Coalition Vows to Fight for Mental Health Reform

The Campaign for Mental Health Reform is seeking enactment of mental health–parity legislation.

BY NELLIE BRISTOL
Contributing Writer

WASHINGTON — A coalition of national mental health organizations—including the American Psychiatric Association and the National Alliance for the Mentally Ill—has launched a campaign aimed at implementing some of the goals set 2 years ago by the New Freedom Commission on Mental Health.

A top priority of the effort, called the Campaign for Mental Health Reform, is the enactment of mental health–parity legislation.

Other priorities include using Medicaid funds for home- and community-based care instead of institutional services and allowing states to fund comprehensive treatment plans. The campaign also will work for legislation aimed at allowing families to buy into Medicaid services for children with disabilities.

Ending discrimination in the treatment of mental illness is "the next frontier," according to Sen. Edward M. Kennedy (D-Mass.), who attended the press event in late July outlining the campaign's agenda.

"It is something that this country has to come to grips with. [We] should and will be the better country, be a fairer, more just country, when we deal with this in the way that we have with physical illness," said Sen. Kennedy, who was joined by several other members of Congress, including Sen. Mike DeWine (R-Ohio), Rep. Patrick Kennedy (D-R.I.), Rep. Sue Myrick (R-N.C.), and Rep. Jim Ramstad (R-Minn).

The coalition's steering committee members are from the Bazelon Center for Mental Health Law, the National Association of State Mental Health Program Directors, the National Mental Health Association, and NAMI. The group developed "Emergency Response: A Roadmap for Federal Action on America's Mental Health Crisis," which lists 28 "action steps" aimed at improving provision of mental health services in the United States.

In 2003, President Bush's New Freedom Commission on Mental Health report called for "fundamental transformation of the nation's approach to mental health care." However, the Campaign for Mental Health Reform noted in its executive summary that "there has been little progress in realizing the commission's goals or implementing its recommendations."

In fact, since the commission released its report, the campaign noted, 63,000 Americans have died from suicide; more than 200,000 Americans with mental illness have been incarcerated; more than 25,000 families have given up custody of their children to get them mental health services; and juvenile detention centers have spent $200 million "warehousing" youth instead of providing treatment.

The campaign estimates that the U.S. economy has lost more than $150 billion in productivity because of unaddressed mental health needs.

Other priorities for the group include reforming copayments for mental health treatment under Medicare and providing early identification and effective treatment both for returning veterans at risk of posttraumatic stress disorder and to mothers and children who receive health care at federally funded maternal and child health clinics.

The coalition also advocates presumptive eligibility for Social Security benefits and Medicaid for mentally ill homeless people and diverting mentally ill individuals who have committed nonviolent crimes into treatment instead of jail or prison.

Some of the group's priority proposals are included in legislation pending in the House or Senate, campaign director Charles Konigsberg said. For example, mental health parity is outlined in the Paul Wellstone Mental Health Equitable Treatment Act of 2005, sponsored in the House by Rep. Kennedy. Attempts to pass mental health–parity legislation have failed for the last several years.

Legislation to encourage states to let parents keep custody of their mentally ill children and still receive services is sponsored in the House by Rep. Ramstad and in the Senate by Sen. Susan Collins (R-Maine).

Mr. Konigsberg said the campaign considers its effort complementary to that of a federal agency agenda for mental health services improvement announced a few days earlier by six federal departments. The "multiyear effort to alter the form and function of the mental health system," includes a federal executive steering committee that would oversee the "mental health system transformation," according to press materials.

The 70-item Mental Health Action Agenda includes reinforcing the message that mental illness and emotional disturbances are treatable and that "recovery is the expectation," through a national public education program sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The agenda also proposes working to reduce the number of suicides through implementation of the National Strategy for Suicide Prevention and helping states formulate and implement comprehensive state mental health plans that would be able to create individualized plans of care.

The federal effort's steering committee includes 13 members from the Department of Health and Human Services and one representative from each of the departments of Agriculture, Housing and Urban Development, Veterans Affairs, Education, Justice, and Transportation, as well as a member from the Social Security Administration. ■

Primary Care Collaboration on Mental Health Care Urged

BY MARY ELLEN SCHNEIDER
Senior Writer

NASHVILLE, TENN. — Integrating mental health and primary care has the potential to reduce medication mistakes and improve communication among providers, experts said at the annual conference of the National Academy for State Health Policy.

"This is a medical error reduction opportunity as well as a quality and cost opportunity," said Joseph J. Parks Jr., M.D., a psychiatrist and medical director for the Missouri Department of Mental Health.

The status quo isn't working, he said. Individuals with mental illness have increased or early mortality, have high rates of medical comorbidity, and receive inadequate and poorly coordinated health care.

Mental illness also predicts underutilization of medical services. A study of older patients with psychiatric disorders found that individuals with diabetes were less likely to receive more than one medical visit if they also had schizophrenia, bipolar disorder, or posttraumatic stress disorder. Patients with hypertension and any psychiatric disorder were also less likely to have more than one medical visit (Psychiatr. Serv. 2002;53:874-8).

There are several models for integrated mental health and physical care, including embedding primary care in a mental health program, creating a unified primary care/mental health program with common administration and financing, and improving collaboration between mental health and medical providers.

Evidence seems to show that trying to create linkage is difficult, Dr. Parks said. "Collaboration is basically an unnatural act between separate organizations," he said. While this model is easier to set up initially, it is harder to make successful over the long run.

Models where primary care is embedded in mental health clinics or primary care and mental health programs are unified are harder to set up initially but easier to operate day to day, he said.

In general, the colocation of services is popular with both patients and providers. On the provider side, it allows physicians and other providers to have a more accurate understanding of one another's incentives, methods, and constraints, Dr. Parks said. Colocation also allows physicians to maintain a single clinical record, which requires less time and creates less potential for errors.

For patients, it breaks down some of the barriers to care, said Susan C. Braun, a nurse practitioner and project director of the Center for Integrated Health Care at the University of Illinois at Chicago.

She runs a program that brings primary care services into an established psychiatric rehabilitation program. That setup allows mentally ill patients to access medical services without going to a large medical center. Instead, they are cared for in a familiar setting, she said.

Providers at Cherokee Health Systems Inc. in Talbott, Tenn., have taken the opposite approach. There, a behavioral health consultant is embedded with the primary care team.

For example, a behaviorist is involved in all well-child visits, said Dennis Freeman, Ph.D., chief executive officer of Cherokee Health Systems. Behaviorists also manage the psychosocial aspects of chronic and acute diseases, address lifestyle and health risk issues, and comanage treatment of mental disorders.

Dr. Freeman said that state regulators and policy makers should reject carved out payments for mental health services because the majority of these services will continue to be delivered by primary care physicians. And he encouraged more payers to implement the Health and Behavior Assessment/Intervention CPT codes 96150 through 96155 that were issued in 2002. The codes are for use by nonphysicians for services involving the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.

Contractual requirements and financial incentives through state Medicaid programs will also help encourage integration of services, Dr. Parks said.

"People will start doing things because it's the right thing to do, but people don't always keep doing things once the excitement dies down," he said. ■

Congress Lifts Opioid Treatment Limit

Large health plans and other group providers will be able to treat larger numbers of opioid-dependent patients, thanks to a bill passed recently by Congress.

The measure lifts a cap that allowed practices to treat no more than 30 such patients at any time. "There has been broad acknowledgement that the 30-patient group limit doesn't make sense from a clinical perspective or any other perspective," Nicholas Myers, director of government relations at the American Psychiatric Association, in Arlington, Va., said in an interview.

The limit, which applied to group practices and individual physicians, was a response to concern about the potential for diversion and abuse, he said. The individual physician limit remains in place.

—Joyce Frieden