Survey Shows That a Majority of Correctional Facilities Fail to Provide Substance Abuse Treatment for Inmates

The first national survey on the availability of substance abuse treatment in the nation's adult and juvenile correctional facilities has revealed that 60 percent do not provide any type of treatment services. A report of the 1997 survey, *Substance Abuse Treatment in Adult and Juvenile Correctional Facilities,* was released in late April.

The report notes that 94 percent of the 129 federal prisons and 60 percent of the 1,187 state prisons in the U.S. provided some type of treatment in 1997. However, treatment was offered in only 37 percent of the 3,127 juvenile facilities and 34 percent of the 3,121 jails.

In the facilities that provided treatment, approximately 173,000 persons were receiving services, representing about 11 percent of the adults and juveniles in correctional facilities. Thirteen percent of those in treatment were under age 18, the report notes.

The survey, conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) in collaboration with the Department of Justice, was undertaken in response to a growing recognition among federal and state agencies of the need to break the cycle of substance abuse and crime.

The report cites studies showing that in 1996 drug offenders accounted for the largest proportion of federal prison inmates– 60 percent. In addition, between 1985 and 1997, state correctional facilities saw a sixfold increase in their drug offender populations. Data from a 1998 study cited in the report indicated that about two-thirds of adult arrestees and more than half of male juvenile arrestees tested positive for at least one drug at the time of arrest. One in six state and federal prison inmates committed crimes to obtain money for drugs, the report notes.

According to SAMHSA administrator Nelba Chavez, such data suggest that a large number of persons who enter correctional institutions each year have some form of substance abuse problem. "This new survey shows that we have a great deal of work ahead of us if we are to be successful in breaking the cycle of crime and drugs," she said.

Commenting on the report's release, Barry McCaffrey, director of the White House Office of National Drug Control Policy, said, "Our dominant approach of primarily incarcerating drug offenders is a failed social policy. We are now replacing it with a common-sense approach of treatment and testing combined with law enforcement. Our goal is to encourage the expansion among federal, state, and local jurisdictions of alternatives to incarceration for nonviolent offenders and treatment for drug-dependent offenders in all phases of the criminal justice system."

Besides determining the proportion of facilities providing treatment, the survey also sought to describe the treatment. It showed that 70 percent of the inmates who received treatment were treated as part of the general facility population, 28 percent were treated in specialized substance abuse units, and 2 percent were treated in hospital units.

Among the facilities providing treatment to inmates for substance abuse, about 87 percent offered individual counseling, and 83 percent offered group counseling. Family counseling was provided by 40 percent of all the facilities and by 75 percent of the juvenile facilities.

The report, along with related materials, is available online at www.samhsa.gov/oas/correctionalfacilities.htm.

Review Finds Big Percentage of Medicare Claims for Acute Hospital Outpatient Services Fail to Meet Payment Criteria

Almost 59 percent of the claims paid by Medicare for outpatient psychiatric services at acute care hospitals in 1997 did not meet Medicare criteria for reimbursement, according to a report released in March by the inspector general of the Department of Health and Human Services (HHS). Review of the claims showed that the services failed to meet Medicare documentation requirements, were not reasonable and necessary, or were rendered by unlicensed personnel.

The review continues the scrutiny of Medicare claims for psychiatric outpatient services that began with a five-state review of claims for partial hospitalization services in community mental health centers. That review of 1997 claims found that more than 90 percent of all Medicare payments for partial hospitalization services were unallowable or highly questionable (see the December 1998 issue, page 1634). Ongoing audits of Medicaid claims in ten specific hospital outpatient programs are also being conducted.

The review of acute care hospitals was conducted in the ten states with the highest volume of psychiatric outpatient claims. They were California, Connecticut, Florida, Illinois, Louisiana, Massachusetts, Michigan, New York, Pennsylvania, and Texas.

Data from the Health Care Financing Administration (HCFA) showed that in calendar year 1997 Medicare paid 712,184 claims nationwide to acute care hospitals for outpatient psychiatric services that were valued at almost $495 million. Claims in the ten states accounted for 473,976 claims, 67 percent of the nationwide total, and were valued at $382 million, 77 percent of the total.

Two hundred of the claims filed in the ten states, which were valued at $168,857, were randomly selected for audit. Of those claims, $94,716 did not meet Medicare reimbursement requirements, $44,496 because of insufficient documentation, $42,025 because the services were considered not reasonable and necessary, and $8,195 because they were

rendered by unlicensed personnel.

The sample contained 38 claims for partial hospitalization services valued at $100,897. The review found that 22 of these claims, totaling $51,889, were made in error. The remaining 162 claims for other outpatient services were valued at $67,960. Of those, 85, valued at $42,828, were judged to be claimed in error.

On the basis of the review, the HHS inspector general estimated that in 1997, acute care hospitals in the ten states reviewed submitted $224.5 million in Medicare claims that were unallowable or unsupported. That figure constitutes almost 59 percent of the total claims in those states.

On the recommendation of the inspector general, HCFA agreed to strengthen oversight of claims for outpatient psychiatric services in acute care hospitals by requiring Medicare fiscal intermediaries to increase postpayment reviews of claims for services and to initiate recovery of payments for claims found in error. HCFA also agreed to further emphasize its documentation requirements for all types of outpatient psychiatric services through seminars, education sessions, and newsletters.

Ten-State Review of Outpatient Psychiatric Care Services at Acute Care Hospitals is available online at www.hhs.gov/progorg/oas/cats/hcfa.html.

State Officials Say Managed Care Increases Access to Public Mental Health Services and Improves Outcomes

Despite the controversy surrounding the use of managed care in public mental health systems, many states that have adopted managed care report considerable success. The positive effects include increased access to services, decreased use of inappropriate inpatient care, an expanded array of services, more flexibility in service delivery, and an increased emphasis on accountability and outcomes.

The problems and successes in states' use of managed care are outlined in a report from the Bazelon Center for Mental Health Law and the Milbank Memorial Fund. The report is based on meetings over several years with senior government officials in states whose Medicaid programs have shifted to managed behavioral health care.

The report notes that increasingly states are seeking to extend the managed care approach to people who have serious mental or emotional disorders; 31 states now have Medicaid managed care plans for at least some persons in the public mental health system. Twenty-one of these states have specialized statewide carve-out models for mental health care contracts, five have county or regional specialized managed mental health care, and three have smaller private pilot projects. Only two states provide coverage over significant areas of the state (one has statewide coverage) using integrated plans that provide both health care and acute and extended mental health managed care. In all states that have adopted managed care plans, financing and delivery of services are integrated, usually through risk-based contracts, and some form of utilization control is included.

The report says that the greatest successes with managed care plans have been obtained when policymakers started with a vision of what goals they wanted the service system to achieve and then, engaging in comprehensive planning with stakeholder groups, used managed care to reach those goals.

Problems arise when risk-based contracts provide an incentive to underserve people with serious disorders, the report says. Managed care contracts may also focus unduly on acute care, neglecting rehabilitation and other services that provide significant long-term benefits in improved functioning. The use of Medicaid managed care contracts may make it more difficult to serve the non-Medicaid population, who then have no access to public mental health services. Other complications include frequent problems with billing and payment during the startup phase and difficulties in ensuring quality and outcomes consistently across regions.

A number of states initially sought carve-out contracts with nationally known private, for-profit managed behavioral health care companies to provide services for people with serious mental illnesses, but today several new trends are emerging, the report says. Full-risk contracts with managed behavioral health care companies are being replaced by agreements that provide for administrative services only or are otherwise limited. States are becoming their own managed care entities, shifting their systems to performance-based contracts and providing their own management. Especially in larger states, attention formerly given to statewide system reforms has shifted to the development of county-based systems or systems organized through existing community mental health boards. States are increasingly relying on traditional safety-net providers.

The report, released in May, is entitled *Effective Public Management of Mental Health Care: Views From the States on Medicaid Reforms That Enhance Service Integration and Accountability*. It is available online at www.milbank.org/bazelon. Copies can be obtained from the Bazelon Center, 1101 15th Street, N.W., Suite 1212, Washington, D.C. 20005; phone, 202-467-5730, ext. 41.

NEWS BRIEFS

Administrative psychiatry examination and award: Psychiatrists interested in taking the 2000 examination for certification in administrative psychiatry must submit an application, including required letters of reference, by August 31. A written examination is given in December, and successful candidates take the oral section in May. The examination is conducted annually by the committee on psychiatric administration and management of the American Psychiatric Association. Additional information may be obtained from the APA Web site at www.psych.org or from

the committee at the Office of Continuing Medical Education, APA, 1400 K Street, N.W., Washington D.C. 20005; phone, 202-682-6109. Nominations are also being sought for the Administrative Psychiatry Award, sponsored jointly by APA and the American Association of Psychiatric Administrators. The award honors a board-certified APA member who has demonstrated extraordinary competence in psychiatric administration and has contributed significantly to the field through teaching, research, or other activities. Nominations may be made in a letter indicating why the nominee should receive the award and enclosing a copy of the nominee's curriculum vitae. The material should be sent to the committee on psychiatric administration and management in the APA office of education at the address above. The deadline is August 31, 2000.

Health leadership awards: The Robert Wood Johnson Foundation is seeking nominations for its Community Health Leadership Program (CHLP), which honors individuals for their work in creating or enhancing health care programs serving communities whose needs have been ignored and unmet. Each honoree receives $100,000, which includes a $5,000 personal stipend and $95,000 for program enhancement over a three-year period. Nominations can be made by consumers, health professionals, community leaders, and others. More information is available at www.communityhealthleaders.org or from CHLP, 30 Winter Street, Suite 920, Boston, Massachusetts 02108; phone, 617-426-9772.

Psychiatric ethics association: The International Association for Psychiatric Ethics was recently founded to increase cooperation and communication between professionals who are interested in matters related to psychiatric ethics. Willem Martens, M.D., Ph.D., of Rhenen, the Netherlands, is chairman and adviser for the new association, which was formed in recognition of the increasing internationalization of health care policy. The association is intended to play an advisory role to governments, hospitals, educational organizations, and mental health professionals. For further information, contact Dr. Martens at Rozenlaan 40, 3911 DW Rhenen, the Netherlands.

Free screen-savers: The Center for Mental Health Services (CMHS) is offering free screen-savers to enhance the public's awareness about children's mental health. Created by the child, adolescent, and family branch of CMHS as part of its Caring for Every Child's Mental Health campaign, the screen-savers feature a variety of photographs and messages that emphasize the benefits of good mental health for children and the mental well-being of families. Available in Spanish as well as in English, the screen-savers are free and can be downloaded from the Knowledge Exchange Network (KEN) Web site at www.mentalhealth. org/child. The KEN Web site also contains information for parents and children about children's mental health.

PEOPLE & PLACES

Appointment: ***Lloyd Sederer, M.D.,*** has joined the staff of the American Psychiatric Association in the new position of director of the division of clinical services, which will coordinate the work of the APA departments of quality improvement and psychiatric services. Dr. Sederer formerly was affiliated with McLean Hospital in Belmont, Massachusetts, where he most recently served as medical director and executive vice-president.

Elected: ***Pedro Ruiz, M.D.,*** began a two-year term as president of the American Association for Social Psychiatry during the APA annual meeting in Chicago in May. Dr. Ruiz is professor and vice-chair of the department and behavioral sciences at the University of Texas Health Science Center in Houston.

Award: ***Daniel C. Javitt, M.D., Ph.D.,*** is the first psychiatrist to receive the Burroughs Wellcome Fund Clinical Scientist Award in Translational Research. Dr. Javitt is associate professor of psychiatry at the New York University School of Medicine and director of the program in cognitive neuroscience and schizophrenia at the Nathan Kline Institute for Psychiatric Research in Orangeburg, New York. The award, which provides funding of $750,000 over a five-year period, will be used to investigate the basis for negative symptoms in schizophrenia.

Death: ***Seymour S. Kety, M.D.,*** 84, whose neuropsychiatric research helped establish the genetic basis of schizophrenia and led to the development of current brain imaging techniques, died May 25 at his home in Westwood, Massachusetts. During his long career, Dr. Kety was the first scientific director of what became the National Institute of Mental Health, professor and chairman of the department of psychiatry at Johns Hopkins University Medical School in Baltimore, and professor of psychiatry at Harvard Medical School in Boston, where he directed psychiatric research laboratories at Massachusetts General Hospital and McLean Hospital in Belmont, Massachusetts. He retired in 1983.

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