**HADM 201A, Spring 2018 Final Exam**

**Assignment 1: Policies to Deal with Care of the Mentally Ill**

In their article, “*Prescription for mental-health policy*,” Satel and Torrey (2016) undoubtedly capture in detail the inadequacies of the health system in America as far as mental health is concerned. According to their research, the problems surrounding care and treatment of the mentally ill in America are many and equally diverse. However, to address these problems, I believe a lot of focus should be put on three key areas which would effectively lead to an overall and more positive change towards the betterment of the health system as far as improved care and treatment of the mentally ill is concerned.

Arguably, the biggest impediment towards a better system is the limiting and often misinformed legislature effected today. Consequently, the first and most effective way to correct the system would be to implement better legislative policies. According to Satel and Torrey (2016), the current situation has been as a result of the progressive implementation of laws that are regrettably misguided and leading in the wrong direction. In particular, the Medicaid laws effectively preventing mentally ill people between the ages of 22 and 64 from accessing government-sponsored care in Institutions for the treatment of mental diseases (IMD’s) have been detrimental in the fight of a better health care system. These laws were intended to discourage extremely mentally ill patients from being admitted, voluntarily or otherwise, in asylums which were, at the time, in deplorable and inhumane conditions and unable to the offer needed treatment (Johnson, 1992). In return, community-based care facilities were favored to treat mental patients as directed by the Mental Retardation Facilities and the Community Mental Health Centers Construction Act. However, these approaches had serious deficiencies. Critically mentally ill patients were not accorded the same dedicated and thorough treatment in community-based institutions as they were in State hospitals and asylums. Therefore, these patients were discharged without effective treatment and ended up in correction institutions or became homeless and destitute (Wang, Demler & Kessler, 2002).

Therefore, legislation policy changes should be effected to (1) remove the limitation to the kind of institutions that patients can seek treatment and still be legible for government sponsorship. This will ensure that federal monies are geared towards treatment and care of patients regardless of where that treatment is offered. (2) Laws governing deinstitutionalization should be revised as state hospitals and asylums nowadays are better equipped than most community nursing homes and clinics in dealing with severe mental illnesses. Moreover, such laws should require that there are a minimum number of specialized IMD’s in each state depending on the population which is government-sponsored and overseen by professionals in the field of psychology. Similarly, these laws should also legalize and elaborate on the mechanisms needed for benign paternalism which would, in turn, give judges more leeway to recommend treatment instead of jail terms.  (3) Finally, Legislation policies should seek to completely overhaul the existing institutional and funding infrastructure that has increasingly encouraged organizations such as SAMHSA to deviate from their mandated responsibility while still utilizing federal funds. Some have deviated so far from their objectives that they pursue and implement counteractive and opposite agendas that are retrogressive in the fight for better care and treatment of mental patients. New frameworks and institutions that are more dedicated to the cause should be set up and appropriate funding laws implemented to ensure that funds are not misdirected to non-issues,

Apart from legislative policies, policies touching on research and harmonization of ideologies concerning mental health should be formulated. As Satel and Torrey (2016) report, the deceleration in the quality of care for mentally ill patients began in 1977 when dubious notions surrounding the cause and treatment of mental health were accepted as facts. Subsequently, public health models were formulated based on these false premises. As such, there should be an effort to formulate policies that filter out false ideologies in the field by utilizing credible research and professionals. Further, considering there has been very credible research carried out within the past few decades, ideological differences particularly those surrounding the classification, and severity, statistical or otherwise, of mental illnesses should be harmonized. In so doing, it would help inform legislative changes geared towards better care.

Finally, policies directed at screening and employment of suitable and qualified leaders in concerned institutions should be implemented. The current problem has been partly attributed to leaders who have little, if any, knowledge of mental health. Consequently, appointing professionals who are well-versed in psychiatric matters at strategic leadership positions in the pertinent institutions and agencies, will be crucial in ensuring better care of the mentally ill.

**Assignment 2: Quantitative and Qualitative Health Policy Research Method**

The line between qualitative and quantitative research approaches, in this case, is quite thin. While qualitative research is purposive, exploratory, and subjective, quantitative research is random, conclusive, and objective.  Consequently, the case study is a qualitative research despite employing quantitative tools for data analysis. The case study has a specific purpose, the hypothesis is exploratory, and the reasoning is rather inductive-deductive as general trends of improved health care are inferred from particular instances and communities. Further considering that the short answer is the level of disparity, which is a non-quantifiable and abstract concept, a qualitative approach is best suited.

In conducting the study, the first prudent step is to plan by gauging the amount of time and resources available. In doing this, we establish a time frame, amount of people required, and resources, monetary or otherwise. This also helps inform how thorough the study will be and the methods to be used. (2) The second step is to identify the communities and Health Center’s (HC’s) to be included in the study. (3) Involves formulation of study parameters and hypothesis to be investigated with consideration to the resources, methods, and timeframe among others. (4) The fourth step is data collection using the preferred methods. (5) After collection, analysis of data is done for conclusions and recommendations. (6) Finally, the results of the study are presented.

In determining the hypothesis, we first examined the goal of the case study given. The goal is determining whether or not HC’s have an impact on racial disparities. In this case, we framed the hypothesis, which forms the basis for research, in a positive manner as there is already evidence suggesting the same. Consequently, the hypothesis based on the case study was “health centers which incorporate the federally-qualified health center model reduce health disparities across racial or ethnic and socioeconomic subpopulations.” A simple hypothesis is particularly suitable because it gives us the freedom in the number of approaches and methods that can be applied.

In defining the study type and scope of the study, we examined the kind of information, resources, and support, monetary or otherwise, that is available to us and based on the limitation in both time and resources, a limited number of quantitative and qualitative approaches were available to investigate the hypothesis. Further, the scope of the study will have to be limited to a single multicultural community as opposed to different communities in different geographical locations. In the first approach, we use quantitative methods in the study. Survey research and archival research methods of data collection are the two main quantitative methods particularly suited for this study research.

Through a survey research, we gather information directly from a community within the different socioeconomic and ethnic parameters defined in the scope. Due to the time limitations, cross-sectional surveys are preferred whereby information is collected periodically as opposed to the continued collection of information over a given period.  Information is however captured through the use of tools such as questionnaires and digital recordings. At this point, information gathered relates to the accessibility, comprehensiveness, and quality of the health services within their respective jurisdictions and communities. For example, sample questions include how many times in the past year have you visited a health center? What was the issue? How would you say your experience was on a scale of one to ten? Have you visited any other HC’s within or outside your community? if yes, was there a difference in quality? This method is less costly and time conscious as opposed to other data collection methods. As well, the hypothesis is not time-dependent, and the quality of services rarely improves or worsens drastically unless other factors are involved. Therefore, longitudinal surveys are not necessary and this further reduces the cost of the study.

Archival research, on the other hand, involves the study of existing data, and databases to test the hypothesis (Feldman, 2013). We employ archival research as a secondary method of data collection which gives a broader data pool and better accuracy rate. In this case, there already exists a number of studies and research that despite not touching on the specific study question, have data related to the study (Amico, Chilingerian & van Hasselt, 2013). Therefore, we used these studies, analyzed them and extrapolated the data therein to suit the parameters of this particular study.

Still, on data collection, we employed observation as a qualitative method by observing the situation in HC’s in various communities with different racial and socioeconomic compositions (Feldman, 2013). In so doing we collected information not only on the quality but also on the number of people who visit these institutions and their demographic characteristics as far as the parameters of the study are concerned. Other elements we include in the study are the findings based on the information collected. The analysis done afterward converts the data into a quantitative form that can be utilized in presenting the information and drawing conclusions. The final element of the study is the conclusion and recommendations where the hypothesis is either approved or disapproved and relevant recommendations given as per the challenges and findings of the study.

**Assignment 3: Effective Policy Measures to Deal with the Opioid Epidemic**

The opioid epidemic that has plagued the country for the better part of the 20th and 21st century can be attributed to two main causes. The first is the gap exists in the monitoring of controlled drugs hence facilitating the availability of these opioids to the population through both illegal and legal means (as in the case of over prescriptions). The second propellant of the opioid epidemic is the lack of a systemic approach to addressing the problem (National Academies of Sciences, Engineering, and Medicine, 2017). As such, in my opinion, any viable policy measures that could facilitate addressing the epidemic should be addressed at these causative factors.

As Compton and Volkow (2006) assert, the best and most viable option to deal with increased opioid abuse is to curtail and restrict access. This would involve monitoring the supply chain of opioids from the manufacturer all the way to the consuming patients. Despite the significant effort exerted towards this objective (that is, through the implementation of monitoring systems in pharmacies and hospitals), not enough follow up is done and as a result, rogue doctors and hospital staff misuse their privileges to prescribe these drugs to patients for a price. Additionally, policies should be implemented to have opioids under the jurisdiction of the Drug Enforcement Agencies (DEA) and punitive measures similar to those of cocaine and heroin dealers enforced. However, they should not target consumers but rather the rogue dealers and manufacturers who avail these drugs to the population. In so doing, manufacturers and physicians will be forced to follow up on their drugs and patients respectively. The problem can then be curtailed at the source through promptly ceasing supply to suppliers and patients who are abusing the opioids.

However, I believe the best most viable option would be to adopt a systemic approach. A systemic approach is more holistic and addresses all avenues. For instance, the DEA concentrates on non-prescription opioid abuse while in the real sense opioids, whether from restricted drugs such as heroin or from prescription medication are all part of the same problem. Therefore, developing policies that exclusively involve prescription opioids is futile as there are other substitutes that are often lethal. According to the National Academies of Sciences, Engineering, and Medicine (2017), people first get addicted to prescription opioids and once they are unable to financially sustain this addiction through the regular means, they opt for black market opioids which more than often lead to overdose as their content and concentration is not empirically known.  As such, policies formulated by the DEA should also encompass prescription opioids.

Another systems approach strategy would be to involve the community more. This would be in the form of public sensitization on the effects of opioids and the role of naloxone in preventing overdoses much as in the same way, birth control measures are emphasized in schools and HC’s (Compton & Volkow, 2006). There should also be hospital-patient partnerships in which patients on opioid prescriptions check-in and are examined for addictions after stipulated time periods and on a regular basis until their illnesses abate. Finally, even with monitoring and adoption of a systems approach, it is also crucial that unused medication has a definitive mechanism for disposal. The disposal programs should be at a grassroots level to eliminate any leaks in the supply chain that might put unused medication intended for disposal at the hands of abusers.

**References**

Amico, P., Chilingerian, J., & van Hasselt, M. (2013). Community Health Center Efficiency: The Role of Grant Revenues in Health Center Efficiency. *Health Services Research*, *49*(2), 666-682. doi: 10.1111/1475-6773.12106

Compton, W., & Volkow, N. (2006). Major increases in opioid analgesic abuse in the United States: Concerns and strategies. *Drug and Alcohol Dependence*, *81*(2), 103-107. doi: 10.1016/j.drugalcdep.2005.05.009

Feldman, R. (2013). *Understanding Psychology* (2nd ed., pp. 37-39). New York, NY: McGraw Hill Education.

Johnson, A. (1992). *Out of Bedlam: The Truth about Deinstitutionalization*. New York, N.Y.: Basic Books.

Satel, S., & Torrey, E. (2016). A Prescription for Mental-Health Policy. Retrieved from <https://www.nationalaffairs.com/publications/detail/a-prescription-for-mental-health-policy>

The National Academies of Sciences, Engineering, and Medicine. (2017). *Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use*. Washington, DC: The National Academies Press.

Wang, P., Demler, O., & Kessler, R. (2002). Adequacy of Treatment for Serious Mental Illness in the United States. *American Journal of Public Health*, *92*(1), 92-98. doi: 10.2105/ajph.92.1.92