

Parity-Plus

A Third Way Approach to Fix America's Mental Health System

By Art Levine

The United States has a mental health crisis that is not being seriously addressed, even though it is a major underlying cause of a host of social problems. Despite a few high-minded government reports and sporadic promises of reform, untreated mental illness still contributes significantly to everything from crime and homelessness to student failures and unemployment. The nearly 16 million American adults and children with serious, disabling mental illnesses and emotional disturbances have been denied something essential: reforms that hold the nation's fragmented, wasteful mental health system accountable for producing meaningful results in their lives.

The best-known reform goal, instituting parity for mental health care with other medical coverage, has been supported in the platforms of both political parties. But even with a majority of legislators in both houses of Congress endorsing the concept, it has yet to be carried out under federal law. The drive for parity has been thwarted at the federal level by some Republican legislators and powerful business groups raising false alarms about potential costs. Meanwhile, mental health reform advocates and their allies have been unable to overcome the opposition simply by arguing that parity is fair, compassionate, and affordable.¹

There is a way, however, to break this impasse with a Third Way policy solution—"Parity-Plus." Lawmakers should require health insurance companies to provide equal

coverage for mental health care, but also hold health care providers accountable for delivering high-quality, cost-effective services. That will require broader reforms of the mental health system. Specifically, legislation must also promote recovery for people with mental illnesses, rather than lifelong dependency, by removing obstacles that prevent proven treatments from being widely used. Legislation should also empower consumers of mental health services to be partners in their own care, and it should encourage and support mentally ill people who want to work.

By offering rigorous fiscal and quality controls, more individual choice, and compassionate, effective care, the Parity-Plus proposal acknowledges the legitimate concerns of all sides of this policy battle. This

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***“One person with a belief is a social power equal to
ninety-nine who have only interests.”***

—John Stuart Mill

The Progressive Policy Institute

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The PPI invents new ways to advance enduring progressive principles: equal opportunity, mutual responsibility, civic enterprise, public sector reform, national strength, and collective security. Its “progressive market strategy” embraces economic innovation, fiscal discipline, and open markets, while also equipping working families with new tools for success. Its signature policy blueprints include national service, community policing, and a social compact that requires and rewards work; new public schools based on accountability, choice, and customization; a networked government that uses information technology to break down bureaucratic barriers; pollution trading markets and other steps toward a clean energy economy; a citizen-centered approach to universal health care; and a progressive internationalism that commits America’s strength to the defense of liberal democracy.

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reform plan from the Progressive Policy Institute (PPI) seeks to transcend the current deadlocked debate by showing that businesses, families, and the U.S. economy as a whole can benefit when mental health problems are addressed in a cost-effective manner. As it is, both pro-business conservatives and liberal reformers have too often been stalemated on the question of spending more or spending less on mental health care. Neither side has forcefully addressed broader issues such as ensuring that we are paying for the right results.

That should be the starting point for real reform. Surprisingly, 98 percent of workers with job-based coverage have some mental health benefits, but you would not know it by looking at the scope of mental illness'

devastating impact.² There are so many strict limitations in coverage—such as a maximum of 20 visits per year—that these private plans simply are not designed to cover serious or chronic mental illnesses, forcing families to go broke spending on treatment, or to abandon loved ones to a public mental health system that is in chaotic disarray.³

Mental illness is the country’s leading cause of disability, and, despite a host of effective new medicines and treatments, the archaic, maze-like mental health system blocks most people from accessing them. What is the result of this failure? There are some 30,000 suicides a year, and millions of people face needless disability, unemployment, and incarceration. Less than 40 percent of those with serious mental illness receive stable,

ongoing treatment, while 25 percent of homeless people have serious mental disorders and generally do not receive any treatment.⁴

Both political parties have mostly responded with either indifference or a limited vision of what is needed to create significant mental health care reform. A weak parity law passed in 1996 had so many loopholes that businesses and their health plans easily evaded it. A stronger measure, the Paul Wellstone Mental Health Equitable Treatment Act (S.486/H.R.953), has languished in Congress since 2001, blocked by a coterie of Republican legislators, including House Speaker Dennis Hastert, and health insurance industry lobbyists. These critics of parity have generally offered a knee-jerk conservative response to the long overdue need for fair mental health coverage, clinging to the old saw that parity would impose a burdensome mandate on businesses, while ignoring the real-world savings a cost-effective approach to parity offers. In fact, strong evidence shows that parity would provide enormous workplace and hospitalization savings while raising premiums less than \$1.50 a month per person.⁵ Meanwhile, President Bush has done nothing to break the congressional logjam, even though he promised to seek parity legislation when he set up his New Freedom Commission on Mental Health in April 2002.⁶

While parity legislation is necessary, however, it is not sufficient to transform a system that has been described as a “shambles” by the president’s own mental health commission. Parity must also be linked with accountability and patient-oriented outcomes. This type of enhanced parity would bring together a wave of cutting-edge reforms—some proposed, some already proven—that aim to promote effective treatments and tangible results, often reinforced by pay-for-performance or other incentives. These imaginative, cost-effective solutions, including

outreach teams that can cut hospitalization rates for the severely mentally ill, share a single-minded focus on ensuring worthwhile results are delivered.

Surprisingly, despite the grim failures in the mental health field, there are also promising signs of bipartisan interest in reform. In 2004, Congress authorized an \$82 million initiative to promote youth suicide prevention programs.⁷ It also passed the Mentally Ill Offender and Crime Reduction Act, which promotes programs such as mental health courts that route mentally ill offenders into court-monitored treatment instead of jail.⁸

There is also cause for concern, however. The president’s FY2006 budget proposed \$45 billion in cuts to Medicaid during a decade, and while Congress has pared back those cuts to \$10 billion, the consequences could still be severe for the mentally ill who depend heavily on Medicaid.⁹ A sharp reduction in Medicaid funding could be devastating for mental health care, since Medicaid is the primary vehicle for public funding of mental health services—and public funds currently account for 63 percent of all U.S. mental health spending.¹⁰ Nonetheless, it is clear that both the federal government and the states are looking for ways to reduce Medicaid spending, because it has risen more than 50 percent since 2000 to more than \$300 billion per year.¹¹

Against that tide, two bipartisan groups of elected officials are pushing for long-term Medicaid reform as an alternative to budget-driven cuts at the federal level. The National Governors Association, led by Govs. Mark Warner (D-Va.) and Mike Huckabee (R-Ark.), has made preliminary proposals to reform Medicaid while strengthening other forms of health care insurance and long-term care coverage. Sens. Jeff Bingaman (D-N.M.) and Gordon Smith (R-Ore.) led a group of senators in support of a bipartisan commission to study the program’s failings and recommend

long-term improvements.¹² President Bush has agreed to create a commission but has handicapped it from the start. He has not worked with Democrats on Capitol Hill to make it bipartisan, and he wants proposals for short-term budget cuts before long-term reforms.

Reforming mental health care and improving Medicaid must go hand in hand to avoid the specter of draconian cuts. Indeed, there is even a detailed roadmap for restructuring mental health services within Medicaid that has already been offered at the state level by a coalition allied with the Tennessee chapter of the National Alliance for the Mentally Ill (NAMI). In response to the threat of deep proposed cuts in Tennessee's expanded Medicaid program, TennCare, the local branch of NAMI, embraced several innovative reforms that promote quality care and cost savings, including the use of evidence-based treatments such as medication management.¹³

Saving and overhauling Medicaid, however, is not enough to achieve a new vision, which is emerging, of a system that makes recovery possible for the seriously mentally ill. Real reform efforts must also acknowledge that even with a disability, the mentally ill have the right—and the capacity, with varying degrees of help—to work and live independently. To that end, reform advocates usually do not refer to people with mental illness as, say, “schizophrenics” or “patients,” which would define them by their illness and treat them as passive objects who can be manipulated by health professionals. Instead, they are often called “consumers” of mental health services. If the system is to be held accountable, its key players have to produce measurable results that matter to these consumers.

Creating a system that promotes recovery is now a realistic goal. At the heart of any genuine progressive alternative to our current failed mental health care is a transformed view

of what is now possible—even for people with the most serious mental illnesses—a life in which they have a far greater role in making health care choices and are given the support they need to enter the workforce rather than remain forever disabled. The best hope for reforming a failed system lies not the shibboleths of either the left or the right, but in a fresh approach that incorporates the bedrock principles of requiring accountability for the providers of mental health services and the empowerment of those who use them. Here, then, are PPI's five recommendations for helping to end the preventable tragedies, ruined lives, and economic waste caused by poorly treated mental illness:

1. Enact mental health parity with provider accountability;
2. Promote recovery from mental illness through proven treatments;
3. Ensure that funding follows the consumer, not the agency;
4. Provide mental illness screening to protect children; and
5. Encourage work, rather than lifelong dependency.

The Mental Health Scandal We Are Not Addressing

It is especially troubling that even though there are now state-of-the-art treatments that can allow people to recover and lead fulfilling lives, there is a mental health crisis in America and it is spiraling out of control. Since the seriously mentally ill make up 5 percent to 7 percent of the adult population—or nearly 12 million people—the shortage of accessible, effective, and affordable services wreaks havoc on them, their families, and our society.¹⁴ The

system's breakdown is most clearly illustrated by overcrowded jails and prisons with 16 percent of inmates, or more, seriously mentally ill—three times as many as in the civilian population, according to the U.S. Justice Department.¹⁵ In some areas, such as Broward County, Fla., the number of mentally ill inmates has grown as much as 81 percent since 2000. They now account for 23 percent of the jailed population in the county, a sure sign that the local treatment system has failed.¹⁶

The chairman of President George W. Bush's mental health commission, Michael Hogan, aptly summed up the basic problem: "The so-called mental health system is fragmented and in such disarray that it is often not capable of getting treatments that work to the people who need them."¹⁷ Here are some of the primary failures:

Lack of Access to Good Care

About one-half of those with serious mental illnesses are not receiving any treatment at all, while a chaotic system too often provides ineffective or ineptly delivered treatments to those who do manage to find some help. For instance, the definitive federally funded Patient Outcomes Research Team (PORT) found that the outpatients it studied with schizophrenia were misprescribed medications 71 percent of the time, while less than 10 percent of all those with schizophrenia had access to the most effective "psychosocial" treatments, such as relapse-prevention programs for families and patients, that can promote recovery and cut hospitalization rates.¹⁸ That study, of course, did not measure those mentally ill people who do not receive treatment at all. One reason for the gaping hole in treatment is that private health insurance plans are so limited they do not pay for expensive, chronic mental illnesses such as bipolar disorder and schizophrenia,

which require ongoing treatment and the most modern medications.¹⁹ In many other cases, accessing public mental health services requires overcoming a forbidding array of eligibility roadblocks. Still other people with serious mental illnesses do not realize they even need treatment, and little is done to help them get it.

Exorbitant Cost to Society

In addition to the day-to-day tragedies of suicides and wasted lives, the monetary cost to the nation of the wave of untreated, or ineffectively treated, mental illnesses is truly staggering. There are 650,000 suicide attempts each year that are serious enough to require emergency medical attention.²⁰ Indeed, the total annual cost for mental illnesses in the public and private sector is at least \$150 billion in lost productivity and treatment costs, according to the president's commission on mental health.

The cost is also felt outside the mental health system in homelessness, a 90 percent unemployment rate for the seriously mentally ill (higher than any other disability),²¹ and most obviously in the criminal justice system.

That crisis is overwhelming: There are five times as many mentally ill people (nearly 300,000) in jails and prisons than in all state hospitals combined.²² With deinstitutionalization, the jails and prisons have become the *de facto* public hospitals in our communities, with, sadly, special sections that have often become the new "snake pits" for the most violent mentally ill. Deranged people can refuse treatment while raving and babbling incoherently in conditions reminiscent of 19th century asylums. And in some prisons, according to Human Rights Watch, mentally ill prisoners, often sentenced for nonviolent crimes, are abused, exploited, and sometimes killed either by fellow inmates or untrained guards while being denied adequate care.²³

The fragmentation that leads the most seriously mentally ill to bounce between clinics, emergency rooms, the street, and jail also has enormous personal and taxpayer costs. In King County, Wash., for example, officials studied 20 mentally ill people who were repeatedly hospitalized, jailed, or admitted to detoxification centers. Providing emergency services to just these 20 people cost the county \$1.1 million a year. While clearly not all seriously mentally ill people cost so much in resources, when you multiply the impact on communities of the millions who relapse because they do not get proper care, the scope of the problem becomes even clearer.²⁴

Damaged Children

For children, the system is even more fragmented, and effective screening and referrals for those with serious emotional disturbances are rare. As a result, a shocking 80 percent of children entering the juvenile justice system have mental disorders.²⁵ A large part of that is due to the lack of affordable, specialized care for children—all exacerbated by private health plans that do not cover mental illness at the same levels as physical illness. One tragic consequence is that thousands of middle-class families who are not eligible for Medicaid must relinquish custody of their emotionally disturbed children to state agencies—and sometimes hellish care—in order to secure treatment for them, as the General Accountability Office (GAO) reported in 2003.²⁶

The Disability-Dependency Trap

The nation now spends \$25 billion per year on disability payments as low as \$550 a month per person for the seriously mentally ill, most of whom want to work and can do so with targeted help. But they are trapped in lifelong dependency and poverty, risking their vital government health

care benefits, mostly Medicaid, if they return to work. Unfortunately, current Social Security disability insurance-related programs like Ticket to Work, which could help them retain their medical benefits if they start working, are either poorly designed or underused.²⁷

Ineffective Medicaid Policies

The federal-state Medicaid program, which pays for a majority of public mental health care, does not adequately cover the most scientifically proven treatment programs.²⁸ Although the federal Medicaid agency offers relatively meager grants to some states to promote the adoption of evidence-based practices (EBPs), it has not made adopting them a top priority or ended the confusing patchwork of spotty funding that makes implementing them a bureaucratic nightmare.²⁹

These cost-effective approaches offer some of the best ways to end the poor treatment and sharply rising costs that too often plague Medicaid-funded programs. One example is “supported employment,” which helps mentally ill people win and hold competitive jobs. Another example is Assertive Community Treatment (ACT), which sharply reduces hospitalizations and jailings by using mobile, interdisciplinary teams able to provide round-the-clock assistance to the most hard-to-reach mentally ill.³⁰ When states fail to adopt such practices, the cost of preventable hospitalization soars. Compounding matters, Medicaid continues to waste money on ineffective programs such as dreary, hospital-style “day treatment” that critics say are often just another version of the old state hospital wards, complete with cigarette breaks and televisions.³¹ The president’s own commission recommended that federal and state programs be restructured to support evidence-based practices. An essential element of this change is holding the key federal and state agencies

accountable for promoting recovery goals, including employment, and offering financial incentives to improve performance—rather than paying for ineffective traditional day treatment programs or offering such low reimbursement rates that skilled doctors leave the program.

Short-Sighted Service Cuts

The Medicaid program's limitations have been worsened by budgetary problems in the states, which pay a significant portion of the program's costs. Cost-cutting and restricted services in many states have led to jumps in psychiatric emergency room visits as high as 50 percent in states such as Texas, or loss of Medicaid coverage for an estimated 9,000 mentally ill people in Oregon.³²

Other states are following suit. In the last three fiscal years, 70 percent or more of states have implemented Medicaid prescription drug cost controls, raised co-payments, reduced eligibility, and cut benefits, according to the Kaiser Commission on Medicaid and the Uninsured.³³ Higher co-payments may be a useful strategy for reducing unnecessary medical services, but they are devastating when applied to the low-income mentally ill. They are faced with huge barriers to obtaining their vital medications or even remaining on the program. In Oregon, after the state expanded Medicaid coverage, more than one-half of the newly enrolled mentally ill people could not afford to pay a new \$6 monthly premium because they had *no* income, so they lost their coverage soon after they were granted it.³⁴

With cutbacks at all levels of government, the situation is doubtless going to get worse in most of the country. One reason is that \$10 billion in one-time federal Medicaid relief to the states ended on June 30, 2004; some states, such as Florida and Tennessee, have already won or are seeking so-called "super-waivers" and other approvals from the federal government that would allow them to

essentially cap Medicaid spending while slashing enrollment and benefits.³⁵ Worst of all, the president's proposed FY2006 budget, with at least \$40 billion in cuts in the federal share of the Medicaid program during the next decade, targets the most vulnerable while doing little to make the program itself more cost-effective.³⁶ In this climate, reform seems even more unlikely as a mental health system already in "shambles" starts to unravel even further in many states. On top of that, agencies with tight budgets cannot afford to spend on the training and monitoring needed to make evidence-based practices succeed. In sum, transformation of a system in crisis cannot occur if deep cuts take the place of real change.

Five Key Steps to Mental Health Reform

The growing mental health crisis is clear enough. As are the most important solutions, thanks to innovations already under way, as well as the reforms proposed in the president's commission report (which the president has essentially ignored). These solutions share a focus on genuine recovery for consumers of mental health services. In practice, recovery means either living a fulfilling and productive life—including employment—despite a disability, or living a full life with a reduction or remission of symptoms. To that end, these vital reforms seek to end government obstacles to obtaining help while holding the system accountable for producing consumer-driven results.

1. Mental Health Parity With Provider Accountability for Results

There is a strong consensus among legislators and reform advocates on the need to provide equal coverage for mental health care by insurers. But no one should accept parity itself as the final goal. Parity should raise the quality of mental health care, not limit it

to the often dubious quality of care now offered. **Specifically, parity legislation should require the disclosure of performance results, not just reimbursement for any service provided.** Some pioneering health plans, such as PacifiCare Behavioral Health (PBH), are already using sophisticated measuring tools to monitor clients' emotional health. "Don't just pay us for the process of care, X number of sessions for X number of people," says PBH president and CEO Dr. Jerry Vaccaro. "Instead, use the consumer [results] to hold us accountable for outcomes."³⁷ Indeed, as PPI has long advocated, all health care providers, not just those in the mental health field, should be held accountable for their performance.

Still, parity legislation is long overdue. The barriers to treatment, such as higher co-payments, shorter treatment periods, or no coverage at all, take a severe toll on people who need affordable mental health care. Those barriers also shift costs to the public sector in the form of expensive treatments for patients who have exhausted their own financial resources and whose care might have been far cheaper if they had been well served upfront. Penny-pinching in private insurance plans ultimately translates into higher emergency room costs, unnecessary incarceration, and increased hospitalization.³⁸

Even though 34 states have enacted parity laws that appear to resemble the proposed Wellstone parity act, they are generally more limited. For example, many states extend coverage only to select groups, such as those with severe mental illness or state and local government employees. States also do not usually match the full scope of mental health coverage already enjoyed by members of Congress and other federal employees under the Federal Employees Health Benefits program. Most critically, they do not offer protection for the roughly one-half of all workers in companies with more than 50 employees.³⁹

Traditional parity legislation has been met with resistance from business and health insurance groups concerned about added government mandates and extra costs.⁴⁰ But the added costs would be so minor and the payoff for businesses and their employees so great that it would clearly be most cost-effective to adopt parity. The Congressional Budget Office has estimated that the Wellstone legislation would increase health insurance premiums by less than 1 percent. PricewaterhouseCoopers estimates it would amount to approximately \$1.32 per person per month, an estimate buttressed by actual state experience.⁴¹ As for the savings mental health parity would generate, a study for the McDonnell Douglas Corporation found that its program yielded a four-to-one return on investment after considering medical claims, reduced absenteeism, and reduced employee turnover.⁴² Indeed, after North Carolina adopted a comprehensive parity plan in 1992, spending on mental health hospitalization dropped 70 percent.⁴³ PacifiCare's mental health program cut worker impairment in half in about two months.⁴⁴

The problem with the Wellstone legislation, however, is that it does not go far enough: it needs to be enhanced with tough accountability measures. Without some form of accountability, mental health parity risks turning into a blank check for mediocre treatment-as-usual. **Parity legislation should include a requirement to use at least some of the measurements that have been developed by the Substance Abuse and Mental Health Services Administration (SAMHSA).**⁴⁵ One of SAMHSA's measuring tools that should be far more widely used is the Mental Health Consumer-Oriented Report Card, which has been available in various forms since the mid-1990s.⁴⁶ These tools evaluate the quality of care based on patient satisfaction surveys, administrative data, and clinical outcomes.

They address everything from how easily consumers can access care, to whether they are doing better at work or school, to the frequency of re-hospitalizations after treatment.⁴⁷ This report card was pilot-tested by several state agencies, and meeting such outcomes will become mandatory by 2007 as part of the agency's block grant program.⁴⁸

By adding performance disclosures, those health plans and care providers that can deliver high-quality services across a large population will be rewarded with more customers. For example, PacifiCare, the California-based health plan, uses a high-tech ALERT (Algorithms for Effective Reporting and Treatment) system to flag levels of distress in patients. Clinicians fax in a patient's self-reported Life Status Questionnaire to PacifiCare, where it is automatically entered into the company's patient database. The ALERT system notices deviations from expected progress, flagging early suicide signs and identifying patients at risk of dropping treatment. Care managers then advise practitioners on ways to intensify treatment. They may decide to provide more treatment sessions, or add services, such as a new medication evaluation by a psychiatrist, group therapy, or other aid.⁴⁹ **Congress must provide incentives to both public and private health care payers to use an ALERT-style, real-time evaluation of providers.** That is a critical first step in weaving together the often fragmented care that patients encounter in the current system. The intensified monitoring and case management of higher-risk patients, coupled with bonus payments to providers who produce the best results, creates incentives throughout the plan's health care system to offer quality care that addresses both the patient's physical and mental symptoms.

The results of such careful performance measurements can be dramatic. A 2003 study published in *Crisis*, a suicide prevention journal, found that practitioners missed suicide

warning signs 57 percent of the time without patients' self-reports, compared to 39 percent when patients' self-reports were available, a still-troublesome percentage.⁵⁰ PacifiCare has also used the ALERT system to pay clinicians bonuses who produce better-than-expected results, and to demonstrate that outpatient treatment of just nine weeks cut clients' work impairments in one-half.⁵¹

A new parity law could offer a prime opportunity to start pressuring public agencies and private providers to be accountable for their results. As Vijay Ganju, the director of the state mental health directors' Center for Mental Health Quality and Accountability, sums up, "You've got to provide good services, whether they're evidence-based or not; monitor whether they work; and have some mechanism to effect change."⁵²

2. Recovery From Mental Illness Through Proven Treatments

A system that works so poorly and leads to such widespread harm as the current U.S. mental health system will not fully change even with greater accountability. It must also be flexible enough to adopt new treatments as soon as they are proven to be effective. In medicine, there has traditionally been a 15- to 20-year gap in implementing well-proven treatments into everyday practice. The impact of denying patients the best care is particularly disastrous in a mental health system that is already so dysfunctional. **Federal policy should remove the barriers to using evidence-based practices and deploy them through financial incentives and penalties.** These practices should be implemented based on verifiable results in promoting genuine recovery that moves people from being perpetual patients to leading productive and fulfilling lives.

A basic evidence-based practice that should be quickly implemented is known as Medication Management Approaches to

Psychiatry (MEDMap).⁵³ It provides doctors with up-to-date research and guidance on the best ways to prescribe medicine and assess the results, in part through a Web-based decisionmaking flow-chart and technical assistance. Pioneered in Texas, it has already been shown to reduce side effects and symptoms. One reason for its success: Patients are not just passive recipients of medication; they are active partners in their care and their responses are part of the uniform outcome measurements built into the program.⁵⁴

Medicaid policy is essentially blocking widespread adoption of MEDMap. Currently, state and local agencies seeking to put such sound practices in place face a hodge-podge of confusing Medicaid rules limiting reimbursement, along with state budget restrictions that can hinder offering new treatments successfully. States generally have to negotiate with the Centers for Medicare & Medicaid Services (CMS) for permission to even win partial reimbursement for these services under various waivers and rehabilitation “options.”⁵⁵ **Instead of paying lip-service to evidence-based practices and wasting years with so-called “systems change grants,” CMS and other agencies should make evidence-based practices their top priority in reimbursement.** They should be actively promoting technical assistance to states on financing EBPs, training professionals in delivering them, and ending the current regulatory obstacle course.⁵⁶

Congress also needs to act and amend Medicaid law to provide funding for EBPs. The intensive evidence-based practices that have been shown to dramatically cut costs and improve outcomes, such as ACT, are hobbled by the need to get financing from numerous different funding streams in federal, state, and local programs. **Congress should enact legislation that would allow states to pool Medicaid and other funds to pay for**

these intensive, evidence-based community services.⁵⁷ Medicaid should also start paying higher rates for EBPs than less proven approaches, as long as agencies that put scientifically proven practices in place demonstrate they are carrying them out properly.

Even more can be done to support the spread of proven practices. **Congress should require that federal officials leverage the existing Federal Mental Health Services block grant (\$433 million for FY2005) to focus primarily on developing EBPs in the states.** Enforcing outcome measurements, such as reduced hospitalizations and increased employment, will help move the state and local agencies to adopt evidence-based practices. The federal government needs an even greater emphasis on using grants to create a state infrastructure to promote EBPs and related support systems that aim to improve quality continually, such as the university-based “Centers of Excellence” in Ohio that offer training and support. Medicaid and SAMHSA also need to pay directly for more evidence-based services.⁵⁸

Evidence-based practices can save money and produce better results. Their impact has been shown to reduce hospitalization rates by 75 percent or more, and find jobs for up to 80 percent of the seriously mentally ill.⁵⁹ Examples of programs that achieve such results include “supported employment” that brings the mentally ill quickly into mainstream jobs while providing counseling and on-the-job support; ACT outreach teams that work, around-the-clock if necessary, with the most severely mentally ill homeless and other severely disturbed people; and “family psychoeducation” that teaches patients and families together how to manage and understand the mental illnesses they face.⁶⁰

There are, though, some pitfalls facing the growing movement toward evidence-based practices. Accountability and positive outcomes

can only occur if the local clinics show fidelity to the programs' proven formats and are measured on results that matter to consumers and their families. **Federal health care agencies should enhance the consumer's role in measuring outcomes. This includes establishing assessments by trained teams of mental health consumers who speak anonymously to clients about how they are faring.** Equally important, programs that show promise as "emerging best practices," such as peer-run support services, should not be frozen out of funding simply because they do not yet have the extensive research base of EBPs; they can be a vital resource for the evolution of effective care. As the evidence grows for these newer best practices, the rates of pay for them should also increase. Even so, many consumer-based support services have the added advantage of being far less expensive than traditional psychiatric services while playing a critical complementary role by promoting improved functioning and independence.⁶¹

Unfortunately, if Medicaid's current restriction on EBPs continues, their cost savings will not be available to the program—and state and federal officials will more likely turn to short-term budget cuts.

3. Funding Should Follow the Consumer, Not the Agency

Bureaucratic boundaries and financing rules for mental health care have created a fragmented maze of services. Instead, financing needs to be flexible so that it follows consumers to different mental health care service providers. **Each consumer in a federally funded program should have an individual health plan developed by the consumers and their families in cooperation with care providers and coordinated by a case-manager.** Each state should ensure that the many agencies in

control of mental health services follow the plan. In turn, the plan should require different providers—for example, psychiatrists, social workers, and job counselors—to coordinate their care and share information about patient outcomes. A similar system for individualized health and education plans is already in place for aiding the developmentally disabled.⁶²

To make this all possible, researchers and mental health advocates are supporting "self-directed services," which focus on giving consumers direct control of their spending on approved services. Whether with a government-funded debit card, cash, or vouchers, this approach combines consumer empowerment with free-market forces to compel providers to offer humane, respectful, quality care. If the providers do not actually serve the patients well, these consumers will simply choose to go elsewhere, and that local agency will not get its usual funding. Leading experts such as University of Illinois researcher Judith Cook, along with the president's New Freedom Commission, contend that offering consumers a far greater role in making health care choices—with counselors aiding consumers in managing the funds for services—can improve the quality of care, patient outcomes, and system accountability.⁶³ A voucher-like approach is not the only model that can promote greater self-determination in care. **Congress needs to fund more demonstration projects that would evaluate various types of self-directed care and other promising approaches, including peer-to-peer services.**

As Cook shows in her in-depth research on consumer-directed spending, strong early results have already been demonstrated in Medicaid's "cash and counseling" programs for the physically and developmentally disabled. These cost-effective programs, permitted under a special Medicaid waiver, provide budgetary planning by a local agency and cash allowances directly to the disabled to buy such

services as personal care for help with daily activities.⁶⁴

A similar approach can be used for the mentally ill, with appropriate safeguards. This includes using an “advanced directive” that outlines the consumer’s choice of providers during any psychiatric emergency.⁶⁵ In addition, federal officials are studying an innovative Food Stamp-like “personal independence” debit card that can be used on pre-authorized Medicaid and Medicare providers. When consumers are in charge of which providers they see, aided by professional budgetary oversight, market forces can indeed provide a short-cut to improved quality and accountability. Some health care providers will likely resist such a change, but taxpayers and mental health consumers can both benefit. Such innovations have shown good preliminary results, as in a Florida self-directed care program that appears to decrease hospitalizations.⁶⁶

The coordination required among funding sources can be achieved with or without consolidation; the key is to focus on serving the individual. Take “Wraparound Milwaukee,” which offers cost-effective, comprehensive care to seriously disturbed children and their families, linking a crisis team, a provider network, and access to 80 different services through a single public agency. One of the guiding principles is “No Wrong Door,” which ensures that, regardless of where a child enters the system, he or she can be linked to other services. This is one of the best ways shown so far to overcome the confusing array of programs offered in most localities. Thanks to the No Wrong Door principle applied in the Milwaukee program, the rates of felonies and misdemeanors by the young clients decreased by about one-half.⁶⁷ **Congress should require that federal agencies measure whether a program or agency has met a No Wrong Door standard in offering coordinated care.**

States with multiple agencies serving the mentally ill can be coordinated through an outside organization. In New Mexico, which has the country’s most ambitious plan to end fragmented services, Gov. Bill Richardson announced in 2003 his intention to bring together behavioral health-related services handled by at least 17 different agencies into one delivery system. The agencies are not being merged—but their mental health and substance abuse services are being drawn together through a “behavioral health purchasing collaborative” that will oversee services, spending, and performance outcomes. The new system, scheduled to be operating by July 2005, will be administered by a managed care company that is required to meet “system performance and consumer outcomes” goals, or face the potential loss of the contract.⁶⁸ **Federal officials should offer more planning grants to states to provide coordinated care.**

The need for well-designed, more personalized care is long overdue. As the president’s commission reported, “The system is fragmented and in disarray. Many of the problems are due to the ‘layering on’ of multiple, well-intentioned programs without overall direction, coordination and consistency.” A policy of funding following the consumer will put an end to the millions of people being blocked from easy access to treatment, getting overwhelmed by the maze of disconnected programs, or falling between the cracks of the network of services.

4. Early Screening to Protect Children

Early detection and treatment of mental illness can significantly shorten and reduce the impact of the disease—and prevent suicides.⁶⁹ Nearly one-half of the states flout a federal mandate to provide mental health and substance abuse screening to Medicaid-

insured children and adolescents.⁷⁰ With this type of screening, childhood behavioral disorders that can lead to school failure and suspensions—or a sentence in a juvenile detention facility—have an opportunity to be diagnosed and treated. At the same time, it is vital to protect a child's privacy rights and avoid stigmatizing him or her when implementing a screening program. In any case, **Congress should demand that CMS enforce the existing screening mandate and impose penalties on states that fail to comply.**

Since most people who have mental disorders do not initially see psychiatrists, it is critical that professionals who do have contact with them, whether school counselors or primary-care doctors, be able to spot mental illnesses that need treatment. **Congress needs to spend more funds on supporting mental health “first responders.”** They need to be trained in spotting the early signs of mental illness, and Congress should provide incentives for state medical boards to mandate such training as part of primary doctors' continuing education requirements.

Such funds could also be offered as a match to local and state education agencies to support programs like the pioneering school-based Youth and Family Centers in Dallas. That program reduces stigma by offering physical and mental health care together at nine centers, and has raised awareness among staff by training school nurses, counselors, and principals to identify mental problems. It embodies, too, the spirit of Sen. Joe Lieberman's (D-Conn.) proposal to support a national system of school health centers.⁷¹ **Congress should fund more demonstration projects of school-based health centers that incorporate mental health treatment.**

For prevention to be effective for children, however, there needs to be enough mental health professionals to serve them. **Congress should pass the Child Health Care Crisis**

Relief Act (H.R.1106/S.537), sponsored in the U.S. House of Representatives by Rep. Patrick Kennedy (D-R.I.) and in the Senate by Sen. Jeff Bingaman (D-N.M.), which would address the shortage of child and adolescent psychiatrists with financial incentives to encourage medical students to enter the field. Less than 20 percent of children with mental illnesses receive any treatment at all, while many others are overmedicated. More doctors with specialized training are clearly needed.⁷² A pattern of low Medicaid payments also contributes to a shortage of mental health providers; higher pay for good performance could help lure providers back into the field.

Access to care is also necessary to make screening efforts effective. Taking care of mental health needs should not wreak devastation on families who are already struggling. For example, severe restrictions on Medicaid eligibility and limited private insurance often forces parents to give up custody of their mentally ill children to state agencies in order to obtain services for them. **It is vital that Congress finally pass the “Keeping Families Together Act,” co-sponsored by Sens. Susan Collins (R-Maine) and Mark Pryor (D-Ark.) and Reps. Patrick Kennedy (D-R.I.) and Jim Ramstad (R-Minn.) (S.1704/H.R.3243), to give states incentives to offer coordinated home- and community-based services to keep families intact.**⁷³ And of course, affordable health care for all, as PPI has proposed elsewhere, is critical to ensuring access to mental health care services.

5. Work, Not Lifelong Dependency

Even though 70 percent of people with serious mental illness would like to work, only a fraction of them have been exposed to “supported employment,” the most effective type of employment program. Supported

employment has several features that set it apart from traditional vocational training. It has an employment specialist, or “job coach,” assigned to the treatment team serving an individual. Such specialists aid consumers by conducting rapid job searches and helping them land truly competitive jobs, aided by ongoing support and site visits. Adding supported employment to the current mental health system would require some additional spending on training and implementation. It would also require re-ordering budget and service priorities to encourage, whenever possible, a return to work. But it can more than pay for itself by ending long-term unemployment for the mentally ill, promoting recovery, and ultimately saving billions of dollars in disability payments, while still being coupled with the safety net of continuing government medical coverage until it is no longer needed.

Under the current system, the mentally ill get little work or effective training. Traditional vocational programs, which emphasize extensive pre-job training, generally fail to help the mentally ill land real jobs, according to the president’s commission. Too often, they end up in demeaning sheltered work programs.⁷⁴ Under current law, vocational services usually cannot be covered by Medicaid. Some elements of supported employment could be covered, such as those involving counseling, but too often they are not. Given the value of work in reducing dependence and improving lives, it is vital that Congress makes sure Medicaid does more to back supported employment under current rules. At the same time, with the bipartisan appeal of increasing work opportunities, Congress should end the disability-dependency trap by holding federal and state Medicaid administrators accountable through publicly reported outcomes linked, in part, to the rates at which mentally ill recipients land jobs. To make that possible, **Congress should**

ensure that all Medicaid-related legislation gives administrators the flexibility needed to cover supported employment and other evidence-based practices.⁷⁵

People with mental illness are reluctant to get back to work for fear of losing their medical benefits. There are existing laws and programs that could help them, but they are not widely used, largely due to bureaucratic inertia. For instance, in 1999, Congress passed a law allowing states to use Medicaid “buy-in” options that subsidized Medicaid for working disabled people whose income would otherwise bar them from the program. **Congress needs to provide incentives for more states to actively use the Medicaid Buy-In option.** The once-hyped Ticket To Work program that is supposed to offer more vocational training options and transitional medical care has so far gotten a poor response because of its weak incentives, according to economist David Salkever of the Johns Hopkins School of Public Health.⁷⁶

A better bet might be 1619-b, the little-known Social Security provision that permits people who are disabled to earn far higher income—more than \$40,000 in some states—than Supplemental Security Income beneficiaries are usually allowed if they need Medicaid to continue working.⁷⁷ These Social Security benefit rules are so complex and underpublicized, however, that few know about accessing any helpful programs.

It will take a high-level commitment to make federal and state Medicaid administrators and the Social Security Administration (SSA) collectively accountable so that the mentally ill get the aid they deserve while being permitted to work. The savings in Social Security disability payments would more than make up for any initial increase in Medicaid costs if supported employment were more fully covered. **Congress needs to toughen oversight by setting goals for**

the SSA on moving people from disability to work without jeopardizing their medical safety net. This oversight would prompt a creative approach to problem solving from the usually hidebound agency. To start, Congress must demand that the agency's outreach program offer far better and more accurate explanations of current employment options to the mentally ill. That improvement would be all the more powerful when combined with changes in the federal Medicaid reimbursement rules that limit supported employment.

Conclusion: The High Cost of Failed Leadership

Despite all the innovative solutions that can be used to fix the mental health morass, there is no forceful federal leadership focusing on achieving results. Parity with accountability—Parity-Plus—is the essential first step to reform, and it is a cost-effective, sensible approach that should appeal to people across the ideological spectrum. It is not an old-fashioned entitlement program. It is a way to leverage the current private insurance system to provide fair, equitable coverage, while getting good results for both individuals and society as a whole.

The parity issue, in fact, is one of the clearest illustrations of how President Bush has failed to follow up on his mental health promises. That failure has real consequences when the stakes are high and important reforms are overdue. During the 2000 campaign, he referred to himself as a reformer with results. Now, he has a real chance to prove those claims were more than just empty rhetoric.⁷⁸

To date, virtually nothing has been done to advance a reform agenda. Last fall, even though Congress passed a suicide prevention bill, it only appropriated \$10 million, and it did not make the new financing contingent on improvements through the accountability and performance measures outlined in the president's commission and elsewhere. And it did nothing on the parity bill. In fact, that bill, facing an ongoing stalemate, has languished without a vote since being first introduced in 2001 during the 107th Congress. It was reintroduced in both the House and Senate during the 108th Congress, yet to no avail. And now, in the 109th Congress, it has been reintroduced again in the House and—referred to the Subcommittee on Health “for a period to be subsequently determined by the Chairman”—once again lies dormant. This inaction continues, despite strong majorities in both houses of Congress endorsing the bill and the nominal support of the president.

The five-step Parity-Plus plan can relaunch an effort to reform mental health care with a new framework that cuts across ideology and includes accountability, true recovery (including work), and empowerment for mental health consumers.

Those basic values are essential to making reform possible after years of inaction. Whether it is a results-oriented approach to parity or a full-scale effort to bring the mentally ill into community life through supported employment, these ideas offer a hopeful, pragmatic vision of a mental health system that can work for all. Every suicide, every death of a mentally ill inmate, and every life wasted without a real job is another sign that the changes proposed here are long overdue.

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