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# Challenges for Mental Health Patients and their Families

By Steven Madonick, MD, Editor

More frequently than I would have thought, I hear from friends and family members seeking help finding proper psychiatric treatment for someone close to them with grave mental health needs. Unfortunately, our mental health care system places financial, social and institutional impediments that affect even intelligent, educated, and well-to-do families when they need to access standard of care treatment. These relatives and friends often underestimate their need for education, support and advocacy. We have plenty of room to improve access to treatment and support for patients and their families.

Several weeks ago, I received a call from my mother-in-law. Her neighbors were distraught and did not know how to help their adult son. He had a history of depression and alcohol use disorder with a suicide attempt many years ago. He resisted seeing a psychiatrist or taking medication. Their son had a successful career but divorce and bankruptcy were accompanied by isolation, renewed depression and suicidal thoughts. We discussed the criteria for hospital evaluation and inpatient admission but they had no idea what other levels of care were available. We talked about state agencies and medical school departments of psychiatry, clinical teams, Intensive Outpatient Programs, Partial Hospital Programs and co-occurring disorder programs with medical assisted treatment for alcohol use disorder. His parents had no familiarity with any of these services although they are all available in Connecticut where they reside. Such services are scarcer in the state where their son lives. He also lost his health insurance when his company went bankrupt.

In the end, at great personal and financial sacrifice, his parents provided support for him to attend an Intensive Outpatient Program at a prestigious medical center. They are paying in cash. They needed to consult me, a family friend who is a community psychiatrist and liquidate their saving in order to get proper mental health treatment for their 50-year-old son with relatively common mental health concerns.

At a recent CPS council meeting, Thomas Barr from NAMI

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# The Potential Impact of Psychiatry on Life Expectancy

By Sheila Cooperman, MD, CPS President

The Journal of the American Medical Association published "Life Expectancy and Mortality Rates in the United States, 1959-2017" on November 26, 2019. If you have not read it, it is worth a look. I will briefly touch on some of the more salient features that intersect with Psychiatry.

The review article points out that not only has life expectancy in the United States lagged other highly developed countries, it has decreased. The examination of vital statistics and analysis of contributing factors through a literature search focused on mid-life deaths from ages 25-64. It was noted that from 1959 to 2016 life expectancy increased from 69.9 years to 78.9 years, then began to decline beginning in 2014 for the next 3 years. The mortality rate for the 25-34 age group increased by 29 percent from 2010 to 2017. The underlying contributing factors pointed to substance use leading the way with an increase in drug overdoses and alcohol abuse as well as suicide. From 1999 to 2017, mid-life drug overdose deaths increased by 386.5%. Those aged 55-64 had a 909.2% relative increase in overdose deaths. The death rate for those with alcoholic liver disease increased by 40.6% for the mid-life group. The suicide rate for the mid-life group increased by 38.3% and by 55.9% in the 55-64 year age group.

The National Research Council identified 9 areas where the United States has fallen behind in terms of healthcare outcomes when compared to other high income countries: adverse birth outcomes, injuries and homicides, adolescent pregnancy and sexually transmitted infections, HIV and AIDS, obesity and diabetes, heart disease and chronic lung disease (2). It was noted

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# Resident Column: Looking Through a Dual Lens

By Amanda Calhoun, MD, MPH, PGY-1
Yale Psychiatry Resident, Albert J. Solnit track

"He even has bruises on his wrists." I still remember my mother's words and the way my eyes watered as I held the phone. My older brother, who is severely autistic, had been thrown on the ground and handcuffed in the Science Center. Even though he was accompanied by a staff member, who repeatedly told the guard that she was trained to handle my brother's agitation, the guard ignored her. He did not look at my brother and see a patient with a neuropsychiatric disorder, not harming anyone, who was in need of assistance. He saw an aggressive man with dark brown skin whom he could exercise undue and unnecessary violence against. I took a deep breath and went to work.

Being an intern and an underrepresented minority in medicine is like looking at things with two different lenses. There is the clinical "learn how to be a doctor" lens and there is the "is this system really helping to rectify institutionalized racism against those who look like me?" lens. Some would argue that I should focus on the former first, and then handle the latter, but that is not only, in my opinion, incorrect, but impossible. Not when college graduate African American women are more likely to die from preventable childbirth complications than white high school dropouts, due to racial bias and neglect. Not when a 2016 survey showed that half of all White medical students queried believed at least one false statement about biological differences between Blacks and Whites, such as Blacks having less sensitive nerve endings compared to Whites or a faster blood coagulation rate. Not when those same medical students who endorsed false beliefs also showed more racial bias and were less accurate in their treatment plans. Not when physicians are more likely to underestimate the pain of Black patients compared with other patients.

I am not just a doctor learning medicine. I am often the only African American or Spanish-speaking doctor amongst a sea of white coats in the patient's room. And that matters. It shows in the knowing look that the patient and I exchange. Often, the patient will beckon me over quietly as people begin to file out of the room, asking me if I agree with the treatment plan suggested, which is code for "Can I trust them? They don't look like me, and historically and currently, the medical system has and does not take care of people like me". Their anecdotal concerns are reflected in the evidence base, which shows that ethnic minority patients are treated with less empathy, attention, and given less information compared to their White counterparts, and African American patients are less likely to receive medical services than White patients with the same complaints.

Studies have shown that pa-

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# ACCESS Mental Health: A Successful Consultative Model

By Brian Keyes, MD

Following the Sandy Hook tragedy, the CT Legislature passed an act authorizing the creation of ACCESS MH to increase access to mental health care for children and adolescents in CT regardless of insurance coverage. This idea was based on a model that was already successful in Massachusetts and is now being used fully or partially in 25 states in the US and in development in 5 more. It provides the ability for primary care practices registered with this service to call in to consult with a child and adolescent psychiatrist about patients they have mental health concerns or questions about during business hours Monday-Friday. 86% of primary care practices treating children and youth in CT participate in this, and three regional centers provide this service.

Primary care practitioners have been highly satisfied with this service which has provided more than 30,000 consultations serving more than 5800 youth and families from inception in June 2014 through June 2019. Although the service is in place for youth under 19, approximately 5% of the consultations are provided for youth 19-26 years old. The cost per year, which is state funded, is about $1.7 million. Attempts have been made to have this supported to some degree by commercial insurance reimbursement, but these efforts have thus far not been successful.

In Massachusetts some insurance coverage for this has been mandated and the model has been expanded to include pregnant women and postpartum women. In Minnesota the model includes some ability to have consultations for adults, but it is limited.

Expanding the service in CT to include adults could provide a significant improvement in access to care for mental health needs for patients throughout the lifespan, and insurance coverage for this service would lessen the burden on CT taxpayers.

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# A Short Legislative Session

Carrie Rand-Anastasiades, CPS Lobbyist
and Jacquelyn Coleman, CPS Executive Director

The General Assembly will convene on Wednesday, February 4, 2020 for what is known as a short session. It is the second year of the term and there will be much less pomp and circumstance this year then there was last year. Neither legislators nor Governor will be sworn into office. Governor Ned Lamont will present his budget adjustments for the biennium on the opening day of session and it will be off to the races. The short session is only three months and although much less gets accomplished, a lot is crammed into a very short time and the pace is furious.

The fact that the short session is in an election year can make for interesting times. Although the session is supposed to deal only with financial and other urgent matters, many other important topics will be brought up. Individual legislators cannot submit bills because that is a privilege reserved for the committee chairs; however, legislators can advocate for bills to be raised by the committees of cognizance. So, just about anything can come up.

Two legislators will not be back and special elections to fill their seats will take place soon, but otherwise we will deal with the same faces, personalities, and committee chairs as we did last year. The split of the legislature is very decidedly Democrat with the House of Representatives having 91 Democrats and 60 Republicans. The Senate has 22 Democrats and 14 Republicans. Republicans will be more vocal than they have ever been headed into this election cycle to try and win back seats to make the legislature more balanced. The last election marked a loss of ground for President Trump and the Republicans. The impending elections will see legislators position themselves with regaining this ground on their minds.

This will also be the last term of Speaker of the House Joe Aresimowicz. He will not be seeking re-election next year. Currently, Majority Leader Matt Ritter will be running for Speaker and several other legislators will be looking to run for Majority Leader Ritter's vacated spot. People looking for Leadership posts will also look to make their mark on the session.

Healthcare is always an issue of the greatest importance to legislators and this year will be no different. We expect to see many of the same issues we have dealt with in the past, including psychology prescribing, Parity/MAT issues, public options for healthcare, drug pricing, civil commitments, and vaccines to name a few. In addition, we will be working on a task force to further expand treatment at colleges and universities in CT. It will be a full session, but we are confident our membership and grassroots support will make us successful once again.

In addition to our specific issues, we will work cooperatively with CSMS on their agenda, which includes high deductible health plans, vaping, red flag laws, liability reform and physician retention and recruitment. The December Council Meeting was attended by Bo Subbarao, M.D., President of the Connecticut state Medical Society and a member of CPS; William Emmell, M.D., Chair of the CSMS Legislative Committee; and Ken Ferrucci, CSMS Government Relations Director and Acting Executive Director. We look forward to partnering with CSMS to advocate for all agenda items that impact physicians.

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# Looking Through a Dual Lens

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tients who do not trust their physicians are less likely to adhere to their recommendations. In short, no matter how great your medical knowledge is, if your patient does not trust you, your patient care is limited. The medical experimentation and abuse of minorities has extended far beyond that of the infamous Tuskegee, Henrietta Lacks or Havasupai tribe atrocities. As recent as the 1990s, a study recruited exclusively African American children to assess the genetic etiology of aggression which involved several human rights violations. I believe it is essential to our training as doctors to not only learn about the history of medical atrocities committed against people of color, but also to understand the current documented health disparities due to racism. It is essential to understand why people of color, myself included, do not fully trust the medical system, if we aspire to have all of our patients trust us and to be the best doctors we can be.

# The Potential Impact of Psychiatry on Life Expectancy

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that those countries with higher life expectancies had universal access without a cost barrier to care, care coordination, and timely and effective health care that reduced premature death (3,4,5).

What does all of this have to do with us as psychiatrists? How can we contribute to increasing the life expectancy of our patients? One of the conclusions of the JAMA article is that with the increase in substance use, suicide and organ system diseases, psychiatric services and health systems need to be strengthened and along with the need to increase our capacity to treat chronic diseases (6). How can we accomplish this in Connecticut?

**Improve Access to Care and Care Coordination**

Parity was passed by the Connecticut legislature last session and this is a start to increasing access to care. However, the insurance companies need to be monitored to confirm that they are abiding by the law and are paying psychiatrists equitably for their work. This is a necessary precursor to having psychiatrists on insurance panels who are actively open to taking new patients.

It will be helpful for us to coordinate treatment with our primary care providers using the Collaborative Care Model as outlined on the APA website. Primary care practices that use this model can bill Medicare and some commercial insurers by using 99492, 99493, and 99494 codes for their psychiatric collaborative care management services. One example of this model is a large primary care practice in Indiana that hired a psychiatrist to consult on cases and train their case managers to systematically assess, track and review patients with the psychiatrist. This has led to an improvement in diagnosis and treatment of depression as well as other psychiatric disorders in their practice. Given the forecast of psychiatry workforce shortage, collaborating with our primary care peers is crucial. Frequently, the PCP is consulted prior to a suicide. Therefore, improved training in how to screen for suicide for PCPs would be helpful in reducing the risk for morbidity and mortality. We can help with consulting on their simpler cases and provide our expertise by evaluating more complicated cases ourselves.

Telemedicine can be a useful adjunct to seeing patients in person and can be utilized in the more rural parts of the state. A program in Illinois sends their clinical teams out to see their established patients with laptops while their psychiatrists remain at the clinic and consult with the patient and team in the patient's home via video. The psychiatrist uses the video function to assess their patients' mental status and has input from the team without leaving the office and this has resulted in an increase the number of patients the psychiatrist can treat in a day.

**Removing Cost as a Barrier**

Mandated insurance coverage for medication for addiction treatment was removed from the parity bill last session but CPS plans on lobbying for passage this session so that buprenorphine, methadone, acamprosate, disulfiram, naltrexone, varenicline, bupropion, and all forms of nicotine replacement are covered. I encourage all of you to treat your patients who have an addiction with appropriate medication when indicated. These medications are underutilized and improve patients' lives and their life expectancy.

**Prevention of Premature Death**

I don't want to take up your time by reminding you to assess for suicide, and treat depression and drug dependence aggressively when you diagnose it because it is obvious to all of us that such actions are important. However, there are some interventions that may not be so obvious and they require our attention as well.

Tobacco remains the leading cause of preventable death in the United States. In Connecticut, according to the Department of Public Health Website, it is re-

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# Challenges for Patients and Families

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gave a talk and I remembered my mother-in-law's friends. There is a degree of isolation and hopelessness that is involved with helping a loved one with mental illness. People in this situation require more than good treatment for their family member. They need emotional support and greater understanding of what their family is facing. It was reassuring to learn that NAMI has nine active chapters throughout Connecticut. They provide numerous programs in the areas of support, education and advocacy. I will refer my mother-in-law's friends to the NAMI Family to Family program. This renowned program reviews research on the causes of serious mental illness and provides information, resources and support based on the lived experience of other family members. There are also many other NAMI programs that may benefit our friends.

Helping a relative or friend with a mental illness or substance use disorder is complicated, stressful and expensive. There is a need to understand treatment, how to access it and pay for it. There is also the need for camaraderie and emotional support. NAMI helps with these challenges.

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# The Potential Impact of Psychiatry on Life Expectancy

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sponsible for 4,300 deaths per year. That is more than 4 times higher than the predicted death rate from opiate overdoses (~ 1000) this year. There remains 12.7% of Connecticut adults who smoke (7), yet there is no Medicare or private insurance company mandate in the state to cover all forms of Nicotine Replacement Therapy. CPS will ask to have it covered. Encourage your patients to stop smoking and help them any way you can by advising them and prescribing smoking cessation medication.

Obesity, Diabetes and Cardiovascular disease are common secondary diagnoses that our patients struggle with and lead to premature death. Using weight neutral medications when appropriate (full disclosure, I receive no financial support from any drug companies) like lamotrigine and bupropion can be helpful and may reduce the risk of weight gain and diabetes. Consider recommending that they follow a plant based diet as supported by the Montefiore Cardiac Wellness Program (again, I don't get paid for saying this). Dr. Robert Ostfeld, the cardiologist who directs the program, points out that for those patients who comply with this change in their diet, they may lower their cholesterol and weight, reverse their diabetes and reduce their cardiac symptoms.

There is more to be learned from this review article on the lowering of life expectancy in the United States. We can have considerable influence and can help to reverse these trends.

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# Save the Date!

## CPS Annual Meeting

May 27, 2020
The Lawn Club
New Haven, CT

Guest Speaker:

**Jeffrey Geller, MD**
Incoming President
American Psychiatric Association

## CPS Announcements

- Shaukat Khan, MD has been elected a Distinguished Fellow of the APA.
- Walter Luchsinger, MD has been elected a Fellow of the APA.

# News from the APA

## APA Applauds Mental Health Funding in Federal Spending Bill

WASHINGTON, D.C. — This week Congress passed a $1.4 trillion fiscal year 2020 spending bill that includes several provisions that will fund medical research and treatment programs for people with mental illness and substance use disorders (SUD).

Among these provisions were:

- Significant resources to combat the opioid epidemic, including $1.5 billion for state opioid response grants and $800 million for research. The bill also includes $12 million in new funding for a student-loan repayment program for the SUD workforce and $26.7 million in new funding to establish grants to train professionals to provide treatment for mental illness and SUD, both administered through the Health Resources and Services Administration (HRSA).
- $5.9 billion for SAMHSA, including $14 million for the Minority Fellowship Program which is a $1 million increase over last year's funding.
- $41.68 billion for the National Institutes of Health, a 6.7 percent increase in funding. Of that, $2 billion will fund the National Institute of Mental Health, an increase of $155 million. The NIH and Centers for Disease Control and Prevention both received $12.5 million to take a comprehensive approach to studying the underlying causes and evidence-based methods of prevention of firearm injury.
- Funding to extend key expiring health care programs through to May 22, 2020, including the Certified Community Behavioral Health Clinic (CCBHC) demonstration program that provides a range of mental health and substance use disorder services in vulnerable communities.

"This budget includes many investments in programs that will hopefully help relieve the millions of Americans who suffer as a result of the opioid crisis," said APA President Bruce Schwartz, M.D. "APA is also pleased to see funding for research into preventing firearm injury and deaths, a provision we've supported alongside other medical professionals for many years."

"We are pleased that Congress has also funded the APA-supported loan repayment program that will encourage psychiatrists and others to serve communities in need, especially those with high opioid use that also have a shortage of clinicians," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "This is an important piece of addressing physician shortages across the country."

## American Psychiatric Association To Offer Solutions at White House Mental Health Summit

WASHINGTON, D.C. – American Psychiatric Association (APA) President Bruce Schwartz, M.D., will be among many mental health advocates and others attending a White House Summit on Transforming Mental Health Treatment tomorrow, Dec. 19.

The summit will cover a wide range of topics, during which Dr. Schwartz will put forth the APA's positions on several key mental health issues, including:

- Improving Access to Treatment and Services for People with Mental Health and Substance Use Disorders: APA urges policymakers to take steps to address the lack of available services for people with mental health and substance use issues, including shortages of hospital beds and workforce. To address the workforce needs we need to implement effective new and innovative health care delivery models such as the Collaborative Care Model. We need to provide more treatment options for people in crisis and living in rural areas such as telemedicine.
- Violence and Firearms: The majority of violence in our society is not perpetrated by people with mental illness. In fact, people with mental illness are much more likely to be victims of violence. Reducing firearm-related violence and suicide requires keeping firearms out of the hands of persons who may harm themselves or others. APA supports restrictions that are applied appropriately by limiting access to such individuals rather than limiting access solely on the basis of a mental or substance use disorder. The APA also calls for further research into firearm violence, which is a public health crisis.
- Enforcement of Mental Health Parity and Related Anti-Discrimination Laws: Despite passage of the Mental Health Parity and Addiction Equity Act in 2008, many insurance plans continue to discriminate against people with mental illnesses and substance use disorders. APA asks that state and federal policymakers hold health insurance plans accountable to the law and ensure that mental health and substance abuse benefits are treated the same as all other health benefits. The APA continues to advocate for parity-enforcement legislation at the state and federal level.

# News from the American Psychiatric Association

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"In the midst of the opioid epidemic and the increasing rates of suicide, state and federal governments must come together to elevate the priority of mental health in America," Schwartz said. "As medical leaders, we have an obligation to advocate for our patients and bring forth solutions to improving mental health care in the U.S."

## APA Urges Action to End Disparities in Mental Health Coverage

WASHINGTON, D.C. — People seeking treatment for mental illness and substance use disorders continue to pay more and face more barriers to accessing care than those seeking care for physical illness, according to a report released today from Milliman, Inc., and the disparity has worsened over the past two years.

Patients using commercial PPO health plans – considered "Cadillac plans" because of their "generous" coverage – are significantly more likely to have to pay out of pocket for mental health care compared to general medical care, according to the report, commissioned by The Bowman Family Foundation. When patients cannot find a physician in the plan's network, they must go out of network and incur financial responsibility for a large portion of the bill. In 2017, 17% of behavioral office visits were to an out-of-network provider, compared to 3% for primary care providers and 4% for medical/surgical specialists. This disparity is a major financial obstacle to many with mental illness or substance use disorders.

These results are consistent with "secret shopper" studies the American Psychiatric Association has done indicating that provider directories provided by plans for mental health care are inaccurate and it is often not possible to obtain a mental health appointment in a reasonable amount of time because the plan discourages participation by mental health providers through discriminatory reimbursement rates.

In 2017, primary care reimbursements were about 24% higher than behavioral reimbursements. In 11 states primary care reimbursements were 50% higher than behavioral health reimbursements. To make that clear, if a patient sees their primary care provider for treatment of depression, the plan will pay that doctor up to 50% more than it would pay a psychiatrist – a medical doctor with four to five years of additional residency training in mental health care to treat that same patient for depression. This disparity is designed to discourage mental health professionals from participating in plan networks and to ensure that plan participants do not access care. "The results of this study should set off alarm bells for all of us who care about our nation's health," said APA President Bruce Schwartz, M.D.

"Discriminating against people with mental illness by restricting their access to care means that more people will suffer and some will die as a result of lack of access to life-saving treatments," he said. "Given we are in the midst of an opioid epidemic and a public health crisis of rising suicide rates, insurers, states, law enforcement, plantiffs' attorneys, and the federal government must do better to ensure people who need it can access care."

"Many states are trying to enforce the Mental Health Parity and Addiction Equity Act, which would preclude these results and APA appreciates their efforts," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "But the problem is urgent and needs everyone's attention. If a plan charges a patient for a product – access to mental health and substance use disorder treatment – and then ensures through its business model that there will be no providers to deliver that treatment – it is an unfair and deceptive trade practice."

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