VIEWPOINT

Fixing the Troubled Mental Health System

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Untreated and poorly treated serious mental illness affects the lives of individuals, families, and communities every day. Each year, approximately 39 000 people commit suicide,[1] and the majority of them have acute mental illness. More than half of suicides are the result of a self-inflicted gunshot wound.[1] Many other persons with serious mental illness have lives of isolation, are homeless, or are incarcerated. Because of the stigma of mental illness, an inability to know that they are ill, or troubling experiences with mental health services, people with mental illness often do not seek or follow through with treatment.

In New York State, more than 5 million individuals have Medicaid coverage. The most costly medical care is used by those with mental and substance use disorders who also have chronic physical illnesses.[2] Primary medical costs for these people are for hospitalizations for heart disease, diabetes, pneumonia, and trauma—not for mental illness. In some health policy circles, these individuals are described as having trimorbid illness, reflecting their morbidity across a variety of diseases. A small number of these individuals account for the majority of cost. In Missouri, 5% of Medicaid recipients have comorbid mental, substance use, and physical health disorders, representing 93% of the cost of potentially preventable hospital readmissions.[3]

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The greatest benefits for people with mental (and addictive) disorders in the next decade will derive from providing better care based on current knowledge. Spending money effectively to treat persons with serious and persistent mental illness, reducing their rates of incarceration and homelessness, and providing care are among the great challenges in US society. These patients need comprehensive and uninterrupted treatment (ie, medications, therapy, rehabilitation, and wellness programs) delivered over time, as with any chronic illness. The integration of mental health and substance use treatment with general medical treatment is a goal and vision of the Affordable Care Act that must be pursued.[4]

Three important questions should be addressed.

What Is Affordable Mental Health Care?

Safe and humane mental health and substance use treatment should be provided in the least-restrictive environment, namely, communities and neighborhoods not jails or prisons, nursing homes, shelters, or long-term hospitals. Inpatient care should be used for crisis stabilization with discharge to comprehensive services with evidence-based treatments customized to a patient's stage of illness and preferences. Crisis services should be available in every community, as alternatives to inpatient care, with intensive community teams (eg, assertive community treatment) mobilized when ongoing clinic services are inadequate for engaging and stabilizing patients with psychotic conditions. Assisted outpatient treatment (court-ordered outpatient commitment) should be available as a last resort, with appropriate funding, for persons who do not believe they are ill despite abundant proof that their illness leads to multiple arrests, incarcerations, and rehospitalizations.

Patients and families must come first, not the convenience of payers, practitioners, or health care organizations. Patients who need immediate access to care should have same-day appointments or home visits. Clinicians will need to meet with patients and their families outside their offices in settings more natural and less stigmatizing. Patient "navigators," care managers, and peer-support specialists should be part of teams to help vulnerable people and their families engage and remain in care that will give them a chance for recovery. Shared decision making with patients and families will promote mutual understanding, giving responsibility to patients for their health and recovery.[5]

Medications should be judiciously prescribed to limit the adverse effects that deter adherence, and an array of psychosocial treatments should be available to avoid overreliance on medications, especially for children. The combination of psychosocial interventions and rehabilitation services with medications should be the prevailing mode of practice, and early intervention should become the standard of care. Youth should be assisted to remain in school and adults in work. Supported employment programs (another evidence-based approach) should be widely accessible for persons who have become disabled yet want lives of work and contribution.

Families should be included in the treatment process. Existing privacy laws should be modified so that families can serve as reliable and enduring sources of support for people with serious mental illness.[6] Families often serve as the best early warning system for a relative's mental illness problems and also as the safety net when relatives with mental illness are discharged from the hospital or other institutional settings.

Diversion and alternatives to incarceration for people with mental illness and addictions should be-

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come overarching public health goals of a new, responsive mental health system. Jails are no place for people with serious illnesses of any kind, yet they have become the largest institution for people with mental disorders in this country. Dade County, Florida, has been extraordinarily effective in diverting "emotionally disturbed people" from jails and hospitals, using a partnership between police, the courts, and crisis services (written communication, Judge Steven Leifman, 11th Judicial Criminal Mental Health Project, Miami-Dade County, June 2014).

How Should Progress Be Assessed?

Federal and state governments should prioritize the move of patients from the criminal justice system to the treatment system by focusing on available data that can show change, setting targets for improvement, and creating financial and regulatory incentives. Reducing the volume of people with serious mental illness in jails and prisons and increasing their numbers on the rolls of outpatient-oriented accountable care organizations or health homes (behavioral or primary care) are the best and most convincing ways to measure success in a reformed mental health care system.

Continuously measuring outcomes, and continuing ongoing performance improvement built into standard care and service contracts, will suggest progress is being made. Reliable measures of symptoms, function, and quality of life for mental and substance use disorders now exist. The scores on these measures change as a patient improves, much the same way that blood glucose and blood pressure levels improve to normal values as treatment becomes effective and a person begins recovery. Many mental health measures are simple inexpensive checklists, not costly brain images or large panels of blood tests.

Physicians and patients should work toward shared goals, developed early in their mutual partnership. The goal is not just symptom reduction; patients want to spend time with friends and family, to succeed in work or school, and to contribute to their families and communities.

What Are the Essential Next Steps?

By focusing and reducing the overuse of emergency services, providing special attention to frequent users of these services (high-need and high-cost patients), and engaging them, an essential first step is to retain them in treatment. Targeting of resources to these populations will be essential. For some patients, safe and affordable housing will be a necessary first step toward recovery and accessibility to care. It is important to make high-need, high-cost patients welcome in care, and to engage and retain them in treatment so their conditions and lives come under control for their sake, for those who love them, and for the society that supports them.

Two bills in Congress are currently aimed, for the first time in 50 years, at improving the US mental health care system: The Helping Families in Mental Health Crisis Act (HR 3717, 113th Cong [2013]), a bipartisan bill introduced by Congressman Timothy Murphy, PhD (R, Pennsylvania and a trained psychologist); and The Strengthening Mental Health in Our Communities Act of 2014 (HR 4574, 113th Cong), introduced by Congressman Ron Barber (D, Arizona).

There are substantial differences between these bills. Aspects of the Murphy bill have met with considerable opposition from some advocates (eg, for its support of involuntary outpatient treatment and its proposal to change the federal agencies responsible for mental health). The Barber bill has been criticized for proposing too little. Efforts to find common ground between these 2 bills are under way.

Legislative action is needed to support improvements in a mental health system widely regarded as flawed. A bipartisan bill that increases voluntary and, when necessary, involuntary access to a variety of mental health services, values the judgments of clinicians and families, sensibly extends information heretofore limited by HIPAA (Health Insurance Portability and Accountability Act), and promotes public education about what to do when faced with acute mental illness could be a vital contribution to improving lives and reducing the far-too-common risk of violence by people with serious mental illness, to themselves and others, that aggrieves and frightens families and communities across the United States.[7]

The measure of a society is how well it cares for its sick and vulnerable. That kind of mental health reform is much needed in the United States and can make the greatest difference of all.

ARTICLE INFORMATION

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REFERENCES

1. American Foundation for Suicide Prevention. Facts and figures. http://www.afsp.org/understanding-suicide/facts-and-figures. Accessed July 28, 2014.

2. Melek SP. *Milliman Research Report: Bending the Medicaid Healthcare Cost Curve Through Financially Sustainable Medical-Behavioral Integration.* Denver, CO: Milliman Publications; July 2012.

3. Lewin Group; Missouri Department of Social Services. *Missouri HealthNet Medicaid Pharmacy Report.* Falls Church, VA: Lewin Group; November 16, 2009.

4. Sederer LI. What does it take for primary care practices to truly deliver behavioral health care? *JAMA Psychiatry*. 2014;71(5):485-486.

5. Deegan PE, Drake RE. Shared decision making and medication management in the recovery process. *Psychiatr Serv*. 2006;57(11):1636-1639.

6. Sederer LI. The tragedy of mental-health law. *Wall Street Journal*. http://online.wsj.com/news/articles/SB10001424127887324081704578234002322233718. January 11, 2013.

7. Baird M, Blount A, Brungardt S, et al; The American Academy of Family Physicians. The development of joint principles: integrating behavioral health care into the patient-centered medical home. *Ann Fam Med*. 2014;12(2):183.

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