

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



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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?



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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



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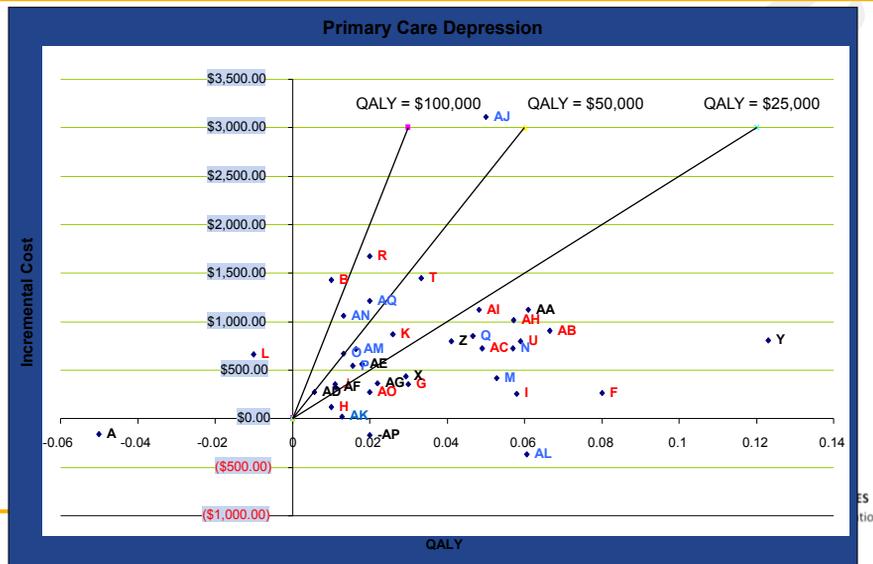
Evidence on IPS

- 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



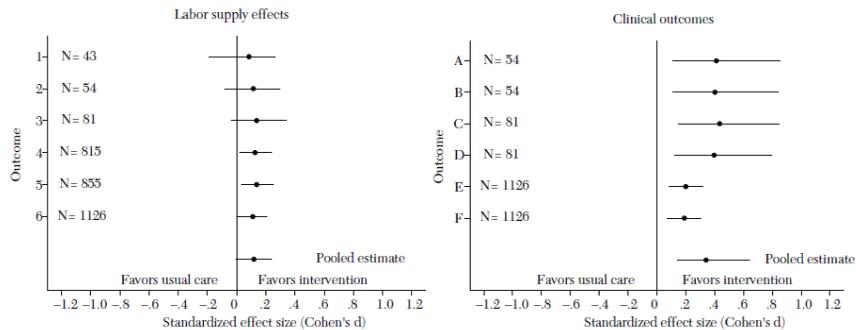
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Collaborative Care



Clinical versus Work Place Effects

Forest plots of study-specific and pooled estimates of labor supply effects and clinical outcomes associated with interventions for major depressive disorder



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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



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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)



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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



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