Why our mental health care system’s problems remain uncorrected

Nathaniel S. Lehrman, M.D.
Clinical Director, retired, Kingsboro Psychiatric Center, Brooklyn NY
N.S. Lehrman, M.D. <nslmd@verizon.net>

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An effective care system that I saw - and then set up
I saw an effective care system for hospitalized psychotics in Cambridge, England, in 1978. The same psychiatrist who treated a patient in hospital followed him afterward in the clinic until discharging him as recovered. For me, who had just retired as Clinical Director at Kingsboro Psychiatric Center in Brooklyn, this was truly a road to Damascus experience.

I repeated what I saw in England when I returned to another New York state hospital as a part-time, after-care staff psychiatrist. That repetition was the most exciting and satisfying professional experience of my entire life. Expecting that my unselected aftercare patients could recover, staying in touch with them even when they needed brief rehospitalization, and working with them on their unique individual problems, fears and relationships, I gradually helped over a hundred toward recovery.

The essential elements in this successful approach were (1) continuity of care - care by the same professional from start to finish of treatment - and (2) the expectation that full recovery could be attained. That expectation came in part from my own experience - full recovery from a schizophrenic break in 1963. Later, several colleagues, reflecting the hopelessness long pervading psychiatry, insisted I was incorrectly diagnosed because I did recover.

Loren Mosher, researchers in northern Finland, and others have done essentially what I did, altho in different ways. But common denominators for them all are continuity of care and the expectation of recovery.

Psychiatry’s justified gloom
Why then the gloom which has long pervaded psychiatry? Thomas Insel, M.D., Director of the National Institute of Mental Health, wrote recently (Arch. Gen. Psychiatry 2009, p. 129), “In contrast to the steadily decreasing mortality rates of cardiovascular disease, stroke and cancer, there is no evidence for reduced morbidity or mortality from any mental illness.”
has been no change in the prevalence of mental illness between 1992 and 2002, but increased rates of treatment... from 20% to 33% during this ten year period. Curiously, despite increased treatment, there was no evidence for decreased disability. Indeed, the more recent cohort shows a loss of income that is considerably greater than all previous reports. In other words, psychiatric treatment seems increasingly unsuccessful.

What's more, mental illness represents a mounting fraction of all disabling illnesses. Insel notes that the World Health Organization Global Burden of Disease study listed mental illnesses as the leading source of disability in Americans and Canadians aged 15 to 44 years, accounting for nearly 40% of all medical disability in this age group.

Two reasons for this increasing failure are (1) the mounting fragmentation (discontinuity) of mental health care, and (2) therapeutic fearfulness and hopelessness, the latter often being explained by the alleged biological basis of mental illness. Over-reliance on medication as our primary treatment modality has resulted. Organizational changes within public psychiatry have aggravated these failure-producing factors: discontinuity of care and evocation of fear instead of hope - sometimes deliberately.

The mounting fragmentation of care
Until 1979, at New York State Office of Mental Health facilities, the same chief of service headed both in-patient and aftercare facilities for a given catchment area. Then a statewide reorganization placed all aftercare services under one assistant director, thus giving two administrators sequential responsibility for patients instead of one.

In 1984, aftercare services for New York State facilities were transferred from hospital-based clinics to private agencies. As of 2002, the state had 2,378 such agencies.

In Cambridge, England, the continuity of care system I admired was later discontinued - in order to facilitate research, I was told. In Israel, while a continuity of care system was admittedly desirable, its implementation was supposedly prevented by psychiatric training needs.

The centrality of continuity of care was the heart of my paper on Effective Treatment of Chronic Schizophrenia at a panel I organized on treating chronic patients for the American Psychiatric Association’s 1980 annual meeting. But the term was redefined in another panel paper (Continuity of care: a conceptual analysis, by a University of Maryland sociologist) as the orderly, uninterrupted and unlimited movement of patients among the
The deliberate evocation of fear and hopelessness
Mental patients rarely, if ever, recover beyond their caretakers¹ expectations. When caretakers are hopeful, patients will tend to be also. But when caretakers are fearful and intimidated, patients suffer accordingly. The dangerous extent of that fear today is shown by a recent report that many mental health commissioners place their role in ensuring public safety ahead of their treating the mentally disturbed.

In 1979, a fear epidemic was deliberately created throughout New York public psychiatry after ²mental patient² Adam Berwid, on authorized hospital pass, premeditatedly slaughtered his ex-wife. Then, with a local prosecutor standing beside him, he lied to the media that he had warned his doctors of his plans, but they gave him the fatal pass anyway. With the media’s unquestioning acceptance of the murderer’s officially supported lies, psychiatrists at that hospital became totally panicked - afraid even to write orders without the consent of their nurses (a nurse had just been appointed hospital director). The psychiatrist chief-of-service involved in the case needed hospitalization after refusing, despite two weeks of pressure from the state mental health commissioner, to confirm the latter’s claim that he had ordered the ward psychiatrist not to issue the pass. It took two years before the killer was finally found guilty of murder and given a maximum sentence. But the fear which reverberated throughout the care system did not help its patients.

Conclusion
Effective care of the mentally disabled requires continuity of care and hope for recovery. The latter can be eclipsed by the creation of fear. The Berwid case is a striking example of that fear-creation: the active sabotage of mental health care by some of the professionals organizing and providing it. Psychiatry will continue harming its patients until those within the profession responsible for that harm are brought to public attention and dealt with appropriately.