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The mentally ill deserve better care

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PRIOR TO THE shutting down of the large state hospitals in the 1960s and '70s, there was very little homelessness. Warehousing broken souls wasn't good, but setting free these souls with few if any community supports was not progress. The state saved millions of dollars, sick people died like flies, and we came to accept large numbers of untreated mentally ill people living in the streets as OK.

Hearing voices is not a lifestyle choice. Delusional thinking is not a matter of personal convictions. Most of the people living on the streets are not there as a consequence of not competing well in a competitive economy. While a lack of affordable housing is part of the equation, it's not a very big part. Homelessness, with few exceptions, is about untreated illness.

Homelessness is the tip of an iceberg. The nontreatment of mental illness has deep roots. The majority of Americans believe that there's not really such a thing as mental illness. They think it's about character or morality or making good choices. That we're all a little crazy anyway. That there's no way to diagnose mental illness without impinging on peoples personal freedom. That if the mentally ill really wanted to get better they could "snap out of it." That there are no effective treatments for mental illness. That if there were effective treatments we couldn't afford them, and, besides, crazy people are just going to go crazy again anyway.

Getting well become less likely the longer you've been ill.

Bizarre thinking and behavior tend to catch most of our attention and distract us from the real problem, which is that mental illness disables people. What the very different illnesses — schizophrenia, manic depression, major depression, alcoholism, substance abuse, autism spectrum disorders, as well as many forms of brain injury and mental retardation — have in common is that the sufferer's world often becomes so disordered and discontinuous that navigating the world independently is not possible and patients find themselves dependent on the beneficence, good intentions, and clinical skills of others, things in short supply even in the best of times.

What these illnesses also have in common is that we now have a wide variety of educational, behavioral, and pharmacological interventions that are remarkably effective and can make the difference between dependence and independence. We know much more than we did 30 years ago, but much of what we know goes to waste because we haven't figured out how to pay for mental health care. Patients and their families are left to struggle and figure out things on their own. Our facilities are pathetic. The cost of providing services is controlled mostly by having them be unavailable.

Good care would be good for patients and their families and good for the community and society as a whole. Unfortunately it's not good for the third-party health insurance industry, and it's not a good deal for states with budget problems. In both cases, noncare — evading the costs of and responsibility for providing mental health care — is too easy, and the down side of noncare is borne too quietly and out of sight by patients and their families.

Two weeks ago, with the stroke of a pen, Massachusetts disavowed responsibility for 200 chronically ill patients. Private hospitals will have to absorb the cost of their care. I predict that private hospitals will accomplish this by noncare.

Along with simply refusing to pay for care, the insurance industry distorts the care they do pay for with carveouts and arbitrary rules that force hospitals and providers to spend as much time and effort filling out forms to make sure they get paid as they do providing care.

What can and can't be done for any given patients depends as much on their insurance as it does on their diagnosis and symptoms. With some insurers I'm allowed to diagnose and treat depression, with others I have to say they have a headache or some other "physical" ailment because I'm not trained as a psychiatrist. A system where the dollars were allocated by patients, their families, hospitals, and other providers rather than an industry with a proven negative interest in mental health care would be a big step in the right direction.

Mental illnesses are not self-limited diseases. Getting well and having a life worth living become less likely the longer you've been ill. Being depressed for a month doesn't carry as ominous a prognosis as being depressed for a year. The chances of having another psychotic break are directly proportional to how many you've already had. The longer a child is allowed to stay in autistic isolation the less likely they will be able to join the world. At certain point in all these illnesses the patient's spinning wheels dig ruts so deep that the chances of getting well become remote.

What if hospitals and doctors diagnosed, stabilized, and treated illness? What if the focus was on how illnesses take choices away from patients rather than whether the patients were dangerous to themselves or others? What if patients could be protected and taught how to take better care of themselves, as we do with other illnesses?

There's every reason to believe that the difference between those who get better and those who don't is good and early care. One of the reasons patients and their families don't make more noise is the shame involved. Families affected by mental illness think they are the only ones, but the truth is that families unaffected by mental illness are rare. It's time for the rest of to speak up and find a way to not throw so many human beings away.

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