HEALTH in MIND

Why MENTAL ILLNESS is one of the HARDEST SOCIAL WELFARE PROBLEMS TO SOLVE

BY RENEE HALTOM

The nation's first mental hospital, the Public Hospital for Persons of Insane and Disordered Minds, part prison and part infirmary, received its first patient in 1773 in Williamsburg, Va. A century later, 110 mental hospitals around the country were up and running.

The system kept growing. By 1950, well over half a million Americans lived in state mental hospitals — about a quarter as many inmates in the entire federal, state, and local jail system today. Unfortunately, those hospitals were no place to get well. They were often filthy. Psychotropic drugs and tranquilizers hadn't yet hit the market, so the halls were filled with people dazed and rambling from their psychoses. The science of the time offered electroshock therapy, lobotomies, and little else by way of treatment. Most of the staff were unskilled custodians, and many patients were locked away and never expected to reenter society.

That's about when the downsizing of state mental hospitals began. As of 2010, just 46,000 people resided in roughly 240 state and county psychiatric hospitals, according to the Substance Abuse and Mental Health Services Administration (SAMHSA). That's a small number compared to the 45.6 million adults that have some form of mental illness, such as anxiety, mood, or impulse control disorders, and even compared to the 11.5 million adults with serious mental illness, such as schizophrenia, bipolar disorder, psychotic depression, or other debilitating diseases. Thanks to better science on the treatment of mental illness, the vast majority of people with even serious mental illnesses can live full, productive lives, a virtual impossibility 50 years ago.

But it's clear that too many people still lack adequate mental health care. The mentally ill are overrepresented in bad walks of life. One-fifth of the population has a mental illness, according to SAMHSA, but they make up more than half the inmates in jails and prisons, and one-third of the homeless population. Suicide claims more lives each year than car accidents, and more than twice as many homicides. And there are unspeakable costs that the people of Virginia Tech, Aurora, Colo., and Tucson, Ariz., won't ever forget.

People with mental illness have a better chance than ever at thriving. But do we know how to deliver care that maximizes quality of life for the people who aren't?

The Challenge

It's not easy to say what an efficient mental health care system would look like, according to Harvard Medical School economist Richard Frank, co-author of the 2006 book *Better But Not Well* with Columbia University Mailman School of Public Health economist Sherry Glied. One can point to some good signs: "We've virtually doubled the rate at which people who have an illness get treated," Frank says. "We've also increased the chances that people who get treatment get the treatment that is likely to make them better."

Science is responsible for much of that; more treatments are available, and the side effects of medication are more tolerable. But we've also expanded and improved the system's ability to deliver care. Before the 1950s, treatment was mostly limited to state mental hospitals and about 7,000 psychiatrists, many located in small private practices in urban areas, Frank and Glied wrote. There were also 13,500 psychologists and 20,000 social workers, but most didn't provide mental health care. Today, there are more than half a million licensed psychiatrists, psychologists, counselors, family therapists, nurses, and social workers working across 4,800 public and private mental health organizations that provide varying intensities of care. More than 31 million people get mental health treatment each year. In addition, society is more respectful of patients' rights, and the stigma of mental illness is gradually eroding.

An ideal system creates opportunities for as many people as possible to live independently, Frank says. "On the other hand, for both humane reasons and externality reasons, you don't want to let them fall too far."

It would be prohibitively expensive, in all likelihood, to reduce the number of people who fall through the cracks to zero. Still, most people would agree that the sheer volume of bad outcomes makes it clear that our system needs improvement. The number of mentally ill people in jails and prisons is now orders of magnitude larger than the number in mental hospitals. To some extent, that's because the mentally ill are twice as likely to abuse drugs, which can lead to jail. But they are unlikely to get better there. Only a third of inmates with mental illness receive any treatment — hospitalization, medication, or therapy — once incarcerated.

Potentially even worse off are those who don't enter any system of care. Two out of five people with serious mental illness receive no treatment. In 2010, more than 38,000

people committed suicide, according to the Centers for Disease Control and Prevention. In 2011, more than 1 million people attempted it, and 8.5 million had thoughts of it. A third of the homeless population is mentally ill, according to the Treatment Advocacy Center, a nonprofit that advocates involuntary treatment for some severely ill people.

In economics terms, involuntary treatment is justified in part by the externalities associated with mental illness — the fact that people who fall through the cracks tend to become society's problem, whether through crime, homelessness, or the drain on public resources. Externalities aside, it is also thought to be justified by the fact that individuals with some severe mental illnesses lack the capacity to make rational decisions about treatment that could improve their lives. In an attempt to safeguard against overuse of involuntary treatment, many state laws require that a person have already exhibited dangerous behavior in order to receive treatment against their will.

Critics such as the Treatment Advocacy Center argue that overly high standards for involuntary commitment could cost the system resources down the line. A famous 1999 study out of Duke University found that programs like court-ordered outpatient therapy and medication reduced hospital admissions among people with schizophrenia and other psychotic disorders by 72 percent. Critics also contend that in the absence of involuntary commitment, some of the mentally ill are, in effect, sentenced to life in the streets. But to other advocates, patients' liberties outweigh the public and private benefits of commitment.

Even in a system that brought all mentally ill people into treatment, it would be a challenge to treat all people effectively because the diseases are so complex. People with identical diagnoses can have vastly different symptoms and needs. "Even if you know the genes, the environment and early life experiences all figure into it," Frank says.

Health care markets in general have problems that prevent buyers and sellers from coming together to negotiate services efficiently. The science on this goes back to economist Kenneth Arrow in 1963, who was the first to explain why efficient health care systems are so scarce. Uncertainty is a key component: No one knows his chances of getting sick, so people pool their risk through insurance. But the health insurance market is riddled with adverse selection (sicker patients will tend to buy more insurance, and insurers can't immediately identify them) and moral hazard (once insured, people overuse service).

Market failures for mental health care are the same, only worse. Adverse selection is more pronounced, and studies show that uptake of services when someone else pays is at least twice as high for mental health than for other health services. As many as 8 percent of people who seek mental health treatment have no diagnosable condition at all.

Insurers counteract market failures by providing better coverage for minor psychological conditions to attract low-risk consumers. Many insurers ration care, but more dramatically for mental health. Since the 1990s, that has been done through caps on service facilitated by managed care organizations — HMOs and other intermediaries between patients and doctors. States, in turn, have counteracted rationing with parity laws. These laws force plans to cover a certain level of mental health service, different in every state. The result is that almost all private insurance plans cover mental health services, but private insurers cover just over one-quarter of the total expenditure on mental health.

In most cases, private insurance doesn't even enter the picture. Many disorders can make it difficult to hold a job, and life stressors can exacerbate genetic conditions. A recent study in the *Journal of Mental Health Policy and Economics* found that households with a severely mentally ill person are three times as likely to be poor, and they fall further below the poverty line. For a variety of reasons, "having a severe mental illness makes you poor, and being poor also increases your chance of having a mental illness," Frank says.

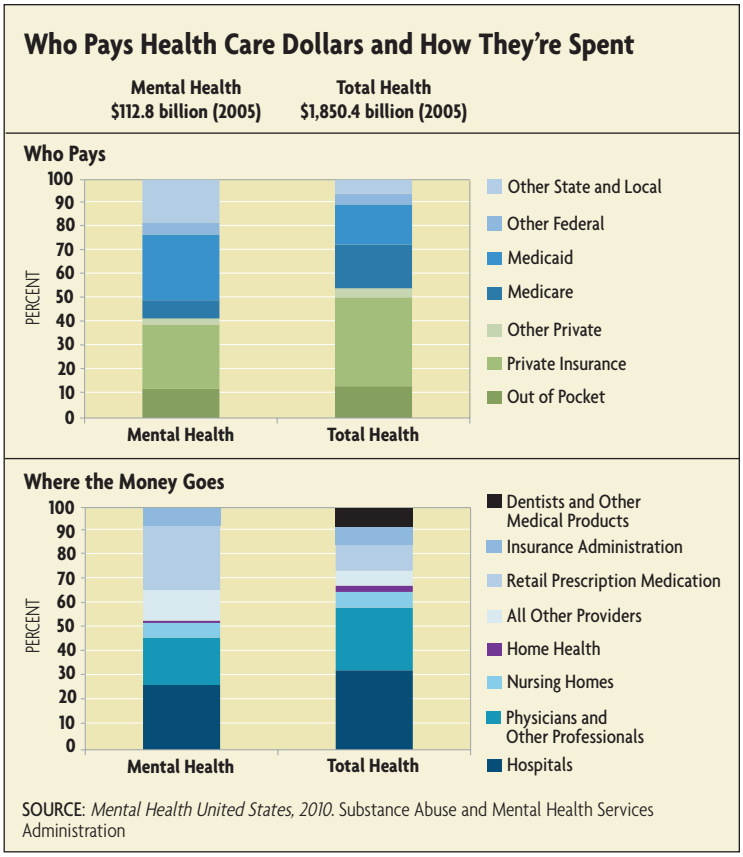
That means Medicaid, Medicare, and Social Security disability programs are more likely to be involved. Public payers cover 58 percent of mental health spending, compared to 46 percent for overall health (see chart). The majority of public funds for mental health come through Medicaid, a federal program run by the states. Most mental health services are considered optional under Medicaid rules, meaning states get to decide which services are covered. The funds are matched dollar for dollar by the federal government, or more in poor states. For people who don't qualify for Medicaid, states use general mental health funds to pay for treatment. (For a quick look at how recent health care reform is expected to affect mental health care, please see the online supplement to this article.)

Shifting Payers and Priorities

Entitlement programs were never intended to be a major provider of mental health services — they just came along at the right time. Medicare and Medicaid were created in 1965, and Social Security's Supplemental Security Income (SSI) program was created in 1972. This was just as state mental hospitals were in steep decline.

State mental hospitals downsized mostly because care got better. The first antipsychotic drugs hit the market in the mid-1950s, which for the first time allowed people to be stabilized, rehabilitated, and discharged. The average hospital stay of six months in 1954 dwindled to just 23 days by 1980. That meant fewer beds and smaller hospitals. By 1980, the number of long-term residents in state mental institutions had dropped from 559,000 to just 154,000.

At the time, there were few alternatives for care. That began to change in 1963, when President Kennedy launched a system of community-based mental health care. Before then, mental health care was almost entirely a state issue. States were legally responsible for funding, so state legislators effectively set mental health policy by allocating their budgets, mostly devoted to state mental hospitals. Kennedy tripled federal funds to build a system of community mental



SOURCE: *Mental Health United States, 2010.* Substance Abuse and Mental Health Services Administration

health centers (CMHCs). Within 15 years, there were 650 CMHCs covering 43 percent of the population and serving 1.9 million people per year.

Though they were never intended to be used that way, entitlement programs made the federal government a permanently bigger player in mental health. When hospitals downsized, entitlement programs stepped in to fill the void. Medicaid and Medicare funded medical needs, and SSI provided income for food, housing, and other nonmedical services. Entitlement programs were designed to make it hard for states to shift the funding burden on to the federal government. Most notably, Medicaid cannot be used for treatment in state mental hospitals. States got creative; they shifted patients to nursing homes and general hospitals. The latter doubled their psychiatric beds in barely more than a decade of Medicaid's launch. Within six years of its creation, Medicaid accounted for 16 percent of all mental health spending, and it was 28 percent in 2005 (see chart). The share of state spending fell from more than half in the 1950s to less than a quarter by the early 1970s, where it has stayed.

The federal government's larger role has also helped determine the focus of care, says Howard Goldman at the University of Maryland School of Medicine. The old state mental hospitals focused on the sickest and most disabled people. Kennedy's community system, by contrast, was focused on overall "mental health," which the World Health Organization defines as mental wellness, not just the lack of an active disorder. For many people, this was a great thing. For the first time, even people with mild depression or anxiety had treatment options.

But it proved difficult for people with serious illnesses to navigate the full range of services that they needed — both medical services and nonmedical support like food, housing, help finding and keeping a job, and social lifelines to aid the reintroduction into society. Many resided in nursing homes and slum apartments. In 1977, the Government Accountability Office wrote a scathing report of the CMHCs' lack of support for people with chronic mental illness, and federal and state mental health services began to focus again almost exclusively on people with the most debilitating conditions. The gentrification of cities in the late 1970s and early 1980s brought many of them into the streets, creating a visible problem that sapped the remaining public support for the community system. Appropriations to CMHCs were pulled under President Reagan's deficit reduction efforts, and replaced with smaller block grants. Today, the vast majority of federal spending on mental health services comes through Medicaid.

The pendulum has started to swing back, Goldman says. "There has been a drive over the last 20 years to expand the scope of who has a mental illness."

The profession follows the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, known as the DSM, to diagnose patients and assign treatments. It now includes behavioral conditions, like attention deficit disorder. The fifth release, issued in May 2013, is even more expansive, including conditions like bereavement and caffeine withdrawal. Although public mental health services are not directed at the same expanded list of conditions, there is a greater interest in early intervention and bringing people into the system, Goldman says.

Dwindling Funds

As the definition of mental illness is expanding, funding is being drained by the ongoing state revenue crisis that has afflicted state governments since the onset of the Great Recession.

At $37.4 billion, mental health expenditures were 2.3 percent of total state budgets on average in 2010 (see chart). But those numbers are falling. States cut $4.35 billion from mental health spending from 2009 to 2012, according to the National Association of State Mental Health Program Directors, which represents the states' mental health agencies. Over the same four-year period, the state system saw a nearly 10 percent increase in utilization in publicly financed inpatient and outpatient behavioral health treatment services. South Carolina cut funding more than any other state; its general fund budget for mental health dropped by 39 percent between 2009 and 2012, according to a separate study by the National Alliance on Mental Illness (NAMI), an advocacy group. Washington, D.C., was among the top 10 at 24 percent. Nine other states cut funding by more than 10 percent.

"The states are devastated by the budget cuts. There's just no nice way to say it," says Lisa Amaya-Jackson at Duke University's School of Medicine.

The poor are the most vulnerable, but budget problems spill over. Non-Medicaid spending tends to be cut first, since cuts to Medicaid lose the federal matching funds too. That happened when stimulus funds ran out in June 2011 and pulled $14 billion from state Medicaid programs. One hospital in Phoenix, Ariz., reported a 40 percent spike in emergency room psychiatric episodes after services were eliminated for 12,000 people with serious mental illnesses who did not have Medicaid, NAMI reported.

Agencies are starting to use evidence-based treatment (EBT) as a way to protect services from budget cuts. The EBT philosophy emerged in the 1990s for overall health care, but has amassed wide support in mental health in just the last decade. The approach is based on rigorous follow-through of each step of a scientifically validated regimen.

As the name suggests, not only is EBT arguably more effective, but it is perceived as such by state legislatures deciding where limited state funds should go. Amaya-Jackson is the director of Duke's Evidence-Based Practice Implementation Center (EPIC), which trains clinicians on EBT. After following through on the training program, EPIC puts the clinician's name on a public roster. Amaya-Jackson says that agencies in North Carolina have become more eager to partner with EPIC in lean times because appearing on that roster signals accountability to legislatures. It has also created a network of clinicians within the state that third-party payers — Medicaid and insurance companies — want to work with, maximizing the clinicians' reimbursement rates.

Searching for Welfare Gains

It is not clear what overall level of spending for mental health would be optimal. Among countries that spend about what we do on mental health as a share of GDP, some do better and some do worse, as measured by homelessness, incarceration rates, and the number of people who get EBT, Frank says. Australia matches our spending levels, and is known for its effective system.

With any social welfare problem in which resources are scarce, there are usually ways to squeeze blood from a turnip by distributing resources more efficiently. For example, effective treatment could prevent many of the socially destructive behaviors that land people in prison. North Carolina had 3,300 public and private inpatient psychiatric beds in 2007. But the previous year, more than 5,500 inmates in the states' prisons — 14 percent of the state's prisoners — had a serious mental illness. Budget cuts have already removed well over 3,000 of the nation's psychiatric beds, more than 6 percent of the total.

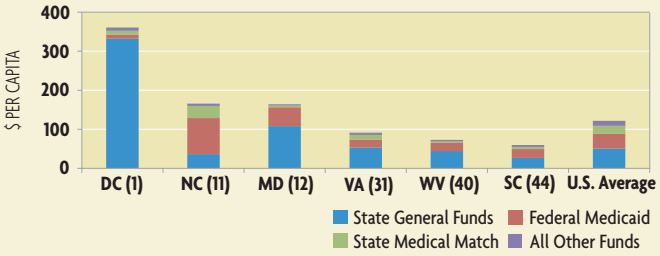
The combination of mental illness and substance abuse is a particularly vulnerable area, Frank says, responsible for many of the mass shootings in recent history. "Someone with schizophrenia is more likely to be a victim than a perpetrator, and they are no more likely to be perpetrators than the rest of us." But if you combine schizophrenia with substance abuse, they are much more likely to inflict harm. "The issue is that, unfortunately, people with schizophrenia are more likely to abuse substances."

In many cases, the difficulty is getting people into the treatment system in the first place. That means treating illnesses before they snowball into bigger problems, especially for children; the average onset of mental illness is at just 14 years old. There are also big gains from treating mothers with depression, since children with depressed mothers do worse in school and are more likely to become depressed themselves. "That's a cheap fix," Frank says. "It's maybe $1,200 to get effective treatment for depression. It's not very expensive to get people decent treatment for your common mental illnesses."

Though there is no obvious wholesale fix to the system, here's the good news: A lot of progress has been made in a very short amount of time. We have good ideas of how to treat mental illness, and how to enable people to live controlled, productive lives, and we have greatly improved the rate at which people enter the system. By further improving the ability of markets to allocate care, there is hope of further driving down the number of people with mental illness who are imprisoned by their diseases. **EF**

Per Capita Spending by Fifth District States

State mental health agencies spent roughly $37 billion on care in 2010. Here's where the funds came from in the Fifth District.



NOTE: State's rank for total mental health agency spending in parentheses.
SOURCE: National Association of State Mental Health Program Directors Research Institute, and author's calculations

Readings

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