2020 Spring Highlights Meeting: President-Elect Address

Jeffrey L. Geller, M.D., M.P.H.

There are acute crises, like the devastation wrought by COVID-19, that hardly anyone fails to notice, and there are long, drawn out crises with tremendous costs to humanity that few take note of. Today, I address the latter.

> Of the 22,000 insane persons in the United States in 1848, only 5,000 receive hospital services.
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> More than 17,000 are unsuitably placed in jails, poorhouses, private dwelling and almshouses; where they are kept in cages, stalls, pens, garrets, cellars, corn houses, cells, small shacks, huts, blockhouses, pits, and sold at auction; where they are bound with galling chains, bowed beneath fetters and heavy iron balls, attached to drag chains and chained to logs, lacerated with ropes, scourged with rods, put in severe restraints, and strapped upon beds with coarse, hard straps of leather; where they are without light, pure air, warmth, or cleansing, absolutely destitute of everything securing comfort or decency; and they are terrified beneath storms of profane execrations and cruel blows, subject to gibes, and scorn, and torturing tricks—now abandoned to the most loathsome necessities, or subject to the violent and most outrageous violations.
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> Humanity requires that every insane person should receive the care appropriate to his condition…. But to confine the insane to persons whose education and habits do not qualify them for this charge, is to condemn them to a mental death.

These are the words of Dorothea Dix in her message to the U.S. Congress. Ms. Dix lobbied her bill through four presidential administrations. Six years after her address, the bill was passed by Congress in 1854. President Franklin Pierce vetoed that bill and began more than 100 years of the federal government ignoring the needs of persons with mental illness, stating they were the states' responsibility.

How are we doing in the 21st century?

In 2004, in the United States, there were 100,439 psychiatric beds in public and private psychiatric hospitals and in the psychiatric units of general hospitals. That's one psychiatric bed for every 3,000 Americans. In 1955, there was one psychiatric bed for every 300 Americans.

The number of patients in the U.S. presenting to emergency departments with psychiatric complaints increased by more than 50% between 2006 and 2018. The average ED stay for psychiatric patients ranges from 7 to 34 hours—three times longer than patients presenting with physical illnesses and injuries. Some individuals with serious mental illness have stayed in EDs longer than a month while staffers search for a bed.

Currently, at least 20% of inmates in jails and prisons have a serious mental illness. In 1983 that percentage was 6.4%. There are over three times more seriously mentally ill persons in jails and prisons than in hospitals. There is a very strong correlation between states that have more mentally ill persons incarcerated and states that spend less to treat mental illness. Mentally ill inmates have more repeat admissions, cost more, stay longer, are major management problems, are subject to greater abuse, and are more likely to commit suicide.

There are also correlations between the decreasing availability of psychiatric hospital beds and the increase in crime, arrest rates, and homelessness. People with untreated serious mental illness are one-third of the total homeless population in the United States. Major cities in the U.S. have declared "homeless emergencies." The most extensive survey ever undertaken reported 564,708 people were homeless on a given night in the United States. This means 188,000 homeless individuals were seriously mentally ill at any given point in time, or about 1.5 times the number of patients in all psychiatric beds in the U.S. at that time.

Suicide rates in the U.S. increased by 33% between 1999 and 2017, with the increase in some states as high as 59%. In comparing the change in rates of suicide between 2000 and 2012 in Canada, China, Germany, Japan, Russia, United Kingdom, and United States, the U.S. is the only country where the suicide rate increased.

Between 2000 and 2017, unintentional deaths and suicides related to opioid use increased substantially. From 2012 through 2018, the rate of drug overdose deaths involving cocaine more than tripled, and the rate for deaths involving psychostimulants with abuse potential (drugs such as methamphetamine) increased nearly fivefold. Moreover, persons with serious mental illness are significantly more likely than their peers to receive chronic opioid medications, even adjusting for medical comorbidities and chronic pain diagnoses.

But we cannot just focus on what we have yet to do. The spring of 2020 has seen more than its share of despair. Where are we succeeding?

Telepsychiatry was blossoming, even before COVID-19. If rational minds prevail, telepsychiatry should be the nail in the coffin of psychologist prescribing.

APA offers such a rich array of continuing education opportunities; if reason trumps tradition, the APA will replace the ABPN as having responsibility for maintenance of certification (MOC).

Our knowledge of insight impairments in serious mental illness, most particularly anosognosia, is such that if acting responsibly overrides acting politically, the judicious use of involuntary treatment in in- and outpatient settings will shed its contentiousness.

We have relearned what we knew from the 1700s to the 1950s: work is important for a meaningful life for persons with serious mental illness. We have made significant strides in assisting persons with serious mental illness to achieve employment, particularly through clubhouses.

Before COVID-19, almost 60% of the U.S. labor force was paid by the hour. These unpredictable work schedules have negative health consequences: poor mental and physical health outcomes in adults and behavioral problems in young children. Now, many of these workers have increased stress as they are without any income. We have ways to help folks in stressful circumstances, but reaching this population remains a challenge. Health inequities are rampant.

We have marched forward with the expansion of delivery systems for psychiatric medications as demonstrated by new long-acting injectable medications. The expansions of long-acting injections should make a significant dent in the prevalence of nonadherence to psychiatric medications.

After a series of stutter-steps, we are creating innovative models of integrated care, forming outpatient models of collaborative care, which, ironically, public psychiatric hospitals have used for inpatients for 100 years.

We are chipping away at the arcane IMD exclusion, a practice that excludes persons with mental illness from Medicaid coverage in psychiatric hospitals while persons with knee replacements in orthopedic hospitals or cataract surgery in eye hospitals or cardiac stints in heart hospital are not excluded.

We are making progress in treating those with substance use disorders with the expansion of buprenorphine prescribers and the modification of caps, the ready availability of Narcan and the concurrent treatment of dually diagnosed individuals.

We are both broadening and fine-tuning our psychiatric responses to devastation wrought by climate change and to the pandemonium in the face of viral epidemics like COVID-19.

On March 4, 2020 the FDA banned the use of electrical shock devices that were employed to attempt to modify behavior in persons with psychiatric and/or developmental disorders. We have removed another barbarism used in the name of improving dysregulated behavior.

As never before, APA members understand the consequences of the marginalization of persons with serious mental illness. It's time we move away from a discussion of stigma to a discussion of prejudice. Discrimination against those with serious mental illness is no different than prejudice against other groups deprived of equal opportunity due to their genetics, infections, or accidents.

In her presentation to Congress, Ms. Dix quoted the keeper of a poorhouse in Illinois, "We want hospitals, Miss, we want hospitals, and more means for the crazy everywhere." He was right in 1846, and he'd be right today.

Fundamental to extricating ourselves from the current quagmire of services for persons with mental illness is getting to the right number of psychiatric beds. Too few, and we have the conditions I've described. Too many, and we pull resources away unnecessarily from alternatives to hospitalization.

Not knowing how many gives the U.S. Department of Justice the opportunity to sue states for having too many beds. And the hospitals need to be of the highest caliber. We can never return to the dismal days when Harry Solomon noted in his APA presidential address in 1958: "In many of our hospitals about the best that can be done is to give a physical examination and make a mental note on each patient once a year, and often there is not enough staff to do this much."

Finally, our most significant progress in the 21st century is all of you. Just think how different we are from our predecessors.

In 1890, the APA had 175 members, 139 of whom were still living. All were Caucasian men, 90% had a beard and/or a mustache.

Now, the APA is an organization of enviable heterogeneity.

And we shall continue to progress with more and more underrepresented group members having more and more of a presence in the APA. And in our efforts to be more inclusive, we need to recognize a yet to be acknowledged, underrepresented group in the APA: psychiatrists who have serious mental illness themselves.

In the APA Annual Meetings of 1918 and 1919, no mention of the raging influenza epidemic was made. We shall not commit the same oversight. Together, we thank our fellow psychiatrists who have been on the frontlines every day and our trainees who have been pinch-hitting wherever they've been needed. And in quiet moments, each in our own way, we can remember our colleagues whose work with COVID patients ceased with the end of the doctor's life.

When the COVID-19 crisis has passed, we need to tackle, with equal intensity, our long-standing crises: health inequities, social marginalization of persons with serious mental illness, and inadequate resources to treat psychiatric patients. We know what these resources are, but like PPEs in the COVID pandemic, there just aren't enough around. And it's a lot harder to get the resources psychiatrists need than it is to retool a factory to make masks.

Thank you.

AUTHOR AND ARTICLE INFORMATION

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