Mental Health and Changing Health Care Landscape

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Mental health and illness care evoke many different responses. It is engaging, challenging, mystifying but critically important. And has endured a variety of societal response over the years. I want to discuss the challenges, the history and finally the future with potential dangers and innovations.

A few weeks ago, a number of national leaders from mental health, government, finance, etc. attended a conference sponsored by our Policy Center at New York-Presbyterian because of our concern about the state of mental health care. The problems highlighted were many. Let me cite some:

1. Integrating mental health and general health
2. Ensuring in a changing environment that mental health is appropriately included in standards for new models of care such as medical homes, ACOs, etc.
3. Training and consulting with our primary care colleagues as well as training mental health providers for the changing mental health care of the future.
4. Incorporating substance abuse into care.
5. Developing tools to identify mental health co-morbidities.
6. Integration informatics into mental health care.
7. Promoting evidence-based treatments.
8. Integrating promising treatments not yet part of the common practice.
9. Developing appropriate indicators, metrics, registries to help us measure and evaluate
10. Encouraging greater attention to early intervention and prevention.
11. Dealing with the vast number of problems of the chronically mentally ill.
12. Bringing attention to the socioeconomic and physical burdens associated with serious mental illness,
13. Improvising the handling of transitions in patients’ health care to reduce the frequency of relapse and rehospitalization.

There are many, and we could list more. Of note is the fact that over the last year, we have heard many calls urging leadership to take responsibility for addressing the mental health care system and creating greater advocacy. Just 2 days ago, this same issue was brought to me by a very distinguished former Congressman.

Now, the history of the mentally ill and the treatment of the mentally ill is rich and engaging. It is instructive to reflect on it as we enter a new potentially rapidly changing era. The volatile up and down nature of mental health policy and care creates formidable challenges.

The treatment of mental illness for centuries involved approaches close to barbaric. There was moderation over time. By mid-20th Century, state hospitals conducted a great deal of care. At their peak, these hospitals conducted a great deal of the care. At their peak, these hospitals had close to 600,000 people hospitalized for lengthy periods of time. But in the 50’s, they became a target of increasing criticism due to inadequate and low quality treatment and care. Sharp cuts in state hospital facilities began.
By 2010, there were only some 40,000 state hospital beds, less today, for psychiatric patients in the U.S. There is good news and bad news in these developments. It was good news that many people had started to receive new and more active treatment (psychopharmacology, psychological and behavioral treatments). This helped many people return to some level of reasonable functioning.

But, we also experienced the negative aspects of the deinstitutionalization of the 60’s. One response was supposed to be a new national policy creating Community Mental Health Centers. The National Community Mental Health Center Program launched by President Kennedy in 1963 was designed to create 1,500 centers each treating some 200,000 people. That would total to about 300 million people, the projected size of the U.S. population when the total 1,500 centers were to be fully in place.

The Community Mental Health Centers were supposed to pick up patients coming out of state hospitals. But Community Mental Health Centers seemed to repeat what many individual practitioners had been accused of doing—treating the patients who were less psychiatrically ill and under attending to the sickest patients.

Additional issues contributing to deinstitutionalization included the availability of new treatment agents, the focus on patients’ rights (including the right not to be in the hospital), and the desire to bring mental health out of the closet (by which I mean remote settings) and place Community Mental Health Centers in the general community.

President and Mrs. Carter in the late 70’s formed a Presidential Mental Health Commission, which helped increase NIMH research, support, and introduced the Mental Health Systems Act to increase mental health services for underserved populations, i.e. children, elderly, minorities, the chronically mentally ill and patients in general health settings. It was passed by Congress in the fall of 1980. This was an interesting exercise in that it took close to three years to get the plan through and it took the Reagan Administration just a few months to abort it. The Reagan Administration sent the money that was previously setting up new Community Mental Health Centers to the states in the form of block grants. The new administration favored state control and wanted to reduce federal involvement. Congressman Henry Waxman played a major role in blocking their effort to make the money unrestricted. He insisted the block grants be for mental health and substance abuse programs.

I was at NIMH in 1980-81 during the transition from the Carter Administration to the Reagan Administration. I was told I could make no objection to the policy change which dramatically reduced the federal role. When I asked OMB whether we could at least evaluate the change in policy being it was so significant, I was told there was no point, because we no longer provided those services.

There was excitement generated in the late 70’s through 80’s and 90’s and even in this century as the neuroscience field exploded. Imaging, molecular biology, genomics, et al. generated hope. Hope increased that this would lead to new methods of diagnosis and treatment and change the prospects for people with psychiatric illness. There was increased activity on the part of citizen advocacy organizations. In 1980, the National Alliance for the Mentally Ill (NAMI) was launched in Wisconsin and not too long after that NARSAD, (now called Brain & Behavior Research Foundation or BBRF) was created. Others like the Depressive and Manic-Depressive Association, The American Mental Health Foundation, the Anxiety Disorders Organization, and support groups for Obsessive Compulsive Disorders, Borderline Personality Disorders, and et al. all arose in those years.
During the Nixon and Ford Administrations, the research support for the National Institute of Mental Health had declined while the budgets of other institutes were rising. Unfortunately, the Proxmire Golden Fleece Awards pointing out questionable research had repeatedly singled out NIMH for poor research. Along with the relative disinterest of those administrations in mental health, many factors combined to make mental health a diminished priority for funding.

Over the last 20-25 years, with the Federal Government and NIMH especially playing less of a role in mental healthcare, the states have gone their own way. There has been a dramatic deterioration in the mental health system. The number of people with mental illness but no mental health care jumped from some 4.3 million in 1997 to over 7 million in 2010. Abhorrent is the realization that the busiest or largest psychiatric hospital in the county may be the Los Angeles County Jail. This regrettable situation is not unique to any one state but it reflected all over the country. Most recently at the Mental Health Conference to which I referred, the care of the mentally ill in Florida was discussed and displayed by Judge Steven Leifman and was horrifying. People were crowded in small ugly prison rooms. It looked like a return to the inhuman care of pre 20th Century approaches.

Now, mental health has always found it difficult to compete against other areas of medicine. It was not unusual for someone to visit a hospital where there would be a spanking new medical and surgical building and somewhere in a remote part of the grounds a diminished and somewhat dilapidated mental health facility. The facilities matched the degree of inattention to patients.

This is not a situation whose responsibility should be placed at the feet of any one constituency. Yes, government tried. Administrative and financial officers in state and local settings did the same. Mental health providers, patients, and families all tried. While we can applaud the fact that there has been genuine improvement in treatment over the years, there had simultaneously been a sense of diminished progress in recent years and a failure to match the hope and promise energized as neuroscience took on life in the 70’s and 80’s.

In addition, stigma has had a huge impact. Many people despite having mental healthcare coverage to go for care were reluctant to go. Potential donors seemed to make themselves scarce, avoiding any association with mental illness. You know the endless ways by which stigma has manifested itself.

So what do we have today?

We have estimates that annually somewhere between 19%-26%; of the population has psychiatric illness. We have considerable variations in treatment amount and quality as you go state to state. The fight over insurance and parity had gone on for decades. I can remember arguing with the Chief Administrative staffer for the Senate Finance Committee in the late 70’s about the value of psychological therapies and the need for reimbursement. He finally told me that all the data I could bring were irrelevant because in his words, “the barn doors were locked and no one else is coming in”.

The modest reimbursement for outpatient work for practitioners taking care of patients with mental health conditions causes many doctors to shun people with government reimbursement as a source of their payment. Many people seek private care if they can pay privately. This means a limit on the number of patients who receive psychiatric care. And at the same time, the absence of access to care often results in the mentally ill winding up on the streets or in prisons.

Another unfortunate development in the last few years has been the loss of some of the most supportive and effective Congressional proponents for mental health care and reimbursement. These include Senator Ted Kennedy and much of
the Kennedy Family, although some like Patrick still work at this today. We also lost people like Senator Paul Wellstone, Senator Daniel Patrick Moynihan, Joe Early, Sylvia Conte, Pete Dominici, Warren Redman and many others.

We do have some very forceful and helpful leaders in Congress, but the loss of some of our most devoted leaders along with the national economic problem has created a formidable situation for those arguing for support for mental healthcare. It is well known there are many people with psychiatric illness who do not get any access to care. Yet, the influence and import of psychiatric illness and also the behavioral aspects of all health care is gaining some recognition.

**Mental Health Today**

One can divide the problems of the mentally ill in a variety of ways. Problems related to children and adolescents are great and getting more attention as a result of some of the horrifying recent violence. Finding enough providers, appropriately involving families, tracking school progress, making services culturally appropriate, including mental health/SA at every well child visit constitute some of the needs. Beyond the issues special to the children and adolescents, a useful way of dividing the population is first to look at people with relatively common and often episodic disorders usually seen in the general medical sectors and getting treatment of varying quality.

Then a look at the second group involves the more severe and disabling disorders such as severe depression, bipolar disorders, schizophrenia and the like. The number of people with needs in mental health in this country, but no care access was recently documented at 7.2 million in 2010. A disturbing report indicated that some half of the individuals with schizophrenia receive no treatment or suboptimal treatment.

Central to any discussion of mental health is the issue of financing policies for support of care. Coverage for mental health and substance abuse care has gone up and down over the last four decades. There has been a decline though in generosity of the treatment for mental health care which has worsened in recent years more than any worsening in the general medical arena.

Mike Hogan, one the country’s best mental health commissioners who recently stepped down from the position in New York, points out that the wellbeing of people with mental illness is better but not great. He ascribes this in large measure to the mainstreaming of benefits.

He feels that more people have insurance and more with serious mental illness have SSI/SSBI. He feels that more people get some care and it is mostly not bad but advances secondary to treatment of technology improvements have been overstated.

And he particularly emphasizes as a problem the tensions around the question of whether to put services under mental health or under Medicaid Directors.

He notes that with reform, lots of additional people will be getting coverage, and hopefully greater parity, but he is concerned about the loss of influence and judgment input by mental health leaders.

Dr. Hogan refers to major federal actions which could strengthen the attention to mental health. These include:

1. The “Mental Health Parity and Addiction Equity Act” - (MHPAEA) 2008 which stressed parity but allowed plates to restrict covered diagnoses.
2. The “Patient Protection and Affordable Care Act” - (PPACA)
These have been generated in the context of a fragmented system overlooking many people, and giving many other mixed quality care. The mental illness populations are experiencing much distress. They have high medical co-morbidity, high mortality rates and also high health care costs.

The MHPAEA of 2008 extended parity for substance abuse and mental health conditions co-morbid with substance abuse and required parity in the quantity of care allowed as well as the degree of regulation or oversight.

The law improved benefits for some who had mental health/substance abuse coverage. The expectation was that this would reduce the out-of-pocket burden but would have little effect on utilization or total spending, since almost all care is managed care.

The Patient Protection and Affordable Care Act includes a rich variety of measures many of which can improve the prospects of people requiring health care. Assets of the PPACA offer the best opportunity since the 1963 Community Mental Health Act to remedy discrepancies and improve quality in the mental health system. Some of the most noteworthy and positive aspects of the ACA are:

1. Increased Medicaid coverage to a larger number of people.
2. Elimination of pre-existing condition as a basis for denying coverage.
3. The end of a lifetime cap on reimbursement.
4. The allowance for coverage of young people up to 26 years old in their family’s coverage.
5. The establishment of health exchanges enabling more people to gain mental health coverage at more reasonable cost given the requirements for attention to mental health service for people with psychiatric illness.

The ACA represents an enormous policy change with multiple impacts and opportunities. In the context of a desire to gain parity, many of the ACA actions augment the possibilities for care in mental health for the overall population.

RAND suggested that by 2019, 28 million people will purchase their insurance through the Exchanges. The individual mandate, of course, has further potential impact for increasing the number of people covered. There is a mandate for mental health and substance abuse benefits under the “Essential Health Benefits” required in the exchanges. Employers must meet PPACA Mental Health and Substance Abuse requirements if they have at least one subsidized worker.

**New Organizations in Healthcare Reform**

A variety of new structures have been introduced through the ACA including:

1. Medical Homes
2. ACO’s
3. Health Homes- particularly designed to help manage and coordinate care for the seriously mentally ill

**Broad Factors Influencing Attention to Mental Health**

The ACA arose alongside a number of developments which are bringing more attention to mental health and behavior.

1. The World Health Organization in recent years has shown the enormous impact of conditions like depression on the relative health of the population around the world (and also in general function).
2. The recognition that people with mental health problems who also have other medical problems whether they be substance abuse or other non-psychiatric medical problems present a substantial financial challenge. The care of patients which such co-morbid conditions is extremely costly.
3. The recent tragic set of events involving violence and the tendency to link inappropriately the violence to mental illness ironically has been an additional factor in increasing attention.
4. Further forcing mental health into the attention of the country is the mental health problems of veterans.

One could argue that mental health has an opportunity given these factors to arouse greater public scrutiny and general support for people with mental illness. On the other hand, we face the obstacle of extraordinary fiscal constraint. Looking for additional resources is a challenge. Still, it does attract financial experts, medical people and public health people to realize that appropriate treatment for psychiatric conditions, particularly when partnered with other conditions, may hold value not only for improving the population’s health and mental health but also value for cost control.

So, in broad stroke one could say this is a rather remarkable time in the history of mental health treatment and could represent an opportunity given those developments along with the possibilities that the ACA brings.

**Challenges**

The challenges are as widespread as the opportunities. Many hospitals and emergency rooms are chock full of psychiatric patients with no potential place to which they can be sent. Facilities are being closed or downsized:

1. The psychiatric unit in Cedar Sinai was closed.
2. One of the main state hospitals in Connecticut and all of the state of hospital facilities in one of the southern states were recently closed.
3. Many states and cities are looking everywhere to cut, and their mental health budgets are tempting.

**New Ideas**

Despite the challenges, many mental health people are working to find ways of improving care while restraining or cutting costs:

1. In the state of Washington, Jürgen Unützer has a program working on a population focused approach to depression.
2. In Westchester, the Commissioner of Mental Health has been using peers to provide an additional source of person power to provide services.
3. The Westchester Division of the New York-Presbyterian system has developed a Second Change program which cares for patients who have been in state hospitals for over five years. The program has been successful in restoring large number of patients to greater functionality and enables them to leave hospitals. The program is providing better quality and helping reduce cost.
4. The Massachusetts System for Children’s Mental Health has developed a structured arrangement to make children’s mental health specialists more easily and quickly available.
5. There is a new program to address the general medical problems of psychiatric patients in Missouri.
6. At New York-Presbyterian Hospital, the so-called regional collaborative program has included a productive focus on patients with depression and comorbidity and reported double figure reductions in hospitalization and emergency room visits.

**Conclusion**

Many issues in mental health are familiar. Some but not all are similar to problems in general health care. We see a mixed picture of improvement; increased access, better treatments, the development of evidence-based treatments such as Clozapine, Lithium, cognitive behavioral therapy, a focus on recovery and rehabilitation, also on early intervention and evaluation. We also witness their negative counterparts; fragmentation, unevenness, insufficient provider population along with the problem of inadequate behavioral care within the general and primary health care settings.
There are, however, additional challenges that are unique to mental health:

1. Pharmaceutical companies leaving the field of new medication development for mental health is noteworthy.
2. The diminished NIMH fiscal support along with a tendency to focus more narrowly in particular areas, often giving short shrift to services and clinical research.
3. The concerns that the trend toward mental health, substance abuse, and general medical services being housed under one roof is not all positive. Often when non mental health leaders are in charge, mental health gets low priority. This may improve by virtue of the considerable current attention being brought to mental health today, but it is questionable.
4. The uneven caliber of behavioral care delivered by the general and primary healthcare provider population may be exacerbated by time pressure on the health care providers to see patients rapidly and to do it efficiently. This may intensify the challenge for primary health care people caring for behavioral or psychiatric problems. This requires another look at effective efforts of educating primary health care people to make their actual care for such patients more fitting, comfortable and effective.
5. The impact of housing: ensuring there are sufficient facilities whether they are hospital beds, housing with mental health, other residential services is important to replace the disturbingly crowded settings; emergency departments and hospitals, in which psychiatric patients languish with no place to go.
6. Sherry Glied has also alerted us to the fact that a look at SSI and SSBI is imminent. Patients currently able to make their way with those kinds of support may as well be a result of a tighter or reduced payments be more financially stressed going forward. This is unfortunate although some say this may be productive in part by reducing disincentives for people to get back to work. On the other hand, there are people for who this is not a matter of easy choice.
7. A need for greater attention to the evaluative aspects of health reform including better quality and outcome metrics, indicators that are accurate and useful, etc.
8. The need to use caution regarding possible over reliance on pharmacological interventions for populations like Attention Deficit Disorders.
9. The need for more tightly coordinated- not just co-located care.
10. The need to educate and influence the field to move in the direction of evidence-based interventions.
11. The combined issues of aging clinician base and workforce shortages both in child and adolescent psychiatry and geriatric mental health, as well as maldistribution and inadequate diversity.
12. Overriding almost all of this is the pernicious and uniquely negative impact of stigma. Stigma has been a problem in other areas over the years- cancer, AIDS, and others. But its universal nature in mental health and its destructive effect throughout the world make mental health care a lower priority everywhere.

We applaud new ideas and new programs which seem to be helping many. We want to spread that news and bring best practices to all parts of the country. If ever there was time when mental health needed committed people concerned about providing better care to people in need, this is it. We need the providers, we need the commitment of those who care, and we need the advocacy on behalf of all patients and families who suffer from these most damaging diseases. We also have to gain not only the attention of the government and policy leaders but the willingness to work with us and concretely act to address these set of critical issues.