

# Treating Our “Situations” with Science, Not Shame

Katherine L. Record, J.D., M.P.H.

“We all have situations in our lives,” Antoinette Tuff reminded the heavily armed Michael Brandon Hill, as he stood before her holding an Atlanta elementary school hostage. Seeing the terror in Hill’s eyes, Tuff did something that is all too rare — she reassured him that he was not alone, that he could find treatment, feel better, and have another day.

Hill was lucky: Tuff saved him from making the gravest mistake of his life and spending the rest of it behind bars. She may even have saved his life, not to mention those of the terrified children in the building.

Yet Tuff should not have been the first to recognize that Hill had stopped taking his medications and that his bipolar disorder was spinning out of control. As was the case with many perpetrators of recent gun-related tragedies, Hill’s condition was no secret: he was sick and needed care.

The same was true of Aaron Alexis. The 34-year-old veteran had sought treatment twice, just weeks before he murdered 12 civilians in the Washington Navy Yard. He had visited a Veterans Affairs hospital and had spelled out his symptoms to police: hotel walls were emitting microwaves and speaking to him. The police passed his reports on to the Navy, but the military took no action to help him secure care.

People with severe mental illness account for a negligible fraction of crime, and mental illness alone is not a predictor of violence.<sup>1</sup> Yet the haunting recur-

rence of massacres perpetrated by people known to have symptoms of untreated conditions demands attention — and not just from the press, which uses these stories to associate mental illness with unspeakable violence, a link that perpetuates groundless stigma. Rather than ignore the common thread running through

***People with severe mental illness account for a negligible fraction of crime, and mental illness alone is not a predictor of violence. Yet the recurrence of massacres perpetrated by people with symptoms of untreated conditions demands attention.***

these cases, in an attempt to avoid propagating the myth that all mentally ill people are dangerous, we must take the opportunity to highlight the dreary outlook the mentally ill currently face.

Our health care system’s inadequacy in diagnosing and treating mental illness is systemic and not easily solved. Still, we can start by addressing three critical components. First, primary care physicians (PCPs) have neither the time nor the training to screen patients for many mental illnesses. Second, health plans do not provide adequate coverage for care. And third, the pharmacologic options for serious mental illness are often inadequate, helping some patients but leaving others with recurrent psychotic breaks or blunted minds.

Health crises affect standards

of care. Continuing medical education (CME) requirements, guidelines, and protocols change when epidemics emerge or enter the public consciousness. PCPs, for example, now screen baby boomers for hepatitis C virus infection and all sexually active persons for HIV infection; they also inquire about domestic violence and strive

to balance responsible narcotic prescribing with humane pain control. And we are in fact facing a crisis: more than 43 million adults in the United States alone had a diagnosable mental illness in 2012.<sup>2</sup> The most common point of intervention is the PCP,<sup>2</sup> but neither family practice nor internal medicine boards (which certify 90% of PCPs) require providers to fulfill related CME credits. PCPs do screen for some mental illnesses (e.g., postpartum depression and emotional or behavioral problems), but these are a very small subset of mental health conditions.

Because of training, time, and reimbursement constraints, few PCPs are as familiar with the symptoms listed in the *Diagnostic and Statistical Manual of Mental Disorders* as they are with symptoms

of physical diseases — and therefore cannot effectively screen for signs of mental illness. Insofar as they serve as gatekeepers to care, PCPs should have a basic understanding of the possible presentations of all illnesses — not just lumps, high glucose levels, migraines, or chest pain, but also behavioral indications of possible mental illness.

PCPs may be inadequately informed about mental illness in part because it has been the stepchild of the health insurance industry. Identifying a need and referring a patient for care are of little value if treatment is inaccessible — and are unlikely to occur if the time PCPs spend on such activities is not reimbursable. Indeed, the U.S. Preventive Services Task Force does not recommend screening for such conditions as depression unless a patient has coverage for pharmacologic treatment, talk therapy, or both. Disparities in mental health care are thus closely correlated with coverage (although utilization varies along other lines as well).<sup>3</sup>

This bifurcation of physical and mental health care is both outdated and underestimated. The Mental Health Parity and Addiction Equity Act of 2008 requires plans that cover any mental health or substance-use disorder benefits to provide them at parity with physical health and surgical benefits, and the Affordable Care Act expands this law, applying it to most health plans (those created or substantially changed since March 2010) — but notably not to all. Furthermore, the law still does not mandate that plans cover all mental illnesses or include all medically necessary treatment. In addition, quantitative limits (e.g., 30 days of inpatient care)

can be placed on psychiatric care, as long as they similarly apply to physical benefits, such as physical therapy or skilled-nursing-facility stays. Moreover, if in-network providers or facilities are not available, insurers need not provide beneficiaries with alternative options. The growing number of psychiatrists refusing third-party payments only exacerbates the crisis.

Of course, referrals and adequate insurance don't help if treatment is ineffectual. Although antidepressants and anti-anxiety drugs have multiplied, reducing the impetus for self-medication that can lead to substance-use disorders, antipsychotics prove therapeutic only for some patients, and their unpredictable effects necessitate trial-and-error prescribing. For many patients, efficacy is marginal and side effects can be significant, making adherence less likely. With many pharmaceutical companies exiting the mental health market,<sup>4</sup> mental health advocates should push industry and the government to invest in antipsychotics at a level commensurate with the burden of illness, just as HIV advocates fought for access to antiretroviral therapy (ART). The scientific advances in ART changed the diagnosis of HIV infection from a death sentence to a chronic condition. Our understanding of the causes of mental illness remains imprecise, whereas the identification of HIV as the cause of AIDS allowed drug developers to target a specific infection. Still, it was the substantial financial investment, which has yet to be made in mental health, that allowed HIV to evolve from a complete unknown to a controllable condition in only two decades.

In 2012, the National Institutes of Health (NIH) spent nearly 26% more research dollars on HIV than on mental health, even though the prevalence of serious mental illness is more than three times that of HIV infection.<sup>5</sup> The brain is complicated, but that doesn't mean it should be neglected. Asserting that better treatments are not possible does our health care system no service. Given that the market for tolerable and effective antipsychotics is far larger than that for ART, it makes both financial and scientific sense for the pharmaceutical industry and the NIH to invest much more than they currently do in relevant research and development.

We need more people like Antoinette Tuff to come forward and admit that mental illness touches us all. It is crucial that physicians, certainly PCPs, be able to recognize signs of mental illness and treat accordingly, whether directly or through referral and follow-up. All insurance plans should cover all mental illnesses and substance-use disorders at parity with physical health and surgical benefits. And if advocates became more vocal, perhaps increased investment in developing effective and tolerable antipsychotics would bear fruit. Serious mental illness need not result in repeated tragedy, but our first step is to acknowledge that it wreaks havoc on us all, not just the patients we see in the news. After all, we all have situations.

Disclosure forms provided by the author are available with the full text of this article at [NEJM.org](http://NEJM.org).

From the Center for Health Law and Policy Innovation, Harvard Law School, Cambridge, MA.

1. Elbogen EB, Johnson SC. The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Arch Gen Psychiatry* 2009;66:152-61.
2. National Institute of Mental Health. Any mental illness (AMI) among adults ([http://www.nimh.nih.gov/statistics/1ANYDIS\\_ADULT.shtml](http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml)).
3. Miranda J, McGuire TG, Williams DR, Wang P. Mental health in the context of health disparities. *Am J Psychiatry* 2008;165:1102-8.
4. Weintraub K. Dr. Steven E. Hyman, on understanding drug treatments for mental disorders. *Boston Globe*. August 5, 2012.
5. NIH Research Portfolio Online Reporting Tools. Estimates of funding for various research, condition, and disease categories (RCDC). April 10, 2013 ([http://report.nih.gov/categorical\\_spending.aspx](http://report.nih.gov/categorical_spending.aspx)).

DOI: 10.1056/NEJMp1401127

Copyright © 2014 Massachusetts Medical Society.