionalism has bred distrust and undermined efforts to address the needs of people with serious mental illness. They

propose the formation of a Public Mental Health Policy Commission, guided by principles of deliberative democracy, to overcome factionalism and to improve policy making to meet the needs of people with serious mental illness. The commission must include a diverse array of stakeholders, especially individuals with lived experience of serious mental illness.

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Political factionalism presents a significant challenge in the development of public health and health care policies. For decades, political factionalism has been especially problematic for developing policies to help approximately 5% of the U.S. population who live with serious mental illness, such as psychotic disorders, bipolar disorder type 1, or treatment-resistant depression (1). These individuals face compounded inequities and are recognized to be among the most disadvantaged members of society. They die on average 10–20 years earlier than people in the general population, a mortality gap that has widened over time (2–4). They are at significantly higher risk for suicide (5) and cardiovascular disease (6), and they are more likely to receive inadequate general medical care, worsening these risks (7). Individuals with serious mental illness also experience numerous adverse social determinants of health, including frequent housing instability, high rates of incarceration, and, for individuals with schizophrenia, 80%–90% unemployment (4). Roughly 20% of incarcerated individuals have a serious mental illness, and thus carceral settings have been inappropriately transformed into de facto mental health care facilities (8).

Ongoing efforts to address these inequities have been hampered by ideological and scientific differences. The political history of deinstitutionalization and the long-standing conflicts between competing groups in policy making for people with serious mental illness are well documented (9–15). How these conflicts have created obstacles to funding for and implementation of evidence-based services for people with serious mental illness may be less well

understood. Likewise, there appears to be only limited awareness of potential solutions that have been developed in other areas to aid in the development of evidence-based public policy.

The problems of factionalism are not unique to policy making for addressing serious mental illness. Political theorists have developed accounts of democratic deliberation to address factionalism and have applied them in other policy domains, including in health care priority setting and bioethics policy (16–19). On such theories, in a democratic society, citizens and their representatives must carefully

## HIGHLIGHTS

- Those engaged in policy making for addressing serious mental illness—including government officials, health care professionals, patient self-advocates, and advocacy organizations—have long been divided into competing factions.
- Such factions reinforce misrepresentation of evidence, of other advocates, and of those with lived experience, breeding distrust and impeding policy development.
- Use of general principles, drawn from deliberative democratic theory, can protect against such factionalist tendencies to encourage productive and respectful policy making.
- A Public Mental Health Policy Commission provides an ideal setting to institute these principles and begin to reform this factionalist policy-making environment.

deliberate together to make the laws and policies they will live under (20, 21).

In the context of health policy, representatives most obviously include government officials, but others as well, such as health care professionals, lobbyists, and disease advocates. Clinicians—by dint of their professional obligations—must represent their patients and advocate on their behalf for improved policies (22). Similarly, mental health advocates and advocacy organizations, who aim to influence policy on behalf of particular patient populations, assume special obligations as representatives through their political activity. When these stakeholders do not follow shared rules of deliberation or when deliberative processes are not carefully designed to address power asymmetries, ideological entrenchment is reinforced, resulting in suboptimal policies. This has been the case in policy development for individuals with serious mental illness.

Focusing chiefly on the federal level of policy making, we first describe how factionalism has short-circuited ethically sound policy development for serious mental illness. We then recommend that the Biden administration establish a Public Mental Health Policy Commission (PMHPC) focused squarely on the development of evidence-based policies for people with serious mental illness. Finally, we propose a set of shared rules and procedures based in deliberative democratic theory to ensure the outputs of this commission are evidence based, equitable, and broadly accepted.

## **FACTIONALISM FROM DEINSTITUTIONALIZATION TO EARLY PATIENT SELF-ADVOCACY**

Factionalism is significant in psychiatry, as evidenced by controversies about nosology, divisions between “brain-based” and “mind-based” approaches to diagnosis and treatment, and turf wars among different professional organizations (9, 14, 23–27). But factionalism is particularly prominent in serious mental illness policy making, where conflicts are partially rooted in the promises and failures of deinstitutionalization in the United States.

Deinstitutionalization began with a coalition of former patients, mental health professionals, activists, journalists, and politicians that catalyzed the rapid closure of state psychiatric hospitals beginning around 1955 (15). The coalition was motivated to end the abuses exposed in state hospitals and—with the advent of the first antipsychotic medications—to provide superior treatment in the community. Meanwhile, conservative policy makers saw hospital closure as a way to relieve states of significant costs (28).

By the early 1960s, patient self-advocates found support in the recommendations of the Joint Commission on Mental Illness and Health (JCMIH), which advocated for community treatment, significant reduction in institutionalization, and reforms to mental health hospitals. The JCMIH also expressed concerns about social needs in the community setting and recommended significant funding at various levels of community treatment (29). In so doing, the

commission navigated interprofessional politics and raised concerns that any overreaching claims to authority by the psychiatric profession would undermine public confidence (9). But it did not address mounting concerns about paternalism, rights infringement, and stakeholder involvement from patients and the community; the JCMIH did not formally include patients and advocates in policy making.

Members of the coalition supporting deinstitutionalization were overly optimistic about the effectiveness of outpatient treatment for several reasons. These reasons include, specifically, promising evidence about the efficacy of antipsychotic medications in acute cases (without evidence that, alone, these medications were sufficient for recovery in the community). Many also hoped that the successes of dynamic therapy for patients with milder symptoms could easily be extended to treat patients with serious mental illness (9, 23). Unfortunately, policy makers and advocates of deinstitutionalization ignored JCMIH’s recommendations for reform of inpatient settings as well as the significant financial support necessary for individuals to live in the community—when all housing, social, and nutritional costs had been borne by mental health asylums.

Instead, with the promise of federal funding under the 1963 Community Mental Health Care Act, policy making focused directly on building a system for community treatment (9, 14). Regrettably, long-term funding for community mental health centers never materialized, leaving instead a fragmented and underfunded community mental health system lacking robust social supports. Soon, as the clinical and economic expectations proved overly optimistic, the coalition dissolved; the only contemporary period of general agreement on policies for serious mental illness ended. Politicians would turn to other matters as the psychiatric community’s focus shifted toward populations with less severe illness (9).

Around this time, a schism occurred between established medical institutions and the psychiatric survivors’ and rehabilitation movements. Growing out of the revolutionary ethos of the 1960s, many advocacy groups emphasized a liberatory struggle. They rejected broad involuntary commitment laws and inhumane restraint policies. Some sympathized with the view that mental illness was little more than an oppressive myth (30–32). In contrast, many in “establishment” psychiatry hoped to improve the lives of people with serious mental illness but held paternalistic and stigmatizing beliefs about those with these conditions (11–13, 33–35). Opportunities to address the continued fractured and underfunded community mental health system were overlooked—in part because of infighting reinforced by these ideological gaps.

## **FACTIONALISM AND PREVIOUS MENTAL HEALTH COMMISSIONS**

Despite this schism, a series of government commissions attempted to address the problems in the mental health care

system that became apparent in the wake of deinstitutionalization. New calls for significant reform began in the 1970s, resulting in the Carter Presidential Commission on Mental Health (PCMH), which promulgated a national plan that prioritized serious mental illness (27, 36, 37). Although delayed by changes in presidential administrations and growing fiscal conservatism, several of the PCMH's recommendations for improving social services for those with chronic mental illness were eventually implemented (36).

Nevertheless, the larger system remained underfunded and fragmented. President George W. Bush's New Freedom Commission (NFC) reassessed these concerns and catalyzed institutional psychiatry's partial embrace of recovery-oriented programs that more fully recognized the importance of patient autonomy and shared decision making (38–40). This recognition elevated the recovery movement, helped to partially integrate it into psychiatric services, and partially bridged earlier rifts between establishment psychiatry and the earlier survivors' movement.

Notably, each commission built on its predecessors' recommendations, calling for systemic reform and financial and social support for individuals with serious mental illness. Nonetheless, 20 years after the NFC, the system remains fragmented and underfunded, and individuals with serious mental illness continue to experience several inequities. Critically, however, no previous commission has fully addressed factionalism within the policy-making and advocacy communities.

For instance, the JCMIH's formation was sparked by an understanding that political and sociological problems contributed to the plight of those with mental illness and cautioned psychiatrists against statements of authority where they lacked expertise, warning that this would undermine public trust (29). But the JCMIH was driven by and composed of representatives from major professional organizations, and, perhaps unsurprisingly, its concerns about overreaching professional authority were shaped by concerns about public perception, rather than by concerns for including the voices of those with lived experience (9). Although the later commissions began to include some individuals with lived experience (27), representation of those with lived experience remains modest at best.

Like the JCMIH, the PCMH featured varying competing interest groups. The groups ultimately achieved consensus but only when the commission's chair was given authority to compose the final report rather than collate the diverse and potentially conflicting and confusing preliminary reports (27). The PCMH also featured nonexpert members. But some commentators have suggested that these individuals were not prepared to identify non-evidence-based claims and thus could not differentiate evidence-based policy commitments from antiexpertise and ideological commitments; in turn, commentators claim that those nonscientific commitments held sway over the PCMH (14, 27).

Today, the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) in the Substance Abuse

and Mental Health Services Administration (SAMHSA) is the most notable deliberative body in the U.S. government dedicated to serious mental illness. Established under the 21st Century Cures Act in December 2016, ISMICC reports to Congress about public psychiatry needs and provides input to the National Institute of Mental Health on funding priorities (41, 42). Yet, because the ISMICC is an interdepartmental institution of the executive branch, its roster includes a large proportion of executive branch appointees with expertise from their home departments. The proportion of representatives with lived experience is smaller. This composition may be reasonable given the ISMICC's mission; the ISMICC is not designed to resolve factionalism or to conduct deliberation involving a broad array of stakeholders. The ISMICC is therefore not an ideal venue to address the challenges we raise here.

### **FACTIONALISM IN CONTEMPORARY POLICY MAKING FOR SERIOUS MENTAL ILLNESS**

Given that previous commissions did not address the factionalist problems or clearly establish the deliberative norms required to overcome them, it is unsurprising that deep divisions remain. Points of significant disagreement include the appropriate role of inpatient hospitalization in a comprehensive mental health system, the acceptability of compulsory treatment, and the evidence base for various interventions (8, 43). For instance, some advocates of expanding inpatient treatment have at times declared trauma an “invented illness,” suggested the recovery movement was simply profit-driven pseudoscience, and questioned the epistemic value of lived experience (44, 45). In contrast, opponents of involuntary commitment have created barriers to addressing the national inpatient bed capacity shortage (46). Other advocates have overstated the harms of neuroleptics and electroconvulsive therapy (47–51) by using selective reviews of the literature (52).

Disagreement is to be expected among reasonable people on complex policy matters (16, 20, 53, 54). Obviously, the goal of political deliberation should not be to eliminate disagreement entirely (55, 56). Nonetheless, normative guardrails exist to guide how stakeholders should collectively deliberate when they disagree (16, 20, 53, 54, 57). These ethical constraints discourage discourse that then regresses toward “anything-goes warfare” (58). Unfortunately, as the aforementioned examples indicate, in the serious mental illness policy arena, respectful deliberation has broken down.

Focus on extreme cases might mislead one to presume that all disrespectful political engagement should be attributed to bad actors who are unwilling to reasonably engage. However, factionalism creates an environment of distrust that discourages collaboration even among well-meaning people. Those with extreme views are not the only ones who fail to deliberate together; so too do more moderate stakeholders who feel that they cannot trust political opponents.

For example, the selective use of incomplete evidence is a commonplace example of a violation of deliberative norms that undermines evidence-based policy making. Advocates for involuntary treatment have implicated links between serious mental illness and mass shootings (59, 60) despite evidence to the contrary (61, 62). Similarly, recent presidential candidates proposed mental health reforms with minimal input from researchers and clinicians. The use of incomplete evidence has resulted in platforms focused exclusively on the expansion of community resources (43), ignoring evidence that the United States has a significant shortage of inpatient hospital resources and has bed capacity below recommended targets, which evidence suggests results in shortened hospital stays, failures of stabilization, and exacerbation of suicide risk after hospital discharge among patients with serious mental illness (8). Instituting norms of democratic deliberation will make possible a collaborative trust that is essential in complex policy-making efforts.

### **A NEW DELIBERATIVE BODY FOR SERIOUS MENTAL ILLNESS POLICY MAKING**

The JCMIH, PMHC, and NFC had wide-ranging mandates (29, 38, 63), which may account for why their recommendations were often nonspecific and difficult to implement. In contrast, the PMHPC should focus exclusively on serious mental illness policy reform and directly address the political factionalism that persists among serious mental illness policy makers. A single commission cannot eliminate factionalism that has been entrenched for decades and has impeded serious mental illness policy reform. However, by instituting deliberative democratic norms, it can begin to change the trajectory and encourage further trust and collaboration by changing the norms that incentivize political gamesmanship.

Broadly, democratic deliberation requires participants to justify their favored policies in terms acceptable to all reasonable people who are willing to cooperate—whether or not they agree with the conclusions. By giving reasons for their views and listening to the reasons of others, deliberators extend mutual respect to one another (16, 20, 21, 53, 54). Under the right conditions, this respect builds trust in the decision-making process, its outcomes, and the potential for future reform (64–66). In addition to the basic requirement of reason-giving for democratic deliberation, four additional principles should guide the PMHPC in developing serious mental illness policies: include diverse views on mental health and illness, identify areas of consensus, clarify areas of disagreement, and hold participants accountable regarding evidence and transparency.

#### **Include Diverse Views on Mental Health and Illness**

A long-standing principle of deliberative democracy is that inclusion of a representative array of stakeholders is critical for a fair outcome of deliberation. In the context of serious

mental illness policy development, inclusion ultimately reduces bias and stigma commonly experienced by individuals with serious mental illness. Individuals with lived experience, advocates for persons with serious mental illness, and mental health professionals must therefore all be included.

Each of these groups adds critical knowledge to the deliberation. Failure to engage clinical and policy experts will undermine fidelity to scientific evidence, and failure to engage politicians and the advocacy community will neglect real-life political trade-offs, stoke partisanship, and make implementation unlikely. In turn, failure to include persons with lived experience and their advocates neglects the knowledge that comes from firsthand experience of living with serious mental illness. Moreover, the full range and heterogeneity of experience with serious mental illness must be included because relying only on representatives with less severe conditions or with greater privilege (in virtue of, e.g., socioeconomic status or powerful roles in advocacy organizations) can reinforce biases (67, 68).

Notably, engagement of those with lived experience in serious mental illness policy must be carefully structured to create a productive deliberative environment. Stigma and previous iatrogenic trauma may discourage some individuals from expressing their needs, and severe symptoms may inhibit individuals from fully recognizing their needs. The input of individuals with lived experience must be actively sought out and, when necessary, facilitated. A recent proposal to expand investment of researchers with lived experience (69) would be one means of doing so. But such investment is long term, and addressing the factionalism in serious mental illness policy making should not wait for that investment if it is slow to come; indeed, addressing that factionalism in the context of a new PMHPC might promote such an investment.

#### **Identify Areas of Consensus**

Even if consensus is not the only goal of deliberation (55, 56), limited points of consensus offer a promising way to achieve the goal of building a policy-making community based on mutual respect and on finding mutually acceptable reasons (16, 20). Such a community fosters further dialogue. For serious mental illness policy making, identifying consensus can reduce polarization within the mental health community, reframe policy-making goals, and identify potential allies in policy making. By doing so, consensus can open new avenues of political engagement, counter factionalism and distrust, incentivize cooperation, and discourage unfair portrayal of those with opposing views.

We therefore recommend that the PMHPC first identify areas of general agreement. Examples of potential items of consensus may include the following claims. First, serious mental illness research is severely underfunded. Second, decriminalization of persons with serious mental illness is an immediate need. Third, morbidity and mortality rates among those with serious mental illness are unacceptably high. Fourth, policy-relevant research should be expanded



to broaden the evidence base. Finally, implementation science research should determine how to translate policy recommendations into real action.

Consensus building is an iterative process that builds on its own successes. Previous success at establishing some consensus can foster confidence that further consensus can be found as deliberators' skepticism of each other decreases. In turn, less obvious areas of agreement can be identified as deliberation unfolds about the initial points of agreement.

### Clarify Areas of Disagreement

Mutually respectful disagreement can be productive (55). Such disagreement enables the realization of three goals: prevention of misunderstanding and misinterpretation, promotion of transparency, and highlighting of trade-offs. Together, these goals clarify targets of further deliberation and areas where more evidence is needed. To set benchmarks and ensure progress, we suggest that within 6 months of its formation, the PMHPC establish a goal to identify the most significant items of disagreement that are empirically testable and, in collaboration with funding agencies, request grant proposals for trials to assess these issues within the first year. But not all disagreement is directly testable. Often, disagreements about trade-offs among policy priorities or moral and political values are not. When empirical studies cannot settle disagreements, deliberation to solve policy problems will be, perhaps, more important.

We also note that overemphasizing consensus while failing to clarify disagreement may mask underlying disagreements and, in turn, may prevent further deliberation that might improve policy. For instance, ethicists, physicians, policy makers, advocates, and families almost universally agree that respect for patient autonomy and shared decision making is critical to the ethical practice of medicine; this agreement masks the fact that there is far less agreement on what these values actually require in a particular case.

For example, there is reasonable disagreement among these groups about risk tolerance in support of patient autonomy and what steps providers may take when patients prefer treatment plans that strike providers as unsafe (70). Likewise, many experts argue that different forms of shared decision making are appropriate for different contexts (71), but there seems to be disagreement on which forms apply to what contexts. Hence, the vague general agreement on shared decision making and patient autonomy may leave some stakeholders with the sense that patient autonomy is valued in name, while advocates of moderate parentalism may feel that the sickest patients are being abandoned.

Similar observations might be made for the importance of recovery-oriented or patient-centered care, and other widely endorsed concepts central to debates about serious mental illness policy. Indeed, disagreement exists on what mental illnesses should count as serious. Serious mental illness is a broadly defined and heterogeneous set of conditions, and any operationalization of it will include and exclude some marginal cases. For instance, some patients

who are not considered to have serious mental illness might object to not being given priority for benefits that those with serious mental illness receive. Alternatively, some patients with milder symptoms might object to being deemed to have serious mental illness and reject diagnostic labels they see as applying only to individuals with more serious symptoms. (By way of comparison, a similar problem arose in debates about including individuals who were previously deemed to have Asperger's disorder in a general category autism spectrum disorder in the *DSM-5* [72]). So, the contours of serious mental illness itself must be an object of deliberation to reach agreement, but to reach such an agreement, we must begin from the rough working notion of the concept of serious mental illness that is broadly shared by the community.

### Hold Participants Accountable Regarding Evidence and Transparency

Factionalism encourages stakeholders to overemphasize evidence supporting their own view and to discount evidence that supports their opponents' views. Hence, holding deliberators accountable to accurately present their evidence and acknowledge contrary evidence will be critical. Emphasizing such accountability both reduces misrepresentation of evidence and encourages fair portrayal of other parties' rationales.

To promote awareness of evidence and enable responsible discussion, public interest subgroups may be formed that would proactively educate the community about the types of challenges the PMHPC examines. Social media, podcasting, and videoconferencing may all be used to connect with and educate the public on the policy ideas and to gather real-time, real-world feedback. The PMHPC should thus be framed in the public eye as both a policy incubator and an educational resource.

Examination and deliberation about the quality and state of evidence will also be critical. There is disagreement about how much evidence is needed before implementation and policy making. This sort of disagreement has led to resignations from SAMHSA, intense debates about its leadership, and unilateral, nontransparent changes to what SAMHSA considers adequately evidence-based interventions without open deliberation or stakeholder involvement (73–78). It will be critical to bring disagreements about the state of evidence into transparent deliberation.

### WAYS FORWARD

A new presidential commission, the PMHPC, based in the core principles of democratic deliberation, offers a promising way to reform serious mental illness policy for two reasons. First, it can institutionalize principles to encourage mutual trust, principles that are not otherwise likely to be complied with or enforced in public discussion. When they are designed and applied carefully, institutionally enforced principles of fairness prevent deliberators from ignoring

various existing power structures, such as limited access, unequal power dynamics, lack of information, and competing power dynamics that otherwise unfairly influence deliberation (56, 79).

On the one hand, mistrust in serious mental illness policy may stem in part from the fact that people with lived experience and advocates for persons with serious mental illness have been unfairly excluded from important policy decisions. Therefore, the PMHPC must prioritize patients' and advocates' involvement in policy decision making. On the other hand, researchers and clinicians may also worry that if antiexpertise sentiments prevail, evidence-based policy making might give way to ideology—as some argue has happened in past commissions. Hence, the PMHPC must balance recognition of the expertise of mental health professionals with the firsthand knowledge of those living with serious mental illness.

Second, the PMHPC will call attention to the underappreciated problem of factionalism in health policy making. The commission may serve as a highly visible forum, increasing awareness of the adverse impact of factionalism on serious mental illness policy development and serving as an exemplar of democratic deliberation among patients, advocates, and mental health professionals to develop effective policies. Further steps, such as the use of public interest subgroups and social media suggested above, could augment the public efforts of the PMHPC.

## CONCLUSIONS

Entrenched factionalism has complicated the development and implementation of serious mental illness policies for decades, and democratic deliberation suggests a means to overcome this problem. Such deliberation enables well-informed, respectful compromise; in serious mental illness policy making, it may create the opportunity for true rapprochement and reform. We believe these goals may be accomplished through a new presidential commission on public psychiatry, the PMHPC, rooted in the ideals of democratic deliberation and evidence-based policy development.

## AUTHOR AND ARTICLE INFORMATION

Department of Psychiatry (Smith) and Department of Medical Ethics and Health Policy (Sisti), University of Pennsylvania, Philadelphia. Send correspondence to Dr. Smith (william.smith@penmedicine.upenn.edu).

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