Healing the Broken Places

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May is Mental Health Month; in recognition of this—and our 25th anniversary—we decided to reprint this 2008 feature article on the state of mental health care in the United States. It's the story I am personally most proud of telling, but rereading it today leads me to wonder: How much progress have we actually made? Please share your thoughts and experiences with me at ahoppel@frontlinemedcom.com. —AMH

Broken. Grossly underfunded. In crisis. That's how psychiatric and behavioral health specialists describe the current state of mental health care in the United States. The problems that plague the health care system in general—workforce shortages, barriers to access, and inadequate reimbursement—are only exacerbated in mental health.

"Mental illness isn't glamorous," says Don St. John, MA, PA-C, who practices in adult outpatient psychiatry at the University of Iowa Behavioral Health in Iowa City. Taking an example from the academic medical center setting, he adds, "It's nice to have the cardiac surgery wing dedicated to or named after your family—but nobody wants a mental health wing named after them."

Stigma is perhaps the greatest challenge with this patient population. "Until this country really embraces the notion that mental health is inherent in every aspect of a person's general health," says Gail W. Stuart, PhD, APRN, FAAN, Professor and Dean of the College of Nursing at Medical University of South Carolina, Charleston, "I think the stigma issue is going to continue to make it difficult to overcome these problems."

FROM HOSPITALS TO JAILS

The current state of mental health care in the US is perhaps a direct result of the deinstitutionalization that occurred in the 1980s. By that time, most mental health hospitals were overcrowded and, in the worst cases, patients were subject to neglect and even abuse. (Recall, if you can, Geraldo Rivera skulking through the dark at Willowbrook State School in Staten Island, NY; his 1972 exposé brought the issue to the forefront.)

Following the public outcry over the treatment of these patients who—mentally ill or not—were *people*, there was a movement to reduce the number of long-term hospitalizations for mental illness. Along the way, the number of hospital beds available for mentally ill patients also declined, as freestanding hospitals and private facilities closed. What have these patients been left with?

"The thought was that people would be maintained in the community—there would be community support services, halfway houses, boarding homes, community-based programs," says Catherine R. Judd, MS, PA-C, President of the Association of Psychiatric PAs, who works in the Department of Psychiatry at the University of Texas Southwestern Medical Center, Dallas. "The idea is good, but unfortunately, most of those programs have really not materialized to the extent or with the capacity to take care of the people who are out there."

Without these services—and with an overtaxed health care system in general—many patients with mental illness find themselves adrift. And, eventually, incarcerated. An estimate from the US Department of Justice indicates that 24% of state and 21% of local prisoners have a recent history of mental ill-

ness. The largest psychiatric hospital in the country is the Los Angeles County Jail.

The problem is so widespread and so serious that both Judd and Jeanne Clement, EdD, APRN, BC, FAAN, President of the American Psychiatric Nurses Association (APNA), describe it in identical terms: "The jails and prisons have become the de facto mental health system."

"More and more mentally ill people are in the streets, not receiving services, not taking medication as prescribed, with less-than-optimal case management in the community," says Judd, who also works with the chronic mentally ill at the Dallas County Jail. "So, they are picked up on substance abuse–related charges or criminal trespassing or burglary. Consequently, they're brought to jail."

In Dallas, a *divert court* has been established, with the aim of getting chronic, persistent mentally ill patients "back to clinics and back on medication as quickly as possible without incarcerating them," Judd notes. For such a program to succeed, of course, you need clinics—and providers—to divert these patients to.

PROBLEMS OF ACCESS

Talk with clinicians who work in psychiatry, mental health, or behavioral health settings, and you'll hear a familiar litany of problems. For one thing, there is the shortage of providers. "Here in Iowa, we've got areas where we have one psychiatrist covering five counties," St. John says. "It's almost impossible to get in with someone, and then when you do, it's a five- or 10-minute appointment, because they're just so busy."

The number of clinicians choosing psychiatry—particularly psychiatric nursing—has declined significantly, perhaps due to insufficient funding for educational programs. "The highest number we had going into psychiatric nursing was when the National Institute of Mental Health, which was then separate from the NIH, had training grants," explains Clement, who is the Director of the Graduate Specialty Program in Psychiatric–Mental Health Nursing at Ohio State University, Columbus. "And many of us who had those training grants are getting way past retirement age!"

The allure of other specialties also keeps people from mental health fields. "There are a lot of jobs and openings for PAs in psychiatry," St. John says, "but there are a lot of jobs in orthopedics or surgery, too—and that's what tends to draw them."

The shortage of mental health care providers and subsequent lack of access to services means a larger role for primary care providers. High-profile expert panels have highlighted the need for integration of mental health into primary care settings—which St. John says is already largely the case.

"Most mental illness is treated in primary care, not in mental health settings," he points out. "Mental health settings should really be reserved for the more challenging patients, the more difficult diagnoses and problems, and co-occurring illnesses."

"Most primary care clinicians have some education in relationship to diagnosing and treating mild to moderate mental health issues, and then they refer on when needed," Clement says. "The problem is, referring on is more and more difficult if there aren't any people to refer to, or if waiting lists are as long as they currently are."

Time is just as much of a problem in primary care as it is in specialty care, and when it comes to psychiatric and behavioral disorders, you can't just order a lab test or an x-ray. "In psychiatry, you have to talk with the person and try to figure out what's going on in their head and how that's affecting their function," St. John says. "It takes more time, and in primary care, that's the problem they have. They've got appointments that may only have 10 minutes sched-

uled, and that's not adequate to obtain a decent psychiatric history."

The importance of both primary care providers and mental health specialists cannot be downplayed, because mental illnesses are among the most disabling and deadly. "If you look at disabling conditions, depression is right up there at the top," St. John says. "Actually, it's predicted that in the next three or four years, worldwide, depression will be the number one disabling illness."

Anorexia is associated with a 15% death rate, and the completed suicide rate for persons with severe depression is also 15%. "If you were to look at one issue alone that we're missing the boat on, it's suicide," Stuart says. "There are more suicides globally than there are deaths from war and violence combined—and the incidence of suicide is rising. So if, for example, a primary care provider sees someone who's depressed, they have to go the next step and also ask about potential suicidal thought."

Clement says it is equally important to integrate primary care services into mental health settings, since many patients with mental illnesses "are not going to show up in a private office in a primary care setting. And people with mental illness die 25 years earlier than the general population, from treatable medical illnesses."

This is why, for example, the APNA is partnering with the Smoking Cessation Leadership Center. "Persons with mental illness are purchasing approximately half of the cigarettes that are being bought in the US," Clement says. "And many of the treatable medical illnesses that people are dying from are related to smoking. It's a whole person you're working with, not just a brain or a body."

REIMBURSEMENT ISSUE

Reimbursement is one of the major deterrents to the pursuit of a career in mental health care. "The whole reimbursement issue makes it difficult to attract people to work in mental health, particularly in community-based clinics, state hospitals, prisons, and jails," which Judd says results in a lack of services for the seriously mentally ill and decreased access for people of low income.

The biggest problem is parity—or rather, the lack of it. What services are covered and at what rate tends to vary by state, and mental health is often not covered at the same rate as physical health. "There are a number of states that now have parity in mental health," Clement observes. "If insurance is offered for physical health and [includes] mental health coverage, it has to be at exactly the same level as physical health, in terms of copays and lifetime limits." But even so, there is not always parity in parity.

Furthermore, many people who need mental health services fall under the Medicaid program, which is state-based and just as variable. "Definitions of 'medical necessity' differ, and providers don't get paid unless they can document according to medical necessity," Clement says. "Even though what people—particularly those in the Medicaid and public mental health systems—*need*, along with their treatment, is a community-based program that helps people find jobs and housing. But that's not 'medical necessity.'"

> *"Services are more readily available to those with jobs and insurance—signs of higher functioning to begin with."*

Another problem is the sheer expense of some of the medications for mental disorders. "A lot of the drugs that we use to treat serious mental illnesses are horrendously expensive," St. John notes. "They'll almost bankrupt some states.... We just don't have those budgets."

Achieving parity and improving reimbursement is a slow process. Clement has been involved at the federal level with a parity bill, but as she notes, "that has not been resolved in terms of the differences between the House and the Senate." Since so many of the programs are administered at a state level anyway, some suggest that might be a good place to begin working on reform.

In October 2007, the Annapolis Coalition, of which Stuart is President of the Board of Directors, released an action plan for reforming the mental health system—particularly for addressing workforce needs. The report (available at www.annapoliscoalition.org) includes the most specific recommendations possible in an overarching "framework" document, and Stuart says the coalition is currently working with some states—including North Carolina, Connecticut, New Mexico, and California—to identify and prioritize their needs and determine how best to tailor the plan to them.

"We're really approaching it not at a federal level

but seeing that the true change would come about at a state level," Stuart says. "The need is derived differently by each state. If I can use the analogy, it's a little bit like having a general way of approaching hypertension, but then you tailor it to the individual."

Whether at the state or federal level, St. John thinks major changes to reimbursement for mental health care will require a cultural shift. "We reimburse for activity, we reimburse for procedures; we don't reimburse for time spent or for decision making or thinking," he points out. When a clinician is being reimbursed 50% (compared to 90% for other medical care), or $12 to $15 per visit for providing medication management, "You have to see large volumes of people in order to get reimbursed enough to pay for yourself and your staff."

In the current economic climate, finding the money is going to take some shuffling. "It would be unrealistic to say that there are new dollars out there, because clearly there are not," Stuart says. "So I think the issue is to reallocate the current resources that are out there and evaluate, Are we getting the best return on our investment of these dollars?"

The irony is that the people with the greatest needs for treatment, monitoring, and support services are the ones who face the biggest barriers to accessing care. "Services are more readily available to people who have jobs, have insurance—which would tell you in and of itself they're probably higher functioning to start with," Judd says. "I mean, if you're having stress holding down a job, you're probably higher functioning at your baseline than the homeless person who is living in the streets and under bridges and doesn't go to shelters because they're too paranoid to be around other people."

TAKING THE SHAME OUT OF MENTAL ILLNESS

No discussion of mental health care can be complete without addressing the stigma associated with mental illness. Americans may have responded with outrage when they saw the deplorable conditions at mental hospitals, but many are still leery of being associated with a mental illness, whether in themselves or in a family member. And the cases that garner the most media attention are not necessarily the ones that reduce stigma.

What Americans see on the nightly news is the schizophrenic man who stops taking his medication and then stabs another man to death while he's waiting for a train. Or the mother with chronic depression who can't get out of bed until someone notices her kids look dirty and underfed, and Social Services steps in to remove them from the home. Do we, as a society, recognize the double tragedy of those situations? Or do we shake our heads in disgust, slap on a "crazy guy" or "bad mom" label, and change the channel?

Public service campaigns are trying to reduce the stigma associated with mental illness, to point out that it can affect anyone. The faces of the mentally ill are diverse: There's the grandfather with Alzheimer's disease who mistakes his granddaughter for his daughter. The 2-year-old autistic girl who has difficulty connecting with family and friends. The soldiers returning from the war zones in Iraq and Afghanistan, struggling with posttraumatic stress disorder (PTSD).

"The message that is being sent that needs to be broadcast more and heard with a different ear is that there is no health without mental health," Clement says. St. John adds that it will take "a lot of time and education" to get that message out to the public, to let people know that it's OK—in fact, it's better—to acknowledge mental illness and seek help for it.

Stuart thinks the troops' return from overseas, which is generating more stories about traumatic brain injury, PTSD, depression, and suicide, may start to turn the tide. "Perhaps because these are our veterans and our heroes, they've served the country, it's opening up a public discussion in a way that's different from seeing the aberrant, violent patient who does something very disruptive," she says. "So, in a sense—and this sounds odd—we're normalizing mental health problems, saying that all kinds of people from all walks of life can develop mental health problems, just as they can develop physical health problems."

The key will be ensuring that the pendulum doesn't swing too far the other way and cause the "stigma reduction" movement to generate its own problems. "On the one hand, we're trying to destigmatize mental illness, but on the other hand, it [sometimes] seems like we're calling any aberrant behavior or problems in life, stress or problems of adjustment, a mental illness," Judd observes.

There are certain niches in which mental illness seems almost "trendy," and industry advertising may encourage that. "Pharmaceutical companies are putting advertisements out there that would imply, 'Gee, you're getting divorced because you had conflict in your marriage—maybe you have bipolar disorder' or 'Your child isn't doing well in school, so surely he has

ADHD and needs to be on medication,'" Judd says. "There's this promoting of drugs for anything and everything. And so that's kind of the other extreme, where any problems in life in functioning must be because of a mental illness, and therefore you need a drug."

RESTORED TO LIFE

With such a grim picture of mental health care in the US, it hardly seems surprising that clinicians don't flock to the specialty. Yet, Clement, Judd, St. John, and Stuart did. Why?

For Judd, "the science of it is extremely interesting." She thinks that as psychiatry becomes more biological and clinicians delve more deeply into what is affecting a patient's function (Is it trauma, prenatal influences, infection, genetics?) and how that impacts treatment choices, more practitioners might choose mental health care. But the biggest reward, she says, is seeing people "return to a higher level of functioning."

"I have never, ever sat down with a client that I have not felt privileged to be allowed into their lives," says Clement, who has been a nurse for 49 years and a psychiatric nurse for 47 of them. "People allow clinicians into their lives in a very different way than they do anybody else."

That can be especially true in mental health, when clinicians must interact on a very intimate level with their patients. It can be challenging, frustrating, even devastating (such as when a patient takes his or her own life). But it can also be infinitely rewarding. That is why St. John moved from family practice and emergency settings to psychiatry, where he has spent the past 15 years.

"When you see people who kind of get back into life and start working more toward their life goals, and you start seeing them get back into their family and their work and their social function, perking up and engaging in the world," he says, his voice conveying a deep sense of fulfillment, "there's just nothing more rewarding than that." **CR**

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