The Public Mental Health System

Analysis and Suggestions for Improvement

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Topics

- What is Mental Illness?
- Getting What We Pay For
- The Need for Other Options
- The Right to Other Options
- The Effort to Create Other Options

What is Mental Illness?

- Chemical Imbalance?
  - No Proof
- Genetic Defect?
  - Studies Seriously Flawed; Not established
- Any Kind of Brain Defect (Medical Model)?
  - Still looking
- Most Likely: Event(s) Caused

Getting What We Pay For

- Medicaid/Medicare/SSDI/SSI System Requires People to be Certified Permanently Disabled and Permanently Poor as Criteria for Services.
- Other Funding Sources Virtually Eliminated Over Last 15 Years
- We Are Getting Permanently Disabled and Permanently Poor (non-working) People
  - Less than .5% (one half of one percent) of People Put on SSDI Later Work

The Need for Other Options

- 6-fold increase in disability
- Psych Drugs are of Limited (at best) Efficacy
- Psych Drugs are Extremely Harmful
- Other Approaches Yield Far Better Outcomes for many People
  - Current System At Least Doubling Number Certified as Chronically Mentally Ill
  - Idea that MI has to be life-long is erroneous

Psychiatric Drugs at Least Doubling People Certified Chronically Mentally Ill

- Anatomy of an Epidemic, *Ethical Human Psychology and Psychiatry*, Volume 7, Number I: 23-35, Spring 2005
  - 6 times *Per* Capita Disability Increase for Mental Ilnness since 1955 when Thorazine Introduced.
  - "Atypicals" Doubled Already Elevated Mortality in Ireland Study.
  - Ritalin, etc., Cause Psychotic Reactions in Significant Number of People → DX Serious MI
  - SSRI Anti-Depressants Cause Psychotic Reactions in Significant Number of People → DX Serious MI
- Each "atypical" increment increases mortality by 2.5 Times (Brit. Jrnl. Psych 2006)

Our Massive Drugging of Kids is an Abomination

The Stimulants (Ritalin, Etc)

- Chemically Similar to Cocaine
  - Kids given Ritalin 4 times likely to use Cocaine according to N. Lambert study
- No Long-Term Benefit
- Serious Harm
  - Causes Psychotic Reactions in Many, Resulting in Mental Illness Diagnosis and Ruined Lives.
  - Cardiovascular harm
  - Retards Growth
  - Many others.

The Antidepressants

- Also Chemically Similar to Cocaine
- Most Not Approved for Kids
  - No one knows what these drugs are doing to kids' developing brains
- Efficacy Not Established
- Causes Homicides and Suicides
  - It Appears All or Virtually All of the School Shooters Were on Antidepressants or Other Psych Drugs
  - Healy estimates 20,000+ suicides caused by SSRIs (not just kids)
- Also Cause Psychosis in Significant Numbers resulting in MI Diagnosis and ruined lives
- Sleep Disruption
- Suppresses Growth
- Endocrine Problems (including lactation, sexual dysfunction, cancer, heart disease and on and on)

Neuroleptics

(e.g. Thorazine, Haldol, Zyprexa, Risperdal)

- Not Approved for Kids
- Dubious at Best Efficacy
- Very Harmful, Even Fatal and Seriously Shorten Lives
  - New Ones Probably Worse than Old
  - Tardive Dyskinesia and other Extra-Pyramidal Symptons
  - Neuroleptic Malignant Syndrome (Often Fatal)
  - Diabetes
  - Massive Weight Gain
  - Brain Damage
  - Etc.
- Even Infants Being Given These Drugs
- People Giving These Drugs to Kids Should Be Taken Out and Shot [Disclaimer: Rhetorical Device]

Kid Drugging

- ADHD is a Fraud
  - ADHD=Being a Kid
- Screening is a Drugging Dragnet
  - Invalid Instruments
  - Don't Need to Look for Younger Kids With Problems
- Blaming Kids for Failures of Adults in Their Lives
- Drugs Are Used to Make Kids Behave Like Adults Want (especially schools)

There Are Effective Non-Drug, Non-Coercive Alternatives

- Soteria
  - Being Done In Europe
  - Italy Abolished Hospitals in 1970's
- Finnish "Open Dialogue" Program (Seikkula). 5 Yr Results:

  Out of 42 patients, 82% did not have psychotic symptoms at end of five years, 86% had returned to their studies or jobs, and only 14% were on disability. Only 29% had ever been exposed to a neuroleptic medication and only 17% on neuroleptics at end of five years.
- Michigan Psychotherapy Study
- Community Mental Health: A Practical Guide
- http://psychrights.org/Research/Digest/Effective/effective.htm

Coercion: Psychiatry Has Lost Its Way

- "Therapeutic Alliance" Most Important Thing.
- Involuntary Commitment and Forced Drugging Should be Exception and Hard to Obtain.
  - Instead "Path of Least Resistance"

When Involuntary Commitment Constitutionally Permissible

1. Confinement takes place pursuant to proper procedures and evidentiary standards,
2. Finding of "dangerousness either to one's self or to others," and
3. Proof of dangerousness is "coupled ... with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality.'

Kansas v. Crane, 534 U.S. 407, 409-10, 122 S.Ct. 867, 869 (2002).

- Incapable of surviving safely in freedom. *Cooper v. Oklahoma*, 517 U.S. 348, 116 S.Ct. 1373, 1383 (1996).

When Forced Drugging Constitutionally Permissible?

Court Must Conclude:

1.Important governmental interests are at stake,

2.Will significantly further those state interests - substantially unlikely to have side effects that will interfere significantly (with achieving state interest),

3.Necessary to further those interests. The court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results, and

4.Medically appropriate, i.e., in the patient's best medical interest in light of his medical condition. The specific kinds of drugs at issue may matter here as elsewhere. Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success.

Sell v. United States, 539 U.S. 166, 177-8, 123 S.Ct. 2174, 2183 (2003) (Competence to Stand Trial Case).

Involuntary System Operates Largely Illegally

- Estimate (JG) No More Than 10% of Involuntary Commitments Meet Statutory and Constitutional Requirements
- Doubt Forced Drugging Can Ever Meet the Best Interest/Least Intrusive Alternative Standards

Why?

“If my client wasn’t crazy, She’d know this is good for her.”

Importance of Effective Attorney

"Empirical surveys consistently demonstrate that the quality of counsel 'remains the single most important factor in the disposition of involuntary civil commitment cases." . . . Without such [adequate] counsel, it is likely that there will be no meaningful counterbalance to the hospital's "script," and the patient's articulated constitutional rights will evaporate.

Perlin, "*And My Best Friend, My Doctor/Won't Even Say What It Is I've Got": The Role And Significance Of Counsel In Right To Refuse Treatment Cases*, 42 San Diego Law Review 735 (2005)

Attorney Abdication

“Traditionally, lawyers assigned to represent state hospital patients have failed miserably in their mission”

Houston Law Review January, 1991 Health Law Issue COMPETENCY, DEINSTITUTIONALIZATION, AND HOMELESSNESS: A STORY OF MARGINALIZATION Michael L. Perlin

The Trial Courts Go Along

Courts accept . . . testimonial dishonesty, . . . specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends." . . .

Experts frequently . . . and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment . . .

This combination . . . helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to insure that the allegedly "therapeutically correct" social end is met . . .. In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.

The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone? by Michael L. Perlin, *Journal of Law and Health*, 1993/1994, 8 JLHEALTH 15, 33-34.

Alaska Public Defender Agency

- No Meaningful Defense Put On.
- No Appeals Ever Taken.
- Unclear on Patients' Side.
- Violation of Professional Ethics?
- Right to Vigorous Representation Issue in *Wetherhorn* Appeal (pending decision)

The Right to Other Options

- Psychiatry Erroneously Equates Standard of Care With Right to Force
- Constitution Requires Best Interest and Least Restrictive/Intrusive Alternative
  - *Myers* Opinion

The Effort to Create Other Options

- Soteria-Alaska
- CHOICES, Inc.
- (Peer Properties)
- Law Project for Psychiatric Rights

Goals

- Substantially Increase Recovery Rate from diagnosis of Serious Mental Illness
- Non-Coercive
- System Support of People's Non-Medication Choices

Recovery – JG Definition

Getting past a diagnosis of mental illness to a point where a person enjoys meaningful activity, has relationships, and where psychiatric symptoms, if any, do not dominate or even play a major role in their life.

Recovery: Responsibilities and Roadblocks, by Jim Gottstein, http://akmhcweb.org/recovery/RecoveryResponsibilitesRoadblocks.pdf

Soteria-Alaska

- Non-coercive, non-drug option for people who would otherwise be facing hospitalization.
- Replicate Original Soteria-House Model
  - 6-8 People
  - Two staff at all times.
  - 48 hour shifts [?]
  - Be With not Do To
- Mental Health Trust Authority:
  - Continued development funding of the Soteria-Alaska project through Fiscal Year 2007
  - Committed $160,000 of Trust funds and recommended $220,000 in Mental Health General Funds in Fiscal Year 2008 to open Soteria-Alaska.

Consumers
Having
Ownership
In
Creating
Effective
Services

- "Consumer" Run
- Non-coercive, Non-drug Choices In Community
  - Helping People Get What they Want
  - Ch. 9 of "Community Mental Health: A Practical Guide" (Mosher & Burti)
  - "Pass-Through" to Other Consumer Run programs
- Independent Case Management/ Flexible Support Services Grant
  - Have "Medicaid Number"
  - Trying to Leverage to Sustainability
  - Working with Community Mental Health Center

Peer Properties

- Peer Run Housing
- Allows Non-drug Choice
- No "services," but peer support principle
- One 4 bedroom House Owned & Operated
- 11 Unit Grant/Low Income Housing Tax Credit Construction Project Abandoned
  - Too Expensive to Operate?
  - Too Complicated Financing?
  - Too Little Organizational Capacity?
- Six-Plexes on Ingra Available, but no way to buy
- Still Need Organizational Capacity for Expansion

PsychRights

- Encourage Climate for Other Options by Changing "Path of Least Resistance"
  - Could "break" API's Involuntary Commitment/Forced Drugging Assembly Line.
- *Myers* (Decided)
  - Best Interests
  - Least Restrictive Alternative
- Wetherhorn (Pending Decision)
  - Ineffective Assistance of Counsel
  - Illegality of "(B)" Prong Gravely Disabled Definition
  - Invalidity of Commitment and Forced Drugging Orders
  - [also attorneys fees in 2nd appeal]
- Bavilla – Forced Drugging in Prison (Need New Case)
- Informed Consent Lawsuit Drafted
- Possible 42 USC § 1983 Litigation??
- Ethics Complaints Against Public Defenders?
- Kid Drugging Lawsuit(s)?
- Recruiting *Pro Bono* Attorneys

Take Away Points

- Mental Health System Should Be Re-Directed towards Recovery
- It is Known What to Do
- The Opportunities Exist
- Escalating Strategic Litigation to "Encourage" is Available

Suggested Reading

- *Mad in America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentally Ill* (2001) by Robert Whitaker
- *Rethinking Psychiatric Drugs: A Guide to Informed Consent*, by Grace E. Jackson, MD, (2005)
- *Brain Disabling Treatments in Psychiatry: Drugs, Electroshock, and the Role of the FDA* (1997) by Peter Breggin, MD.
- *The ADHD Fraud: How Psychiatry Makes "Patients" of Normal Children* (2006) by Fred Baughman, MD, with Craig Hovey.
- *Community Mental Health: A Practical Guide* (1994) by Loren Mosher and Lorenzo Burti
- *Soteria: Through Madness to Deliverance*, by Loren Mosher and Voyce Hendrix with Deborah Fort (2004
- *Psychotherapy of Schizophrenia: The Treatment of Choice* (Jason Aronson, 1996), by Bertram P. Karon and Gary R. Vandenbos
- *The Hidden Prejudice: Mental Disability on Trial*, (2000) by Michael L. Perlin

Ethical Human Psychology and Psychiatry, Volume 7, Number 1, Spring 2005

Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America

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Cambridge, MA

Over the past 50 years, there has been an astonishing increase in severe mental illness in the United States. The percentage of Americans disabled by mental illness has increased fivefold since 1955, when Thorazine—remembered today as psychiatry's first "wonder" drug—was introduced into the market. The number of Americans disabled by mental illness has nearly doubled since 1987, when Prozac—the first in a second generation of wonder drugs for mental illness—was introduced. There are now nearly 6 million Americans disabled by mental illness, and this number increases by more than 400 people each day. A review of the scientific literature reveals that it is our drug-based paradigm of care that is fueling this epidemic. The drugs increase the likelihood that a person will become chronically ill, and induce new and more severe psychiatric symptoms in a significant percentage of patients.

Keywords: antipsychotics; antidepressants; mental illness; epidemic; schizophrenia

The modern era of psychiatry is typically said to date back to 1955, when chlorpromazine, marketed as Thorazine, was introduced into asylum medicine. In 1955, the number of patients in public mental hospitals reached a high-water mark of 558,922 and then began to gradually decline, and historians typically credit this emptying of the state hospitals to chlorpromazine. As Edward Shorter wrote in his 1997 book, *A History of Psychiatry*, "Chlorpromazine initiated a revolution in psychiatry, comparable to the introduction of penicillin in general medicine" (Shorter, 1997, p. 255). Haldol and other antipsychotic medications were soon brought to market, and then antidepressants and antianxiety drugs. Psychiatry now had drugs said to target specific illnesses, much like insulin for diabetes.

However, since 1955, when this modern era of psychopharmacology was born, there has been an astonishing rise in the incidence of severe mental illness in this country. Although the number of hospitalized mentally ill may have gone down, every other metric used to measure disabling mental illness in the United States has risen dramatically, so much so that E. Fuller Torrey, in his 2001 book *The Invisible Plague*, concluded that insanity had risen to the level of an "epidemic" (Torrey, 2001). Since this epidemic has unfolded in lockstep with the ever-increasing use of psychiatric drugs, an obvious question arises: Is our drug-based paradigm of care fueling this modern-day plague?

THE EPIDEMIC

The U.S. Department of Health and Human Services uses "patient care episodes" to estimate the number of people treated each year for mental illness. This metric tracks the number of people treated at psychiatric hospitals, residential facilities for the mentally ill, and ambulatory care facilities. In 1955, the government reported 1,675,352 patient care episodes, or 1,028 episodes per 100,000 population. In 2000, patient-care episodes totaled 10,741,243, or 3,806 per 100,000 population. That is nearly a fourfold per capita increase in 50 years (Table 1).

A second way to assess this epidemic is to look at the number of disabled mentally ill in the country. Up until the 1950s, the number of hospitalized mentally ill provided a rough estimate of this group. Today, the disabled mentally ill typically receive a disability payment either from the Social Security Disability Insurance (SSDI) program or the Supplemental Security Income (SSI) program, and many live in residential shelters or other subsidized living arrangements. Thus, the hospitalized patient of 50 years ago receives either SSDI or SSI today, and this line of evidence reveals that the number of disabled mentally ill has increased nearly sixfold since Thorazine was introduced.

In 1955, there were 559,000 people in public mental hospitals, or 3.38 people per 1,000 population. In 2003, there were 5.726 million people who received either an SSI or SSDI payment (or from both programs), and were either disabled by mental illness (SSDI statistics) or diagnosed as mentally ill (SSI statistics).[1] That is a disability rate of 19.69 people per 1,000 population, which is nearly six times what it was in 1955 (Table 2).

It is also noteworthy that the number of disabled mentally ill has increased dramatically since 1987, the year Prozac was introduced. Prozac was touted as the first of a second generation of psychiatric medications said to be so much better than the old. Prozac and the other SSRIs replaced the tricyclics, while the atypical antipsychotics (Risperidone, Zyprexa, etc.) replaced Thorazine and the other standard neuroleptics. The combined sales of antidepressants and antipsychotics jumped from around $500 million in 1986 to nearly $20 billion in 2004 (from September 2003 to August 2004), a 40-fold

TABLE 1. Patient-Care Episodes

Year	Total Episodes	Per 100,000 Population
1955	1,675,352	1,028
1965	2,636,525	1,376
1969	3,682,454	1,853
1971	4,190,913	2,026
1975	6,857,597	3,182
1983	7,194,038	3,084
1986	7,885,618	3,295
1990	8,620,628	3,491
1992	8,824,701	3,580
1994	9,584,216	3,680
1998	10,549,951	3,903
2000	10,741,243	3,806

Data Source: U.S. Department of Health and Human Services, SAMHSA. *Mental Health, United States, 2002.* Per 100,000 numbers calculated according to U.S. Census.

TABLE 2. The Disabled Mentally Ill in the United States

Year	Rate of Disabled Mentally Ill per 1,000 Population
1850	.2
1903	1.86
1955	3.38
1987	13.75
2003	19.69

Source: The disability rates for 1850 through 1955 are based on the number of hospitalized mentally ill, as cited by E. Fuller Torrey in *The Invisible Plague* (2001). The disability rates for 1987 and 2003 are based on the number of mentally ill receiving SSI or SSDI payments, as was reported in 2004 by the Social Security Administration.

increase.[2] During this period, the number of disabled mentally ill in the United States, as calculated by the SSI and SSDI figures, increased from 3.331 million people to 5.726 million.[3] That is an increase of 149,739 people per year, or 410 people newly disabled by mental illness *every day* (Table 3).

A BIOLOGICAL CAUSE FOR THE EPIDEMIC

The notion that psychiatric drugs work by balancing brain chemistry was first raised in the early 1960s. Once Thorazine and the standard neuroleptics were shown to block dopamine activity in the brain, researchers hypothesized that schizophrenia was caused by too much of this neurotransmitter. Thus, the neuroleptics—by blocking the dopamine receptors—helped normalize the brain's dopamine system. Since the tricyclics raised norephinephrine and serotonin levels in the brain, researchers reasoned that depression was caused by low levels of these brain chemicals. Merck, meanwhile, marketed its antianxiety drug Suavitil as a "mood normalizer." These normalizing claims suggested that the drugs were indeed curative of biological ailments.

However, this hypothesis—that the drugs balanced abnormal brain chemistry—never panned out. Although the public may still be told that the drugs normalize brain chemistry, the truth is that researchers did not find that people with schizophrenia had overactive dopamine systems (prior to being medicated), or that those diagnosed with depression suffered from abnormally low levels of serotonin or norephinephrine. As U.S. Surgeon General David Satcher acknowledged in his 1999 report on mental health, the causes of mental disorders "remain unknown" (Satcher, 1999, p. 102).

Yet, scientists have come to understand how the drugs affect the human brain, at least in terms of their immediate mechanisms of action. In 1996, the director of the National Institute of Mental Health (NIMH), neuroscientist Steven Hyman, set forth a paradigm for understanding how all psychiatric drugs work. Antipsychotics, antidepressants, and antianxiety drugs, he wrote, "create perturbations in neurotransmitter functions" (Hyman & Nestler, 1996, p. 153). In response, the brain goes through a series of

TABLE 3. Disability in the Prozac Era

Year	SSDI Recipients Disabled by Mental Illness	SSI Recipients With Diagnosis of Mental Illness	Total Number of SSI and SSDI Payments to Disabled Mentally Ill	Number of SSDI Recipients Who Also Received an SSI Payment	Total Disabled Mentally Ill
1987	800,139	2,630,999	3,431,138	100,017	3,331,121
2003	1,812,021	4,141,418	5,953,439	226,502	5,726,937
Increase from 1987-2003	1,011,882	1,510,419	2,522,301		2,395,816

Data Source: Annual Statistical Report on the Social Security Disability Insurance Program, 2003; and SSI Annual Statistical Report, 2003.

compensatory adaptations. For instance, Prozac and other SSRI antidepressants block the reuptake of serotonin. In order to cope with this hindrance of normal function, the brain tones down its whole serotonergic system. Neurons both release less serotonin and down-regulate (or decrease) their number of serotonin receptors. The density of serotonin receptors in the brain may decrease by 50% or more. As part of this adaptation process, Hyman noted, there are also changes in intracellular signaling pathways and gene expression. After a few weeks, Hyman concluded, the patient's brain is functioning in a manner that is "qualitatively as well as quantitatively different from the normal state" (Hyman & Nestler, 1996, p. 161).

In short, psychiatric drugs induce a *pathology*. Princeton neuroscientist Barry Jacobs has explicitly made this point about SSRIs. These drugs, he said,

> alter the level of synaptic transmission beyond the physiologic range achieved under (normal) environmental/biological conditions. Thus, any behavioral or physiologic change produced under these conditions might more appropriately be considered pathologic, rather than reflective of the normal biological role of serotonin. (Jacobs, 1991, p. 22)

Once psychiatric drugs are viewed in this way, it is easy to understand why their widespread use would precipitate an epidemic of mental illness. As E. Fuller Torrey wrote in *The Invisible Plague*, conditions that "disrupt brain chemistry may cause delusions, hallucinations, disordered thinking, and mood swings—the symptoms of insanity" (Torrey, 2001, p. 315). He noted that infectious agents, tumors, metabolic and toxic disorders, and various diseases could all affect the brain in this manner. What Torrey failed to mention is that psychiatric medications also "disrupt brain chemistry." As a result, their long-term use is bound to be problematic, and that is precisely what the research literature reveals: Their use increases the likelihood that a person will become chronically ill, and they cause a significant percentage of patients to become ill in new and more severe ways.

TURNING PATIENTS CHRONICALLY ILL

Neuroleptics

The study that is still cited today as proving the efficacy of neuroleptics for curbing acute episodes of schizophrenia was a nine-hospital trial of 344 patients conducted by the NIMH in the early 1960s. At the end of 6 weeks, 75% of the drug-treated patients were "much improved" or "very much improved" compared to 23% of the placebo patients. (National Institute of Mental Health Psychopharmacology Services Center Collaborative Study Group, 1964).

However, 3 years later, the NIMH reported on 1-year outcomes for the patients. Much to their surprise, they found that "patients who received placebo treatment were less likely to be rehospitalized than those who received any of the three active phenothiazines" (Schooler, Goldberg, Boothe, & Cole, 1967, p. 991). This result raised an unsettling possibility: While the drugs were effective over the short term, perhaps they made people more biologically vulnerable to psychosis over the long run, and thus the higher rehospitalization rates at the end of 1 year.

In the wake of that disturbing report, the NIMH conducted two medication-withdrawal studies. In each one, relapse rates *rose* in correlation with neuroleptic dosage before withdrawal. In the two trials, only 7% of patients who were on placebo relapsed

during the following 6 months. Twenty-three percent of the patients on less than 300 mg of chlorpromazine daily relapsed following drug withdrawal; this rate climbed to 54% for those receiving 300-500 mg and to 65% for patients taking more than 500 mg. The researchers concluded: "Relapse was found to be significantly related to the dose of the tranquilizing medication the patient was receiving before he was put on placebo—the higher the dose, the greater the probability of relapse" (Prien, Levine, & Switalski, 1971, p. 22).

Once again, the results suggested that neuroleptics increased the patients' biological vulnerability to psychosis. Other reports soon deepened this suspicion. Even when patients reliably took their medications, relapse was common, and researchers reported in 1976 that it appeared that relapse during drug administration was greater in severity than when no drugs were given (Gardos & Cole, 1977). A retrospective study by Bockoven also indicated that the drugs were making patients chronically ill. He reported that 45% of patients treated at Boston Psychopathic Hospital in 1947 with a progressive model of care did not relapse in the 5 years following discharge, and that 76% were successfully living in the community at the end of that follow-up period. In contrast, only 31% of patients treated in 1967 with neuroleptics at a community health center remained relapse-free over the next 5 years, and as a group they were much more "socially dependent"—on welfare and needing other forms of support—than those in the 1947 cohort (Bockoven & Solomon, 1975).

With debate over the merits of neuroleptics rising, the NIMH revisited the question of whether newly admitted schizophrenia patients could be successfully treated without drugs. There were three NIMH-funded studies conducted during the 1970s that examined this possibility, and in each instance, the newly admitted patients treated without drugs did better than those treated in a conventional manner. In 1977, Carpenter reported that only 35% of the non-medicated patients in his study relapsed within a year after discharge, compared to 45% of those treated with neuroleptics (Carpenter, McGlashan, & Strauss, 1977). A year later, Rappaport reported that in a trial of 80 young male schizophrenics admitted to a state hospital, only 27% of patients treated without neuroleptics relapsed in the 3 years following discharge, compared to 62% of the medicated group (Rappaport, Hopkins, Hall, Belleza, & Silverman, 1978). The final study came from Mosher, head of schizophrenia research at the NIMH. In 1979, he reported that patients who were treated without neuroleptics in an experimental home staffed by nonprofessionals had lower relapse rates over a 2-year period than a control group treated with drugs in a hospital. As in the other studies, Mosher reported that the patients treated without drugs were the better functioning group as well (Bola & Mosher, 2003; Mathews, Roper, Mosher, & Mann, 2003).

The three studies all pointed to the same conclusion: Exposure to neuroleptics increased the long-term incidence of relapse. Carpenter's group defined the conundrum:

> There is no question that, once patients are placed on medication, they are less vulnerable to relapse if maintained on neuroleptics. But what if these patients had never been treated with drugs to begin with? We raise the possibility that antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the natural course of the illness. (Carpenter & McGlashan, 1977, p. 19)

In the late 1970s, two physicians at McGill University in Montreal offered a biological explanation for why this was so (one that fits with the paradigm later outlined by Hyman). The brain responds to neuroleptics—which block 70% to 90% of all D_2 dopamine receptors in the brain—as though they are a pathological insult. To compensate, dopaminergic brain cells increase the density of their D_2 receptors by 30% or more. The

brain is now "supersensitive" to dopamine, and this neurotransmitter is thought to be a mediator of psychosis. The person has become more biologically vulnerable to psychosis and is at particularly high risk of severe relapse should he or she abruptly quit taking the drugs (Chouinard, Jones, & Annable, 1978; Chouinard & Jones, 1980). The two Canadian researchers concluded:

> Neuroleptics can produce a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms. An implication is that the tendency toward psychotic relapse in a patient who had developed such a supersensitivity is determined by more than just the normal course of the illness. (Chouniard, Jones, & Annable, 1978, p. 1410)

Together, the various studies painted a compelling picture of how neuroleptics shifted outcomes away from recovery. Bockoven's retrospective and the other experiments all suggested that with minimal or no exposure to neuroleptics, at least 40% of people who suffered a psychotic break and were diagnosed with schizophrenia would not relapse after leaving the hospital, and perhaps as many as 65% would function fairly well over the long term. However, once first-episode patients were treated with neuroleptics, a different fate awaited them. Their brains would undergo drug-induced changes that would increase their biological vulnerability to psychosis, and this would increase the likelihood that they would become chronically ill (and thus permanently disabled).

That understanding of neuroleptics had been fleshed out by the early 1980s, and since then, other studies have provided additional confirming evidence. Most notably, the World Health Organization twice compared schizophrenia outcomes in the rich countries of the world with outcomes in poor countries, and each time the patients in the poor countries—where drug usage was much less—were doing dramatically better at 2-year and 5-year follow-ups. In India, Nigeria and Colombia, where only 16% of patients were maintained continuously on neuroleptics, roughly two-thirds were doing fairly well at the end of the follow-up period and only one third had become chronically ill. In the US and other rich countries, where 61% of the patients were kept on antipsychotic drugs, the ratio of good-to-bad outcomes was almost precisely the reverse. Only about one third had good outcomes, and the remaining two thirds became chronically ill (Jablensky et al., 1992; Leff, Sartorius, Jablensky, Korten, & Ernberg, 1992).

More recently, MRI studies have shown the same link between drug usage and chronic illness. In the mid 1990s, several research teams reported that the drugs cause atrophy of the cerebral cortex and an enlargement of the basal ganglia (Chakos et al., 1994; Gur et al., 1998; Madsen, Keiding, Karle, Esbjerg, & Hemmingsen, 1998). These were disquieting findings, as they clearly showed that the drugs were causing structural changes in the brain. Then, in 1998, researchers at the University of Pennsylvania reported that the drug-induced enlargement of the basal ganglia was "associated with greater severity of both negative and positive symptoms" (Gur, Maany et al., 1998, p. 1711). In other words, they found that over the long term the drugs cause changes in the brain associated with a *worsening* of the very symptoms the drugs are supposed to alleviate. The MRI research, in fact, had painted a very convincing picture of a disease process: An outside agent causes an observable change in the size of brain structures, and as this occurs, the patient deteriorates.

Antidepressants

The story of antidepressants is a bit subtler, and yet it leads to the same conclusion that these drugs increase chronic illness over time. Even their short-term efficacy, in terms of a benefit greater than placebo, is of a questionable sort.

In the early 1960s, there were two types of antidepressants, monoamine oxidase inhibitors (MAOIs) and tricyclics. However, MAOIs soon fell out of favor because of dangerous side effects and a 1965 finding by the Medical Research Council in the United Kingdom that they were no more effective than placebo (Medical Research Council, 1965). Four years later, the NIMH concluded that there was also reason to doubt the merits of tricyclics. After reviewing the medical literature, NIMH investigators determined that in "well-designed studies, the differences between the effectiveness of antidepressant drugs and placebo are not impressive" (Smith, 1969, p. 19). About 61% of the drug-treated patients improved, versus 46% of the placebo patients, producing a net drug benefit of only 15% (Smith, 1969).

This finding led some investigators to wonder whether the placebo response was the mechanism that was helping people feel better. What the drugs did, several speculated, was amplify the placebo response, and they did so because they produced physical side effects that helped convince patients that they were getting a "magic pill" for depression. To test this hypothesis, investigators conducted at least eight studies in which they compared a tricyclic to an "active" placebo, rather than an inert one. (An active placebo is a chemical that produces an unpleasant side effect of some kind, like dry mouth.) In seven of the eight, there was no difference in outcomes, leading investigators at New York Medical College to conclude "there is practical value in viewing [psychotropics] as mere amplifiers or inhibitors of the placebo effects" (Dinnerstein, Lowenthal, & Blitz, 1966; Thompson, 1982).

With such confusion over the efficacy of tricyclics hanging in the air, the NIMH launched an ambitious long-term study of depression treatments in the early 1980s. Two hundred thirty-nine patients were randomized into four treatment groups—cognitive behavior therapy, interpersonal therapy, the tricyclic imipramine, and placebo. The results were startling. At the end of 16 weeks, "there were no significant differences among treatments, including placebo plus clinical management, for the less severely depressed and functionally impaired patients." Only the severely depressed patients fared better on a tricyclic than on placebo. However, at the end of 18 months, even this minimal benefit disappeared. Stay-well rates were best for the cognitive behavior group (30%) and poorest for the imipramine group (19%) (Elkin, 1990). Moreover, two pharmacology researchers at the State University of New York, Seymour Fisher and Roger Greenberg, concluded that if study dropouts were included in the analysis, then the "results look even worse" (Greenberg & Fisher, 1997, p. 147). Patients treated with an antidepressant were the most likely group to seek treatment following termination of the initial treatment period, they had the highest incidence of relapse, and they "exhibited the fewest weeks of reduced or minimal symptoms during the follow-up period" (Greenberg & Fisher, 1997, p. 147).

Once again, the results led to an unnerving conclusion. Antidepressants were making people chronically ill, just like the antipsychotics were. Other studies deepened this suspicion. In 1985, a U.K. group reported that in a 2-year study comparing drug therapy to cognitive therapy, relapse "was significantly higher in the pharmacotherapy group" (Blackburn, Eunson, & Bishop, 1986, p. 67). In 1994, Italian researcher Giovanni Fava reviewed the outcomes literature and concluded that "long-term use of antidepressants may increase the (patient's) biochemical vulnerability to depression," and thus "worsen the course of affective disorders" (Fava, 1994, p. 127). Fava revisited the issue in 2003. An analysis of 27 studies, he wrote, showed that "whether one treats a depressed patient for 3 months or 3 years, it does not matter when one stops the drugs.

A statistical trend suggested that the longer the drug treatment, the higher the likelihood of relapse" (Fava, 2003, p. 124).

Benzodiazepines

This same basic paradox—that a psychiatric drug may curb symptoms over the short term but worsen the long-term course of the disorder—has been found to hold true for benzodiazepines, at least when used to treat panic attacks. In 1988, researchers who led the large Cross-National Collaborative Panic Study, which involved 1,700 patients in 14 countries, reported that at the end of 4 weeks, 82% of the patients treated with Xanax (alprazolam) were "moderately improved" or "better," versus 42% of the placebo patients. However, by the end of 8 weeks, there was no difference between the groups, at least among those who remained in the study (Ballenger et al., 1988). Any benefit with Xanax seemed to last for only a short period. As a followup to that study, researchers in Canada and the UK studied benzodiazepine-treated patients over a period of 6 months. They reported that the Xanax patients got better during the first four weeks of treatment, that they did not improve any more in weeks 4 to 8, and that their symptoms began to worsen after that. As patients were weaned from the drugs, a high percentage relapsed, and by the end of 23 weeks, they were worse off than patients treated without drugs on five different outcomes measures (Marks et al., 1993). More bad news of this sort was reported by Pecknold in 1988. He found that as patients were tapered off Xanax they suffered nearly four times as many panic attacks as the nondrug patients, and that 25% of the Xanax patients suffered from rebound anxiety more severe than when they began the study. The Xanax patients were also significantly worse off than nondrug patients on a global assessment scale by the end of the study (Pecknold, Swinson, Kuch, & Lewis, 1988).

Then and Now

Research by David Healy, a prominent U.K. psychiatrist who has written several books on the history of psychopharmacology, shows how this problem of drug-induced chronicity plays out in society as a whole. Healy determined that outcomes for psychiatric patients in North Wales were much better a century ago than they are today, even though patients back then, at their moment of initial treatment, were much sicker. He concluded that today's drug-treated patients spend much more time in hospital beds and are "far more likely to die from their mental illness than they were in 1896." "Modern treatments," he said, "have set up a revolving door" and appear to be a "leading cause of injury and death" (Healy et al., 2001).

MANUFACTURING MENTAL ILLNESS

It is well known that all of the major classes of psychiatric drugs—antipsychotics, antidepressants, benzodiazepines, and stimulants for ADHD—can trigger new and more severe psychiatric symptoms in a significant percentage of patients. This is the second factor causing a rapid rise in the number of disabled mentally ill in the United States. Moreover, it is easy to see this epidemic-creating factor at work with Prozac and the other SSRIs.

Although serotonin has been publicly touted as the brain's mood molecule, in truth it is a very common chemical in the body, found in the walls of the blood vessels, the gut, blood platelets, and the brain. The serotonin system is also one that could be said to be primitive in kind. Serotonergic neurons are found in the nervous systems of all vertebrates and most invertebrates, and in humans their cell bodies are localized along the midline of the brain stem. From there, their axons spread up into the brain and down into the spinal cord. The first purpose of this neuronal network is thought to be control of respiratory, cardiac, and repetitive motor activity, as opposed to higher cognitive functions.

As one would expect, perturbing this system—and to a degree that could be considered pathologic, as Jacobs said—causes a wide range of problems. In Prozac's first 2 years on the market, the FDA's Medwatch program received more adverse-event reports about this new "wonder drug" than it had received for the leading tricyclic in the previous 20 years. Prozac quickly took up the top position as America's most complained about drug, and by 1997, 39,000 adverse-event reports about it had been sent to Medwatch. These reports are thought to represent only 1% of the actual number of such events, suggesting that nearly 4 million people in the US had suffered such problems, which included mania, psychotic depression, nervousness, anxiety, agitation, hostility, hallucinations, memory loss, tremors, impotence, convulsions, insomnia, and nausea. The other SSRIs brought to market caused a similar range of problems, and by 1994, four SSRIs were among the top 20 most complained-about drugs on the FDA's Medwatch list (Moore, 1997).

In terms of helping fuel a rapid rise in the number of disabled mentally ill, the propensity of Prozac and other SSRIs to trigger mania or psychosis is undoubtedly the biggest problem with these drugs. In clinical trials, slightly more than 1% of the Prozac patients developed mania, which was three times higher than the rate for patients given a tricyclic (Breggin, 2003). Other studies have found much higher rates of SSRI-induced mania. In 1996, Howland reported that 6% of 184 depressed patients treated with an SSRI suffered manic episodes that were "generally quite severe." A year later, Ebert reported that 8.5% of patients had a severe psychological reaction to Luvox (fluvoxamine) (Breggin). Robert Bourguignon, after surveying doctors in Belgium, estimated that Prozac induced psychotic episodes in 5% to 7% of patients (Bourguignon, 1997). All of this led the American Psychiatric Association to warn that manic or hypomanic episodes are "estimated to occur in 5% to 20% of patients treated with antidepressants" (Breggin).

As Fava has noted, "Antidepressant-induced mania is not simply a temporary and reversible phenomenon, but a complex biochemical mechanism of illness deterioration" (Fava, 2003, p. 126). The best available evidence suggests that this is now happening to well more than 500,000 Americans a year. In 2001, Preda and other Yale researchers reported that 8.1% of all admissions to a psychiatric hospital they studied were due to SSRI-induced mania or psychosis (Preda, MacLean, Mazure, & Bowers, 2001). The federal government reported that there were 10.741 million "patient care episodes" in 2000; if 8% were SSRI-induced manic or psychotic episodes, that would mean that 860,000 people suffered this type of adverse reaction in 2000.

Thus, the SSRI path to a disabling mental illness can be easily seen. A depressed patient treated with an antidepressant suffers a manic or psychotic episode, at which time his or her diagnosis is changed to bipolar disorder. At that point, the person is prescribed an antipsychotic to go along with the antidepressant, and once on a drug cocktail, the person is well along on the road to permanent disability. Since Prozac was

introduced in 1987, the number of disabled mentally ill in the US has risen by 2.4 million people, and given the risk of mania and psychosis with the SSRIs, that increase was to be expected.

CONCLUSION

A century ago, fewer than two people per 1,000 were considered to be "disabled" by mental illness and in need of hospitalization. By 1955, that number had jumped to 3.38 people per 1,000, and during the past 50 years, a period when psychiatric drugs have been the cornerstone of care, the disability rate has climbed steadily, and has now reached around 20 people per 1,000. (Table 2). As with any epidemic, one would suspect that an outside agent of some type—a virus, a bacterial infection, or an environmental toxin—was causing this rise in illness. That is indeed the case here. There is an outside agent fueling this epidemic of mental illness, only it is to be found in the medicine cabinet. Psychiatric drugs perturb normal neurotransmitter function, and while that perturbation may curb symptoms over a short term, over the long run it increases the likelihood that a person will become chronically ill, or ill with new and more severe symptoms. A review of the scientific literature shows quite clearly that it is our drug-based paradigm of care that is fueling this modern-day plague.

NOTES

1. These data come from the 2003 annual Social Security reports for the SSI and SSDI programs. The figure of 5,726,937 disabled mentally ill is calculated as follows: There were 1,812,021 SSDI recipients who were disabled because of mental illness. There were 4,141,418 SSI recipients diagnosed as mentally ill. However, one out of every eight recipients of SSDI, or 226,502 people, also received an SSI payment. Thus, the number of disabled mentally ill is: 1,812,021 + 4,141,418 - 226,502 = 5,726,937.

2. In 1985, U.S. sales of antidepressants totaled $240 million, and U.S. sales of antipsychotics were $263 million. From September 1, 2003 to August 30, 2004, U.S. sales of antidepressants were $11.2 billion, and U.S. sales of antipsychotics were $8.6 billion. The source for the 1985 figures is Zore, Larson, Lyons, and Beardsley (1991). The 2004 sales figures are from IMS Retail Drug Monitor: 12 months to August 2004.

3. The calculation for the number of disabled mentally ill in 1987 is as follows: There were 800,139 SSDI recipients who were disabled because of mental illness. There were 2,630,999 SSI recipients diagnosed as mentally ill. One out of every eight recipients of SSDI, or 100,017 people, also received an SSI payment. Thus, the number of disabled mentally ill is: 800,139 + 2,630,999 - 100,017 = 3,331,120.

REFERENCES

Ballenger, J., Burrows, G., DuPont, R., Lesser, I., Noyes, R., Pecknold, J., et al. (1988). Alprazolam in panic disorder and agoraphobia: Results from a multi-center trial. *Archives of General Psychiatry, 45,* 413-421.

Blackburn, I. M., Eunson, K., & Bishop, S. (1986). A two-year naturalistic follow-up of depressed patients treated with cognitive therapy, pharmacotherapy and a combination of both. *Journal of Affective Disorders, 10,* 67-75.

Bockoven, J. & Solomon, H. (1975). Comparison of two five-year follow-up studies. *American Journal of Psychiatry, 132*, 796-801.

Bola, J. & Mosher, L. (2003). Treatment of acute psychosis without neuroleptics: Two-year outcomes from the Soteria project. *Journal of Nervous and Mental Disorders, 191*, 219-229.

Bourguignon, R. (1997). Dangers of fluoxetine. *The Lancet, 394*, 214.

Breggin, P. (2003). Suicidality, violence, and mania caused by selective serotonin reuptake inhibitors (SSRIs): A review and analysis. *International Journal of Risk and Safety in Medicine, 16*, 31-49.

Carpenter, W., McGlashan, T., & Strauss, J. (1977). The treatment of acute schizophrenia without drugs: An investigation of some current assumption. *American Journal of Psychiatry, 134*, 14-20.

Chakos, M., Lieberman, J., Bilder, R., Borenstein, M., Lerner, M., Bogerts, B., et al. (1994). Increase in caudate nuclei volumes of first-episode schizophrenic patients taking antipsychotic drugs. *American Journal of Psychiatry, 151*, 1430-1436.

Chouinard, G., & Jones, B. (1980). Neuroleptic-induced supersensitivity psychosis: Clinical and pharmacologic characteristics. *American Journal of Psychiatry, 137*, 16-20.

Chouinard, G., Jones, B., & Annable, L. (1978). Neuroleptic-induced supersensitivity psychosis. *American Journal of Psychiatry 135*, 1409-1410.

Dinnerstein, A., Lowenthal, M., & Blitz, B. (1966). The interaction of drugs with placebos in the control of pain and anxiety. *Perspectives in Biology and Medicine, 10*, 103-117.

Elkin, I. (1990). National Institute of Mental Health treatment of depression collaborative research program: General effectiveness of treatments. *Archives of General Psychiatry, 46*, 971-982.

Fava, G. (1994). Do antidepressant and antianxiety drugs increase chronicity in affective disorders? *Psychotherapy and Psychosomatics, 61*, 125-131.

Fava, G. (2003). Can long-term treatment with antidepressant drugs worsen the course of depression? *Journal of Clinical Psychiatry, 64*, 123-133.

Gardos, G., & Cole, J. (1977). Maintenance antipsychotic therapy: Is the cure worse than the disease? *American Journal of Psychiatry, 133*, 32-36.

Greenberg, R., & Fisher, S. (1997). *Mood-mending medicines: Probing drug, psychotherapy and placebo solutions*. New York: John Wiley & Sons.

Gur, R., Cowell, P., Turetsky, B., Gallacher, F., Cannon, T., Bilker, W., et al. (1998). A follow-up magnetic resonance imaging study of schizophrenia. *Archives of General Psychiatry, 55*, 142-152.

Gur, R., Maany, V., Mozley, D., Swanson, C., Bilker, W., & Gur, R. (1998). Subcortical MRI volumes in neuroleptic-naive and treated patients with schizophrenia. *American Journal of Psychiatry, 55*, 1711-1717.

Healy, D. Harris, M., Michael, P., Cattell, D., Savage, M., Chalasani, P., et al. (2001). *Treating more patients than ever before: 1896 and 1996 compared*. Unpublished manuscript.

Howland, R. (1966). Induction of mania with serotonin reuptake inhibitors. *Journal of Clinical Psychopharmacology, 16*, 425-427.

Hyman, S., & Nestler, E. (1996). Initiation and adaptation: A paradigm for understanding psychotropic drug action. *American Journal of Psychiatry 153*, 151-161.

Jablensky, A., Sartorius, N., Ernberg, G., Ansker, M., Korten, A., Cooper J., et al. (1992). Schizophrenia: Manifestations, incidence and course in different cultures. A World Health Organization ten-country study. *Psychological Medicine*, (Monograph Suppl. 20), 1095.

Jacobs, B. (1991). Serotonin and behavior: Emphasis on motor control. *Journal of Clinical Psychiatry, 52* (12 Suppl.), 151-162.

Leff, J., Sartorius, N., Jablensky, A., Korten, A., & Ernberg, G. (1992). The international pilot study of schizophrenia: Five-year follow-up findings. *Psychological Medicine, 22*, 131-145.

Madsen, A., Keiding, A., Karle, A., Esbjerg, S., & Hemmingsen, R. (1998). Neuroleptics in progressive structural brain abnormalities in psychiatric illness. *The Lancet, 352*, 784-785.

Marks, I. (1993). Alprazolam and exposure alone and combined in panic disorder with agoraphobia. *British Journal of Psychiatry, 162*, 790-794.

Mathews, S., Roper, M., Mosher, L., & Menn, A. (2003). A non-neuroleptic treatment for schizophrenia: An analysis of the two-year postdischarge risk of relapse. *Schizophrenia Bulletin, 5*, 322-332.

Medical Research Council. (1965). Clinical trial of the treament of depressive illness. *British Medical Journal*, 881-886.

Moore, T. (1997, December). Hard to swallow. *Washingtonian*.

National Institute of Mental Health Psychopharmacology Service Center Collaborative Study Group. (1964). Phenothiazine treatment in acute schizophrenia. *Archives of General Psychiatry, 10*, 246-261.

Pecknold, J. C. (1988). Alprazolam in panic disorder and agoraphobia: Results from a multicenter trial: Discontinuation effects. *Archives of General Psychiatry, 45*, 429-436.

Preda, A., MacLean, C., Mazure, C., & Bowers, M. (2001). Antidepressant-associated mania and psychosis resulting in psychiatric admission. *Journal of Clinical Psychiatry, 62*, 30-33.

Prien, R., Levine, J., & Switalski, R. (1971). Discontinuation of chemotherapy for chronic schizophrenics. *Hospital Community Psychiatry, 22*, 20-23.

Rappaport, M., Hopkins, H., Hall, K., Belleza, T., & Silverman, J. (1978). Are there schizophrenics for whom drugs may be unnecessary or contraindiciated. *International Pharmacopsychiatry, 13*, 100-111.

Satcher, D. (1999). *Mental health: A report of the surgeon general.* Available: www.surgeongeneral.gov/library/mentalhealth

Schooler, N., Goldberg, S., Boothe, H., & Cole, J. (1967). One year after discharge: Community adjustment of schizophrenic patients. *American Journal of Psychiatry, 123*, 986-995.

Shea, M., Elkin, I., Imber, S., Sotsky, S., Watkins, J., Collins, J., et al. (1992). Findings from the National Institute of Mental Health Treatment of Depression Research Program. *Archives of General Psychiatry, 49*, 782-787.

Shorter, E. (1997). *A history of psychiatry*. New York: John Wiley and Sons.

Smith, A. (1969). Studies on the effectiveness of antidepressant drugs. *Pscyhopharmacology Bulletin, 5*, 1-20.

Thomson, R. (1982). Side-effects and placebo amplification. *British Journal of Psychiatry, 140*, 64-68.

Torrey, E. F. (2001). *The invisible plague: The rise of mental illness from 1750 to the present*. New Brunswick, NJ: Rutgers University Press.

Zore, J. J., Larson, D., Lyons, J., & Beardsley, R. (1991). Expenditures for psychotropic medications in the United States in 1985. *American Journal of Psychiatry, 148*, 644-647.

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Longitudinal Studies of Recovery
Identified by Courtney Harding
(2002)

Study	Sample Size	Length in Years	Recovery Rates
Bleuler (1972) Zurich	208	23	53 to 68%
Huber et. al. (1974) Germany	502	22	57%
Ciompi and Muller (1976) Lausanne	289	37	53%
Tsuang, et. al. (1979) Iowa	186	35	46%
Ogawa, et. al. (1987) Japan	140	22.5	57%
Harding, et.al. (1987) Vermont	269	32	62 to 68%
DeSisto, et. al. (1995) Maine	269	35	49%

Report
By the
Alaska Mental Health Board
Budget Committee
On the
2003 Budget Summit
With Recommendations

Adopted by AMHB Budget Committee – July 11, 2003
Adopted by AMHB – August 08, 2003

Report

By the Alaska Mental Health Board
Budget Committee
On the

2003 Budget Summit
And Recommendations

June, 2003

I. Table of Contents

II. Executive Summary

The focus of the Alaska Mental Health Board's 2003 Budget Summit was to look at what is being "purchased" by the Mental Health Program (Program) and, if it is not what is desired, make recommendations regarding how to make it do so.

Alaska's Mental Health Program funding, as is true in most of the country, is designed around eligibility criteria and authorized services. This is based on the assumption that the eligibility requirements identify those people who should receive services and the authorized services are what those people need. However, it has become increasingly clear that this may not be the optimal approach because evaluation of the Program rests on what services are provided, rather than whether desired results are achieved for the recipients of those services. The Budget Committee therefore suggests a budget based on the following:[1]

- Funding should be based on achieving desired results and those should be achieving the goals of consumers.
- In order to achieve this, the Mental Health System (System) should be flexible and needs based.
- The System should if at all possible respond before a person is in crisis.
- Medicaid, Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) should allow or, better yet, facilitate people returning to the mainstream, including gainful employment in appropriate jobs.

There were discussions of what data the System should be collecting and using to evaluate and manage the Program as well as whether it was clear enough from the data that the current reliance on psychiatric medications substantially increases chronicity. These and similar items are referred to the full Board/Planning Committee for further development and consideration.

III. Proceedings

The Budget Summit was "kicked off" on March 8, 2003 in Juneau with an advertised public meeting as part of the regular Alaska Mental Health Board meeting. Approximately 25 people attended the meeting, including representatives of the Alaska Mental Health Trust Authority, the Department of Health and Social Services and numerous members of the public. Budget Committee Chair, Jim Gottstein gave a short presentation on the current budget process and posed certain issues and questions that might be addressed. Many attendees provided input and there was a general discussion of the issues among participants.

[1] This approach essentially follows what the Alaska Mental Health Trust Authority has been urging for the last few years.

The Budget Summit continued in Anchorage on April 11-12, 2003, with all 4 Budget Committee members present (Jim Gottstein, Tony Mander, Barry Creighton, Keggie Tubbs), 3 other Board Members attending, Jeanette Grasto, Tracy Barbee and Bill Hogan, staff Kate Webster and Kay Klose, 3 other Division of Mental Health and Developmental Disabilities (DMHDD) personnel, and 5 or so other people representing stakeholders and the public in attendance all or part of the time. April 11th was devoted to presentations of information, including updated budget and outcome data, public input, and a roundtable discussion over what should be in the final report and recommendations. On April 12th, the discussion of recommendations and conclusions continued. This Report was unanimously adopted in concept on April 12, 2003, subject to approval of final language. Approval of the final language of this report occurred during the Budget Committee's July 11, 2003 meeting.

IV. Budgeting Process

Alaska has a unique budgeting process as a result of the settlement of the Alaska Mental Health Lands Trust Lands Litigation in 1994 (Settlement). The Settlement, among other things, resulted in a cash payment of $200 million dollars and conveyed almost one million acres of land, some of it subsurface only to the Alaska Mental Health Trust Authority (Trust) created as part of the settlement. Under AS 47.30.046:

> (a) The [Trust] shall annually, not later than September 15, submit to the governor and the Legislative Budget and Audit Committee a budget for the next fiscal year and a proposed plan of implementation based on the integrated comprehensive mental health program plan prepared under AS 47.30.660(a)(1). The budget must include the authority's determination of the amount
>
> (1) recommended for expenditure from the general fund during the next fiscal year to meet the operating and capital expenses of the integrated comprehensive mental health program;
>
> (2) in the mental health trust settlement income account, if any, that is not reasonably necessary to meet the projected operating and capital expenses of the integrated comprehensive mental health program that may be transferred into the general fund; and
>
> (3) of the expenditures the authority intends to make under AS 37.14.041 and 37.14.045, including the specific purposes and amounts of any grants or contracts as part of the state's integrated comprehensive mental health program.

Under AS 37.14.045 and the Settlement Agreement, the Trust has the power to spend Trust Fund income (MHTAAR)[2] directly without an appropriation; however state

[2] The statute refers to this as Mental Health Trust Authority Authorized Receipts which becomes the acronym MHTAAR.

agencies need an appropriation to spend the funds. In order for the Trust to develop its budget recommendations, it requests recommendations from the four Trust beneficiary boards[3] (Request for Recommendations or RFR).

The Trust explains the process this way:

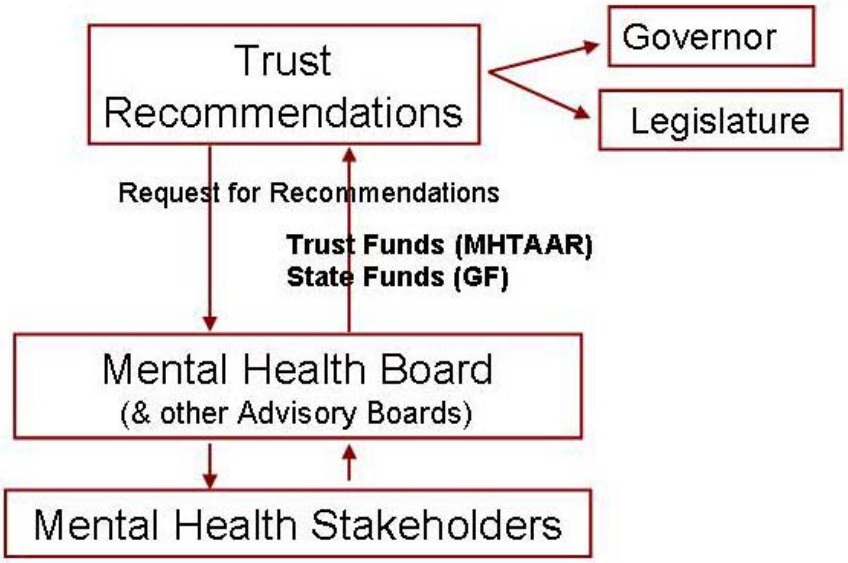
> **The Separate Appropriation Bill**
>
> The separate appropriations bill for the Comprehensive Integrated Mental Health Program includes several components. They are:
>
> **General Fund/Mental Health Base (GF/MH Base**): This is the amount established by identifying the mental health services funded within the state's general fund budget. The Trustees calculated that amount to be $131 million for fiscal year 2003. These general funds are designated as general fund/mental health dollars, or GF/MH Base. The final budget from the previous fiscal year establishes the GF/MH Base.
>
> **Adjustments to the Base:** As The Trust and the associated boards and commission further refine the definition of beneficiaries and accurately track funds for the Comprehensive Integrated Mental Health Program, the Trustees suggest adjustments to the base each year.
>
> **GF/MH Increments:** When the Trustees identify better and more cost efficient ways of providing on-going services or providing for unmet needs, they make recommendations in the form of GF/MH increments.
>
> **Capital Budget:** The separate appropriations bill includes that portion of the state's capital budget that funds mental health projects. This often includes funds from the Alaska Housing Finance Corporation to provide housing for beneficiaries as part of the Comprehensive Integrated Mental Health Program.
>
> **Mental Health Trust Authority Authorized Receipts (MHTAAR):** The Trustees authorize state agencies to spend Trust funds for specific operating and capital projects. These state agencies must have legislative approval to receive and expend Trust funds.
>
> The Trustee's recommendations for the mental health bill are due to the governor on September 15th for the following state

[3] Alaska Mental Health Board, Alaska Commission on Aging, Governor's Council on Disabilities and Special Education, and Advisory Board on Alcohol and Drug Abuse.

fiscal year. However, because the Trustees rely heavily on the recommendations of the four Advisory Boards, the Trust budget process actually begins early in the calendar year when the Trust sends the Advisory Boards a Request for Recommendations (RFR). The Trustees review these recommendations in late summer and make their funding decisions in time to meet the September 15th deadline.

The Board also seeks input from its stakeholders in the Request for Recommendations process and many stakeholders identify mental health service needs that they would like to have funded. The Board takes this information and then makes decisions on what to recommend to the Trust. In doing so, the Board does not normally recommend that any particular program get funding; rather it takes specific proposals that it receives and converts them into a "generic" budget category.

The following graphic illustrates this budget building process:



V. Budget Data

It is not possible at this juncture to say what the total mental health budget is because it is spread across so many different budget categories and agencies. No one has attempted to compile such a total since the early 1990's when it was done in connection with the Mental Health Trust Lands Litigation. In addition there is not agreement as to what expenditures should be included as being part of the Mental Health Program. What could be identified follow:

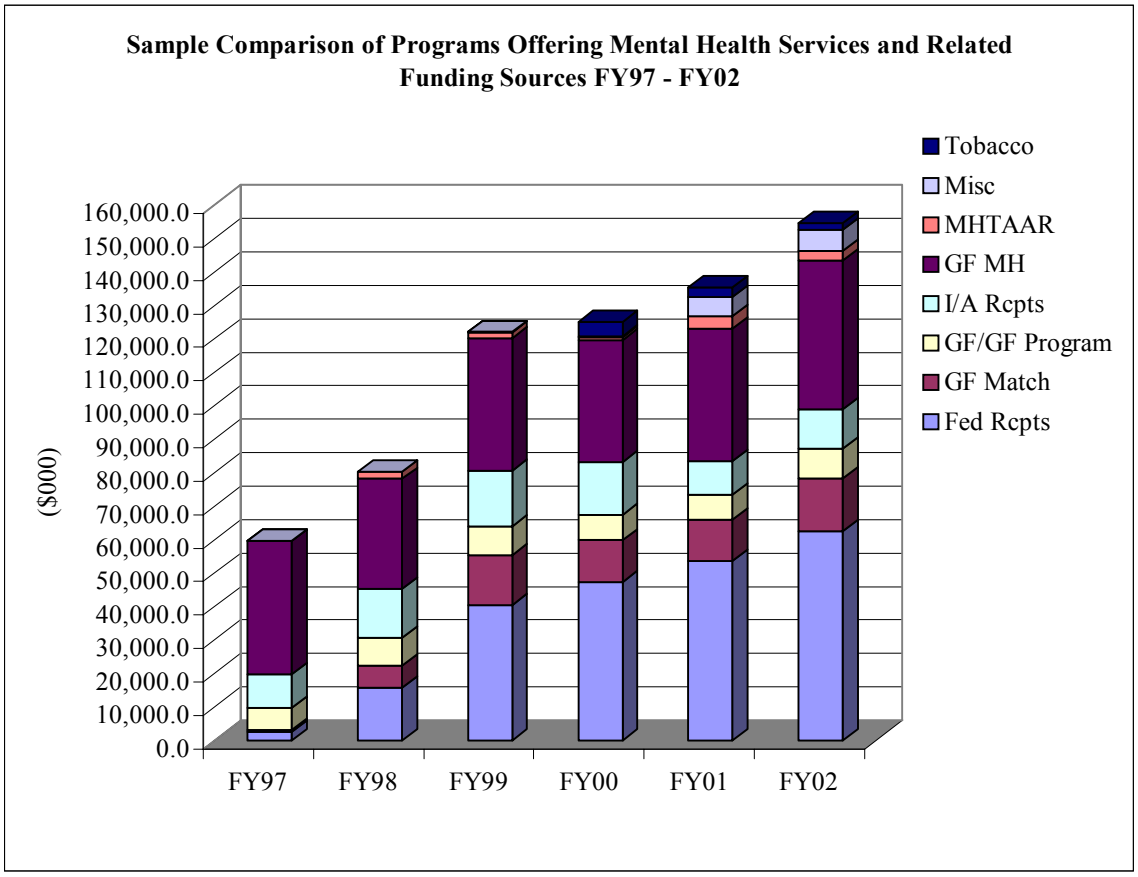
AMHB Sample Comparison of Programs Offering Mental Health Services and Related Funding Sources FY98 - FY03

Bare Bones Mental Health Budget FY97-02

	Fed Rcpts	GF Match	GF/GF Program	I/A Rcpts	GF MH	MHTAAR	Misc	Tobacco	Totals
FY97	2,649.0	564.4	6,575.8	9,982.1	39,789.7	37.5	0.0		59,598.5
FY98	15,742.9	6,682.0	8,309.6	14,530.6	32,886.5	2,039.0	142.4		80,333.0
FY99	40,528.8	14,740.5	8,766.0	16,516.5	39,559.4	1,769.9	146.5		122,027.6
FY00	47,269.6	12,500.0	7,586.6	15,871.2	36,465.0	696.6	247.2	4,314.2	124,950.4
FY01	53,611.2	12,419.5	7,389.2	9,908.9	39,628.2	3,917.5	5,562.3	2,956.8	135,393.6
FY02	62,399.1	15,994.5	8,696.0	11,895.9	44,466.6	2,897.5	6,264.0	1,963.6	154,577.2

Notes:
FY97 Does not include any Medicaid Funding--Not included in Enacted Summary
Tobacco revenue begins in FY00 with majority of funds supporting Medicaid services
All Medicaid Expenses calculated at 15% of total Medicaid (Tobacco tax also calculated at 15%)
FY00 $25,447.7 went into Medicaid Services

Miscellaneous categories, depending on FY, include: 1047, Title20; 1050 PFD; 1077 Gifts/Grt; 1091 GF/Desig; 1061 CIP Rcpts; 1108 Stat Desig; 118 Pioneers;1156 Rcpt Svcs; 1171 PFD Criminal



As can be seen from the below figures expenditures for inpatient services is very close to that spent on Community Mental Health.

Some Mental Health Services Purchased FY '02		
Inpatient Medicaid	$ 44,000,000	
API GF/MH	$ 17,000,000	
DET GF/MH	$ 3,000,000	
Total Inpatient		$ 64,000,000
Community Mental Health		$ 75,000,000

Also, Medicaid paid $19 Million for psychiatric drugs in FY 02.

Another comparison raising questions is the per capita and per client range of Community Mental Health Grant and Medicaid Expenditures:[4]

Catchment Area Ranges			
	High	Low	Avg
Per Capita	$ 233	$ 44	$ 117
Avg Client Cost	$ 7,068	$ 361	$ 4,120
Medicaid (per capita)	$ 203	$ 0	$ 65
Grant Funds (per capita)	$ 197	$ 21	$ 52

While it is clear there are great disparities in per capita and per client expenditures between community mental health centers it is important to be careful in drawing conclusions because of various factors. For instance, there is a high probability that high needs clients migrate to the larger cities where more intensive (costly) services are provided and that community mental health centers with small catchment populations can not spread their overhead across as many people. Having said that, however, there are still great differences that suggest widely varying Medicaid billing practices and possible over reliance on grant based services.

As to where Community Mental Health dollars are going, the available data revealed:

Community Mental Health Grand Funding FY '03		
General Community Mental Health	$ 3,377,700	9%
Psychiatric Emergency Services	$ 8,368,400	23%
Services to Seriously & Persistent Mentally Ill	$ 15,450,700	43%
Designated Evaluation & Treatment (DET)	$ 1,836,800	5%
Severely Emotionally Distrubed Youth	$ 7,165,500	20%
Total	$ 36,199,100	100%

[4] A detailed analysis of these expenditures for all of the community mental health centers in the state is attached as Appendix A.

VI. Results Data

At the end of the "Kick-Off" in March, the following question was posed. Is the Budget Purchasing?

Housing Relationships Jobs/Meaning In life Recovery		Protection Control Stabilization Dependency

The system increasingly talks about the items on the left as being the desired results, but with the possible exception of "dependency" the other results have also been seen as desirable. In fact, "protection" and "control" have been suggested as the primary reason that the public pays for mental health services. Protection includes the community as well as the recipient and is clearly a highly valued result. While perhaps not viewed as positively, controlling disturbed and disturbing behavior has also been a major goal of the public mental health system. Stabilization is a good outcome when compared with deterioration and also if the course of mental illness is assumed to be a steady or progressive worsening of condition. However, good housing, relationships, being productive and recovery are all preferred and, to the extent they are achieved, the other goals no longer need to be achieved.

It is being accepted around the country that recovery from mental illness is possible for many people that have previously been considered to be destined to a life of great disability. The most important factors identified in recovery are Hope, Housing, Relationships, and Employment/Meaningful Activity. As the focus of the program shifts towards improvement in the lives of mental health system recipients the question arises whether we are purchasing these results. There is even more limited data regarding these results.

A. Housing

Data from the Division of Mental Health and Developmental Disabilities' Management Information System on housing status indicates that 29 % of community mental health center clients live either alone or with an unrelated person(s) and 54% live with a relative(s) (54%). The remaining 17% are shown as "Housing Unknown." It does not seem safe to assume that all of the unknown are homeless, nor is there great confidence that the other categories exclude being homeless. The Mental Health Board, as part of its planning process, has estimated there are approximately 1,400 of its beneficiaries who are homeless. Another factor that is not addressed is whether consumers consider their current housing situation ‘ideal’ or whether they even consider it safe and affordable.

B. Employment

One area that there is some data on is employment:

- Only 1% of Community Mental Health Center clients are receiving employment services from the Community Mental Health Center.
- Less than 1% of people go from SSDI to Employment
- Less than 10% of people on SSI are gainfully employed.

This data starkly shows that under the present system once a person gets placed on SSDI they are very unlikely to ever return to the workforce. Since placement on SSDI and SSI are criterion for receiving Medicaid services, and that people have to be both disabled and very poor to be in these programs, the clear result of this funding mechanism is that **the Medicaid/SSDI/SSI eligibility and funding mechanism is essentially a one way ticket to permanent disability and poverty**. This is probably the single most important information contained in this report.

VII. Evaluation of The Budget Building Process

The Trust was extraordinarily successful in leveraging its relatively small financial contributions to the mental health program to not only prevent budget declines, but increase the mental health program budget during a time of budget declines. It was able to do this at least in part through the process outlined above by recommending "increments" (increases) and using Trust Funds to get programs going and then moving them to other funding sources, which was typically the General Fund.[5] The value of being able to bring even the relatively small amount (but in the millions of dollars) it has "to the table" is much more than the amount it has to contribute and the Trust has been incredibly skillful in this process. However, due to the financial crisis the state is facing, it appears that for the first time this strategy was unsuccessful and Program funding is faced with a substantial General Fund decline.

All processes should be periodically reviewed to determine if they continue to optimize results. The state's budget crisis, the new administration resolved to reduce spending to address this crisis, the increasing reliance on federal funds (e.g., Medicaid) and data results suggests this is a good time to re-evaluate Alaska's mental health budget building process.

A number of things leap out from the circumstances and data. The first is the absence of consideration of Medicaid mental health expenditures in the budget building process, which equals or exceeds the parts of the budget that is part of the Trust's Request for Recommendation process. The second is that the focus on increments (increases) may no longer be tenable. Perhaps even more important is by not looking at the effectiveness of expenditures in the "base" (which this Report suggests should include

[5] The Trust calls this an "Exit Strategy" meaning that the Trust, as a general matter, is not prepared to continue funding programs indefinitely.

Medicaid) in achieving desired Results, there has been little, if any incentive or requirement to achieve desired Results. In other words, the entire mental health budget program should be evaluated.

Therefore, it is suggested that the Board should regularly and rigorously review results and identify gaps, rather than relying so heavily on stakeholders bringing specific proposals for consideration. A somewhat similar proposal, known as "Strategic Budgeting" has been before the Board as a proposal for a number of years. The Budget Committee believes results based budgeting (i.e., the Friedman Model) will be a beneficial way to proceed in the future.

VIII. Recommendations

The Budget Summit proved to be a useful endeavor and resulted in a number of recommendations, which can be categorized into these four broad categories:

A. Funding Should Be More Explicitly Tied to Desired Results

B. Medicaid/SSDI/SSI Should Be Re-Tooled as Possible to Achieve Desired Results

C. The Planning Committee Should Review Whether the Current Level of Reliance on Psychiatric Medications is leading to Desired Results.

D. The Budget Building Process Should be Re-evaluated.

There are a number of parts to each of the main recommendations.

A. Funding Should Be More Explicitly Tied to Desired Results

The Budget Committee wholeheartedly supports moving to results based budgeting that the Trust has been advocating for a number of years, known as the "Friedman Model." In essence, the approach is to (1) define what results (also known as outcomes) are desired, (2) develop measurement(s) for determining how well the system is doing in "purchasing" desired results, and (3) this data should be regularly collected, analyzed and acted upon. In other words, what does the data reveal about effectiveness of programs? Where are the gaps? What changes in program funding should be made to achieve desired results? In order to achieve this the Budget Committee recommends that:

1. The Planning Committee develop a recommendation to the full board regarding the desired results; and

2. The Planning Committee determine/develop recommendations to the full board regarding what results to measure

3. Programs should be evaluated and funded based on recipient results. In other words, goals and benchmarks should be established and funding based on the extent to which these are achieved.

4. Financial incentives should be given providers for producing desired results.

5. Grants should be re-tooled to produce desired results.

6. Non-traditional and flexible approaches should be part of the Program and evaluated for achieving desired results along with traditional approaches.

7. The following data should be acquired:

    a. Who Are the Recipients of the Mental Health Program?
    b. What services constitute the Mental Health Program?
    c. What is spent on the total Mental Health Program, including Indian Health Service spending (Alaska Native Tribal Health Consortium)?
    d. Who are receiving services?
    e. What are the results for various populations? In other words, are there differences in results for different groups of people, such as Natives or other minorities?
    f. What are the SSDI/SSI Recipient Population Trends?
    g. What are the Indian Health Service Population Trends?
    h. What Are the Results Geographically?
    i. Which Programs are Achieving Desired Results and Vice Versa?
    j. Why is There Such a Difference in per capita Medicaid Billing?

B. Medicaid/SSDI/SSI Should Be Re-Tooled as Possible to Achieve Desired Results

The Medicaid/SSDI/SSI eligibility mechanism has come to dominate Program financing. Thus, to the extent possible within federal requirements, this mechanism should be reviewed and adjusted to achieve desired results. To the maximum extent possible:

1. Eligible services should be based on achieving desired results.

2. Eligible services should be flexible in order to allow services to be tailored to what individuals need to achieve desired results including, if possible, non-traditional approaches.

3. Disincentives to achieving desired results should be ferreted out and corrected, where possible.

C. The Planning Committee Should Review Whether the Current Reliance on Psychiatric Medications is leading to Desired Results.

The Mental Health System currently relies heavily on psychiatric medications. It is recommended that further research on how the use of these medications impact desired results should be conducted.

D. The Budget Building Process Should be Re-evaluated.

1. In developing budget recommendations, the entire Program budget and desired outcomes should be considered.

2. While stakeholder input should always be sought, it should be evaluated in the context of results based budgeting that considers the entire mental health budget.

3. The Trust should consider reviewing its RFR process to determine if it is producing optimal results. Specifically, in addition to taking the entire Program budget into consideration, the Trust might re-evaluate its policy of requiring an Exit Strategy to be eligible for Trust funding.

4. The Board should remember that its budgetary responsibilities are broader than the Trust's.

5. Existing and potential revenue sources should be more seriously pursued, such as:

a. Federal Medicaid
b. Federal Discretionary
c. Community Mental Health Services Block Grants
d. State
e. Recipients
f. Foundations
g. Trust Lands - Find Oil and/or Gas on Trust Land.
h. Partnering
i. Federally Qualified Health Centers
j. Others

IX. Conclusion

The Budget Committee's conclusions arising from the Summit are (1) more data needs to be developed and regularly evaluated to help steer program funding to achieve desired results based on data, (2) the precise desired results need to be determined, based on consumer and community values, and (3) the budget should be built around purchasing the desired results.

Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder

A. Either (1) or (2):

(1) six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
(b) often has difficulty sustaining attention in tasks or play activities
(c) often does not seem to listen when spoken to directly
(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
(e) often has difficulty organizing tasks and activities
(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

(2) six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

(a) often fidgets with hands or feet or squirms in seat
(b) often leaves seat in classroom or in other situations in which remaining seated is expected
(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
(d) often has difficulty playing or engaging in leisure activities quietly
(e) is often "on the go" or often acts as if "driven by a motor"
(f) often talks excessively

Impulsivity

(g) often blurts out answers before questions have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

Some Teen Screen Questions

- Has there been a time when nothing was fun for you and you just weren't interested in anything?
- Has there been a time when you felt you couldn't do anything well or that you weren't as good-looking or as smart as other people?
- How often did your parents get annoyed or upset with you because of the way you were feeling or acting?
- Have you often felt very nervous when you've had to do things in front of people?
- Have you often worried a lot before you were going to play a sport or game or do some other activity?
- Have you tried to kill yourself in the last year?
- Are you still thinking of killing yourself?
- Have you thought seriously about killing yourself?
- Have you often thought about killing yourself??
- Have you ever tried to kill yourself?