Delivery System Aspects of Policy for Mental Health and Work

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Overview of Remarks

• Technologies for Treatment
  – Severe and Persistent (Enduring) Mental Illnesses
  – Other mental disorders
• For what populations and in what contexts do treatment technologies work best?
• Are economic incentives in mental health care delivery aligned with effective provision of care?
• Summary Reflections
  – From a U.S. perspective
  – General comments
Treatment Technologies

• What are the potential benefits from applying the best science aimed at improving work outcomes?
  – For people with SPMI?
  – For people with other common disorders: depression and anxiety?

• Are these interventions cost-effective?
  – Compared to what?

Evidence of Effectiveness

• Supported Employment (IPS model) for people with SPMI
  – Significant interest in Europe and U.S. (Medicaid and Social Security)

• Collaborative Care for Anxiety and Depression
  – Most widely studied model in U.S. and Canada
Evidence on IPS

- Multiple randomized controlled studies have shown
  - IPS realizes better outcomes re: entry into competitive employment; duration of employment compared to Vocational Rehabilitation and Day Treatment
  - Earnings are only modestly different
- Vast majority stay on public programs
- Attachment to competitive labor market tenuous

Collaborative Care

Incremental Cost

QALY = $100,000
QALY = $50,000
QALY = $25,000

QALY

Incremental Cost

www.oecd.org/els/disability
Clinical versus Work Place Effects

New Developments

- Work in neuroscience and some initial studies suggest that early interventions with first episodes of psychosis may have promising work impacts
- Studies on the life course of children with conduct disorders (UK, Australia, US) suggest that prevention efforts may yield important work outcomes

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Observations on Evidence

• Key evidence based treatments result in improved work outcomes for people with SPMI and other mental disorders
• The extant evidence suggests potential benefits are more limited than the most enthusiastic observers claim
• Much can be gained from shifting spending from traditional approaches to treatment towards evidence based treatments
• Early intervention efforts are promising yet largely untested

Observations

• High powered incentives to economize on community care COMBINED with low powered incentives on institutional care discourages community based innovation
• Creating budget competition between mental health and other community based health programs is typically harmful to mental health
• Horizontal fragmentation drives a wedge between social and private costs/benefits resulting in distorted decision making (e.g. cost shifting behavior)
Aligning Programs and Contexts

• We frequently design interventions that are hard to align with the providers and delivery system contexts within one must “operate”
  – Supported employment and payment arrangements in the U.S.
  – Collaborative care clinic organization and practice (fifteen minute visits)
• Focus on fidelity may be less important than identification of minimal required elements
• Evidence on IPS suggests heterogeneity in response—opportunities for targeting

Summary Remarks

• There is a great deal of convergence in the treatment technologies that are gaining favor in many OECD nations
• Given how different OECD health systems are; there are striking similarities in the sources of misaligned incentives
• We must restrain historical tendencies toward therapeutic optimism—in placing bets on different approaches to addressing disability associated with mental illnesses