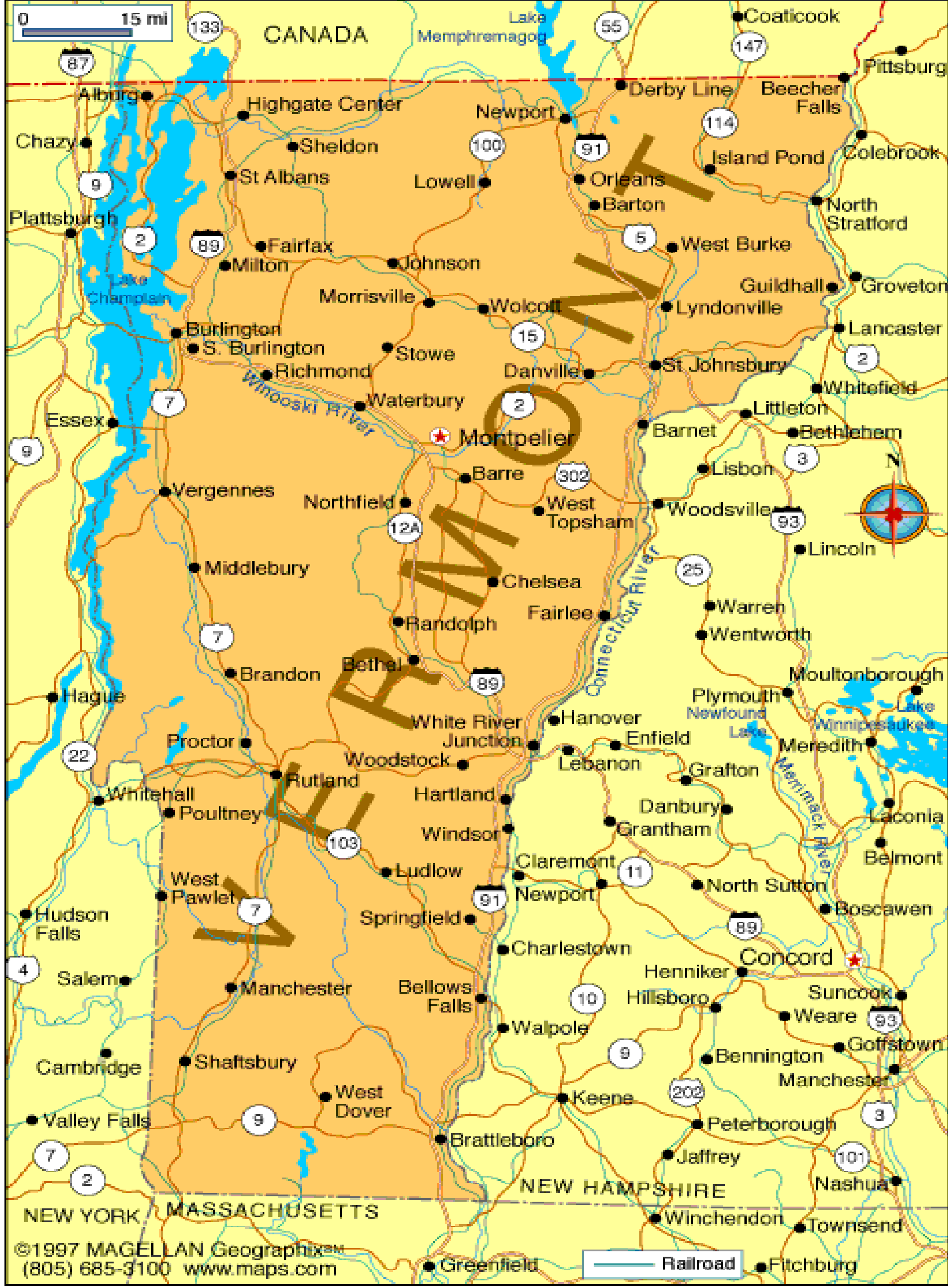
Where is the dignity in the US mental health care system? It depends on who you ask!

Sandra Steingard, M.D.
Chief Medical Officer, Howard Center
Associate Professor of Psychiatry
University of Vermont Larner College of Medicine
Burlington, Vermont, USA



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Brief Personal Introduction

- Chief Medical Officer of large community mental health center
- Critical Psychiatrist
  - Disgust with pharma and medicine
  - Critical view of psychiatric diagnosis
  - Concern about long-term harms of drugs
- Interest in Open Dialogue, Hearing Voices Network
  - Relational, non-medicalized ways of thinking about mental distress

Howard Center, Burlington, Vermont

- Vermont - population ~ 650,000
  - Chittenden County – ~ 120,000
  - Burlington – ~ 40,000
- Howard Center employs ~ 1500
- Operating budget ~ $90,000,000/year
- Most revenue - Medicaid
- We serve thousands
  - Children, adults, developmental disabilities, substance abuse, crisis services, residential
- Community Support Program ~ 650
  - Program developed to serve individuals who – in another era – would have lived in a state hospital
  - Mostly diagnosed with psychotic disorders

Key Elements to Understanding US Mental Health System

- Insurance
- Laws
- Hospital/Community
- Professional Guilds
- Most of these are all driven by state structures so there is no “US” mental health system

US Insurance System

- Private
  - Mostly through employer
- Medicare
  - Elderly and disabled
- Medicaid
  - Income sensitive
  - State/Federal partnership
  - Strong impact of state policy
- Social Security
  - Income for elderly and disabled

US Mental Health Care

- Private Insurance
  - Fee for service
  - Moving towards population health initiatives
- Public Insurance
  - This is where more people with disabling conditions are treated
  - Varies from state to state
  - Funds community mental health care
  - Primarily Medicaid

Impact of Insurance Driving Systems

- This requires a medicalized view of human distress
- Everyone requires rapid diagnosis
- Everything needs to meet “medical necessity”
- Privileges physicians, technical approaches
- Impact of Medicaid’s income sensitivity
  - Medicaid funds many social service supports
    - Home/community based services
  - One needs to keep income below a certain level or supports are lost

Laws

- State laws dictate commitment and guardianship laws
  - There are similarities between state
  - Dangerousness drives commitment
  - "Capacity" drives guardianship
  - Often culture can influence application of law more than the way the law is written

- National legal precedent influences liability and civil rights
- Struggle between beneficence and autonomy

Community Mental Health

- Arose in 60s and 70s
- Entire country is divided into “catchment” areas
- Largely funded by Medicaid
- Services
  - Psychiatric care
  - Psychotherapy
  - Housing
  - Case management
  - Employment

Barriers to Dignity

- Medicalizes human suffering/ human experience
- The system decides how to characterize the problem
- The "soft bigotry of low expectations"
- Pull to remain poor
  - Fewer services in private sector
  - Challenge to earn enough money to make loss of disability "worth it"
  - Expensive education, housing, food without support

“Help” is experienced in different ways depending on perspective

“God Knows Where I Am”

Rachel Aviv, The New Yorker, May 30, 2011

- 51 year old woman discharged from one-year hospital stay
- Heard voices, delusions
- Refused medications, plans for after care
- She did not believe she was ill
- Wandered into an abandoned farmhouse
- She did not leave because she did not want to be returned to the hospital; she also feared conspiracies and Satan’s workers
- She cleaned the house, deliberately evaded detection, stored apples for the winter
- Four months later, she died of starvation
- Her letters were used for the article and a documentary

Preserving Dignity vs. Neglect

- For those who favor beneficence Linda Bishop's story is an argument for forced care.
  - She shouldn't be allowed to starve
  - She did not have capacity to make that choice
- For those who favor autonomy, her story support favors respect of individual rights
  - She was miserable in the system.
- Is there a third path?

“Dignity” depends on perspective

	Perspective
Individual	Varies but wishes may not ally with what others want
Family	Concern, worry, love Often protective
Professionals	Resistance/refusal of treatment considered a symptom
Society	Public safety concerns Economic pressures may favor autonomy but this can also look like neglect

Initiatives to promote dignity

- Recovery oriented care
- Trauma informed care
- Person centered care
  - These all encompass ideas to place individual needs above system needs or at least acknowledge that system needs may not overlaps entirely with individual needs
- Dialogic practice
  - Transparent and democratic
  - All voices brought into room
  - Humility, no one “truth”, no one “expert”