Report Cites Modern Quality Improvement Tactics and Consumer-Directed Care as Keys to Change

"In the past, quality improvement was thought to depend on the imposition of negative sanctions by external agents. In contrast, modern quality improvement strategies rely on direct benchmarking by health care providers themselves, with extensive input from primary consumers and family members. . . . This change, effected in a period of fewer than 10 years, is nothing short of revolutionary."

So begins chapter 1 of *Mental Health, United States, 2004,* the latest edition of a compendium of information documenting trends in mental health services. The work has been updated every two years since 1983 by the Center for Mental Health Services. For the first time the compendium includes chapters on quality improvement and its application to the mental health field. The compendium also highlights two other notable trends: the growing impact of consumer organizations and the role of information technology in transforming human and organizational relationships.

In chapter 1 Ronald W. Manderscheid, Ph.D., principal editor of the report since its inception, introduces a quality improvement framework developed by the Institute of Medicine in its *Quality Chasm* series that will drive the broad-based transformation of the mental health system called for by the President's New Freedom Commission. The framework's four strategies are implementation of evidence-based practices, better initial and continuing training of health care providers, reform of financing mechanisms, and adoption of improved information technology and performance measures. Subsequent chapters in section 1 of the compendium detail the model and how it is being used as a blueprint for change.

Section 2 of the compendium reviews performance measures, which are essential to any quality improvement initiative. A range of tools are available on the Web site of Decision Support 2000+ (www.mhsip.org/ds2000/newindex.htm), a secure network through which users report, analyze, and manage their own data and design and direct their operations within the site. The chapter describes consumer and provider surveys and vehicles for entering, processing, and benchmarking quality measures. Another chapter discusses a joint federal effort to develop common measures across the mental health and substance abuse fields. The MHSIP (Mental Health Statistics Improvement Program) Quality Report is also discussed. The report is a second-generation, consumer-oriented report card used to evaluate services on the basis of concerns identified by mental health consumers.

Separate chapters recount the history of the mental health consumer movement and present results from a national survey of consumer organizations, which are defined as organizations run by consumers for the purpose of providing services to other consumers. There are now approximately 2,100 such organizations, a number that has doubled since 1990. The report notes that although there is a history of ambivalence between consumer organizations and the traditional mental health system, more than 95% of such organizations now receive referrals from the traditional system.

The survey also found that 61% of all consumer organizations provide access to case management services or help people obtain needed services; of these, about half provide help directly, not via referral. Survey results show that consumer organizations are having a significant impact in addressing workforce shortages among mental health providers. An increasing number of consumers are being certified, and their services are being reimbursed by Medicaid. Consumer participation will lead to fundamental changes in the character of the workforce serving people with serious mental illness, the authors conclude, chiefly because consumer organizations are in a unique position to address barriers to care, such as stigma, fragmented services, high costs of care, lack of available services, and lack of knowledge among consumers about how to obtain services.

In a separate chapter, "Information Technology Can Drive Transformation," Manderscheid notes that in 1993 the Web had fewer than 50 operational sites of any kind. He describes ways that technology has changed interpersonal communication—through acceleration of communication, equalization of communicators, and disintermediation, a process by which intervening entities are eliminated in favor of direct communication between end users. Not only do such changes dramatically affect the relationship between the health care provider and consumer, he notes, they also erode boundaries to collaboration between "stovepipe" organizations and the larger environment and create new expectations for accountability.

A chapter on mental health practitioners and trainees updates statistics on the workforce. There are approximately 14 clinically active, private-sector nonfederal psychiatrists per 100,000 individuals in the U.S. population. A notable decrease has occurred in the number of psychiatrists who work in more than one setting—76% in 1988 and 45% in 2002. In 2002, about 11% of psychiatrists reported a hospital as their primary work setting, down from 28% in 1988. One major change has been the decrease in time psychiatrists spend in direct patient care, with more of their time being devoted to administrative activities: 8.7 hours per week in 2002, up from 5.8 hours in 1988.

As in past editions of the compendium, dozens of tables present data on prevalence and correlates of serious mental illnesses, mood disorders, and emotional and behavioral problems of children as well as data on state and federal trends in service provision by provider type, referral sources, and other characteristics of organized mental health services.

Mental Health, United States, 2004 is available for download and can be ordered free of charge on the Web site of the Center for Mental Health Services at http://mentalhealth.samhsa.gov.

NEWS BRIEFS

Medicare Part D and "dual eligibles": In 2006 Medicaid prescription coverage for individuals with low incomes receiving both Medicaid and Medicare benefits (dual eligibles) was replaced by the Medicare prescription drug program known as Medicare Part D. A 46-page report by the Kaiser Commission on Medicaid and the Uninsured provides information on the experiences of three states in the first eight months of implementing Part D. The states—Connecticut, Washington, and Florida—took different approaches to helping this group with Part D expenses: Connecticut offers substantial assistance, paying copayments and providing a "wraparound" to Part D that covers prescription drugs that are not on the Part D formulary. Washington pays copayments but does not cover nonformulary medications. Florida offers neither type of assistance. In addition, all three states cover certain drugs through their Medicaid programs that are excluded from Medicare Part D. Seventy-one key-informant providers were interviewed about affordability, enrollment, formulary and utilization management issues, exceptions and appeals, administrative complexity, state assistance, and lessons learned. The report is available on the Kaiser Web site at www.kff.org/medicaid.

National evaluation data on systems of care for children: Children and youths in systems of care are less likely to engage in self-harmful behaviors, they demonstrate fewer emotional and behavioral problems, and they do better in school than before enrollment, according to newly released data from the Comprehensive Community Mental Health Services Program for Children and Their Families of the Substance Abuse and Mental Health Services Administration (SAMHSA). The data also suggest that youths involved in systems of care experience fewer arrests. This reduction in arrests saves juvenile justice systems nationwide an average of $367 per child per year in costs associated with incarceration. These and other data related to key outcomes, such as improved economic status of caregivers, decreased suspensions and expulsions, and improved school attendance, can be found online at www.systemsofcare.samhsa.gov.

New tool for helping families in the child welfare system: *Screening and Assessment for Family Engagement, Retention, and Recovery* (SAFERR), a new guidebook to help staff of public and private agencies respond to families in the child welfare system who are affected by substance use disorders, is now available from SAMHSA. SAFERR is based on the premise that when parents misuse substances and mistreat their children, the best way to make sound decisions is to draw from the resources of three key systems: the child welfare system, the substance abuse treatment system, and the courts. The SAFERR model helps staff create and guide collaborative teams who can improve services to families by sharing information and coordinating services; support the work of the teams by developing clear expectations; identify and address state-level policies that may block efficient practice; select screening and assessment tools and strategies that can be incorporated into daily practice; support the implementation of improved practices at the local level; and monitor and evaluate successes and problems. SAFERR is available on the Web at http://ncadistore.samhsa.gov/catalog. Free copies may be obtained from the SAMHSA Health Information Network at 877-726-4727.

NAMI guide to mental health for African-American families: The National Alliance on Mental Illness (NAMI) has released *A Family Guide to Mental Health: What You Need to Know,* oriented to African-American families affected by illnesses such as major depression, bipolar disorder, and schizophrenia. The 15-page booklet describes symptoms and treatment options for each illness and provides information about NAMI education and support programs and other resources. It is intended for use by churches, community-based organizations, health and mental health centers, and schools. NAMI's goal in developing the booklet was "to educate in personal terms," and the booklet offers testimony from three families about their experiences with mental illness: a wife whose husband has bipolar disorder, a man whose adult sister has symptoms of schizophrenia, and a woman whose elderly father has committed suicide. The booklet can be downloaded or multiple copies may be ordered (50 copies for $27) at www.nami.org/mac/familyguide. Single copies of the booklet can be ordered free of charge by calling NAMI at 800-950-6264.

SAMHSA Web page for returning veterans: A new section of the SAMHSA's Web site has been launched for veterans and their families. The site provides information on prevention, treatment, and recovery support for mental and substance use disorders. Publications, fact sheets, and links to relevant agencies are provided. Individuals seeking substance use and mental health services can find information about local programs by using a treatment facility locator. In early May SAMHSA convened a meeting with officials from the Department of Veterans Affairs, the Department of Defense, and veterans' service organizations to better understand veterans' needs and to identify ways that community-based organizations can best be prepared to assist veterans and their families. "Resources for Returning Veterans and Their Families" can be found at www.samhsa.gov/vets.