

The President's New Freedom Commission: Recommendations to Transform Mental Health Care in America

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On April 29, 2002, in a speech in Albuquerque, President George W. Bush announced the President's New Freedom Commission on Mental Health, the first presidential mental health commission in 25 years. The President also reaffirmed his support for mental health parity legislation, saying "We need a health care system which treats mental illness with the same urgency as physical illness." This article describes the workings and recommendations of the Commission in the context of current problems and opportunities.

An Executive Order (1) 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." 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." The order listed five principles that set parameters for the Commission (see box on next page).

Background and framework for the Commission

During the 2000 presidential campaign, the National Mental Health Association conducted a survey of the

candidates' views on several issues relevant to people with mental illness. In his response to the survey, then-Governor Bush announced his intention to establish a mental health commission to recommend reforms in the mental health service delivery system (2). 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." It also included an announcement that a mental health commission would be created.

Some New Freedom Initiative programs were launched in the first months of the Administration. However, to initiate the Commission, the lead federal official responsible for mental health care—the administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA)—had to be in place. With the appointment of Charles Curie to this post 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 on Mental Health, and more than two decades before that to the Joint Commission on Mental Health. Thus the mental health field may not be aware

that presidential commissions are appointed frequently to study various problems and make recommendations. The framework for presidential commissions has three core elements. Members and a chair are appointed by the White House, an Executive Order is issued by the President to define the charge to the group, and an executive director is also appointed by the White House.

Federal laws and regulations govern the operation of commissions. The current key laws are the Federal Advisory Committee Act (FACA) and the Freedom of Information Act. 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, who is responsible for ensuring compliance and who has the authority to shut down a meeting if the law is being 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.

Developing the plan for the Commission's work

Considering these parameters, the appointed and federal leaders of the New Freedom Commission on Mental Health reflected on how to proceed with the daunting task set by the President, within the mere 12 months allowed for the task. Several challenges and opportunities were evident. First, lessons from the experiences and results of the Carter Com-

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Principles Governing the Commission

- ♦ The Commission shall focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation
- ♦ The Commission shall focus on community-level models of care that efficiently coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services
- ♦ The Commission shall focus on those policies that maximize the utility of existing resources by increasing cost-effectiveness and reducing unnecessary and burdensome regulatory barriers
- ♦ The Commission shall consider how mental health research findings can be used most effectively in influencing the delivery of services
- ♦ The Commission shall follow the principles of Federalism, and ensure that its recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the States and Indian tribes

mission were still relevant a quarter century later. Second, mental health care has changed dramatically since the Carter era. Deinstitutionalization has been accelerated, and specialty mental health benefits were expanded in Medicare and Medicaid, adding rehabilitation and other specialty benefits beyond the basic services offered in hospitals, nursing homes, and physicians' offices. In addition, the past two decades have seen the devolution of public-sector care to localities, the development of new somatic and psychosocial treatments, and the emergence of managed care. Reviewing their impact would be an essential task of the Commission.

Third, the Commission's work followed major scientific and policy thrusts in mental health, such as the Decade of the Brain, the White House Conference on Mental Health, and the Surgeon General's reports on mental health, on disparities in care for minorities, and on suicide (3–5). Although these efforts had begun to elevate the significance of mental health issues—especially the emerging science of the brain—they had not addressed 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, emerging fiscal and political realities, such as the existence of a more mature and diverse mental health advocacy community, and the dynamics of the federal budg-

et, including newly projected budget deficits, would need to be considered.

Describing all these factors in detail is beyond the scope of this paper, although they all directly shaped the Commission's work. However, several aspects of these issues were central and strategic. Our early review of the work of the Carter Commission included conversations with its Executive Director Tom Bryant. It was evident that the impact of the Carter Commission went beyond its recommendations and their implementation. Because Presidential attention to mental health is rare, use of the New Freedom Commission's processes and report to galvanize change at all levels—not just in the federal government—became imperative.

A particularly useful resource for understanding the impact of the Carter Commission was a 1991 inventory of the progress made since the release of the Commission's report and the development of the National Plan for the Chronically Mentally Ill (6). This review pointed out that much progress was achieved by staged, incremental, midrange changes in major federal programs such as Medicaid, Medicare, and Social Security, rather than by "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, which was passed by Congress in the waning months of

the Carter Administration and then rolled back in the first budget of the Reagan Administration. Ironically, the major recommendation and accomplishment of the Carter Commission was thus ephemeral, whereas "smaller" recommendations developed after the Commission had a larger impact.

These experiences of the Carter Commission shaped our thinking. We determined that subcommittees of the New Freedom Commission would develop detailed reports on components of mental health care (see box below). The reports, which would be published later as working papers, would help create an agenda that could serve the field well in future years. In addition, the reports would help the Commission cover many aspects of a diverse field efficiently and would inform the final report to the President. Engaging experts to advise the Commission's subcommittees would provide a deep level of knowledge on each issue, balancing the practical and clinical experiences of Commissioners. The subcommittees would also provide an opportunity for leadership by Commission members on topics important to them.

A common-sense requirement for the Commission, which was echoed in conversations with veterans of similar efforts, including the Carter Commission, was to ensure ample input from the public and to maintain a

The Commission's 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
Rural Issues
Medications
Interface With General
Medicine
Suicide Prevention
Co-occurring Disorders
Acute Care

good liaison with advocacy and professional organizations. An interactive Web site was set up to receive public comments; more than 2,300 individuals submitted concerns and ideas via e-mail. To ensure opportunities for public input, time was set aside at every meeting for public comment. Commission leaders met early with the Mental Health Liaison Group (MHLG), which includes representatives of all organizations that have a public policy or lobbying presence on mental health in Washington. Regular informal meetings with core members of the MHLG continued for the life of the Commission. Lead members of the MHLG developed shared recommendations for the Commission to consider, and as the final report was being prepared, they took steps to create a new advocacy coalition, the Campaign for Mental Health, to “speak with one voice” on the Commission’s recommendations and other mental health advocacy issues. **[Editor’s note: Comments on the Commission’s report from the Campaign for Mental Health Reform are presented in an accompanying article.]**

In addition to the Commission’s working meetings, which included testimony and presentations from invited experts, subcommittee deliberations, and public comment, the Commission held two meetings “on the road”—one in Chicago, which focused on children’s issues, and one in Los Angeles, which focused on criminal justice, housing, and homelessness issues.

The interim report

The Executive Order that established parameters for the Commission’s overall work and final report also required the Commission to submit an interim report at six months. The interim report was required 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.” The interim report (7) identified five major barriers to care (see box on this page).

However, the aspect of the interim report that seemed to attract the most attention—and to set the stage for the final report—was the Commission’s

Major Barriers to Mental Health Care

- ♦ Fragmentation and gaps in care for children with severe emotional disturbance
- ♦ Fragmentation and gaps in care for adults with serious mental illness
- ♦ High unemployment and disability for adults with severe mental illness
- ♦ Older adults with mental illness are not receiving care
- ♦ Mental health and suicide prevention are not yet a national priority

statement, “The system is in shambles.” This language was criticized by some as too strong, but generally the feedback was, “Finally, someone is telling it like it is.” The 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.

The hope of recovery

Throughout the Commission’s deliberations, the theme of recovery kept emerging, with multiple meanings and implications. Although recovery is often thought of as an end state of complete wellness and freedom from illness, 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 developed by Anthony (8), who wrote that 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 developed a shared view that the possibility of improvement and hope should be available to all individuals who have a mental illness, that complete remission would be achieved by some, and that the spirit of hope implicit in recovery is important. A visit with the Commission by former First Lady Rosalynn Carter solidified this view. Mrs. Carter described the work of the Carter Commission and advised on

approaches that might be useful. She also commented on what she described as “the biggest single difference in mental health now, compared with the time of our Commission—to day, we know that recovery is possible for every person with a mental illness.”

Recovery had been validated in the 1999 Surgeon General’s report on mental health (3), by President Bush in his remarks during the Commission’s launch in Albuquerque, and by a former First Lady and longtime 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.

The final report

The main requirements for the final report of the New Freedom Commission—its mission, goals, and principles—were specified in the Executive Order. The aspirations of recovery had emerged as an organizing theme. Recommendations were advanced by each of the subcommittees. Then the Commission turned its attention to overarching issues and cross-cutting recommendations to 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 problem most frequently identified by individuals who sent e-mails to the Commission (9). In the words of a father who spoke at the Chicago meeting about his family’s experiences, “The system is opaque.”

Fragmentation has emerged as an unintended consequence of earlier reforms. The Commission’s review identified no fewer than 42 different federal programs that might be used by

Proposed Goals for a Transformed Mental Health System

1. Americans understand that mental health is essential to overall health
2. Mental health care is consumer and family driven
3. Disparities in mental health care are eliminated
4. Early mental health screening, assessment, and referral to services are common practice
5. Excellent mental health care is delivered, and research is accelerated
6. Technology is used to access mental health care and information

persons with mental illness (10). Many of these programs are administered through different state and local agencies, and they often have different eligibility and application requirements. As a result, access to diverse, necessary elements of care is scattered, and consumers or families are frequently responsible for coordinating supports and services, often at times of crisis when their ability to accomplish this task is most compromised.

Other problems have been caused by the way in which programs have evolved over the past generation. Many of the federal programs that are most crucial to people with mental illness—Medicare, Medicaid, Social Security programs, vocational rehabilitation, housing, and special education—are mainstream programs in which mental illness is just one of a wide range of concerns. Persons with mental illness often fare poorly in these programs compared with other participants, perhaps because of the unusual combination of the extended course of mental illness, its episodic nature, and its significantly disabling aspects. For example, the number of people with mental illness-related disability in Social Security programs is large and rapidly growing, and emotionally disturbed children in special education programs and mentally ill adults in vocational rehabilitation programs have poorer outcomes than other participants. The scope of many mainstream programs is far greater than that of the only major federal program that specifically supports mental health care—the Mental Health Block Grant.

The complexity of these problems, and the resulting complexity of making changes 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 constituencies. The political dynamics between layers of government are complicated. It is clear that no single reform measure is sufficient to produce needed change, but it is also clear that simultaneous large-scale reform of multiple programs is unlikely to lead to the desired change, especially when mental health concerns—and therefore leverage—are relatively small in the context of major programs like Social Security, Medicare, and Medicaid. 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.

The quality chasm

The Commission's thinking was also shaped by the Institute of Medicine's 2001 study of quality in health care (11). The institute's finding that scientific advances are often not translated into mainstream health care for 20 to 25 years was disturbing given our new awareness that recovery is possible. This problem has particular salience in the mental health field because we know from the Surgeon General's 1999 report that the science underlying diagnosis and treatment has become much better established (3).

Transforming mental health care

The Commission grappled with the challenge of how to approach these

problems. Because mental health care is financed and provided in both the public and the private sectors, solutions do not rest solely with government. In the federal arena, multiple programs and agencies are involved, and substantial change cannot be leveraged in just one place. Finally, most financing of public-sector mental health 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 changes, a consensus emerged. In the words of the final report (12), "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." 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.

National goals and recommendations

Recognizing that it would make many recommendations for change across multiple programs, and that years would be required to effect needed changes, the Commission sought an approach to organize and motivate the work needed to transform the system. In order to organize the recommendations and create a shortlist of benchmarks to be tracked and monitored, the Commission proposed six national goals for mental health care (see box on this page). The goals describe desired conditions for mental health and mental health care in a transformed, future mental health system.

Nineteen major recommendations were proposed by the Commission, although many other proposals for change, and action steps to achieve the recommendations, are included in the report. The recommendations, which are described below, address changes that are needed—and in many cases achievable—at every level of the system, from consumers and families to public and private pro-

viders to government at the local, state, and national levels. In the following discussion, as in the Commission's final report, the recommendations are organized under the proposed national goal that they support.

Goal 1: Americans understand that mental health is essential to overall health. This goal echoes the Surgeon General's report on mental health and calls for the recognition of mental health as a crucial component of personal health—and for mental health care to be seen 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 proposed both a series of campaigns to encourage people to seek treatment if they suspect that they have a mental illness and a strengthened and expedited implementation of the National Strategy for Suicide Prevention (5). These recommendations acknowledge that stigma is a barrier to seeking help and that stigma results from personal attitudes and opinions that are not effectively changed by media campaigns. On the other hand, experience in other areas of health suggests that campaigns can influence health-seeking behavior. The Commission's logic is that encouraging people who need treatment to seek it 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 created by advocates of suicide prevention. The Commission also believes that the scope of the problem of suicide, which, according to the World Health Organization, causes more deaths annually worldwide than homicide or war (13), demands action and presents an opportunity to demonstrate the relevance of mental health care to public health. The remarkable campaign by the U.S. Air Force to reduce suicide in its ranks (14) 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 goes be-

yond personal care-seeking behavior and addresses mental health care in the larger context of health care. It calls for any changes in Medicare and Medicaid, the nation's major health care programs, to appropriately include provisions for mental health care, including prescription drug coverage, support for evidence-based services and supports, and consumer choice.

Goal 2. Mental health care is consumer and family driven. This goal is perhaps the most complex proposed by the Commission, with recommendations that affect care from the clinical level to the national level. The goal of consumer-driven care, in the case of adults, and family-driven care, in the case of children, taps into general preferences about health care that are reflected in the movement away from tightly managed health maintenance organizations to preferred provider organizations in which consumers have more choice among providers.

The Commission made five recommendations—many of them complex—to achieve this goal. The recommendation to develop an individualized plan of care for every adult with serious mental illness and every child with serious emotional disturbance, which will require 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 ensuring that consumers and families have more choices. The second is the fragmentation of care, which increases with the complexity of needs. Coordinated care planning, which is being carried out in wraparound programs for youths such as the Wraparound Milwaukee program identified as a model by the Commission, attacks the problem of fragmentation by bringing multiple caregivers together 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 inclusion of consumers and families at every level of the system.

The recommendation to align relevant federal programs to improve ac-

cess and accountability for mental health services is broad and touches on changes in many programs, including Medicaid, vocational rehabilitation, Social Security, and housing programs. In most cases, specific changes are recommended, but the Commission also expects an ongoing effort to better tailor these programs to the needs of people with mental illness.

Changes in federal programs that finance mental health care are also required to achieve the next recommendation, which is for each state 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 scope of block grant funding, is limited. Because most funding for mental health care comes from mainstream programs such as Medicaid, Medicare, and Social Security that are not controlled by state mental health authorities, the scope of state mental health planning must be elevated to achieve needed change. However, to assist states in achieving their goals for mental health care, 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 mental health agencies—for example, among homeless persons, in jails and prisons, and in the juvenile justice and child welfare systems. Achieving this recommendation will take concerted action over many years.

The final recommendation under this goal is to protect and enhance the rights of people with mental illnesses. Although addressing service delivery problems was a major focus of the Commission, feedback from consumers consistently emphasized enhancing 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 when they are clinically unnecessary. It calls for ending employment discrimination, and for the federal government to provide leadership in this area—for example, by eliminating the use of employment

questionnaires that inquire about the applicant's history of mental health care. The recommendation also calls for ending the terrible practice of "trading custody for care," in which parents relinquish custody in order to obtain Medicaid-paid services that are available to children in foster care.

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* (4), the Commission found that disparities experienced by minority groups in both access to and quality of care remain a persistent problem. Such disparities are also a problem for residents of rural areas. One recommendation for transforming care to eliminate disparities is to improve access to high-quality care that is culturally competent. For minority populations—and for some residents of rural areas, such as frontier states and Appalachia—improving mental health care means not only improving access but also improving clinical quality and ensuring cultural competence—the ability of treatment and support programs to meet people on their own terms and in ways that are culturally familiar.

The Commission also noted serious problems in the education and training of mental health care providers that contribute to problems in access and quality, especially for minority and rural populations. University training programs and professional organizations responsible for continuing education must change to adapt to the changing face of the country.

Another recommendation in this area is to improve access to high-quality care in rural and geographically remote areas. The Commission noted the promise of telemedicine to bring specialty mental health expertise to rural and frontier areas, where primary care providers are often the only practitioners available.

Goal 4: Early mental health screening, assessment, and referral to services are common practice.

The Executive Order that created the Commission emphasized that its focus should be on "children with serious emotional disturbance and adults with serious mental disabili-

ties," which may seem to imply a concern only for those most in need. But the Executive Order also required the Commission to "identify unmet needs and barriers to service." Balancing these concerns, the Commission concluded that early screening, assessment, and treatment must become a national goal. Indeed, many of the worst problems associated with the current system result from failing to detect the development of serious conditions early—when the prospects for effective treatment or even prevention are best—and from intervening too late. This pattern clearly contributes to the high rates of school failure among children and disability among adults with mental illness.

The recommendations to advance this goal emphasize the need for an expanded mental health presence in settings in which mental disorders can be identified effectively under the right conditions and for early screening, identification, and links to care. Four recommendations attack this objective. Their common thrust is a focus on early detection and links to care.

With respect to early childhood, the Commission recommends a commitment to promoting the mental health of young children. *From Neurons to Neighborhoods*, the recent joint report of the National Research Council and the Institute of Medicine (15), noted that "early child development can be compromised by social, regulatory, and emotional impairments. . . . Given the substantial short- and long-term risks that accompany early mental health impairments, the incapacity of early childhood programs to address these concerns and the severe shortage of early childhood professionals with mental health expertise are urgent problems."

In recommending a stronger focus on childhood and early-childhood mental health, the Commission endorsed the emerging concept of "resilience," which is defined in the report as "the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stressors." The Commission recommended broader adoption of the Nurse-Family Partnership, a program that has been shown to be cost-effective in reducing negative

outcomes such as juvenile delinquency by supporting and training young mothers who, along with their children, are at risk. This program flourishes at the boundaries between child development and mental health intervention and between prevention and treatment. The field of early-childhood mental health is in its infancy, but well-researched efforts, such as the Nurse-Family Partnership, that integrate sound child development principles with education and support for parents demonstrate that developing resilience in children is both possible and effective.

With respect to children in schools, where every teacher knows the impact of behavioral problems but where public policy lags behind, 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 noted that "schools are in a key position to identify mental health problems early and provide appropriate services or links to services." The Commission cited the Columbia Teen Screen program as a model approach to identifying mental health needs. This effort is based on the premise—reasonable but radical—that an annual mental health checkup for adolescents is at least equally important as an annual physical checkup. By providing screening and links to care—with assurances of parental consent and confidentiality—Teen Screen also takes the aggressive step of focusing on the "demand side" of mental health. If the need for care is demonstrated, the logic goes, public policy will have to follow.

The third recommendation under this goal is to screen for co-occurring mental and substance use disorders and to provide a link with integrated treatment strategies. This recommendation attacks two persistent problems: the frequent failure to recognize substance use disorders among people with a mental illness—and vice versa—and the failure to provide the kind of integrated treatment that is often most effective as well as more convenient for the consumer.

The final recommendation under this goal is to screen for mental disor-

ders in primary care settings, across the lifespan, and to connect the individual to treatment and supports. This recommendation recognizes that primary care settings are a logical place to detect and treat much mental illness but that this outcome is possible only if the capacity to assess and treat is present—and paid for. The report cites the collaborative care model as an evidence-based, effective approach. Because older people rely on primary care and may be less likely to seek out mental health specialists, the collaborative care approach pairs mental health professionals with primary care physicians in a team approach to care. As noted in the report, Medicare and other payers do not currently reimburse for the specialty mental health services and consultation that are critical to collaborative care. Reimbursement for core components of evidence-based collaborative care would cover such services as case management, disease management, supervision of case managers, and consultations by qualified mental health specialists that do not necessarily involve face-to-face contact with clients.

Goal 5: Excellent mental health care is delivered, and research is accelerated. This goal provides a comprehensive approach to linking science, services, and treatment. It responds to the gaps between science and services cited by the Institute of Medicine and the Surgeon General with four main strategies, each addressed by a specific recommendation. Briefly, the strategies are better-targeted research, 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. Although the Commission recognized that its mission was to address service delivery problems, it felt strongly that it was time to articulate a major, long-range commitment to “go for the cure” of serious mental ill-

ness. A more immediate research-related recommendation follows—to advance evidence-based practices by using dissemination and demonstration projects and to provide oversight by a public-private partnership for their implementation. 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 may not reimburse evidence-based approaches, in part because professional training programs may not teach these methods, and for other reasons. The Commission adopted the Institute of Medicine’s view of evidence-based health care: the integration of best-researched evidence and clinical expertise with patients’ values.

A specific commitment and strategy to accelerate the “science-to-services cycle” is one of the Commission’s most concrete and promising recommendations for improving the quality of care. The report notes that accelerating this cycle requires more than better dissemination of research. Also required is improved research that tests emerging innovations in field settings and considers treatments that are practical. Adjusting reimbursement to cover evidence-based practices is essential.

Evidence is emerging about the mounting workforce crisis affecting mental health care. The Commission heard many concerns about this problem—from the shortage of child psychiatrists to the nursing crisis to the virtual absence of mental health professionals in rural and frontier America. Therefore, one of its recommendations is to improve and expand the workforce providing evidence-based mental health services and supports. This recommendation calls for national leadership by the federal government and for every mental health education and training program to examine its relevance, consistency with new knowledge, and contributions to addressing the workforce problem.

The final recommendation under this goal is to develop the knowledge to inform policy and practice in four understudied areas: mental health disparities, long-term effects of med-

ications, trauma, and acute care. This recommendation addresses the need to rebalance the nation’s incomplete research portfolio by focusing on such areas as disparities in the mental health of different groups, the long-term safety and efficacy of medications, and the impact of trauma, including abuse. Also, the Commission became aware that several regions of the country are experiencing a crisis in access to ambulatory and inpatient acute care; however, the Commission found no national tracking system or data sets that focus on this critical aspect of care. The lack of national data on this problem must be remedied.

Goal 6: Technology is used to access mental health care and information. Although the Commission’s major focus was on issues, problems, and opportunities in mental health care itself, the pace of technological development in general and in health care in particular demanded its attention. Technology, including use of the Internet to obtain information and the impact of computers on care systems, had to be addressed. The Commission observed that the use of technology in mental health care has lagged, and it recommended investments to address this problem. The report describes a model program based in San Diego—the Network of Care (www.networkofcare.org)—that is demonstrating the potential of technology to help consumers cut through system barriers to get information and improve access to care. Access to health information by use of the Internet and to clinical expertise by use of “telehealth” systems is important both in large, complex urban systems and in rural areas. Therefore, the Commission recommended the use of health technology and telehealth to improve access to and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

The Commission also sees great promise in the emerging technology of integrated, personalized electronic mental health records, not only to improve the quality of care—for example, by reducing medication errors and enhancing continuity of care—but also to empower consumers. The report cites the use of information

technology in the Department of Veterans Affairs health care system as a model and recommends a national commitment to developing and implementing integrated electronic health records and personal health information systems. Consumers and clinicians are legitimately concerned about personal health information getting into the wrong hands. The Commission believes that the strongest credible assurances must be provided that the confidentiality and privacy of information is maintained. Once privacy is ensured, the promise that technology has to improve access, consumer control, quality, and efficiency in mental health care should not be ignored.

Will the Commission's work make a difference?

This question must now, and continually, be asked. The members of the Commission are under no illusion that their report, no matter how responsive and well received, will by itself transform a fragmented and often troubled system. We have hope that the rare opportunity of having Presidential attention focused on mental health care, and having follow-through by the Administration, will make a difference.

When the final 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 plan for follow-through. In August, Kathryn Power, former mental health director for the state of Rhode Island, began work as the director of SAMHSA's Center for Mental Health Services and was charged with taking the lead in developing the implementation approach. Having "point responsibility" firmly established for follow-through is a good sign.

Members of the Commission are also encouraged by the shared desire for change that emerged from consumers, family members, providers, and advocates—and by the collaboration among advocates and professional organizations that is occurring. In particular, creation of the Campaign for Mental Health Reform, a coalition of many of the leading advocacy and pro-

fessional organizations in mental health, is a good sign. The campaign's member organizations are committed not only to working within their organizations—for example, with their state chapters—but also to advocating at the national level. Strong action at both levels will be important.

A concern the Commission heard frequently during the process was the hope that "the report must not sit on a shelf." Our view is that the Commission's report is a diagnosis and treatment plan for a system of care that is sick in many ways. But the system also has many strengths—effective treatments, dedicated clinicians, passionate advocates, and the essential ingredient of hope. Our experience suggests that developing a good treatment plan is necessary—but certainly not sufficient—for progress and recovery. Implementation activities must be both "top-down" and "bottom-up." On one hand, national leadership must be provided for activities such as antistigma campaigns and for change in federal programs. On the other hand, people recovering from mental illness can demand greater participation in the development of their treatment plans. In addition, many of the Commission's recommendations for change call for action at other levels of the system: university training programs must examine their curricula, provider organizations must take steps to become more culturally competent, and organizations and professionals at all levels must make efforts to adopt evidence-based interventions.

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 whether participants in mental health care can establish a shared commitment to the changes that are needed and whether the political and economic environments that we work in 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 elected offi-

cials and all members of the mental health community to commit to that goal. ♦

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