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The Colloquium
David Rogers Health Policy Colloquium
Mental Healthcare Reform
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I am delighted to discuss with you issues in health policy with particular emphasis on mental health. As you might imagine the demeanor and management by national leadership has a profound impact on everything and that includes healthcare and mental healthcare. I fortunately attended a conference over the weekend with major national leaders in healthcare today. I felt it would be valuable to review the vast array of issues with which people on all sides of the table are struggling. One chronic concern of course is the fact we spend 18% of our Gross Domestic Product (GDP) on healthcare while the next highest country figure is 11%.

That figure catches everybody's attention. We are witnessing the impact of moves made by the current administration in addition to previous policy moves made before to address similar issues. I would like to have our session be maximally interactive.

The status of the administration in Washington is also influenced overwhelmingly by the political climate and political developments. It was pointed out in our conference that in the last 20 years the president has almost consistently lost something approaching 30 seats in the House each time, and, as we are all aware, there is great attention to the next off year election later in 2018.

Even before that, there are restrictions on how often congress in a year can bring proposals for congressional debate that require less than 60 votes. This is a big game changer. The realization therefore acclaimed by many is that Democrats will now matter.

Issues attracting particular emphasis include drug pricing. I will say more about that particularly in light of the recent report by the National Academy of Medicine headed by Norm Augustine – an extraordinarily distinguished national leader who reported at this meeting just yesterday.

The general sense from many is that entitlements may not enjoy a focus until 2020 or 2021. I say all of these things with hesitation because Washington is always unpredictable and in this administration everything seems unpredictable.

The new nominee for Secretary of Health and Human Services (HHS) Alex Azar, comes from the pharmaceutical industry. The sense is he will focus particularly on payment reform and drug pricing. Meanwhile, the government continues much of its work as best it can regardless of what is happening at the top leadership level, so there has been activity involving changes in bundling; e.g. increasing the number of medical conditions and widening the range of healthcare components covered.

ACA or Obamacare survived except for the loss of the national individual mandate. One key spokesman felt ACA may become more of a program for the poor. The good news is that though the uninsured may rise from its current 8.6% to 9% or 10%, those numbers are certainly better than figures we experienced prior to Obamacare.

National leadership does seem to be assaulting a number of different agencies in Washington particularly Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ) which focuses on quality, the Substance Abuse and Mental Health Services Administration (SAMHSA), and others.

NIH may be in a protected situation. As you know, the administration budget recommended a $6 to $7 billion cut in NIH. Congress resisted and added another $2 billion to the NIH budget which was good news.

Other issues include the rationalizing of quality measures. Many of us have felt troubled by the countless number of quality measures, the uneven value, and the fact that different entities use different quality measures. One critical person who had been working on this in the government until recently said there was great frustration in dealing with the questions regarding quality measures.

There are some possibly fanciful hopes for an increase in funding going to social services. Many have argued for some time that many social factors influence the health of the population. So were this to come to pass, issues like housing, education, and job creation may all receive greater attention. In other countries there is a higher resource allocation to social issues while healthcare is given a lower allocation. This is very opposite to U.S. allocations.

Physician burnout is on people's minds. Possibly connected is the increased number of physician suicides. Problems troubling doctors include changes in drug policies along with large increase in work and time secondary to EMR use. So increasingly there is a constriction of how much latitude the local entity; i.e. providers or provider institutions can have regarding medications and an increasing effort accompanying the direct medical care.

People in public health noted that for the first time since 1973 in this past year life expectancy in the United States was down. It was pointed out too that there was an increase in opioid deaths while there had been good news reflected in a decline in cardiovascular deaths. But 2.5 million people in the United States are said to have substance disorder and 75% of this is occurring within the work place.

Public health advocates are looking for greater attention to infrastructure for public health. Generally, however, there also seems to be financial raids on efforts for prevention.

Another concern in Washington is the ability of the health system to respond to catastrophes. We have seen that here in New York. We take appropriate pride in the fact that when hurricane Sandy hit New York, health people in state government, hospital associations, and institutions were extraordinarily collaborative and responsive. A danger in cuts to teaching hospitals is a depletion of reserves so vital in catastrophes.

Right now many of these arguments in Washington are in play while decision time to raise the debt ceiling by this Friday, January 19th hovers. Specific health care issues caught up in this frenzy include the continued effort to delay reduction of DSH revenues to hospitals and the arguments regarding reauthorizing the CHIP Program, covering children's health among others. Also, causing great concern is the broad conflict regarding 340B legislation. 340B provides funds nationally which reduce drug costs for certain hospitals and indigent patients.

Other ongoing concerns include the recognition that we still have suboptimal figures for infant mortality in the United States and that the threat to entitlements despite the statement I made earlier is always at risk as people deal with budgets, taxes and the like.

Obviously we have to find ways of bringing healthcare costs under control. There has been both effort and progress in that, but there is a long way to go.

Another preoccupying problem is the opioid addiction challenge. It is felt that this problem arose because of aggressive marketing, the establishment of pain as a critical fifth vital sign, and the turn to opioids for pain relief. That was one of the main discussions at the meeting.

The full set of national issues has perennially been a context in which mental health has tried not only to sustain its support, but also its status. In a recent paper, I pointed out that there are a number of developments which could logically argue for greater attention to mental health. Some of those developments include:

1. The World Health Organization has now identified mental illness including depression and other psychiatric disorders as having one of the greatest impacts if not the greatest on the daily function of people all over the world.
2. The recognition many war veterans are returning with depression, suicide, Post-traumatic Stress Disorder and other maladies. This is creating widespread plight in veterans. The uneven reputation of the Veterans Administration Health Program compounds that issue. I think the new head of the Veterans Administration Health Program, David Shulkin is a superb choice. He is addressing this. Related to this is the effort to deal with the times and needs when veterans seek health services and the willingness of the nation to allow them to use non-veteran facilities.
3. The increasing suicide rate in many sectors of the citizen population.
4. The recognition that comorbidity (i.e. coexisting psychiatric and non-psychiatric conditions lead to some of the highest costs in health.
5. The numbers of mass killings by people with severe psychiatric disease.

I cannot cover everything, but I wanted to paint a picture of the extraordinary challenge that people in leadership positions and all aspects of the federal government are struggling to address at a time of pervasive limited resources.

Let me emphasize. I have spent much of my life working in mental health. My first exposure to psychiatric care or the lack of it was as a second year Rutgers College student who went to a state hospital to witness a most distressing sight. That was an empty room with only two things visual to the eye. That was a naked man and the smearing of feces across the wall. What a grotesque picture and a shocking introduction to mental illness.

I will not bore you with my various involvement and positions in mental health, but I will say that I always felt it was strongly connected to the rest of health. Early in my training, I saw that people went to multiple clinics or experienced multiple symptoms which often were modified when appropriate mental health treatment was provided. I experienced that myself with patients in private practice. But, despite that, the contention for resources for mental health has always experienced great opposition.

Before I went to NIMH as the Director, I was asked to prepare a budget for a mental health program in a new geriatric institute in Denver, Colorado. I did, only to have it rejected because the economists concluded it would not be profitable because of inadequate reimbursement.

As NIMH Director, I had to reverse what had been an attack on mental health programs and financing by the administration in the '70s. This was reversed for a time when Rosalynn Carter and the mental health commission initiated by the Carters were active in the late '70s. But new challenges arose when the Reagan Administration was elected in 1980. We had quite a battle inside government in early February of 1981 to preserve elements of the mental health federal involvement. The block grant dictated by the administration redirected monies from community mental health centers which had brought mental health closer to population centers where city citizens could see them and utilize their services. But the block grant would send money to the states with the only stipulation being that the money was for substance abuse and mental health. One might have assumed that stipulation should have been obvious. But it took efforts by democratic congressmen to prevent the federal government inserting a policy which would have said to the state, here is the money and in essence use it as you will.

These issues have not necessarily been as partisan in the past as they are now. There were times when superb republican leaders like Mark Hatfield and Pete Domenici as well as Democrats like Kennedy and Wellstone, and others argued the case for mental health.

Some 5-6 decades ago, mental health had enjoyed remarkable enthusiasm in the early '60s. Psychotherapies were at one time deemed promising in treatment of all kinds of psychiatric conditions. That hope was not borne out. Yes psychotherapy is important and yes it helps in many different areas and today there are many different kinds of effective psychotherapy. But disappointment grew at that time because psychodynamic psychotherapy did not do all its most enthusiastic protagonists proclaimed it would.

That had an impact on mental health manpower because the percentage of graduating medical students, for example, who went into psychiatry in the early '60s went down from about 10% to some 3% by the end of the '70s. Interestingly enough there was, at about that time, i.e. in the '80s increasing great excitement with regard to brain research. In fact the awarding of the Nobel Prize to Roger Sperry for demonstrating the different functions of the two brain hemispheres and the Lasker Award to Lou Sokoloff for introducing the substance that made PET scans a useful imaging technology had a lot to do with reversing what was a rather critical stance of federal government leadership in the early '80s regarding research in mental health. The early '80s experienced improvement with regard to support of mental health research and the NIMH. This period, we witnessed a reorganization and strengthening of the research components of NIMH with a particular focus on psychiatric illnesses and treatment rather than what had been seen as a rather diffuse policy not as directly linked to the problem of psychiatric disorders of patients.

Brain and biological science grew in stature. Neuroscience programs began to flourish.

So these broad issues; i.e. the World Health Organization pronouncement, PTSD and other veteran disorders, the frequency of suicides in this country, the recognition of the cost of care when patients suffer from comorbid conditions of mental health and non-mental health illnesses and others have brought greater attention to the mental health field.

Having said that, if you just think of the broad health issues with regard to national policy, and then observe the priority mental health secured, you can see it led to a low priority for mental health despite its significance.

Now a recent survey the Brain and Behavior Research Foundation (BBRF) did of 84 leading mental health research experts with regard to their level of optimism for research in the field was encouraging. Many felt by virtue of developments in genetics, imaging, molecular biology, new technologies, and the potential of precision medicine, that there are much greater possibilities in light of these current state-of-the-art techniques and devices. Incidentally, there has also been increasing enthusiasm regarding psychosocial programs with CBT and interpersonal therapy; e.g.

One other factor of great interest is the fact that research reveals factors that may be important in one illness may also play a role in another illness. So for example, there is recent information suggesting there are genetic factors which can influence the time of onset of brain diseases. Illnesses may be delayed if individuals have these helpful genetic factors. While the primary focus has been on Huntington's disease in this regard, there may be benefits for other diseases such as ALS and Alzheimer's as well. You can imagine the excitement when people think about somebody who might have contracted Alzheimer's at age 70 having it delayed to 93.

Well, depression is rampant and there are a host of approaches to the treatment. Mood disorders not only cause profound depression and diverse physical symptoms, but are major factors in generating suicide attempts and completion of suicides. Many risk genes have been identified. Yet there is also strong support for the importance of environmental factors.

Dr. Eric Nestler noted in an excellent recent journal of Science that early life stress led to lifelong susceptibility to stress and to the later onset of stress precipitated depression observed in animals. Many experts would say that this is also applicable to human beings.

There has been some concern about the slow pace in which new mental health treatments are developed, but there are a variety of new efforts in this regard. In the area of depression one concern has been the length of time it takes for antidepressants to be effective. There has been work done on a substance called ketamine which at low doses has been shown to work more

rapidly. The problem, however, since there are often problems with new developments, is that there are side effects which can be worrisome in the use of ketamine. So scientists are investigating other ketamine like compounds which may not have the same side effects.

Meanwhile the worldwide number of suicides is about 800,000 each year, one every 40 seconds. In the United States, the incidence is 42,000 per year. Many suggest that 90% of those suicides are current patients suffering from depression.

Let me say one more thing about another disorder which I believe has often gotten short shrift. That is anxiety disorders. Even reflecting back to when I was Director of NIMH, I realize anxiety disorders did not get the kind of attention it should. Today they constitute one of the most frequent psychiatric disorders. Roughly 8% of teenagers from 13-18 have an anxiety disorder and symptoms commonly emerge as early as age 6. Unfortunately, only a fraction of people who have the disorder receive treatment.

Multiple factors lead to such disorders. The dangers, however are great. As Anne Marie Albano has stated anxiety disorders often do not abate without treatment. She says they build steam, they become more complex and we too often have a series of unfortunate results including decline in school work, loss of relationships, family problems and possibly even further destructive behaviors including drugs, undisciplined sexuality, suicide thoughts and even suicide.

I am pleased to say that we have established a new Youth Anxiety Center (YAC) at NewYork-Presbyterian. We have outstanding child psychiatric experts both at NewYork-Presbyterian/Weill Cornell and Columbia. They provide all kinds of treatments, often combination of treatments; e.g. medications and psychosocial treatments, group therapy, and family therapy for adolescents and young adults suffering from anxiety disorders. We see patients at all economic levels. In the few years of its establishment, we have already done well in excess of 50,000 treatment episodes for people. We have clinics in conjunction both with Columbia and also Cornell. We also have partial hospitalization programs in Westchester at the psychiatric hospital as well as at NewYork-Presbyterian (NYP) in Manhattan under NewYork-Presbyterian and Weill Cornell direction. There is research being done led by people such as Frances Lee and Blair Simpson with researchers and clinicians working collaboratively. This whole YAC program has been produced exclusively by philanthropy which is instructive. It is not easy to secure adequate resources for clinical research and clinical mental health care. Fortunately we have had a number of generous donors who have enabled us to proceed.

I will for purpose of time have to skip many other psychiatric disorders; schizophrenia, anorexia, etc. But the conclusion is that those concerned about mental health disorders struggle against

what I explained at the beginning were the extraordinary issues the nation is grappling with for reasonable attention. It is further hampered by stigma which has declined but is not extinguished yet.

We are not without our success. The American Psychiatric Association (APA), National Alliance for the Mentally Ill (NAMI), and the Association of Academic Health Centers (AAHC) among others have been stalwart advocates. One success has been the development of a marvelous organization called the BBRF which provides research support for young, middle, and senior investigators all over the world in all disciplines. This has been the source of a great deal of outstanding and innovative research.

There is a remarkable story of the efforts of the originators of the BBRF at first called National Alliance for Research on Schizophrenia and Depression (NARSAD) to start providing grants for support in psychiatric research. There was a debate about whether to spend the $50,000 they had already accumulated because they did not know if there would be another $50,000. They have in the last 30 years provided close to $400 million for such investigators. Beyond that Steve and Connie Lieber have also created the Lieber Institute at John Hopkins. They are remarkable leaders in this effort. They also recently created the Humanitarian Award to commend people who were doing things in mental health not only in research, but in various areas devoted to mental health. Of note is the fact that the recipients of those awards so far include Rosalyn Carter, Senator Ted Kennedy, Vikram Patel working in India, Constance Lieber, David and Betty Hamburg working in international mental health as well as on efforts to confront and reduce violence globally. They have also been leaders in child and adolescent psychiatry. This year this award was given to Doctors Without Borders because of the enormous effort that outstanding group puts into treating the mental health tragedies related to war. They are terrible tragedies as we have seen around the world.

Mental health is also looking at other ways to maximize treatment and lower cost including integrating care in mental health and general health by getting primary care and other disciplines to work more closely together. There is also momentum in technology and telepsychiatry with great leadership that's been spurred at NYP by Dr. Steven Corwin's identification of technology as a central part of the hospital's efforts going forward in conjunction with simultaneous attention to patient satisfaction in care. New techniques of technology are exploding here. They join NYP's attention to the needs and desires of patients by emphasizing an empathic approach to patients. This combination is a hallmark of NYP's efforts in mental health. We have much to commend and be proud of in the two departments of psychiatry and the leadership provided by Drs. Steven Corwin, Laura Forese, Philip Wilner and the hospital leadership in mental health.

I have put on the table a set of issues that exceeds what one can do in an hour. Our global problems and national problems are serious. The hope for a return to collaboration between the various political leaders in Washington and attention to the great issues that afflict us all is shared by people around the country.

I feel we have been in a national depression in the last year or so and our hope is that with real interchange between the 3 major elements of government and the political parties, and with greater collaboration between patients, providers, payors and government that we will start to address these problems in a constructive and rational way.

There have been great efforts by the mental health people who work at NYP and in the two outstanding medical schools and departments. There has been much invaluable products provided from distinguished faculties in those centers led by Dr. Jack Barchas and his team, Dr. Jeffrey Lieberman and his team, and Dr. Philip Wilner who heads behavioral health for the whole hospital system. We have one of the largest psychiatric programs and faculty in the country. It is right that we are so active and large in size. NewYork-Presbyterian/Columbia and Weill Cornell are leaders in this field, and I think we are well-served by outstanding people working every day to contend with the challenges to bring more and better care to patients here and throughout the world.