THE PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH: TRANSFORMING MENTAL HEALTH CARE

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I. INTRODUCTION

President George W. Bush announced the President's New Freedom Commission on Mental Health, the first presidential mental health commission in twenty-five years, on April 29, 2002, in a speech in Albuquerque, New Mexico. This Article describes the workings and recommendations of the Commission with a focus on problems and opportunities at the interface of mental health care, the law, and criminal justice.

An Executive Order signed by the President outlined the Commission's charge: "The mission of the Commission shall be to conduct a comprehensive study of the United States mental health services delivery system, including public and private providers, and make recommendations to the President."[1] The Executive Order also stated, "The goal of the Commission shall be to recommend improvements that allow adults with serious mental illness and children with serious emotional disturbance to live, work, learn, and participate fully in their communities."[2] This focus on practical outcomes desired by consumers, families, and communities opened the door for examining implications for criminal justice; people with mental illness are not "participating in their communities" if they are incarcerated or engaged in criminal conduct—perhaps because their care was inadequate, or poor collaboration existed between mental health and law enforcement personnel.

II. BACKGROUND AND FRAMEWORK FOR THE COMMISSION

Then-Governor George Bush, during the presidential campaign, pledged to create a commission to review mental health care. The first mention of the commission after the new administration took office was in a broad cross-disability action plan called the New Freedom Initiative, announced by the White House in February 2001. The initiative included ten proposals designed to "tear down the barriers that face Americans with disabilities today," and included an announcement that the mental health

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1 Exec. Order No. 13263, 67 Fed. Reg. 22337 (Apr. 29, 2002).

2 *Id*.

commission would be created.[3] Some New Freedom Initiative programs were launched in the first months of the administration. With the appointment of Charles Curie to head the Substance Abuse and Mental Health Services Administration (SAMHSA) in November 2001, the work to develop a framework for the commission could proceed.

National commissions examining mental health care are a rare occurrence. It has been a quarter-century since the Carter Commission, and more than two decades before that since the Joint Commission on Mental Health. Federal laws and regulations govern the operation of Commissions. The key laws are the Federal Advisory Committee Act (FACA) and the Freedom of Information Act (FOIA). These laws ensure that decisions by these bodies are made in the open, with appropriate public notice, and that records are public. A commission staff member is designated as the "FACA officer" responsible for assuring compliance and authorized to shut down a meeting if the law is violated. Once the core elements of a commission are in place, a federal agency, in this case SAMHSA, is designated to provide administrative support, and a charter establishing a budget and administrative parameters for the commission is approved by the relevant cabinet secretary.

III. DEVELOPING THE PLAN FOR THE COMMISSION'S WORK

The leadership for the Commission reflected on how to proceed with the daunting task set by the President, within the mere twelve months allowed for the task. Lessons from the experiences and results of the Carter Commission were still relevant a quarter century later. However, mental health care has changed dramatically. Deinstitutionalization accelerated, and the role of the federal government in financing care changed dramatically. Public sector mental health care was devolved to localities, new somatic and psychosocial treatments were developed, and authority and responsibility were made much more diffuse. The core problems in mental health care shifted from the heart of the state-managed public mental health system—specifically poor quality in and overuse of state hospitals—to settings in other systems such as jails and prisons, primary care, schools, and among the homeless.

A. *The Law and Mental Health.*

Two sets of issues at the intersection of the law and mental illness are notable for how they have evolved in the past quarter century. First, the laws undergirding care and treatment for those with mental illness were in flux in the late 1970s, and are considerably more stable today. The

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[3] President George W. Bush, *Forward* to the New Freedom Initiative (Feb. 1, 2001), *available at* http://www.whitehouse.gov/news/freedominitiative/freedominitiative.html.

Supreme Court's 1975 decision in *O'Connor v. Donaldson*[4] set in motion changes in state legislation governing involuntary commitment to hospitals. The essence of that decision—that people with mental illness, having committed no crime and presenting no imminent danger to themselves or others, cannot be involuntarily committed to an institution—led to changes in commitment law emphasizing those criteria that still justify commitment, including danger to self or others by reason of mental illness. The subtle, but very significant changes required by these laws, including care in different settings, lessened social control, and a move away from institutions, were playing out in the late 1970s.

At the same time, the deinstitutionalization movement was leading to major changes in the law regarding the structure, auspices, and organization of mental health care in the states. Ohio's mental health law is typical. Following the 1963 federal legislation signed by President Kennedy that began to emphasize community care, Ohio's 1967 legislation created a network of county-level boards to govern and manage community care. However, these boards had no control of state hospital usage or funds. Two decades later, the Mental Health Act of 1988 transferred control over institutional usage and funds to the boards, creating a unified governance approach. Thus, both dimensions of the mental health law were in flux in the late 1970s, and the changes that would result from legal reform were unknown at that time.

A second concern at the intersection of law and mental health is what has been termed the "criminalization" of mental illness. This problem is often expressed in terms of the many mentally ill individuals in prisons, many more than are in mental hospitals. There is no credible evidence, however, that the percentage of mentally ill inmates—about seventeen percent of the overall prison population—has changed much over the years. Nonetheless, the number of mentally ill individuals who come in contact with the police, the courts, and the jails is staggering. This dynamic is universally agreed to represent a failure of social policy, although the cause of the problem, deinstitutionalization, inadequate community care, and low-income housing, welfare reform, or changes in the mental health commitment laws, is fiercely debated.

The commission's work also follows major scientific and policy thrusts in mental health, including the Decade of the Brain, the White House Conference on Mental Health, and the reports of the Surgeon General on Mental Health, disparities in care for minorities, and suicide. These efforts elevated awareness of mental health issues but did not address the implications for care systems. The commission would need to consider scientific advances, and link them to the "real world" of mental health care. Finally, there were many new fiscal and political realities that

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[4] 422 U.S. 563 (1975).

the commission would need to consider, such as the dynamics of the federal budget and the reality of future projected budget deficits.

Our early review of the work of the Carter Commission included conversations with Executive Director Tom Bryant. It was evident that the impact of the Carter Commission went beyond making recommendations. Given the rare occasion of presidential attention on mental health, using the commission's processes and report to galvanize change at all levels, not just the federal government, became an imperative.

A particularly useful resource to understanding the impact of the Carter Commission was an inventory of the progress made following its report and the National Plan for the Chronically Mentally Ill[5] that followed. This review pointed out that many changes were achieved through staged, incremental, mid-range modifications to mainstream federal programs such as Medicaid, Medicare, and Social Security rather than through "big bang" reform measures, or increased support for specific mental health programs. In fact, the centerpiece of the follow-up to the Carter Commission report was the Mental Health Systems Act, enacted in the waning months of the Carter administration and then rolled back in the first budget under President Ronald Reagan. Ironically, the major recommendation and "accomplishment" of the Carter Commission was thus ephemeral, while "smaller" recommendations developed after the commission itself had a bigger impact.

These experiences of an earlier commission shaped our thinking. We were determined to create and develop detailed reports on components of mental health care through commission subcommittees. These reports, published later as working papers, could help create an agenda that could serve the field well in future years. However, they would also help the commission cover many aspects of a diverse field efficiently, and inform the report to President Bush. Engaging experts to advise the commission subcommittees would provide a deep level of knowledge on each issue, balancing the practical and clinical experiences of commissioners. And the subcommittees would provide an opportunity for leadership by commission members on topics important to them. A listing of the commission's subcommittees is provided in Table 1.

TABLE 1: COMMISSION SUBCOMMITTEES

Employment and Income	Housing and Homelessness
Older Adults	Children and Families
Evidence Based Practices	Cultural Competence
Medicaid and Medicare	Criminal Justice
Consumer Issues	Rights and Engagement

[5] Koyanagi & Goldman, *The Quiet Success of the National Plan for the Chronically Mentally Ill*, 42 HOSPITAL AND COMMUNITY PSYCHIATRY 899-905 (1991).

Rural Issues	Medications
Interface with General Medicine	Suicide Prevention
Co-Occurring Disorders	Acute Care

The subcommittee on the interface of mental health care and criminal justice was efficient and productive. It was chaired by Judge Ginger Lerner-Wren, who runs perhaps the first and one of the best-known and researched mental health courts in Broward County, Florida. The subcommittee had the benefit of Henry Steadman as a consultant, one of the best-informed people on the issue. He wrote a very crisp paper that summarized the issues resonating with members of the subcommittee.

There are three broad concepts that emerged on the link with criminal justice that are reflected in the report to the President. First, mental health and law enforcement and the courts in local communities should collaborate to engage people with mental illness who may have committed criminal acts and to divert them, if appropriate, into supervised treatment rather than incarceration. These diversion alternatives include police crisis-intervention teams specially trained to work with people who are mentally ill and collaborate with local mental health providers or mental health courts. In these specialty courts, or more frequently specialty dockets, judges who have case managers and treatment people available hear cases of defendants who have a mental illness. The judges make dispositions for treatment in lieu of trial and sentencing. The second concept is that if mentally ill people commit crimes and are tried and found guilty and incarcerated, they are entitled to get constitutionally-required levels of mental health care while they are incarcerated. The third emerging principle is that when these mentally ill offenders are about to be released, linkages to mental health care and to housing on discharge are critically important.

The commission would need to assure ample input from the public, and work closely with advocacy and professional organizations. An interactive web site was set up to receive public comments, allowing more than 2,300 individuals to submit concerns and ideas via e-mail. Time would be set aside in every meeting for public comment. Commission leadership met with the Mental Health Liaison Group (MHLG), representing the organizations with a public policy/lobbying presence on mental health in Washington. Lead members of the MHLG developed shared recommendations for the commission to consider. Out of these efforts, advocates created a new coalition, the Campaign for Mental Health, to "speak with one voice" on the commission's recommendations and other mental health advocacy issues. To help achieve broader input and visibility, the commission held two meetings "on the road," one in Chicago with a focus on children's issues and one in Los Angeles with focal points of attention on criminal justice, housing, and homelessness

issues. Several early meetings were televised on C-SPAN, adding greatly to the commission's visibility.

IV. INTERIM REPORT

The President's Executive Order creating the commission required submission of an interim report six months from the beginning of the commission's work. This report was to "describe the extent of unmet needs and barriers to care within the mental health system and provide examples of community based care models with success in coordination of services and providing desired outcomes."[6] The Interim Report[7] identified five major barriers to care, listed in Table 2.

TABLE 2: BARRIERS TO CARE

BARRIER 1	Fragmentation and Gaps in Care for Children with Severe Emotional Disturbance
BARRIER 2	Fragmentation and Gaps in Care for Adults with Serious Mental Illness
BARRIER 3	High Unemployment and Disability for Adults with Severe Mental Illness
BARRIER 4	Older Adults with Mental Illness Are Not Receiving Care
BARRIER 5	Mental Health and Suicide Prevention Are Not Yet a National Priority

In the interim report, to make clear the scope of its concern, the commission stated that "[t]he system is in shambles."[8] This strong language was criticized by some as too strong, but generally the feedback was that "finally, someone is telling it like it is." This strong indictment of a failed system—thwarting the efforts of many talented and dedicated clinicians—set the stage for strong recommendations in the final report.

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6 Exec. Order No. 13263, 67 Fed. Reg. 22337 (Apr. 29, 2002).

7 President's New Freedom Commission on Mental Health, *Interim Report to the President* (Oct. 29, 2002), *available at* http://www.mentalhealthcommission.gov/reports/interim_toc.htm.

8 *Id.*

V. A UNIFYING THEME: RECOVERY

The theme of recovery continued to emerge in the commission's deliberations, although it was discussed with many meanings and implications. To a layperson, recovery may be thought of as an end state of complete wellness and freedom from illness. This view attracts concern and criticism as well as support. To some, it implies hope, while to others it denies the reality of serious mental illness. For the commission, a more universal idea of recovery emerged from testimony and input from individuals with mental illness, who tended to describe recovery as a process of positive adaptation to illness and disability, linked strongly to self-awareness and a sense of empowerment. This view of recovery aligns with a definition by Anthony (1993), stating: "[Recovery] is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."

The commission grappled with the multiple meanings of recovery, and came to a shared view that the possibility of improvement and hope should be available to all with a mental illness, that complete improvement/remission would be achieved by some, and that the spirit of hope implicit in recovery is important. In an informal presentation to the commission, former First Lady Rosalyn Carter helped clarify the issue. She commented on what she described as "the biggest single difference in mental health now, compared with the time of our commission—today, we know that recovery is possible for every person with a mental illness."[9] These remarks helped bring the commission to a shared perspective. Recovery had been validated in the Surgeon General's Report,[10] been used by the President to describe an acquaintance's good outcomes in remarks during the commission's launch in Albuquerque, and now was offered as a new paradigm by a former first lady and long-term mental health advocate. The commission determined that recovery too often thwarted today by a fragmented system should become a defining expectation of future mental health care.

VI. THE FINAL REPORT

The main requirements for the commission's final report, including mission, goals, and principles, were specified in the Executive Order. The hope of recovery had emerged as an organizing theme. Each of the

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[9] First Lady Rosalyn Carter, *Presentation* to the New Freedom Commission on Mental Health (2003).

[10] 1999 SURGEON GENERAL, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 45-49.

subcommittees advanced recommendations. Then, the commission turned its sights to overarching issues and cross-cutting recommendations that would address the problem of fragmented care identified by the President.

The impact and magnitude of fragmentation had hit home during the commission's deliberations. Fragmentation was the most frequently mentioned in e-mails to the commission. In the words of a father who spoke of his family's experiences at the Chicago meeting, "The system is opaque." And fragmentation emerged as an unintended consequence of earlier reforms. No less than forty-two different federal programs that might be used by individuals with mental illness were identified in our review.[11] These programs are administered through many different state and local agencies, often with different eligibility and application requirements. The consequence is that access to necessary elements of care is scattered. Often consumers or families are responsible for coordinating supports and services, often at times of crisis when their ability to accomplish this task is most compromised.

Another problem is that many of the federal programs that are most crucial to individuals with a mental illness are mainstream programs such as Medicare, Medicaid, Social Security programs, vocational rehabilitation, housing, and special education where mental illness is just one of a wide range of concerns. This compares with the old institutional model of care. Asylums were abandoned because they were costly, ineffective, and restrictive. However, all services that were provided were provided, literally, under one roof. The new "system" is scattered by comparison. Often, individuals with mental illness fare poorly in mainstream programs compared to other individuals. Examples include the high and rapidly growing number of individuals with mental illness-related disability in Social Security programs, and the poor outcomes of emotionally-disturbed children and mentally ill adults in special education and vocational rehabilitation, respectively, compared with persons with other disabilities in these programs. The scope of many of these mainstream programs is far greater than that of the only major federal program supporting mental health care, specifically the Mental Health Block Grant. And a consequence of these failures is that people with mental illness are unintentionally extruded into homelessness, and end up incarcerated.

The complexity of these problems, and the consequent complexity of making change in mental health care, is daunting. Multiple programs in multiple federal agencies are involved, yet most care is managed by states and localities. The various programs are governed by different statutes, shaped by diverse congressional committees, and "guarded" by multiple

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[11] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America, Final Report* (2003), *available at* http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html.

constituencies. The political dynamics between layers of government tend to frustrate comprehensive reform. No single reform measure is sufficient to achieve needed change. Faced with this challenge, the commission began to grapple with an approach to change that would be both aggressive, because of the scope of the problem, and realistic, given the inherent challenges of change in this context.

A. *Transforming Mental Health Care*

The commission grappled with the challenge of how to approach these problems. Since mental health care is financed and provided in both the public and private sectors, solutions do not rest solely with government. In the federal arena, multiple programs and agencies are involved, so substantial change cannot be leveraged in just one place. And finally, most financing of public sector care is federal, but services are managed at the state and local levels. Therefore, change in public sector services requires change at every level of government. As the commission considered how to describe and frame needed change, a consensus emerged. In the words of the final report, "traditional reform measures are not enough to meet the needs of consumers and families. To improve access to quality care and services, the commission recommends fundamentally transforming how mental health care is delivered in America."[12] By this, the commission implies that many changes, linked together and implemented over time at many levels, are required to achieve the outcomes established by the President.

B. *National Goals for Mental Health*

The commission sought an approach to organize and motivate the transformation of the system, recognizing that it would make many recommendations for change across multiple programs, and that years would be required to effect needed changes. We propose six national goals or desired conditions for mental health and mental health care in a transformed, future mental health system, to organize the recommendations and create benchmarks to monitor. The proposed goals are listed in Table 3.

TABLE 3: PROPOSED NATIONAL MENTAL HEALTH GOALS

GOAL 1	Americans understand that mental health is essential to overall health.
GOAL 2	Mental health care is consumer and family driven.

[12] *Id.*

GOAL 3	Disparities in mental health are eliminated.
GOAL 4	Early mental health screening, assessment and referral to services are common practice.
GOAL 5	Excellent mental health care is delivered, and research is accelerated.
GOAL 6	Technology is used to access mental health care and information.

VII. THE COMMISSION'S RECOMMENDATIONS FOR CHANGE

The commission proposed nineteen major recommendations. Many other proposals for change, and action steps to achieve the recommendations, are included in the report. The major recommendations address changes that are needed, and in many cases achievable, at every level of the system, from consumers and families to public and private providers to government at the local, state, and national levels. As in the commission's final report, the recommendations are organized under the proposed national goal that they support.

A. *Goal 1: Americans Will Understand That Mental Health Is Essential to Overall Health*

This goal echoes the Surgeon General's Report on Mental Health and calls for mental health to be recognized as a crucial component of personal health, and for mental health care to be viewed as an essential aspect of health care. Two recommendations are proposed to support this goal. First, recognizing that stigma remains a barrier to seeking care, the commission proposes a series of campaigns to encourage people to seek treatment if they suspect that they might have a mental illness. The commission also proposes implementation of the National Strategy for Suicide Prevention.[13] The commission's desire is to encourage people needing treatment to seek it. This will be good for their health and will eventually help erode stigma as more people experience positive results. The recommendation to advance the national strategy for suicide prevention seeks to accelerate the positive momentum that is developing from advocates for suicide prevention. The commission also believed that the scope of suicide, which causes more deaths annually world-wide than homicide or war,[14] demands action and presents an opportunity to

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13 *Id.*

14 World Health Organization, *World Report on Violence and Health* (2002).

demonstrate the public health relevance of mental health care. The remarkable campaign by the U.S. Air Force to decrease suicide in its ranks[15] is one of the model programs cited by the commission.

The second recommendation under this goal is to address mental health with the same urgency as physical health. This recommendation addresses not only personal health behavior, but mental health care in the context of health care. It calls for many changes in the nation's major health care programs such as Medicare and Medicaid to appropriately include provisions for mental health care.

B. *Goal 2. Mental Health Care is Consumer and Family Driven*

This goal is perhaps the most complex of those proposed by the commission, with recommendations that touch care from the clinical to the national levels. There are five recommendations, many complex, to achieve this goal. The recommendation to develop an individualized plan of care for every adult with serious mental illness and child with serious emotional disturbance is an example. This recommendation—requiring changes at many levels and in many programs—addresses two issues. The first is the responsiveness of the system, which the commission believes can be increased by providing for more choice on the part of consumers and families. The second is the fragmentation of care, which ironically increases with the complexity of needs. Coordinated care planning, carried out in many "wraparound" programs for youth (such as the Wraparound Milwaukee program identified as a model by the commission) attacks this problem by bringing multiple caregivers together with the child and family to develop a single coordinated plan. A second recommendation, to involve consumers and families fully in orienting the mental health system toward recovery, recognizes the value of self-help and peer support, consumer and family education programs, and of including consumers and families in every level of the system.

The recommendation to align relevant federal programs to improve access and accountability for mental health services is broad, and touches on changes in multiple programs, including Medicaid, vocational rehabilitation, Social Security, housing, and criminal justice programs. Specific changes are recommended in these programs, but the commission expects an ongoing effort to better tailor these programs to meet the needs of people with mental illness.

Changes in federal programs financing mental health care are also required to achieve the recommendation to create a Comprehensive State Mental Health Plan. States are now required to develop mental health plans as a condition of receiving Mental Health Block Grant funds. However, the scope of the plans, like the block grant itself, is limited. To

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[15] D.A. Litts et al., *Suicide Prevention Among Active-Duty Air Force Personnel*, 48 MORBIDITY AND MORTALITY WEEKLY REPORT, 1053-1058.

achieve needed changes in mental health care (recognizing that most funding is in mainstream programs like Medicaid, Medicare, and Social Security, which are not controlled by state mental health authorities), the scope of state mental health planning could be elevated. But flexibility in relevant federal programs should be provided in return for increased accountability. This recommendation is a key strategy to address mental health problems outside the boundaries of the mental health agency. Achieving change for people with mental illness among the homeless, in jails, prisons, and in the juvenile justice and child welfare systems will also take concerted action over many years to achieve.

The final recommendation under this goal is to protect and enhance the rights of people with mental illnesses. Although service delivery problems were a focus of the commission, consumers consistently emphasized rights as perhaps their top priority, and the abrogation of rights as the ultimate form of stigma. This recommendation calls for eliminating institutionalization and the use of seclusion and restraint where they are clinically unnecessary, ending employment discrimination (with the federal government providing leadership by implementing, for example, employment questionnaires that inquire about histories of mental health care) and ending the terrible practice of "trading custody for care," where parents relinquish custody in order to obtain Medicaid-paid services that are available to children in foster care.

C. *Goal 3: Disparities in Mental Health Services Are Eliminated*

Following earlier work such as the *Surgeon General's Report, Mental Health: Race, Culture and Ethnicity*,[16] the commission found that disparities in both the access and quality of care that minorities receive remains a persistent problem. This problem is mirrored for residents of rural areas. Transforming care under this goal requires improving access to quality care that is culturally competent. For minority populations, and frequently in rural areas such as in frontier states and Appalachia, improving mental health care means improving access and clinical quality and assuring cultural competence. The commission also notes that workforce problems are contributing to access and quality of care problems, especially for minority and rural populations. University training programs and professions must change to adapt to the changing face of the country. The commission also recommends improving access to quality care in rural and geographically-remote areas.

D. *Goal 4: Early Mental Health Screening, Assessment and Referral to Services Are Common Practice.*

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[16] 2001 SURGEON GENERAL, MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY: A SUPPLEMENT TO MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL.

The Executive Order creating the commission emphasized "children with serious emotional disturbance and adults with serious mental disabilities."[17] This might seem to imply a narrow concern for those most in need, but the Executive Order also required the commission to "identify unmet needs and barriers to service."[18] The Commission concluded that early screening, assessment, and treatment must be emphasized. Indeed, many problems associated with the current system result from late diagnosis and engagement in care. This pattern contributes to the high rates of school failure for children and disability for adults with mental illness.

The recommendations to advance this goal emphasize the need for early screening and identification and links to care in settings where mental disorders can be identified effectively under the right conditions. Four recommendations attack this objective.

With respect to early childhood, the commission recommends a commitment to promote the mental health of young children. In recommending a stronger focus on childhood and early childhood mental health, the commission endorsed the emerging concept of "resiliency," which it defined as "the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats or other stressors."[19] The commission recommended broader adoption of the Nurse-Family Partnership, a program that has demonstrated its cost-effectiveness in reducing negative outcomes such as juvenile delinquency through support and training to young mothers who are, with their children, at risk. This program flourishes at the boundaries of child development and mental health intervention, and prevention and treatment. The field of "early childhood mental health" is itself in its infancy, but well-researched efforts like the Nurse-Family Partnership signal that developing resiliency in children is both possible and effective.

With respect to school-aged children, the commission recommends that the nation improve and expand school mental health programs. Noting that "no other illnesses damage so many children so seriously," the Commission indicates that "schools are in a key position to identify mental health problems early and provide appropriate services or links to services."[20] The third recommendation under this goal is to screen for co-occurring mental and substance abuse disorders and link with integrated treatment strategies. This recommendation attacks two persistent problems: the frequent failure to recognize substance use disorders in people with a

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17 Exec. Order No. 13263, 67 Fed. Reg. 22337 (Apr. 29, 2002).

18 *Id.*

19 New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America, Final Report* 5 (2003), *available at* http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html.

20 *Id.* at 56.

mental illness, and vice versa, and the failure to provide the kind of integrated treatment that is both more effective and more convenient for the consumer.

The final recommendation under this goal is to screen for mental disorders in primary care settings, across the lifespan, and connect to treatment and supports. This recommendation recognizes that primary care settings are a logical place to detect and treat mental illness, but only if the capacity to assess and treat is present and paid for. The commission cites "collaborative care" as an evidence-based, effective approach. Recognizing that older people rely on primary care, the collaborative care approach pairs mental health professionals with primary care physicians in a team approach. The commission notes that Medicare and other payers do not currently reimburse for collaborative care. Reimbursement for core components of this evidence-based model would cover services by qualified mental health specialists that are essential to support primary care-based treatment.

E. *Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated.*

This goal links science and services, responding to the gaps between science and services cited by the Institute of Medicine and the Surgeon General, with four main strategies and specific recommendations. These include advancing better-targeted research, creating a substantial national commitment to "installing" evidence-based treatments and supports in real world settings, addressing workforce needs with an emphasis on evidence-based care, and filling several pressing national gaps in research and data collection.

The first recommendation under this goal is to accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illness. The commission felt strongly that it was time to articulate a major, long-range commitment to go "for the cure" of serious mental illness while recognizing that its mission was to address service delivery problems. A more immediate research-related recommendation follows immediately, that being to advance evidence-based practices using dissemination and demonstration projects, providing oversight by a public-private partnership. This recommendation recognizes that most people with mental illness do not have access to treatments and supports that are validated by science, in part because proven interventions have not been disseminated, in part because payers for care may not reimburse evidence-based approaches, in part because professional training programs may not teach these methods, and for other reasons. The recommendation for a specific commitment and strategy to accelerate the "science to services cycle" is one of the commission's most concrete and promising ideas to improve the quality of care. The commission notes that improving this cycle requires more than improved dissemination of research. Improved

research that tests emerging innovations in field settings, and considers treatments that are practical is required. Adjusting reimbursement to cover evidence-based practices is essential.

Evidence about the "workforce crisis" in mental health care is emerging. From the shortage of child psychiatrists to the "nursing crisis" to the virtual absence of mental health professionals in rural and frontier America, the commission heard many concerns about this problem. Therefore, the commission recommends improving and expanding the workforce providing evidence-based mental health services and supports. This recommendation includes a call for national leadership, and an effort by mental health education and training programs to examine their relevance, consistency with new knowledge, and contributions to addressing the workforce problem.

The final recommendation under Goal 5 is to develop the knowledge to inform policy and practice in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care. This recommendation addresses the need to rebalance the nation's incomplete research portfolio and data sets. Regarding access to ambulatory and inpatient acute care, the commission became aware that a crisis exists in several regions of the country, but found no national tracking or data sets on this critical aspect of care. This must be remedied.

F. *Goal 6: Technology is Used to Access Mental Health Care and Information*

Although the commission's major focus was on issues in mental health care itself, the pace of technological development demanded our attention. Use of the Internet to access information, and the impact of computers on care systems, had to be addressed. The commission observed that mental health care has lagged in use of technology, and it recommends investments to change this. The commission also observed, in a San Diego based model program that it cites, the potential of technology to help consumers cut through system barriers to get information and improve access to care.[21] Therefore, the commission recommended using health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

The commission also sees great promise in the technology of integrated, personalized electronic mental health records to improve quality by, for example, reducing medication errors, improving the continuity of care, and empower consumers. The commission cites the use of information technology in the Veterans Affairs system as a model, and recommends a national commitment to develop and implement integrated electronic health record and personal health information systems. The

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[21] *See* The Network of Care's Website, *at* www.networkofcare.org.

commission believes that the strongest credible assurances must be provided that the confidentiality and privacy of information is maintained. With these assurances, however, the promise that technology has to improve access, consumer control, quality, and efficiency should not be ignored in mental health.

VIII. WILL THE COMMISSION'S WORK MAKE A DIFFERENCE?

The members of the commission are under no illusion that their report will transform a fragmented and often troubled system by itself. We have hope that the rare opportunity of presidential attention to mental health and the follow through in the administration will make a difference.

As the report was released, Health and Human Services Secretary Tommy Thompson designated SAMHSA Administrator Charles Curie to take the lead for the administration in developing a follow-through plan. In August 2003, former Rhode Island mental health director Kathryn Power began work as the new director of the Center for Mental Health Services in SAMHSA, and was charged with taking the lead on developing the implementation approach.

Members of the commission are encouraged by the shared desire for change that emerged from consumers, family members, providers, and advocates. Creation of "The Campaign for Mental Health Reform," a coalition of many of the leading advocacy and professional organizations in mental health, is another good sign. The campaign's member organizations are committed to both work within their organizations with state chapters and to advocate at the national level. Strong action at both levels will be important.

The commission frequently heard the admonition that the report must not sit on a shelf. Our experience suggests that as with one patient, developing a good treatment plan is necessary but insufficient for progress and recovery. Implementation activities must be both "top-down," with national leadership as in anti-stigma campaigns and change in federal programs, and "bottom-up," as with demands for greater participation in treatment plan development by people recovering from mental illness. Many of the commission's recommendations call for action at other levels of the system, including examination of curricula by university training programs, and implementation of steps to become more culturally competent by provider organizations and efforts to adopt evidence-based interventions at all levels.

Given the complexity of mental health care, with payers and providers in multiple sectors at multiple levels, a simple plan for change is inadequate. This realization led the commission to call for a transformation in care, not a simple reform. Only time will tell if participants in mental health can establish a shared commitment to the changes that are needed, and whether the political end economic environment will allow, support, or thwart change. There is no doubt that

a transformation in mental health care is needed. The commission, having completed its work, urges our elected officials and all members of the mental health community to commit to that goal.