GUESTEditorial

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Of Hype and Hope: The Past and Future of Mental Health Care

This is the fifth of a 12-part series: This year we're focusing on the phenomenal progress that the medical community has made in the 30 years of Federal Practitioner's *existence. Each month we'll feature an editorial written by one of our Editorial Advisory Association members, reminding us how much has changed in their particular medical field over the past 30 years. This month's focus is psychiatry.*

During the golden age of antibiotics when, penicillin miraculously cured infections that were the leading causes of death, many leaders in medicine, including the U.S. Surgeon General, predicted modern medicine would vanquish the age-old scourge of humanity—infectious disease. The emergence and then rampant spread of antibiotic resistance showed the arrogance of these claims.

Over the last 30 years, a parallel trend has occurred in psychiatry. Initial, perhaps naïve, fervor for psychotropic medications has yielded to tempering of an overreliance on psychopharmacology. The first antidepressants and antipsychotics were discovered serendipitously in the 1950s.

Fluoxetine, the first selective serotonin reuptake inhibitor (SSRI), was introduced in 1988. A year later, the first atypical antipsychotic, clozapine was introduced. Since then, pharmaceutical companies have turned out a series of me-too drugs, exerting what many psychiatric ethicists and educators contend is an injurious influence on research and practice. Eager for efficacious agents without the many adverse effects of tricyclic antidepressants and typical antipsychotics, clinicians and patients alike welcomed these new drugs with open arms.

However, within a few years, the data showed that the extrapyramidal symptoms of typical antipsychotics had been exchanged for the metabolic syndrome of the atypical agents. A host of FDA-assigned black box warnings for suicidal thinking with antidepressants and anticonvulsants, and recent articles that concluded antidepressants were not superior to placebo, created a crisis of faith in some sectors of the profession and the public.

The era of the Internet meant that the media reported, and often distorted, these therapeutic limitations, leading many patients to suffer and even die. The best epidemiologic minds in mental health argued that overall these drugs, rather than increasing, reduced suicidal behavior and had a success rate equal to many other chronic medical conditions.

In an effort to provide objective guidance to practitioners, the National Institute of Mental Health conducted the unprecedented real-world Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) Study and the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study. CATIE showed that new medications were not always better than the old ones, just more expensive; STAR*D found that to successfully treat depression, practitioners must try, try again, and then try once more to attain remission.

The findings of each trial cautioned that psychopharmacology was more complicated than the 5-minute medication check that insurance companies and for-profit health care institutions promulgated. The results of these studies were truly mixed, in that they challenged the therapeutic nihilism of many critics of psychiatry and cautioned those professionals who believed the biological revolution had triumphed. For the patients, families, and mental health care professionals holding the middle ground, several encouraging trends were on the horizon, and many of those trends were pioneered by DoD and VA practitioners.

First was the great and enduring value of psychotherapy, especially the evidence-based treatments for posttraumatic stress disorder, such as exposure and cognitive-behavioral therapy and motivational interviewing for substance use disorders. These therapies brought relief of symptoms and recovery of function to millions of men and women.

Second was the primary care/mental health integration movement. Several public health reports have shown that the majority of psychiatric medications are prescribed in general medical settings despite the unfortunate fact that primary care practitioners

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(PCPs) receive little training. Embedding mental health practitioners in primary care with innovative programs, such as Translating Initiatives for Depression into Effective Solutions (TIDES), the nurse-driven telephonic management of depression, and Improving Mood: Providing Access to Collaborative Treatment (IMPACT), the evidence-based treatment for depression in older adults, has shown cost and efficacy benefits. The integration of mental health into primary care destigmatized mental illness, coordinated the care of medical and psychiatric disorders, and improved the knowledge and skills of PCPs, thereby preserving the scarce resources of psychiatry for consultation and the care of serious mental illnesses, such as bipolar disorder and schizophrenia.

These innovations were also necessities if patients were to receive behavioral health care. Workforce experts forecast that the nation will be short 45,000 psychiatrists at the same time that the demand for mental health treatment will increase due to the aging of baby boomers.[1] Both VA and DoD pioneered the use of telehealth and other mental health professionals, to extend the reach of psychiatric treatment into rural and underserved areas.

The evolution of my career in VA mirrors the paradigm change of the profession as a whole. I began as an outpatient clinician providing medications and supportive therapy for patients with serious mental illness. A decade later, I am the chief of a consultation service entirely outside a traditional mental health location staffed with nurse practitioners, social workers, and nurses providing care in the emergency department, primary care clinics, and medical and surgical wards. This shift in mental health care delivery required that psychiatrists hone a different skill set than what I was equipped with when I graduated from my residency. Updating its historic educational mission, VA and DoD provided the many trainees that passed through its doors with competencies in system-based practice, informatics, communication, and multi- and interdisciplinary teamwork that will shape the mental health practice of the future.

Ever more accessible and acceptable ways and means of providing mental health care must be developed if we are to combat the prescription drug abuse epidemic without repeating the iatrogenic mistakes of the past. A lack of judicious prescribing and the American insistence on a quick fix to any life problem have spawned unparalleled addiction, overdoses, and death, too many of them among our military and veteran cohort. Federal mental health care professionals, along with their civilian colleagues, have fought back with evidence-based guidelines for the treatment of chronic pain, office-based treatments for opioids and alcohol, and coordinated care for co-occurring disorders using innovative residential and outpatient venues.

Our more realistic appraisal of the potential of psychotropic medications has perforce led clinicians to turn back to older modalities such as electroconvulsive therapy, still the most effective treatment in psychiatry despite its political opponents, and move forward to promising therapies like transcranial magnetic stimulation and deep brain stimulation. Research in psychopharmacology, much of it conducted under federal auspices, is exploring new neurobiological visions such as glutaminergic and dopaminergic pathways and second messengers. The ancient wisdom of alternative and complementary treatments for mental illness and health are being scientifically examined, and the future of personalized genomic and proteomic psychiatry is, if not within our reach, squarely in our sights.

This month, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) is due to be published, with the heated controversy surrounding its earnest, yet flawed, search for diagnostic clarity and validity in psychiatric disorders that would equal their medical counterparts. Psychiatric researchers and academics labor to empirically differentiate the hype from the hope of neurobiology. Patients and families, who struggle daily and heroically with psychiatric disorders, cannot and are not waiting, but instead have become more informed and empowered advocates for their own mental health and that of their loved ones. I have no doubt that the most influential change in behavioral health in the last 30 years is the recovery orientation, where patients and providers engage in a process of shared decision making toward the goal of improved functioning and quality of life. ●

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REFERENCE

1. Konrad TR, Ellis AR, Thomas KC, Holzer CE, Morrissey JP. County-level estimates of mental health professional shortage in the United States. *Psychiatr Serv*. 2009;60(10):1323-1328.