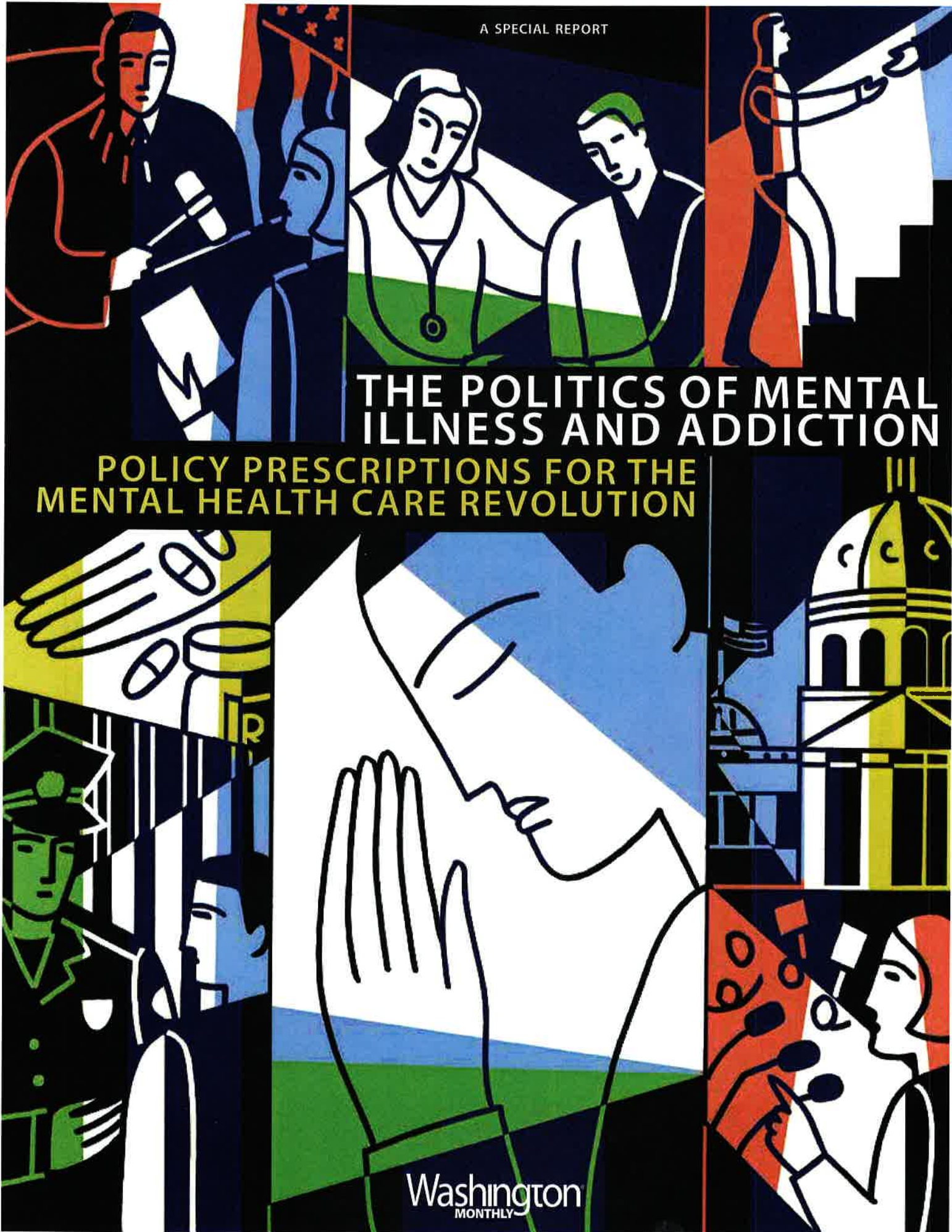


A SPECIAL REPORT

THE POLITICS OF MENTAL ILLNESS AND ADDICTION

POLICY PRESCRIPTIONS FOR THE MENTAL HEALTH CARE REVOLUTION



Washington
MONTHLY

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INTRODUCTION: MENTAL ILLNESS AND ADDICTION DON'T RESPECT PARTY BOUNDARIES

By Norman Ornstein

On January 3, 2015, my brilliant, funny, sweet, and immensely talented thirty-four-year-old son Matthew died in Delaware, an accident caused by inadvertent carbon monoxide poisoning. Sixteen months later, the pain is even greater than it was when we found out. While an accident, Matthew's death was shaped by a lack of judgment itself driven by a ten-year struggle with serious mental illness. In the midst of a successful career in Hollywood, he had a psychotic episode at twenty-four that brought his vibrant life to a grinding halt. Most likely, Matthew suffered from bipolar disorder. There was never a definitive diagnosis, which is not uncommon, but in his case it did not matter. Different diagnoses can lead to different drug combinations or therapies, but a core part of Matthew's illness was anosognosia—an inability to recognize that he suffered from a mental illness, and an unwillingness to accept any treatment. For ten years, we struggled with him and a system that made it impossible to intervene or help; of course, our frustration and pain paled next to the pain he felt and the stigma he suffered despite the fact that he was never a danger to anyone.

In the United States, if an individual is over eighteen, both federal and state laws in most cases give the individual enormous autonomy. Parents and other loved ones, not to mention most medical professionals, are unable to learn about their conditions or to influence treatment in any way. The autonomy flows mostly from an understandable concern about civil liberties, but for those with deep-seated psychoses and/or with anosognosia, the result is not freedom but more often tragedy, from homelessness to bullying to arrest and worse.

For loved ones of those with serious mental illnesses, sometimes the only realistic hope of getting treatment for their conditions is to have them arrested—and have a judge who has both the sensitivity and power to provide an alternative to prison or jail, including assisted outpatient treatment (AOT). That is what happened to the journalist Pete Earley, who recounted, in his 2006 book *Crazy*, the happier ending to the journey he had with his own bipolar son.

One judge who is making a dramatic difference is Miami-Dade's Steve Leifman, who has transformed the way the county deals with mentally ill patients who come through the criminal justice system by developing partnerships with police and 911 responders to get them crisis intervention training (CIT). The judges in his court have separate mental health court hearings and provide an alternative to jail, while mental health, social work, and county officials provide wraparound services, including housing, therapy, medications, and counseling, along with job training, for people with mental illnesses. He has had remarkable success, transforming lives and reducing imprisonment and recidivism, even enabling the county to close a jail and save taxpayers \$12 million.

But Leifman's heroic efforts remain far more the exception than the rule. Many with mental illnesses who come in contact with police—most of whom do not have CIT—end up tased or shot because they do not respond to commands the way others do. And for those in jails, often for petty theft, loitering, or small-time drug offenses (a large number of those with mental illnesses have dual diagnoses, including substance abuse problems), the outcomes can be simply horrific. Last April, as the *Washington Post* reported, Jamycheal Mitchell, who suffered from schizophrenia and bipolar disorder, was arrested for stealing \$5 worth of snacks. A judge ordered him sent for treatment to a state hospital until he was well enough to stand trial. Instead, because of bureaucratic malfeasance and incompetence, he languished for months in a jail, where he got no treatment and no attention and died of heart problems related to extreme weight loss.

Abuses in prison go beyond neglect. Eyal Press's stunning exposé in the *New Yorker* showed mentally ill prisoners beaten, tortured, starved, and killed in Florida and New York, with abuses covered up. Even when officials vow to fix things, underfunding and privatization interfere. Fortunately, the policy dilemmas and the major problems associated with mental illness and substance abuse are now on the radar screen of local, state, and federal officials. A few weeks ago in Washington, D.C., the American Psychiatric Association Foundation, the National Association of Counties, and the Council of State Governments sponsored a conference inspired by Judge Leifman, called "The Stepping Up Initiative," bringing together representatives from fifty counties around the country to share best practices to deal with the burgeoning cost and pain of the mentally ill caught in county jails.

In Congress, we are seeing bipartisan activity on several fronts. In the Senate, the Comprehensive Mental Health and Justice Act, cosponsored by Minnesota Democrat Al Franken and Texas Republican John Cornyn, passed on a voice vote last December after being subject to holds by Republican senators for an extended

period. It has bipartisan support in the House, and should make it across the finish line this year. The act would expand mental health courts and veterans' courts, and vastly increase CIT for police, school officials, and others who come into contact with those suffering from mental illnesses who have a crisis or confrontation, in order to avoid violence and tragedy.

Michigan Democrat Debbie Stabenow and Missouri Republican Roy Blunt were able to pass a bill in the Senate to expand funding for community mental health centers, the first step in a more comprehensive approach. And in both the House and the Senate, bipartisan mental health policy reform bills are inching forward: Tim Murphy, a conservative Republican representative from Pennsylvania as well as a psychologist, is joining with the former psychiatric nurse and Texas Democrat Eddie Bernice Johnson

At a time when few things in Congress are bipartisan and presidential candidates agree on even less, it is encouraging that this area is different.

as chief sponsors in the House; Connecticut Democrat Chris Murphy and Louisiana Republican Bill Cassidy are sponsors in the Senate.

The House bill would provide incentives for AOT, more beds for patients with mental illnesses, and more flexibility in the HIPAA law to enable loved ones to get information about their mentally ill relatives, and would reform a dysfunctional federal government system by reorganizing the Substance Abuse and Mental Health Services Administration to make it more effective and responsive to the problems of serious mental illness. The Senate bill is significantly weaker, but still moves in the same direction.

Some months after my son died, I wrote an op-ed in the *New York Times* about our family's journey, making a

strong plea for the Murphy-Johnson legislation. I was flooded with responses, including from many who themselves suffer from mental illness, many more parents and siblings whose journey was similar to ours (although not always with its horrible ending), and many more yet who had experienced the suicide of fathers, mothers, brothers, and sisters after their struggles with mental illness. For a large number, it was the first time they had spoken or written to anyone about their experiences; some wrote that they had felt alone in their trauma. It has become clear to me that there is scarcely a family in America that has not been touched by these problems and issues. But it is also clear that there has been limited discourse on their experiences, on the policy and medical dilemmas we face, on what paths we need to follow, and on what works and what doesn't.

There are essays in this special section on the unique problems in rural America, on stigma and interactions with police, on the treatments available on addiction and mental illness and what seems to work and not.

And there are articles on the approach of the presidential candidates who have directly addressed these issues in their campaigns, especially John Kasich and Hillary Clinton. Kasich's case is interesting in part because it reflects a reality of political life—lawmakers with passion about these difficult problems are often those who have been profoundly affected in their own families. That was true of Senators Pete Domenici and Paul Wellstone when they championed mental health parity in health insurance coverage (its spotty enforcement is the subject of another essay here).

At a time when few things in Congress are bipartisan, it is encouraging that this area is different. But that sunny reality has some dark clouds on the horizon. The Murphy-Johnson bill faces opposition from both Democrats and Republicans—with many Democrats resistant to anything that impinges on the civil liberties of the mentally ill, even if they are deeply psychotic or don't recognize their illnesses, and many Repub-

licans resistant to spending any money through the federal government, despite evidence that the money spent on effective treatment, including wraparound services and providing beds, along with alternative treatments to imprisonment for those caught up in the criminal justice system, can actually save money as it saves lives and heartache.

While the Franken-Cornyn bill has already moved through the Senate

and has strong support in the House (in part because it is an authorization, not yet an appropriation), this Congress is en route to becoming the most unproductive in modern times and cannot be relied upon to act expeditiously on even consensus bills in an area that has deep needs at all levels. But given the broad support, you can expect similar legislation in the next Congress with a new president at the helm. And per-

haps this special section of the *Washington Monthly* can raise enough consciousness and provide enough grist to create more public demand for action and move us at least a baby step closer to progress. **WM**

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HILLARY CLINTON'S WORK

Step by hard step toward the big goal.

By Greg Sargent

As Hillary Clinton campaigns for the presidency, she frequently invokes her well-known role in crafting her husband's ill-fated 1993 health care plan, to demonstrate to progressives who remain uncertain about her ideological instincts that she has faithfully advocated for universal health care for more than two decades.

But it should also be remembered that as part of that effort, Clinton also pushed for broad reforms to how our nation treats—or mistreats—people with mental illness. It's a cause she has championed for just as long.

Early on, as the leader of the Clinton administration's health care task force, the first lady enlisted Tipper Gore, wife of Vice President Al Gore, to serve as its mental health adviser. Tipper, who had a master's degree in psychology and had long been involved in mental health advocacy, due in part to her own bouts of depression, recommended a policy of "parity"—that is, that the government should require insurance plans to offer coverage on an equal basis to both physical and mental illness. Gore articulated the problem in simple terms: "Why should a woman with diabetes who needs insulin have it covered by in-

surance, whereas a woman with manic-depressive illness who needs lithium not be covered in the same way, when both diseases can be managed and controlled?"

At the time, Hillary Clinton agreed. "It's a problem that permeates the whole system," she said. "We have to do something. I don't think there is a choice anymore." Mental health practitioners and advocates were ecstatic. As *Congressional Quarterly* put it, "For the first time in history, they see a chance that mental illness will get the same insurance coverage as physical illnesses."

As we all know, this entire effort came crashing down, due to industry and congressional opposition, as well as Hillary Clinton's own miscalculations. The chastened first lady retreated from her push for health care reform—mental health reform included.

Or, at least, so it seemed. The full story is that, starting in the mid-1990s and continuing for the next two decades, Clinton kept up the fight, both in public and behind the scenes, for parity. And it paid off with a series of small-bore advances that—while there's still a long way to go—have added up. That narrative sheds light on the continuing challenges presented by the parity issue, and use-



fully illustrates Clinton's broader public philosophy—that is, that incremental reform is worth fighting for, and can produce real change over time.

Only two years after the defeat of the health care bill, President Bill Clinton signed, with Hillary's backing and advocacy, the Mental Health Parity Act in 1996. That law was extremely limited in scope. It secured the same lifetime and annual dollar limits to mental health coverage as for coverage of medical and surgical benefits, but insurers found ways around it by restricting the number of hospital days and outpatient visits for mental health services. As liberal Senator Paul Wellstone, the bill's cosponsor, put it at the time, "We didn't even get half a loaf. We just got crumbs. But it's a start." And indeed it was; the law raised the profile of the parity issue and

prompted states to experiment with parity laws of their own.

Three years later, Hillary and Tipper helped organize the first-ever White House Conference on Mental Health, which brought national attention to the nation's neglect of the mentally ill—and to the cause of parity. “We must do whatever it takes not only to remove the stigma from mental illness, but to begin treating mental illness as the illness it is on a parity with other illnesses,” Hillary declared. At the same conference, the president announced an executive order providing mental health parity for 8.5 million federal employees, retirees, and their dependents covered by the federal government's employee health benefits program. That coverage continues to this day.

By 2000, Hillary Clinton was running for the Senate from New York, and again making the case for parity to voters. “The mind is an organ just like the heart or the liver,” she told one woman on the campaign trail, “and I would like to advocate and work towards parity for coverage for mental illness.” Throughout her first term as senator, Clinton pushed for various mental health care reforms that would have impacted the treatment of mentally ill juveniles in the justice system.

But it wasn't until 2008 that she played a role in another, more significant advance on parity. In that year, she cosponsored the Mental Health Parity and Addiction Equity Act, which went much further than its 1996 predecessor by requiring employers with more than fifty employees to provide equal mental and physical benefits if employee insurance plans covered mental health treatments. While the law—which was signed by George W. Bush as part of the big bank bailout package—did not require mental health coverage, and did not apply to the individual insurance markets, it did lead most insurance companies to eliminate separate co-pays and reduce unequal limits on outpatient visits and inpatient stays.

That same year, Clinton ran for president behind a health care plan that featured mental health parity, along with

coverage for substance abuse treatment. Though she lost the primary fight to Barack Obama, health reform finally became a reality in 2010, with the passage of the Affordable Care Act. That law brought still more parity reform: it mandated mental health coverage as part of required “essential benefits” packages for some small group plans and on the individual market.

Despite that progress, however, there's still a long way to go. Insurers have found new ways to get around the parity mandates in the 2008 law and the ACA—by denying claims, for instance, based on their not being “medically necessary.” Federal and state enforcement has been lax. And, as the National Alliance on Mental Illness (NAMI) points out, Medicare and some Medicaid plans are not subject to the 2008 parity law, with the result that many Medicare and Medicaid beneficiaries find that mental coverage is lacking compared to physical coverage.

“Basically what we have now, thanks to all this incremental progress, is that the vast majority of Americans are now covered by federal parity law,” says Timo-

At the core of Hillary's plan will be a broad effort to tackle that same problem she discussed so long ago: the need for parity in our treatment of people with mental illness.

thy Clement, the policy director of the advocacy organization Parity Track. “But we still have huge problems. The law is not adequately enforced, and very few people are aware that there even is a law. The result is that prevalence of mental illness is high and treatment seeking is low.”

Clinton has continued to talk about these and other problems on the stump during the current election cycle. And while she has not yet rolled out a comprehensive plan for overhauling the way our nation treats those with mental illness, campaign aides say she will soon.

Her plan will include expanding access to mental health care, greater emphasis on early intervention (treating mental illness in early stages to reduce serious outbreaks later) and suicide prevention, and more investments in efforts to treat low-level offenders with mental illness rather than throwing them in jail.

But at the core of her plan, her aides say, will be a broad effort—once again—to tackle that same problem she discussed so long ago: the need for parity in our treatment of people with mental illness. Her proposals, one aide tells me, will be anchored by the “basic belief” that “mental health is a part of a person's general health, and mental illness should be treated no differently from other medical conditions.”

It's unclear whether Clinton's proposals will end up being as ambitious as her campaign indicates. But advocates are cautiously optimistic that the Oval Office could soon be inhabited by someone who has demonstrated—for decades—an understanding of the need for a fundamental change in the way our society views mental health, one that treats it as fully equal to physical health. As Angela Kimball, NAMI's director of advocacy and public policy, puts it, “We need a paradigm shift.”

If Clinton does become president, she may be in a position to finally get parity done and complete that paradigm shift. Or, at least, to get us a whole lot closer to completing it than ever before. The current Democratic primaries have been framed as a choice between a candidate with a bold vision (Bernie Sanders) and one promising only incremental reforms (Hillary Clinton). But in the case of mental health, at least, Clinton has revealed that she harbors a vision that is quite bold indeed, but, tempered by experience, she has also demonstrated the value of advancing incrementally toward it, one hard-fought step at a time. WM

Greg Sargent writes the Plum Line blog for the *Washington Post*. He covered Hillary Clinton's Senate years for the *New York Observer* and *New York* magazine.

JOHN KASICH'S WORK

For the governor, it's personal.

By Daniel McGraw

At a John Kasich town hall meeting in Watertown, New York, in April, a questioner from the audience was having a difficult time formulating his question. He was able to get out that he suffers from autism and is college educated with two master's degrees, but said he has a difficult time finding employment. It seems that employers are often put off by his bad social interaction skills and are worried about his potential ability to fit in with other employees. Because of problems like this, the young man told Kasich, adults suffering from autism have very high unemployment rates.

Kasich moved closer and leaned in, clearly both agitated and consumed by the man's problems. The 600 people in the room could see that Kasich knew what this guy was talking about—not in terms of the specific symptoms of autism, maybe, but in a personal and emotional way. Because if there is one thing John Kasich understands, it is not being understood. Everyone agrees he is bright and likeable, but not everyone agrees that he brings a sense of what we constitute as normalcy.

He has been described as flaky, mean, cheerful, ornery, sullen, distant, and enthusiastic. Someone who is honest but not forceful about his spirituality who often spouts crazy-uncle idioms, who sometimes lectures instead of discussing, and who is always impressed with his own jokes. In a 1995 *Washington Post* article, the then Ohio congressman was described by those with whom he worked as someone who needed both Ritalin and Valium for his own mental balance to balance the federal budget. The writer also observed that Kasich's eyes blinked

thirty-six times in a minute, compared to just two blinks in the same period by "the more inert" Texas Congressman Dick Armey. "[Kasich] radiates so much energy that colleagues in the Ohio delegation, weary and looking for sleep, dread the thought of getting seated near him on flights back to the Midwest," the article said. The *Post* story also declared Kasich to be a "wiry and fidgety politician."

But on this day in Watertown, his eyes seemed to blink slower as he settled the young man down and addressed disability and mental health issues. "When

Though he made the decision not to make his brother a part of the campaign, John Kasich has not shied away from the main reason he expanded Medicaid in Ohio.

it comes to developmentally disabled—and we have to come up with a better term—we just need to integrate people into our system to the level they are able to perform," he said. "We just need to let people know about these issues. It's not hard to bring people in. What the heck, I'd hire you."

This exchange took place at almost every Kasich town hall meeting before he suspended his presidential campaign in April. This was where the presidential candidate told the crowd that we must all—government, private businesses, neighbors—take care of the "people in the shadows," which, in Kasich code, means the developmentally disabled, the men-

tally ill, the drug addicted, and the impoverished. The ones we may have a hard time understanding because they are not like us.

Republicans have hammered Kasich's 2013 decision to expand Medicaid in Ohio, accusing him of being friendly to President Barack Obama's health care reform initiatives and warning that the expansion "would be a disincentive to work." In other words, any health program that is not provided by the private market or a charitable entity—even government-led mental health initiatives—is nothing more than just another welfare entitlement for the poor.

But buried a bit deeper in all the political wrangling is a simpler reason why Kasich expanded Medicaid: more mental health treatment and accessibility for everyone had long been at the top of his policy wish list, and he saw expanding Medicaid as the best way to get it. This was driven by three main factors in the John Kasich belief book. He thinks physical and mental health programs must be conjoined for either to be effective, his Christian beliefs are clearly based in helping the less fortunate, and he's familiar with mental illness issues thanks to family experience. Even with these three driving factors, it's been no easy task.

"When I started out as a judge more than forty years ago, the first thing I noticed was that my docket was full of people with mental health issues, and they kept coming through again and again," says Evelyn Lundberg Stratton, a Republican who served as a justice on the Ohio Supreme Court from 1996 to 2012. "They were recycled inmates. And the sheriffs who ran the jails were saying that incarcerating the mentally ill was consuming most of their resources." John Kasich, Stratton continues, "has been a courageous governor in bucking his own party on this issue, and as a result he has saved many lives."

It was the new allocation of resources that attracted Kasich initially to the Medicaid expansion. Even before he was elected Ohio governor in 2011, states had to reformulate their Medicaid programs to get them more in line with federal mandates as part of the initial Obamacare changes.

So eighteen months before he was elected, Kasich assembled a team—some of whom had worked with him in the 1990s in Washington on the federal budget—that would look at ways to integrate mental health programs into the revised Ohio Medicaid system. “He joked that he was getting the band back together again,” says Greg Moody, who worked on the U.S. House Budget Committee in the 1990s and is now the director of the Ohio Governor’s Office of Health Transformation.

The Medicaid expansion brought about 600,000 Ohioans into the program; more than half of them worked (or had spouses who did) and another 30 percent didn’t work because of chronic disabilities. About half of those with chronic conditions had associated mental health issues. “We have found through numerous studies that most of the mentally ill lose their jobs because of health problems, mostly because getting physical health treatment becomes difficult for them to take care of with the other issues plaguing them,” says Terry Russell, director of the Ohio chapter of the National Alliance on Mental Illness.

The Kasich administration has instituted numerous programs that make Medicaid spending more efficient in integrating mental health into the equation—from increasing childhood access to mental health treatment to changes in opioid addiction treatment policies to spending \$316 million in fiscal years 2016 and 2017 to help Ohioans with developmental disabilities, including programs to find better housing and jobs. “We seem to ignore these people,” Kasich said during a campaign speech in Georgia last year. “Now, I don’t know how many of you know people who struggle with these illnesses, but if you’ve got problems with schizophrenia and you find yourself in prison? It’s a disgrace in this country.”

Selling that line of thinking has been difficult, especially in the evangelical Christian community. According to a 2013 study by Lifeway Research, a Tennessee-based Christian church research group, 48 percent of evangelical, fundamentalist, or born-again Christians believe that prayer and scripture study alone can overcome mental illness. (Interestingly, eighteen- to twenty-nine-year-olds in those groups are

more likely to believe in Bible and prayer treatment than those between the ages of fifty-five and sixty-four.) So while Kasich has been adamant about trying to bring better mental health treatment options to the poor, he is facing a strange battle of sorts within the GOP power base. Not only do many Republican conservatives believe that mental health care provided under the Medicaid umbrella is repackaged welfare, many also believe that prayer is all that’s needed.

Some observers think that may be changing. “There may be some pastors and Christian counselors with platforms who remain very skeptical of mental health professionals and the modern concept of mental illness, but I can’t imagine my evangelical friends rejecting a candidate who strongly supports better funding of mental health research or access to mental health services on that basis, especially if they were demonstrably committed to other issues of interest to evangelicals . . . sanctity of life, religious liberty, school choice, the persecuted church,” says Stephen Grcevich, a psychiatrist in Chagrin Falls, Ohio, who works with church groups on religious and children’s disability issues. Evelyn Stratton thinks that what Kasich has been doing politically—trying to hold down costs while providing services to the mentally ill—will work “because everyone has a mother, father, sister, or brother who has a mental illness problem.”

In Kasich’s case, this is true. His younger brother Rick, fifty-nine and a former postal worker like their father, told the *Columbus Dispatch* in a 1999 interview that “he takes medication and sees a counselor for emotional problems.” The problems were, he said, “chemical in nature. . . I could give you a diagnosis, but I’d rather not.”

The family went through horrific tragedy in 1987, when the brothers’ parents were killed by a drunk driver. There was some disagreement about how the estate would be divided, according to the *Dispatch* story, and bad blood developed between them. Rick Kasich said his brother’s “life can’t be reconciled to me in any degree. . . I have a low view of him. I really don’t want to get involved with him.”



While the two have since reconciled, according to an April story in the *New York Times*, Rick’s opinion hasn’t changed much. “He doesn’t have much to do with me, and I don’t have much to say about him,” he told the *Times*. His older brother’s campaign told the paper, “We love Rick deeply and have shared the struggles that his disease brings with it,” and called for his privacy to be respected.

Though he has made the decision not to make his brother a part of his political campaigns throughout the years—and not to use Rick as an example of why policy changes are needed when lobbying the state legislature in Columbus—John Kasich has not shied away from the main reason he expanded Medicaid in Ohio. During one of the early debates last summer, he was asked why he’d done it: “I had an opportunity to bring resources back to Ohio to do what? To treat the mentally ill. Ten thousand of them sit in [Ohio] prisons. It costs \$22,500 a year [for each one].”

Very simple: Save government money. Practice what you preach. And, more importantly, learn from personal experiences, however painful they may be. WM

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MENTAL HEALTH COURTS

A workaround for a broken mental health system.

By Paul S. Appelbaum

In the mid-1990s, Florida's Broward County had a problem. With a paucity of available mental health programs, police often had no alternative to arrest for people who were behaving bizarrely on the streets. Growing numbers of defendants with serious mental illnesses were appearing in criminal court, charged with crimes such as trespassing that often seemed driven by their disorders. After a short jail stay, usually without treatment, their charges would be dismissed or sentences reduced to time served by judges who knew that their reappearance in court was almost inevitable.

Judges around the country, usually with no background in mental health, faced dockets clogged with similar cases.

Epidemiologic surveys of jails and prisons found that 14 to 24 percent of inmates suffered from serious mental illnesses, conditions more often neglected than treated during confinement. With little public interest in funding adequate services, the problem of how to deal with persons with mental disorders was being left to the already overburdened criminal justice system. Broward County, though, decided to do something to try to tackle the problem: it established the first mental health court (MHC) in the United States.

Drawing on the earlier model of drug courts, aimed at treating rather than punishing addicts, MHCs were designed to divert defendants with seri-

ous mental illnesses from the criminal justice system. Models differ across jurisdictions: some MHCs intervene before trial, others only after a finding of guilt; misdemeanants are the exclusive focus of the Broward court, but defendants accused of felonies are also eligible in some places; most MHCs don't control their own treatment resources, but a small number—like the Miami-Dade program in South Florida—do. Violent or sexual offenders are often excluded from participation, and some jurisdictions impose other limitations. What they have in common is the ability to offer defendants the opportunity to avoid

jail or prison time if they agree to follow a court-approved treatment plan. MHC participation is always voluntary, but participants who complete the program will have charges dropped or sentences suspended. However, failure to abide by the terms of the program can result in a return to the criminal justice system and the prospect of doing time.

MHCs are often paired with other reforms aimed at keeping the mentally ill out of jail. In Allegheny County, Pennsylvania, where Pittsburgh is located, hundreds of police officers have gone through a forty-hour "crisis intervention team" training course on how to manage individuals with mental illnesses. These cops wear small blue "CIT" badges that signal to street people with mental illnesses that they are dealing with officers who understand their conditions and aren't interested in putting them behind bars. As an alternative to jail, police can escort those who commit minor crimes or disturbances—such as a man who repeatedly tried to direct traffic on a busy main thoroughfare, according to the *Pittsburgh Post-Gazette*—to special units at local hospitals.

MHCs have become extremely popular, perhaps not surprisingly given the ubiquity of the problem they are meant to address. At last count, there were 357 adult MHCs in the U.S. and another sixty tribunals dealing with juveniles. The MHC model has been adopted in other countries, including Canada and Australia, and has spawned a similar approach for veterans of the armed forces, who often have a combination of mental health and substance abuse problems. Several of the bipartisan legislative proposals stutter-stepping their way through Congress this year would encourage additional jurisdictions to create MHC programs. But as with so many public policy initiatives, enthusiasm for MHCs has often outstripped the evidence for their effectiveness and advocates tend to ignore the downsides of the programs.

What do we know about how well MHCs work? After some early equivocal findings, most recent studies have confirmed that MHC participation is associated with reduced rates of rearrest and



reincarceration compared with ordinary handling by the courts and correctional system. A newly published study of the District of Columbia MHC, for example, found that 25 percent of misdemeanor defendants with serious mental illnesses who “graduated” from the program were rearrested within two years, compared with 48 percent of defendants who were eligible for the program but didn’t enter it. (Interestingly, MHC dropouts had the highest recidivism rates of all, at 55 percent.) Similarly positive results come from Ramsey County, Minnesota, in which St. Paul is located: misdemeanants who went through the usual criminal process were two and a half times more likely to be convicted in their first year in the community and served almost five times as many days in jail in that period compared with MHC completers.

Although it is often assumed that reducing rearrest and incarceration will result in a net savings, data on costs associated with MHCs has been inconsistent. A Rand Corporation evaluation of the MHC in Allegheny County, Pennsylvania, suggested that savings begin to accrue after the first eighteen months of participation, largely accounted for by reduced jail time. However, an analysis of four MHCs in different parts of the country funded by the John D. and Catherine T. MacArthur Foundation showed that MHC involvement led to increased annual costs of \$4,000 per participant compared with a matched group of non-MHC jail detainees, as the costs of enhanced mental health treatment consistently exceeded the savings from fewer days of incarceration. When it comes to dealing with offenders with serious mental illnesses, MHCs are not offering a free lunch.

What has been harder for researchers to pin down is why MHCs seem to work. Advocates for MHCs, perhaps not unreasonably, assumed that many of the charges faced by defendants eligible for the programs stemmed from behaviors related to the illnesses themselves. Perhaps the euphoria and grandiosity asso-

ciated with a manic state might lead to the kind of public rowdiness that could result in a charge of disorderly conduct. Or the delusional thinking seen in acute psychosis could cause a homeless person to believe that he owned all the retail stores in the city and hence to walk out of a convenience store without paying for a candy bar. Treat the symptoms of the underlying illnesses, the theory went, and the criminal behavior would go away. Although that commonsense proposition has been remarkably difficult to substantiate, a recent reanalysis of data from the MacArthur Foundation study has confirmed that increased medication compliance and use of mental health services were linked to significantly lower rates

Family members desperate to obtain treatment for a loved one may see no alternative but to have the person arrested, hoping detention will lead to diversion to a mental health court.

of arrest. Nonetheless, it’s still possible that more intensive supervision or other nonspecific factors play a role in reducing recidivism too.

Often neglected in the rush to embrace the MHC model are the limitations and potential negative effects of the approach. Since MHCs rarely control their own mental health services, the treatment plans they can impose are necessarily limited by what is available in a given area. Thus, participants who need a service that no local provider offers are simply out of luck. Moreover, given that community mental health services are “maxed out” in many locales, often with waiting lists of weeks or months in duration, creation of an MHC may simply alter who gets access to a scarce resource. Even if a judge’s order jumps an MHC participant to the head of the queue, it will only be at the cost of another person with serious mental illness who has never broken the law but now will have to wait even longer for help. In

short, MHCs are not an easy solution to the problem of an underfunded mental health system.

Embedding access to mental health treatment in the criminal justice system can have other perverse effects as well. Family members desperate to obtain treatment for a loved one may see no alternative but to have the person arrested, hoping detention will lead to diversion to an MHC. In addition to the risk associated with an encounter with the police—nearly a quarter of victims of police killings each year have an identifiable mental illness—an arrest record can lead to subsequent difficulty finding housing, getting a job, and accessing community services, all consequences of endowing a person with the dual stigmata of mental illness and a criminal record. Yet the temptation to gain access to treatment by characterizing illness-related behavior as criminal is real. The ironic result may be an increased flow of people with serious mental illnesses into the criminal justice system, exactly the opposite of the original goal.

Finally, we need to acknowledge the paradox of the “success” of MHCs: if adequate community-based services and hospital beds were available for the treatment of serious mental illnesses, it is unlikely that Broward County and the hundreds of jurisdictions that have followed its lead would have developed MHCs in the first place. To be sure, even with an optimal system of mental health care some people with mental illnesses would end up facing charges and could benefit from MHCs and other diversion programs. But as we listen to politicians, bureaucrats, and others extol the MHC model, we would do well to keep in mind that it is only a workaround. Ultimately, our badly funded and poorly organized mental health system itself needs to be addressed in a more thoughtful and systematic way. WM

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GETTING MEDS

Why does government make it so hard?

By Sally Satel

Any of the 900,000 physicians in the country can—and often do—prescribe, at their own discretion, the kind of opioid painkillers whose abuse has led to a 300 percent spike in overdose deaths between 2001 and 2014. But if they want to prescribe medicines to help patients overcome opiate addiction, they face an array of government restrictions and systemic obstacles.

Take a medication called buprenorphine, approved by the FDA in 2002. Buprenorphine's profile has risen within the last few years. It suppresses drug cravings and quells withdrawal symptoms like muscle aches, sweating, anxiety, agitation, and diarrhea—also called “dope sickness.” The drug is a less potent substitute for the classic opiate replacement drug, methadone, and has less of a potential for abuse. Some patients dose daily over weeks or months as a way to slowly detox from abused opiates. Others stay with buprenorphine for years.

In order to prescribe buprenorphine, Congress requires that doctors undergo special training and certification from the Substance Abuse and Mental Health Services Administration, or SAMHSA. The eight-hour course is not particularly onerous (I did it in three days at my computer, and it was an excellent refresher on opiate psychopharmacology). Nor is it expensive. Yet, according to SAMHSA, fewer than 32,000 doctors are certified. Worse, most doctors with the buprenorphine certification seldom administer the drug—40 percent of physicians allowed to prescribe it never do so, according to SAMHSA. Also, many doctors who prescribe buprenorphine don't accept insurance.

In fact, physicians routinely find that patients who make appointments to begin buprenorphine treatment have already initiated the medication on their own after buying it on the street, an indicator of how hard it can be to find a doctor who prescribes it.

What's more, federal law limits certified doctors to treating only thirty patients at any given time during their first year of prescribing buprenorphine and a maximum of 100 patients thereafter. (If buprenorphine is prescribed by a doctor in a licensed clinic devoted



to the treatment of opiate dependence, then there is no limit per doctor.) “Removing this barrier to buprenorphine is particularly critical in rural and underserved areas, where the growing need for [medication-assisted treatment] often outstrips the number of physicians licensed to supply it,” according to the National Governors Association.

To be fair, the point of the limit is to keep doctors' offices from turning into “film mills” (the drug is administered in a sublingual “film”) that hand out buprenorphine without providing counseling and monitoring for abuse.

But in some regions of the country so few doctors prescribe the drug, and so many patients could benefit, that so many politicians and public health workers have urged raising the limit or lifting the cap altogether and allowing nurse practitioners to prescribe it. While President Obama proposed allowing doctors to treat up to 200 patients at a time after the second year of buprenorphine practice, some observers believe this won't make much of a difference because so few doctors prescribe buprenorphine to a large number of patients in the first place. Soon an implantable form of buprenorphine lasting up to six months is expected to be approved by the FDA. With this, concerns about abuse should decline.

The buprenorphine limit has been only one of several obstacles standing in the way of providing effective drug treatment for addicts more widely, but, fortunately, a bill called the Comprehensive Addiction Recovery Act (CARA) can remove a number of them. The broad intent of the legislation is to promote treatment of addicts over punishment. In service of that mission, it authorizes an expansion of pharmacological treatment for addiction. Using the catch-all phrase “medication-assisted treatment,” or MAT, the bill refers to several kinds of medications that address opiate addiction.

One of these drugs is methadone, a synthetic substitute for heroin and narcotic painkillers that prevents opiate withdrawal symptoms and reduces cravings. I work as a part-time psychiatrist in a methadone clinic near George Washington University Hospital. My main job is to adjust the doses of methadone that patients drink daily in front of a nurse—methadone is addicting in its own right, and must therefore be carefully managed. The methadone is pink and cherry flavored; the lives of the patients are often far less sweet. The average age of our clientele is fifty-seven. Most are unemployed or disabled, and many have prison records. They are old-school addicts: people who started using three to four decades ago, took heroin as their first opiate, and quickly moved to injecting.

Today, by contrast, 75 percent of all heroin users started with painkillers that they bought on the street or from pill mills run by unscrupulous doctors, or stole from the medicine chests of unwitting relatives and friends who were prescribed the narcotics to treat pain. It is this new generation of opiate addict that's galvanized public health officials and politicians. According to the National Survey on Drug Use and Health, the number of first-time heroin users nearly doubled between 2006 and 2013. Ninety percent of that group comprised whites living outside of urban areas who began using opiates in their early twenties. The heroin surge of the 1970s, by contrast, comprised mainly inner-city minorities who initiated use in their mid-teens.

Today most methadone clinics cater to a subset of opiate users: those who have been treated with methadone on and off over the years; those who have failed other medications and counseling; and young users with habits too heavy for treatment with buprenorphine. CARA funds could indeed be used to establish more methadone and buprenorphine treatment, but the most valuable aspect of the legislation with regard to methadone is that it promotes the use of MAT within the criminal justice system. This is an important provision, because many judges, prosecutors, and prison officials still believe that opiate addiction can only be treated with counseling and group therapy.

Another drug covered under CARA is naloxone. Commonly known by its trade name, Narcan, naloxone is the subject of an entire section of the bill. It is basically an antidote; it saves lives by interrupting a potentially fatal overdose. It binds to the same sites in the brain as heroin and most other opioids, notably the breathing center in the brain stem. But it has a tighter grasp, so it can "kick" the opioid drugs off the receptors even after the drugs have taken effect. Pharmacologically speaking, naloxone is an opiate "antagonist." It is delivered as an intramuscular shot, intravenous injection, or nasal spray. Timing is essential: the medication must get to

the brain stem as quickly as possible after opioid ingestion.

For decades following its approval by the FDA in 1971, naloxone had been used almost exclusively by emergency room doctors and first responders. CVS now sells Narcan kits to anyone with a doctor's prescription (patients can simply ask their doctors to prescribe it), and in twenty-three states it can be bought without a prescription. Narcan is also sold online and is available at needle exchanges or public health clinics. Some communities provide kits free to anyone who asks.

Another antagonist, naltrexone (Revia, Vivitrol), blocks abused opioids from producing euphoria or a high by binding tightly to opioid receptors. It is not a substitute for heroin or painkillers—it will precipitate withdrawal in people who are opiate dependent. To avoid dope sickness, a patient must first be opiate free for at least one week before taking naltrexone. There is a small group of people for whom the drug works well, however—patients with stable social situations, a lot to lose, and motivation to succeed, such as impaired physicians or

nurses. Naltrexone is primarily used as an extended-release injection that has to be taken only once monthly. A pellet-like naltrexone implant, which is surgically inserted under the skin and lasts between three and six months, is also available, but it is used rarely and not approved by the FDA. (Unlike buprenorphine and methadone, naloxone and naltrexone are not addictive, and will have no effect on a person who does not use opiates regularly.)

Medication is indeed a critical element in the treatment of opiate addiction in many patients. But it rarely does enough, by itself, to solve an addict's problems: absent serious motivation to recover, no medication will work. Full recovery requires new, more constructive habits, identities, relationships, and a sense of one's future. Ideally, however, the medications can provide an extra dose of stability upon which addicts can rebuild their lives. WM

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RURAL AMERICA

Vermont is finding a way to deliver.

By Elizabeth Hewitt

You could be forgiven for looking at Vermont's heroin crisis—the surging addiction rates, the climbing death tolls, the related crime—and feeling like you've read this book before. After all, rural states across the country are going through the exact same thing. Centers for Disease Control data shows that drug overdose death rates, up nationwide, are particularly high in the most rural parts of the country. Resources for

mental illness and substance abuse are limited, and many people who struggle with those issues end up in the criminal justice system.

"It was the perfect storm," Governor Peter Shumlin said. "Rising addiction, rising prison population, lack of money to keep doing what we were doing, and a real sense of social injustice being served to people who were suffering from a disease that led to petty crime."



Vermont is writing a new chapter, though, with a series of policy responses that have helped lower incarceration rates by keeping addicts in treatment and out of prison. While the shift in policy and attitude began with the previous administration, Shumlin made criminal justice reform a key part of his successful 2010 campaign for governor and has carried the initiative through his second and third terms, dedicating his entire 2014 State of the State address to opiate abuse.

"We must bolster our current approach to addiction with more common sense," he said at the time. "We must address it as a public health crisis, providing treatment and support, rather than simply doling out punishment, claiming victory, and moving on to our next conviction."

Now, if you get arrested on a nonviolent charge in Vermont, there's a good chance you'll never do time behind bars. You might end up in addiction treatment, or with your case on a special drug treatment docket. Circumstances depending, you might not even end up with a charge on your record. Three

Vermont counties have drug courts, one has a mental health court, and another has a DUI court. The treatment dockets are part of a mosaic of initiatives that reroute defendants away from prison and into appropriate treatment for mental health and substance abuse treatment.

These treatment courts reach people when they are already much of the way through the judicial system. Participants in drug court are often charged with drug-related offenses or drug-motivated ones, like theft. The court is specifically for high-risk, high-need individuals, who face the possibility of prison time if they fail out of the program.

At fortnightly meetings, attended by attorneys, social workers, probation officers, a state trooper, and others, the judge checks in, one by one, with each enrollee in the program. If they make

it to their regular urinalysis screenings, group meetings, and therapy sessions, they progress through the program. If they fail to comply, they face sanctions. If they fail too many times, their case goes back to the criminal docket and they go to prison to serve their underlying sentence.

Unlike in drug treatment court, defendants on Vermont's DUI docket, which began in January 2014, do not avoid a conviction or sentence. The goal is to resolve the underlying issues that have led a person to multiple impaired-driving charges. Typically the program takes between eighteen and twenty-four months to complete.

Vermont is still in the process of building out the services that will intercept and divert people in the stages between arrest and conviction. Under

Governor Peter Shumlin made criminal justice reform a key part of his successful 2010 campaign for governor and has carried the initiative through his second and third terms, dedicating his entire 2014 State of the State address to opiate abuse.

the pretrial services program, passed by the legislature in 2014 and rolled out in 2015, every county offers an assessment that calculates an individual's risk factor and indicates what types of services they might need. Anyone cited or arrested has the option to go through a seven-question screening designed to flag potential mental health or substance abuse issues before arraignment.

The program is designed to give the prosecutor and judge more information about an individual before making decisions. The person facing charges may be referred to treatment before even stepping into the courtroom. Depending on the case, the prosecutor, and the individual's success in treatment, he or she may never be formally charged with a crime.

Shumlin and other policymakers are seeing results. Between 1997 and 2008, the number of people incarcerated in Vermont's correctional system grew by 86 percent, according to the Council of State Governments. Given that trend, the council predicted that there would be 2,619 people incarcerated by mid-2015. After years of reforms, that number came in at 1,734.

Several other rural states are implementing similar programs to try to divert nonviolent defendants away from the correctional system. The programs attempt to relieve taxed criminal dockets and maximize exhausted treatment services, while curbing the recidivism associated with addiction and mental illness.

In Kentucky, defendants charged with nonviolent offenses have the option of participating in a diversion program. Under the guidance of a program officer, and with approval of the district judge, defendants are referred to appropriate treatment, therapeutic counseling, and other services. Depending on their success in the program, their charges may be dismissed.

Mike Thompson, director of the Council of State Government's Justice Center, said that Vermont's statewide adoption of risk and need assessments is a significant step. "That's very important, because you don't want judges, defense attorneys, prosecutors making decisions about the kind of program to put somebody in without the benefit of that criminogenic risk assessment," Thompson said.

However, Thompson said, while there have been small gains from various promising initiatives, Vermont lacks a comprehensive system—and, with it, lacks data tracking how well the programs actually function. That's a problem across the country, he said. And without more coordinated efforts to collect and gather the data demonstrating how effective various initiatives actual-

ly are at curbing the prevalence of mental illness in prisons, “we’re going to have the same kind of hodgepodge of stories for the next ten years,” Thompson said.

Amid the many efforts to manage available treatment and court resources, scarcity of services in rural areas remains a significant challenge in efforts to curb opiate addiction and related crimes. It’s a shortage Governor Shumlin readily admits is one of the biggest weaknesses of Vermont’s system. Wait lists for addiction services through Vermont’s system number in the hundreds, and wait times can be weeks. “The demand is higher than what we’ve built out,” Shumlin said.

Bobby Sand, a faculty member at Vermont Law School and Shumlin’s criminal justice liaison, was a key driver of the statewide risk-need assessment system. The various diversion initiatives are promising, he said, but the criminal justice system as a whole is still lacking. “The biggest thing that we’re missing in Vermont is a road map,” Sand said, “an agreed-upon vision for how we collectively address substance abuse and mental health programs.”

One issue, he said, is lack of support at the federal level. Greater investment in programs like treatment courts would be helpful. There’s also a need for more experts and resources in mental health and substance abuse treatment services; the federal government could help with that, Sand said, by setting up a program to incentivize the field, similar to the Title IV-E program that encouraged more people to go into social work.

In the meantime, Sand said he believes that Vermont has been a leader in one key way: recognizing that substance abuse and mental health issues are best served by treatment, not by prison. “I think the biggest thing we’re doing right is recognizing that a heavily based criminal justice response to people who present with a mental health or substance abuse issue is not only not effective but probably counterproductive,” he said. ^{WM}

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DRUG TREATMENT

How to separate the good from the bad.

By Keith Humphreys


In the movie *Annie Hall*, Woody Allen’s character tells an old joke about two elderly ladies at a Catskill mountain resort: “One of ‘em says, ‘Boy, the food at this place is really terrible.’ The other one says, ‘Yeah, I know—and such small portions.’” Well, the good news, when it comes to addiction treatment policy, is that the portions are larger—that is, reforms over the past decade have made treatment for substance use disorders accessible and affordable to more Americans than ever. The bad news is that the quality of much of that care is still terrible.

Even before the overdose crisis began claiming as many lives each year as AIDS did at its peak, the need for sub-

stance use disorder treatment in the United States was immense. More than twenty million Americans meet medical diagnostic criteria for a drug or alcohol disorder, exacting a brutal toll on their health and well-being as well as imposing substantial costs on the community, from intoxicated driving, violence, unemployment, family breakdown, and infectious-disease transmission. But because excessive substance use has until recent years been seen primarily as a sin meriting stigma and punishment, funding for addiction treatment has been in short supply. Many private employers haven’t particularly wanted to provide good insurance benefits for their employees wrestling with addiction, and taxpayers have been reluctant to fund services, with the exception of a few groups who provoke unusual sympathy and concern, like veterans and pregnant women.

However, sustained cultural and political activism, including by recovering addicts themselves, has created a new public understanding of substance use disorder and, with it, a new public policy environment. In 2008, Congress, with strong bipartisan majorities, passed the Wellstone-Domenici Mental Health Parity and Addiction Equity Act, which mandates that substance use and mental health disorder treatment benefits provided by large employ-





ers be comparable to those provided for physical health care. The same year, the Medicare Improvement for Patients and Providers Act substantially enhanced the outpatient substance use and mental health disorder treatment benefits for that program's fifty million beneficiaries. The Affordable Care Act (ACA) advanced access even further in 2010 by mandating coverage for substance use disorder screening and treatment in health insurance exchanges and within the Medicaid expansion provisions. Along with other changes wrought by the ACA, the legislation is estimated by the Department of Health and Human Services to have improved access to care for substance use disorder treatment for more than sixty million people.

People who pushed for these massive reforms (including me) are jubilant that access to treatment has reached a historically unprecedented level. However—and it's a big however—the long-undervalued, undervalued, rickety U.S. addiction treatment system cannot consistently provide the quality of care that policymakers, purchasers, and patients are now going to expect in exchange for a flood of new public and private money. Studies of the system have shown that most programs do not have even one medically trained person on staff who can write a prescription, conduct a physical exam, or diagnose hepatitis, HIV, or tuberculosis. Very few treatment agencies meet current standards for electronic health records, and about a quarter have no computer resources of any kind. Even billing a private insurer or Medicaid is beyond the capacity of most programs. Physical infrastructure is sometimes tatty, and clinics are frequently located in areas that make them unappealing to patients and also isolate them from other health care providers.

While many treatment agencies contain dedicated staff who offer high-quality care, one also sees the sorts of programs one expects to see when a marginalized population receives un-

derfunded services: treatment with no basis in scientific evidence, individuals poorly trained in the professional and ethical requirements of their job, and a culture of low expectations and accountability. The prominent addiction researcher Tom McLellan used to illustrate the field's realities with a classified ad from a Philadelphia newspaper: "Drug counselor wanted, \$12,000, no experience necessary."

When that same Tom McLellan and I were working in President Obama's White House Office of National Drug Control Policy, we shared the view that a root cause of the often poor quality of substance use disorder treatment was its segregation from the rest of the health care system. Although it is far from perfect, the mainstream health care system has established numerous

A classified ad from a Philadelphia newspaper illustrates the addiction treatment field's realities: "Drug counselor wanted, \$12,000, no experience necessary."

mechanisms to attract and retain well-trained staff, to apply scientific evidence in clinical practice, to protect the dignity of patients, and to improve the quality of care. Evaluations of current addiction treatment effectiveness generally show that the average patient benefits despite the challenges, and we believe that bringing addiction treatment out of the shadows and into the larger health care system would not only reduce stigma but also improve the quality of care over the long term.

The most obvious and important way to accomplish such integration was to advocate for full inclusion of substance use disorder care within the ACA. But it also involved other budgetary decisions, particularly preferring expansions of treatment funding within established federally supported

health care systems such as Community Health Centers, the Veterans Health Administration, and the Indian Health Service. This was a change from the previous policy of directing federal dollars preferentially to the onetime bulwark of federal support for treatment, the \$1.8 billion Substance Abuse Prevention and Treatment Block Grant to states. The block grant does significant good, particularly in those states in which this federal largesse is the only support for services. However, it has never had any mechanism to promote quality of care (like pay for performance), nor have the states shown any enthusiasm about such standards being imposed. Further, the set-aside funding led to a set-aside treatment system with little connection to the services and quality improvement mechanisms of the mainstream health care system. In addition, block

grant funding continues to decline in real terms each year. For providers who adapt to the realities of the new policy world, the surge of new public and private funding will more than compensate for the loss of the old funding stream: Medicaid spending alone in 2020 is projected to be more than ten times that of the block grant.

With the new funding and new legitimacy will come new expectations. Substance use disorder treatment programs, like the rest of medicine, will have to consistently employ qualified staff, make use of evidence-based methods, maintain state-of-the-art health care records, and be a part of modern health care networks. The transition will be bumpy, but it is also necessary. Advocates have already won the challenging cultural battle to convince most of the country that addiction is a legitimate health problem. Now we must ensure that those experiencing it receive quality health care. *WMA*

Keith Humphreys is a professor of psychiatry at Stanford University. He served as a senior policy advisor at the White House Office of National Drug Control Policy from 2009 to 2010.

PARITY FOR MENTAL HEALTH

Time to strengthen enforcement.

By Jenny Gold

Michael Kamins's twenty-year-old son had recently been hospitalized twice with bipolar disorder and rescued from the brink of suicide. Then Kamins received a letter from his son's insurer—they had determined that he had improved and it was no longer medically necessary for him to see his psychiatrist two times a week. The company would pay for two visits per month. "There was steam coming out of my ears," Kamins recalled, his face reddening at the memory of that day in June 2012. "This is my kid's life!"

His son again became suicidal and violent, causing him to be re-hospitalized eight months later. Kamins, a marketing professor at the State University of New York at Stony Brook, felt he had to do something. So he found a lawyer and sued his insurer, alleging that it had violated mental health parity law by denying his son needed care.

To Kamins's great frustration, the judge determined that he did not have standing to sue under the parity law—a decision he is appealing. Four years after receiving that letter, Kamins's insurer has still not admitted any wrongdoing or compensated him in any way.

The case is an example of just how difficult it is for patients and families to access what they see as essential—even lifesaving—mental health care, despite heralded legislative changes designed to pry open the door to more extensive and better treatment.

In 2008, President George W. Bush signed a landmark federal parity law banning discrimination in the treatment of people with mental illnesses and substance abuse problems. Senator Edward Kennedy called the law "historic," and praised his colleagues for finally ending

"the senseless discrimination in health insurance coverage that plagues persons living with mental illness."

The law did not require health plans to provide coverage for mental health, but it did require any plan offering such coverage to ensure that its mental health benefits were on par with those offered




for medical and surgical care. Within a few years, most insurers had dropped annual limits on the number of therapy visits they would cover. Separate deductibles and higher co-payments and coinsurance also became less of a problem.

In 2010, President Obama signed the Affordable Care Act (ACA), which

went a step farther: it required that all government plans and those sold on insurance exchanges provide mental health coverage—opening treatment to millions more people.

But neither the ACA nor the parity law has ensured in practice that patients receive fair and equal mental health coverage. Insurance companies were unhappy with the plan to regulate utilization management, like their determination of whether a treatment is "medical necessary," and when those regulations were finalized the insurers said they didn't have enough guidance to implement them properly. "We are not fighting parity. We are trying to understand it and implement it to the best of our ability," said Pamela Greenberg, president of the Association for Behavioral Health and Wellness (ABHW), which represents insurers providing mental health and addiction coverage. "It's a complicated law with a lot of gray areas."

In the case of medical necessity, professional opinions can vary from case to case. And it's not easy to compare the necessity for treatment across mental health and other medical disciplines—certainly not as easy as comparing deductibles and co-pays. But mental health care advocates have accused insurers of using medical necessity to deny coverage. Michael Kamins's case, for instance, hinges on it—his doctor says treatment is necessary, but the insurer says it's not. Years later, well after the crisis has passed, the courts may have to decide. "'Medical necessity' is the insurers' last hurrah," says Meiram Bendat, who is representing the Kamins family and has filed other cases alleging parity law violations in several states.



It's difficult to tell the extent to which insurers are complying with the law, because agencies have been enforcing them in private, piecemeal fashion. A review by Kaiser Health News found that in the eight years since the federal law was passed, the U.S. government has not taken a single public enforcement action against an insurer or employer for violating the law. "Our problem is that these investigations are all kept secret," said Carol McDaid, who coordinates the Parity Implementation Coalition, an advocacy group created to make sure parity laws have been properly enforced. This means that the decisions have no effect on what other employers or insurers do, she said.

That lack of transparency can also create problems for patients. Because enforcement isn't assigned to any one federal agency—with various aspects falling to the Departments of Health and Human Services, Treasury, and Labor, as well as to state insurance commissioners—consumers appear to be left with limited or confusing options. When they feel their care has been inequitable, no single agency can be held accountable.

Advocates say most consumers don't even know they have new rights, and those who do know often don't know where to turn. Just four in ten Americans are aware that the government requires insurance plans to provide mental health benefits in parity with medical benefits, according to a recent poll from the Kaiser Family Foundation. The Departments of Health and Human Services and Labor both have consumer assistance lines, but those numbers are not specifically for mental health parity concerns. "It gets very complicated for the average person," said McDaid.

Henry Harbin, former CEO of Magellan Health, a managed behavioral health care company, said insurers have taken advantage of the minimal oversight. "They can micromanage care down to almost nothing," said Harbin, who also served as Maryland's mental health director before becoming a consultant. "The enforcement in this area is a joke."

Clare Krusing, a spokesperson for America's Health Insurance Plans, the

industry's main trade group, said it is "a misperception" that enforcement has been weak. Insurers are working closely with federal and state governments, she said, and "have taken tremendous steps to implement these changes and requirements in a way that is affordable to patients."

Beyond limited enforcement data, it's difficult to empirically assess the results of the parity law—the few studies that have been done have been limited in time or scope, or have been done by advocacy groups. But some analysts point to shortcomings, or at least a slow start.

A study from the health policy center at the University of Colorado School of Medicine found that at least through 2011, eighteen months after the interim regulations took effect, the parity law had little to no impact on access to or use of mental health services.

Thanks to his insurer denying further coverage, Michael Kamins had to tap into his retirement fund to pay for extra psychiatrist visits for his son.

A study published in the journal *Psychiatric Services* found that in the first open enrollment period, from October 2013 through March 2014, a quarter of the plans sold on two state Obamacare exchanges appeared to violate the federal parity law in various ways, including requiring higher cost sharing for mental health. The states, one large and one small, were not named in the research.

"I was surprised. I would have expected that a couple years after the law was implemented it wouldn't be that high," said one of the authors, Haiden Huskamp, a professor in the Department of Health Care Policy at Harvard Medical School.

In a 2015 survey by the National Alliance on Mental Illness, an advocacy group for mentally ill people and

their families, patients said they were denied coverage because treatment was deemed "not medically necessary" twice as often for mental health as for other medical conditions.

In March, President Obama weighed in, suggesting that parity was at risk of becoming "an empty phrase." He announced the creation of a parity task force to create tools and guidelines to hold insurers accountable. "We've got to let the insurance carriers know that we're serious about this," Obama said during a panel discussion at the National Prescription Drug Abuse and Heroin Summit in Atlanta, Georgia.

Several bills are pending that would strengthen the parity law by requiring insurers to disclose the documents revealing how they make coverage decisions on both the mental health and medical-surgical sides of their business. Carol McDaid said that change is crucial to allow advocates, lawyers, and patients to determine and demonstrate whether a violation has occurred.

As for Kamins, he is continuing to wage his own private battle. His court case is proceeding as a breach of contract and deceptive business practice suit, while Bendat said he also plans to bring the parity law violation to an appellate court. Kamins said he wants a change in the insurer's policy, reimbursement for benefits denied, and attorneys' fees.

Kamins said he had to tap into his retirement fund to pay for extra visits for his son. After a year of ups and downs, including rehospitalization, the young man was able to return to college in the fall of 2013. The next year, his father's employer contracted with a new insurer, which Kamins said gave the young man greater access to care and helped him become stabilized. Now twenty-four, he is scheduled to graduate this fall. ^{WM}

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COST AND QUALITY

Integrating behavioral and physical health care is the key.

By Allison Hamblin

Behavioral health issues—mental illnesses and substance use disorders—rarely occur in a vacuum. Many individuals with mental illness or substance use issues also suffer from chronic physical ailments, including diabetes, asthma, and heart disease. All too often, physical needs are ignored due to unresolved and overwhelming behavioral health issues, resulting in costly and frequent emergency department visits and hospital stays. Likewise, many individuals who are hospitalized for acute medical conditions either have or may be at risk for developing a behavioral health condition. Among the highest Medicaid users of hospital care in New Jersey, for

example, 80 percent have a behavioral health diagnosis.

Spending for Medicaid recipients with a behavioral health diagnosis is nearly four times higher than for those without. The average yearly Medicaid costs for someone with diabetes, for instance, are below \$10,000 for those with no behavioral health condition but more than \$35,000 for those who have a mental illness and substance use issue. As many as one in five Medicaid beneficiaries has a behavioral health diagnosis, and this population accounts for almost half of total Medicaid expenditures.

Historically, the nation's health care safety net has separated treatment of physical and behavioral issues, treating body and mind independently and not providing "whole-person" care. This approach ignores the role of mental illness and substance use as a cause of many medical conditions. In some cases, this may be because behavioral health issues overwhelm an individual's ability to focus on physical health problems; in others, as can happen with substance use disorders, the medical conditions develop as a consequence of untreated behavioral conditions.

Stories of Medicaid beneficiaries are complex and diverse: Jerry, a fifty-two-year-old alcoholic who went on disability after a job-related injury and became addicted to opioids, has visited the emergency department fifteen times over the last year for gastritis and pancreatitis. Sharon, a forty-three-year-old grandmother with severe depression, diabetes, and spinal disc degeneration, became unable to manage her complex health needs and was hospitalized half

a dozen times within twelve months. Kevin, a homeless thirty-one-year-old with bipolar disorder, visits the emergency department frequently, and has been in and out of jail eight times in the last three years for disruptive behavior and petty crimes.

A prevailing theme for these individuals is their lack of access to coordinated physical and behavioral health services. State and federal policymakers are increasingly focusing on the need to better coordinate care for this population, not only to improve health and generate potential cost savings but also to help reduce homelessness, end the cycle of repeat jail visits, and improve this vulnerable population's overall quality of life.

Innovations made possible through the Affordable Care Act (ACA), plus growing recognition of the prevalence of behavioral health needs among high users of health care, are helping to integrate behavioral and physical health services. Under its Innovation Accelerator Program, launched in 2014, the Centers for Medicare and Medicaid Services (CMS) is helping states advance new payment and service delivery reforms, including efforts that seek to improve care for those with substance use disorders and co-occurring physical and behavioral health conditions. With CMS support, states are developing new data tools, quality measurement strategies, and payment arrangements that support more coordinated care.

Through the Mental Health Parity and Addiction Equity Act, health insurers must now cover behavioral health treatment at the same level as medical care. Under Medicaid expansion, states must provide newly eligible populations with more robust behavioral health benefits than they previously offered. A new federal initiative will create "certified community behavioral health centers," with heightened requirements for delivering integrated care to individuals with serious behavioral health needs. In addition, current regulatory reform efforts aim to reduce barriers to care coordination imposed by 42 CFR Part 2, a federal privacy law



governing the exchange of information related to substance use disorders.

On a parallel track, the urgency to address the many costs of poorly coordinated physical and behavioral health services is building at the state level. One of the key places this is playing out is in managed care, in which more than 70 percent of all Medicaid beneficiaries are enrolled. Traditionally, most states have excluded specialty behavioral health services from managed care arrangements, either leaving those services unmanaged or contracting with a separate entity to administer behavioral health benefits. A few innovator states, including Tennessee and Minnesota, have long integrated services within a single managed care plan to provide a more holistic focus, but until recently few other states have done so, due to the many complexities associated with this major system overhaul.

More recently, the momentum has increased, with at least sixteen states now providing or planning to provide behavioral health services within an integrated health plan. These states, including Arizona, Florida, Kansas, New York, and Texas, are testing care delivery models that make one entity accountable for physical and behavioral health services. With greater ability to identify and address a more complete array of health needs, as well as bottom-line incentives to prevent avoidable and costly hospitalizations, the end result promises to be more seamless care for beneficiaries.

Other innovations are springing up across states to better serve individuals with behavioral health needs, improve health outcomes, and reduce unnecessary health and social service outlays.

Medicaid “health homes,” for example, made possible under the ACA, give states a mechanism to pay for the intensive care coordination required for individuals with chronic conditions. Currently twenty-one states and the District of Columbia are operating a total of thirty health home programs for

high-risk patients, two-thirds of which specifically focus on adults with severe mental illness. These unique programs are not a physical home; they can be based in a primary care or behavioral health provider’s office or offered virtually. Wherever care is “housed,” services must include comprehensive care management, transitional care and follow-up, and referrals to community and social support services.

Missouri, for example, established Medicaid health homes throughout the state’s twenty-nine community mental health centers. Beneficiaries with behavioral health issues receive mental health treatment from providers who also coordinate medical treatment needs and provide links to social supports, functional skills training, and post-hospitalization services. With-

Jerry, a fifty-two-year-old alcoholic who went on disability after a job-related injury and became addicted to opioids, has visited the emergency department fifteen times over the last year for gastritis and pancreatitis.

in its first year of operation, the program has saved nearly \$100 per month per beneficiary, resulting in \$31 million in Medicaid savings linked to reduced emergency visits and hospitalizations and significant improvements in health outcomes.

Providing a personal connection with peers is one of the most successful strategies for gaining the trust and receptiveness of patients to seek and stay in mental health or addiction treatment. Project Engage, an initiative of Christiana Care Health System in Delaware, uses a team of individuals who have successfully recovered from addiction to build relationships with hospital patients with substance use disorders. Early results show that over 40 percent of patients seen through Project Engage successfully enrolled in substance

use disorder treatment, resulting in significant savings from reductions in hospital and emergency admissions. This program is now being replicated across several hospitals in Pittsburgh. A similar effort in Rhode Island targets individuals visiting the emergency department for an opioid overdose. The AnchorED program connects patients with peer recovery coaches who provide support and resources and, perhaps most importantly, a sympathetic ear. Since the program started, 80 percent of patients have engaged in some type of recovery services.

Because many individuals suffering from mental illness and substance use disorders cycle in and out of jail, connecting people to the care they need to avoid incarceration is a high priority for municipalities and states. For example, in May 2016, Maryland officials announced a first-ever proposal to reduce Medicaid eligibility requirements for individuals upon release from incarceration, with the goal of providing immediate coverage and access to needed services—including behavioral health treatments—upon reentry into the community. Individuals enrolled through this expedited process would receive coverage for sixty days, at which point standard eligibility determination requirements would resume.

At present there is no comprehensive fix to improve care for people with behavioral health issues. But through innovations occurring in states across the country, the health care system is moving toward whole-person care on many fronts. Ensuring that people get coordinated behavioral and physical health care will help to keep them out of the revolving door of emergency care and inpatient stays, improving the health and quality of life for many. ^{WM}

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BETTER POLICE TRAINING

Learning to interact with people living with intellectual or developmental disabilities.

By Harold Pollack

On January 12, 2013, Robert Ethan Saylor, a twenty-six-year-old man living with Down syndrome, went to see *Zero Dark Thirty* at a local theater in Frederick County, Maryland. He was accompanied by his attendant, Mary Crosby. When the movie ended, Crosby asked him if he was ready to go home. Saylor became angry, and Crosby called Saylor's mother for advice on managing the situation. Saylor's mother suggested that Crosby go get the car to give her son an opportunity to calm down.

While Crosby was gone, Saylor decided to go back inside the theater. He sat down in his original seat to watch *Zero Dark Thirty* a second time. Customers aren't supposed to do this, and he was asked to leave. Against Crosby's advice, a theater manager called three off-duty sheriff's deputies who were working security. Things got loud, and then physical as they grabbed the 300-pound Saylor and tried to drag him out. Saylor ended up on the ground in cuffs. He suffered a fractured larynx, and died. The Baltimore Chief Medical Examiner's Office ruled his death a homicide as a result of positional asphyxia.

The officers were never indicted. I believe that was the right call. I doubt these three officers had any desire to hurt Mr. Saylor, let alone to cause his death. That is precisely what makes such cases instructive and frightening. Indeed, the deputies' legal defense was that they had followed their training in their steady escalation of force.

Saylor didn't respond to the deputies' instructions in the way they want-

ed or expected and was clearly angry and frustrated, but he was sitting passively in his seat. They dealt with his disruptive and defiant—but non-dangerous—behavior by putting their hands on him



when they could have kept their distance and waited for him to calm down or for more-experienced help to arrive. His attendant was available to assist them; his mother was en route. This situation could have been managed without force. Instead, as a judge concluded, Saylor died over a \$12 movie ticket.

In this era of Black Lives Matter, protesters, ordinary citizens, policy-makers, and police are trying to find common ground in improving police training and procedures to defuse potentially violent situations of all kinds. Everyone involved in policing also understands that officers require better training, policies, and procedures when they encounter people in behavioral crisis. Many police departments are raising their game to deal with crises that arise from severe mental illness. I myself am involved in two Chicago efforts to reduce the use of force by police in such situations.

Less attention is paid to men, women, and youth who experience behavioral crises involving intellectual disability, autism, communication disorders, and other disabilities. Sometimes, as with Robert Saylor, the disabilities are obvious. Sometimes they are more hidden, or are merely one element in the mix. A disturbing number of violent policing incidents involve individuals living with intellectual and developmental disabilities (IDD). Baltimore's Freddie Gray, for example, appears to have been cognitively harmed by lead paint exposure, and Chicago's Laquan McDonald experienced a complicated mix of mental health challenges and learning disabilities.

This issue is of some personal interest to me. My wife, Veronica, and I are the guardians of her brother Vincent, who lives with an intellectual disability called fragile X syndrome (FXS), the most common heritable cause of intellectual disability. Men with this disorder

sometimes exhibit behaviors that may require interventions, including from law enforcement. In one national survey of caregivers of young people with FXS, one-third of parents reported that they had been injured, often repeatedly, by their sons.

Rebecca Feinstein and I recently surveyed forty middle-aged and older caregivers for individuals with fragile X syndrome. Personal safety was a common concern. One respondent had been pushed down the stairs and suffered a broken rib and punctured lung. Another reported, "He's not aggressive or violent just for the sake of it. . . . I know what triggers it. I spend the vast majority of my days working around knowing how to prevent something like that from happening." As long as the behavior was directed only at her, she had learned to live with it.

Some of the most poignant conversations occurred after the tape recorder was shut off. One mother described how her son had hurt someone in a random outburst and then fought with the police. I asked, "Why is he still living with you?" Her response was straightforward: The best residential placements won't take him because of these behaviors; the places that *will* take him include other young men who exhibit the same behavioral challenges. She was afraid for her son.

Caregivers' concerns are compounded by worry about how their sons might be traumatized, injured, or worse if they summon law enforcement help. They have good reason to be concerned; too many police departments haven't been educated on the issues associated with IDD.

Even positive or inclusive stereotypes don't always help. The population of individuals who live with IDD is diverse, experiencing conditions ranging from Down syndrome and other genetic disorders to the consequences of traumatic brain injury and fetal alcohol syndrome. Some of these disabilities are easily recognized, but others are more subtle or are accompanied by

physical or psychiatric comorbidities, including some that bring them into conflict with others or into contact with police.

Basic improvements to training and procedures can make a big difference. Dr. Bruce Davis, the director of behavioral and psychological services at Tennessee's Department of Intellectual and Developmental Disabilities, and his colleagues offer useful strategies for officers to slow situations down, to use time and distance to keep everyone safe from avoidable physical confrontations. I asked Davis what he was trying to accomplish with this training. "One thing I try to do . . . is to turn around the idea that the successful intervention is a collar, or an arrest," he said. "We turn it into the idea that a successful interaction is a de-

A successful police intervention can be a de-escalation that keeps everyone safe from avoidable physical confrontation rather than a collar or an arrest.

escalation. We talk about *quiet authority* and how much more effective that can be in working with many people, particularly a person with intellectual disabilities. . . . It's a reconceptualization of the police officer's role."

Davis also teaches officers about some of the health problems that individuals with IDD may experience when they are physically restrained. One critical principle is to restrain resistant subjects on their sides rather than face-down, and to monitor the restrained person's face for signs of distress. Many deaths occur because officers restrain someone in a prone position, and then apply pressure to the neck, back, or chest in ways that can cause lethal asphyxiations or positional asphyxiation. Many people with IDD experience respiratory disorders, GI reflux, or mor-

phological defects that make prone restraints especially dangerous.

Sometimes, interpersonal conflicts occur at private residences or group homes because a staff member or caregiver has become overly controlling or has otherwise precipitated conflict. Davis related one case in which a group home resident became angry and unruly because the staff had gotten rid of his pet dog. Family caregivers and staff in residential facilities can also work with local police ahead of time, informing police of a person's specific disabilities and behavioral challenges and formulating a crisis plan.

Not long ago, Vincent wasn't feeling well. He wanted to go to the hospital. So an ambulance was sent to his group home. As usual in such cases, a police officer arrived to help. At some point, Vincent decided that he wanted to slide from his chair onto the floor. The floor was cold and dirty, and Vincent is clumsy. So the officer tried to help by gently pushing on Vincent's shoulders to keep him in the chair. But Vincent didn't like that, and resisted. Fortunately, Veronica was there to help, and the incident was resolved peacefully. But it's scary to think about how this mundane occurrence could have instantly become life-changing for everyone. Vincent is a strong 250-pound man who doesn't always realize the consequences of what he does. My mother-in-law occasionally had marks on her arms because he would flail at her with the back of his hand when he got frustrated.

Vincent didn't pose safety issues in the three years he lived with us; he is blessed with a sweet disposition, and is wonderfully gentle with Veronica and our two daughters. Still, the possibility of behavioral crisis remains in the back of our minds, in the queue of anxieties and worries. As does our concern about whether it would even be safe or wise to summon law enforcement help. ^{WM}

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