11 Points Regarding How We Can Improve Mental Health Outcomes, and Lives

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1. Improve Access to Mental Health Care

- Traditional model of outpatient medical care is not suitable for many people
- But, nontraditional services are rarely available.
  - For example, studies show that Assertive Community Treatment (ACT) is offered to only 2% of patients who could benefit from it
- Many people need more than medication and therapy, and could benefit from supported employment, supported education, wellness, etc
- Very little evidence-based practice is delivered outside of academic research centers, but this can be done
  - For example, CBT can be delivered in people's homes (Smith & Yanos, 2009)

2. Recognize that many people are not motivated to engage in currently available psychiatric treatments

- Negative symptoms, poor insight, and depression can interfere with active treatment engagement
- Research shows that people with delusions do not give them up because the alternative explanations provided by clinicians are not as compelling as their own explanations (often used to explain hallucinations)
- Poor insight has psychological and neurological components, and is a major problem. But a new form of CBT can be useful with people with poor insight.
- Motivational Interviewing can help, but its effects are modest
- Many people have had negative interactions with mental health professionals, and/or significant side effects from medications
- We need better solutions

3. Create a proper balance between pharmacological and psychological treatments

- There has been a disproportionate influence of the pharmaceutical industry in American medicine, including psychiatry.
- Early claims by drug companies are often disconfirmed by later, randomized controlled trials conducted outside of industry
- The causes of mental illness are still largely unknown, but clearly involve a complex interaction of environmental and biological factors
- Too little treatment has focused on restoring functioning
- Medication not always needed, even in cases of SMI
- More research is needed on non-patented substances such as fish oil high in Omega-3 fatty acids
- Psychological interventions are often as effective as medication, yet these are not given as much "press"

4. Treatment programs need to be more concerned with results than with their daily census

- Are evidence-based practices being delivered? (if so, which ones?)
- How qualified are staff that are delivering treatments? (what training/certification is there?)
- What is the evidence that treatments being delivered are effective?
- What processes are in place to improve outcomes and improve staff skills?
- How are treatment decisions made: diagnosis?, no basis at all (everyone gets the same groups?)
- What is needed is for incentives to be given for highly trained staff, and for good outcomes, based on personalized treatment

5. More research on etiology, prevention and treatment is needed

- Bad mothers? Broken brains?
- What about stress, immigration, drug use, exposure to viruses, parental age, birth complications, genetics?
- How do these factors interact to cause mental illness?
- Research funding has not kept up with the number of researchers entering the field
- It is more and more difficult for young scientists to begin a career in mental health research
- This could lead to an exodus of talented researchers from the field of mental health research, and a slowing down of new treatment development

6. We need better interventions for people at high-risk for mental illness

- Current high-risk programs for psychotic disorders delay but do not prevent illness onset
- Few young people wish to be engaged in these treatments
- Treatment needs to be delivered in non-stigmatizing environments, or in people's homes

7. Prevention and early identification efforts need to be improved

- Right now, prediction and prevention efforts are not successful for forms of serious mental illness

- Better health care needed for mothers at high-risk for having a child with a serious mental illness (e.g., where there is risk for 2nd trimester infection, malnutrition, drug use, etc.)

- More intervention needed during "pluripotent risk state"

- Much of this can be school-based, and secondary to routine monitoring of social and academic functioning

8. Diagnostic practices need to be overhauled

- Many diagnoses have poor reliability, questionable validity, and limited utility for guiding treatment
- Our understanding of psychiatric conditions should be based on the dimensions of functioning that are abnormal, for example:
  - Emotion regulation
  - Motivational disturbance
  - Stress reactivity
  - Aggression
  - Cognitive impairment
- This is the basis of the NIMH Research Domain Criteria (RDoC) initiative

9. More and better assessments are needed

- Comorbidity is common
- Comorbid disorders often not assessed, for example:
  - PTSD or OCD along in schizophrenia
  - Depression in ADHD
  - Depression in antisocial personality disorder
  - Anxiety disorders in depression and substance abuse disorders
- More thorough assessment is necessary
- Use of valid assessment instruments by trained staff should be the norm!
- Can this happen in the currently overburdened mental health system?
- Do we have staff trained to deliver the treatments for the comorbid conditions?

10. Society needs to be better educated about mental illness

- A significant percentage of the population has a mental illness: ~1 in 4 in a given year

- Many people are unaware of the nature of mental illness

- Stigma is still a huge problem, placing more stress on clients, and reducing utilization of available treatments

- More pressure is needed on funding agencies to incentivize MH agencies to deliver evidence-based treatments, and promising practices

- Groups like NAMI, and every individual, can play a part in this.

11. Barriers between systems need to be removed

- Those who go on to develop psychosis are often known to child services

- Partitioning of services into separate child and adult systems discourages combined approaches that might enhance outcomes by marshaling all relevant forces

- The discontinuity in service provision inhibits a longitudinal perspective

- And, there is evidence that preventative or ameliorative interventions for adult disorders may require delivery by those who conventionally work with children

Removing Barriers (Continued)

- Closer ties between mental health experts and the following groups:
  - special education teachers
  - juvenile justice program staff
  - social workers
  - developmental psychologists
  - family therapists
- Example:
  - Special education teachers, by definition, work with children with serious emotional disturbance and/or cognitive/academic difficulties, a substantial proportion of whom can be considered at high risk for developing a serious mental disorder
  - They have many skills for improving the social and academic performance of these children and adolescents that are essentially unknown to child psychiatrists and psychologists
  - But, these teachers typically lack training in the identification of risk factors for serious mental disorder, and in interventions developed within psychiatry

Conclusions

- We know more than ever before about mental illness
- The number of research studies and publications has increased dramatically in recent years
- In contrast, funding for mental health services has been reduced, and funding for research on has not increased
- Treatment of mental illness is too tied to diagnosis and the requirements imposed by insurance companies and mental health bureaucracy, and not driven enough by advances in the science of mental illness and its treatment
- Primary and secondary prevention is essentially absent in psychiatry
- There is little accountability in mental health services, and far too little evidence-based care compared to other branches of medicine
- More advocacy is needed