September 30, 2013

The Honorable Max Baucus
Chairman, Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member, Senate Finance Committee
United States Senate
Washington, DC 20510

Re: Response to Request “Better Solutions for Mental Illness”

Dear Mr. Chairman and Ranking Member Hatch:

On behalf of the American Psychoanalytic Association (APsaA), one of the oldest mental health practitioner professional associations in the country, thank you for your letter of August 1, 2013 (a) recognizing that access to mental health care can be a matter of life or death; (b) that mental health care is cost effective for individuals and for the nation; and (c) seeking better solutions for access to needed mental health care.

You have asked generally how we can improve the mental health system in the United States and, more specifically, what administrative and legislative barriers prevent Medicare and Medicaid recipients from obtaining the mental health care they need, what key policies have led to improved outcomes for beneficiaries in programs that have tried integrated care models, and how Medicare and Medicaid can be cost-effectively reformed to improve access to quality mental health care?
General Ways to Improve the Mental Health System

With this letter we provide concrete solutions, backed by extensive research and clinical practice that Congress can take now.

We address your more general question first—how can we improve the mental health system in the United States? Any discussion of mental health in the United States must begin with the mass murders of the innocent children and adults at Newtown and the Navy Yard by severely and obviously mentally ill individuals. There can be no more pressing mental health reform issue than providing better access to mental health care that diminishes the potential for these tragedies to be repeated. By coincidence, many of the findings and recommendations in this letter were mentioned in a “60 Minutes” segment on September 29, which included the following statement:

In the words of one of the country’s top psychiatrists, these were preventable tragedies, symptoms of a failed mental health system that’s prohibited from intervening until a judge determines that someone presents an “imminent danger to themself or others.” The consequence is a society that’s neglected millions of seriously ill people hidden in plain sight on the streets of our cities, or locked away in our prisons and jails.¹

We agree with the statement in your letter that “there is reason to remain positive,” and that better solutions are available, but Congress must recognize the nature of the problem if it is going to devise an effective solution. While less than 4% of those suffering from mental illness are violent, more than half of the mass murderers over the past 30 years have suffered from severe mental illness over an extended period of time and have legally purchased the guns they used in the

killings. Nearly all of the mass shooters over the past 15 years have been severely mentally ill. These individuals do not “just snap,” but rather have suffered from severe mental illness for a period of months or years prior to the shooting and have revealed evidence to others of their worsening conditions.

We also know that there are certain danger signs or indicators which reveal when a mentally ill individual is becoming a serious risk for violence. The predictive ability of such danger signs is not perfect, but as the President said at Newtown, “Surely we can do better than this.” Mental health researchers have reached a similar conclusion.

Recognizing these facts provides an opportunity to identify and get these individuals into treatment before they are shooting the lock off of an elementary school house door.

The solution to reducing violence by the mentally ill is not blindly throwing more money at mental health treatment in general, but rather by making more

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5 President Barack Obama at Newtown, Connecticut (Dec. 16, 2013).
efficient and focused use of the programs we have.\textsuperscript{7} One leading researcher has observed that any mental health reform must include “connecting the dots” about mental illness and violence:

\textbf{Stigma and Violence: Connecting the Dots}

- Stigma Against Individuals With Mental Illnesses has Increased Over the Past Half Century.
- Violent Acts Committed by Mentally Ill Persons Have Increased Over the Past Half Century.
- The Perception of Violent Behavior by Mentally Ill Persons is an Important Cause of Stigma.
- Most Episodes of Violence Committed by Mentally Ill Persons are Associated With a Failure to Treat Them.
- Treating People With Serious Mental Illnesses Significantly Decreases Episodes of Violence.
- Reducing Violent Behavior Among Individuals With Mental Illnesses Will Reduce Stigma.\textsuperscript{8}

It is possible to equip parents, teachers, and other members of the public with the danger signs for violence in the mentally ill so they can be referred to qualified mental health professionals, and equip mental health professionals with the criteria for determining whether an individual is a serious risk for violence so that these individuals can obtain help before committing “suicide by cop.” It must be remembered that the mentally ill mass shooters to date have not been “close cases”—they have suffered from severe mental illness that any competent mental health practitioner could have been expected to diagnose.

\textsuperscript{7} Id.
\textsuperscript{8} “Stigma and Violence: Isn’t It Time to Connect the Dots?” E. Fuller Torrey, Mental Health Policy Org. (June 7, 2011), \url{http://mentalillnesspolicy.org/consequences/stigma.html}. 
If we are going to equip the public and practitioners with better tools for identifying the mentally ill who are a serious risk for violence, we also need to make the process for getting such individuals into treatment more clear and less burdensome on family members and practitioners. Currently, it is virtually impossible to have a potentially dangerous mentally ill individual involuntarily committed unless they are an “imminent threat” for violence as shown by “clear and convincing evidence.”\textsuperscript{9} Other nations, such as England and France, have adopted a “need for treatment” standard which considers the threat for violence and allows an individual to be held for evaluation if a team of physicians and mental health professionals agree.

According to one state mental health official:

“Our civil commitment laws are broken. They are designed to protect individuals from being held against their will. But they have gone too far. They no longer protect society. We’ve had many cases where people who should have been hospitalized have been allowed to languish and they deteriorate into a violent act.”\textsuperscript{10}

The Executive Director of the County Behavioral Health and Developmental Disability Directors has observed that,

“If someone has cancer, they shouldn’t have to wait until they have acute cancer and be dying in the next two weeks before we give them care. But that’s how we operate the mental health system.”\textsuperscript{11}

\textsuperscript{10} “Committing a Mentally Ill Adult is Complex”, USA Today (Jan. 7, 2013), http://www.usatoday.com/story/news/nation/2013/01/07/mental-illness-civil-commitment/1814301/.
\textsuperscript{11} Id.
Even if a patient is involuntarily committed, the average length of stay is five to seven days which is generally not long enough to provide them with effective treatment.12

Our inability as a nation to deal with these issues calls for clear laws that provide insurance coverage and payment for effective treatment of the mentally ill who are a risk for violence. Currently, health insurance plans often refuse to provide coverage for extended inpatient or intensive outpatient psychiatric care, leaving patients and family members with crushing debt.13 Most of the mentally ill who are a risk for violence are young men who are not eligible for Medicaid because they are not custodial parents and not veterans. Further, Medicaid does not cover inpatient care for working age adults at psychiatric facilities with more than 16 beds, under the “institution for mental disease” (IMD) exclusion.14 This provision has provided an incentive for states to accelerate the closure of mental health hospitals.15 Forty state mental hospitals closed their doors between 1990 and 1997. These closures resulted in jails becoming the inpatient mental health treatment facilities of first choice. According to the Department of Justice, nearly 300,000 mentally ill individuals are locked up in the nation’s jails and prisons.16

While it would take years and significant investment to restore the capacity for involuntary commitment of the severely mentally ill, there are programs of more intense mental health services that are relatively low cost and can be implemented immediately. See for example, the Liaison Health Officer Program sponsored by the Department of Justice in six cities, and the Forensic Assertive

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12 Id.
14 “Reality-Based Mental Health Reform,” supra.
16 Id.
Community Treatment (FACT) program that has reduced jail days by 41% and convictions by 19% among the severely mentally ill.\textsuperscript{17}

Some researchers believe that implementation of mental health parity under the Affordable Care Act (ACA) provides an opportunity to make mental health services more accessible to the mentally ill who are a risk for violence but only if “the new law gets translated into regulations and on-the-ground policies that actually address the problems we face.”\textsuperscript{18}

Mental health and substance use disorders services are part of the “essential benefits” that qualified health plans must offer under the ACA, and it is difficult to imagine a more “essential” benefit than one that reduces the potential for mass shootings. As the parents who lost children at Newtown can attest, focusing mental health services on those who are a risk for violence should be a national imperative.

Finally, we can, and must do a better job of keeping the severely mentally ill who are a risk for violence from purchasing or possessing guns. The mental health “prohibitor” in the National Instant Criminal Background (NICS) check system is ineffective in that it captures the names of the mentally ill who are not a threat for gun violence, and does not require the reporting of those who are a threat for gun violence. For example, none of the mentally ill mass shooters over the past 15 years, with the possible exception of the Virginia Tech case, would have been reported to the NICS background check system even if the states had complied with the reporting requirements. The Safe Communities, Safe Schools bill (S. 649), which failed to pass the Senate in April, would not have prevented many, if any, mass shootings by the mentally ill, including the Navy Yard shootings.\textsuperscript{19} Few of the mentally ill mass shooters have been “adjudicated as a mental defective” or “involuntarily committed to a mental institution.”\textsuperscript{20} Thus,

\textsuperscript{17} “Police Program Aims to Prevent Violence Among the Mentally Ill,” Wisconsin State Journal (Jan. 11, 2011) http://host.madison.com/wsj/news/local/crime_and_courts/article_6d637002-1d7b-11e0-91d5-001cc4c002e0.html; “Reality-Based Mental Health Reform,” supra.
\textsuperscript{18} “Reality-based Mental Health Reform,” supra.
\textsuperscript{20} 18 U.S.C. 922(g)(4).
S.649 would have required the collection of more meaningless data leaving the mass shootings by the mentally ill to continue unabated. Clearly, Congress can do better than this.

Ways to Improve Mental Health

So the “solutions” you have requested with respect to mass shootings by the severely mentally ill should include the following:

1. Require stakeholders to develop and distribute of a short list of danger signs and indicators for use by parents, teachers, and other members of the public that mentally ill individuals are a serious risk for violence. (These danger signs might include:

   (a) thoughts or threats of physical or sexual aggression or homicide,
   (b) past record of physical or sexual aggression and threats of homicide,
   (c) current or past record of mental illness,
   (d) impulsivity, including anger management issues,
   (e) fascination with, and access to, firearms, and
   (f) commonly isolated or socially withdrawn.)

2. Require stakeholders to create and distribute to mental health professionals of a list of commonly accepted criteria for use in determining when a mentally ill individual poses a serious risk for violence.

3. Establish a process for mentally ill individuals who have been determined to be a serious risk for violence to obtain mental health treatment, either voluntarily or through involuntary commitment.

4. Revise the NICS mental health “prohibitor” so that individuals with mental illness who have adjudicated a serious threat for gun violence are reported to that database and those who do not pose such a risk
do not have their names reported (with full access to effective Due Process rights to have one’s name removed from the database).

5. Re-title the National Instant Criminal Background data base so that it does not characterize mental illness as a “criminal” activity. Reporting the mentally ill to a “criminal” data base further stigmatizes mental illness.

**Ways to Improve Mental Health Under Medicare and Medicaid**

Many psychiatrists and psychologists have opted out of Medicare and do not accept Medicaid patients because (a) reimbursement is “slow and low,” (b) the rules covering payment of claims are complex and difficult to understand and it is difficult to obtain accurate information from Medicare contractors, and (c) there are increasing fears of being subjected to an audit which may lead to a lengthy appeal process. New billing codes that went into effect in January of 2013 often do not relate to the complex mental disorders confronted by mental health practitioners.\(^{21}\)

Medicare has an “opt out” provision, but it requires a practitioner who wishes to accept private payment from a single patient to execute an affidavit swearing that they will not accept Medicare payment for any Medicare beneficiary for a period of two years.\(^{22}\) Even with this onerous requirement, nearly 43% of practitioners opting out of Medicare are in the specialties providing psychiatric care.\(^{23}\) Roughly 40% of practicing psychologists do not accept Medicare and 55% do not accept Medicaid.\(^{24}\)

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\(^{22}\) 42 U.S.C. § 1395a(b).


The requirement that practitioners agree to not accept Medicare payments for any beneficiaries in order to accommodate the wishes of a single patient creates a barrier to access to needed mental health services for Medicare beneficiaries. Congress should allow mental health practitioners to accept private payment for any Medicare beneficiary without having to opt entirely out of Medicare for all beneficiaries. This makes even more sense now that Congress has passed a provision in the HITECH Act that allows individuals to obtain restrictions on the disclosure of health information if they pay out of pocket for the services. The right to pay privately should also be included in the Affordable Care Act for all qualified health plans under the Access to Therapies section.25 Congress should also require Medicare contractors to provide prompt, accurate information about billing for mental health services and penalize the contractors who fail to perform.

We welcome the opportunity to work with you to achieve any or all of the mental health reform solutions we have outlined.

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25 HITECH Act, section 13405(a).
26 Affordable Care Act, section 1554.