



PRESIDENT'S NEW FREEDOM

COMMISSION ON MENTAL HEALTH

Date: October 29, 2002

Dear Mr. President:

When you launched our Commission on April 29, 2002, you observed, “America’s citizens with mental illness deserve our respect, and they deserve excellent care.” We could not agree more. There are a range of effective treatments for people with mental illness, according to the landmark 1999 report, *Mental Health: A Report of the Surgeon General*. It is our firm conviction that if these effective treatments were more efficiently delivered through our mental health services system, your vision of excellent care would become a reality across America. Millions of Americans would be more successful in school, at work, and in their communities. They could contribute more fully to the vibrancy of American life.

Our review for this interim report leads us to the united belief that America’s mental health service delivery system is in shambles. We have found that the system needs dramatic reform because it is incapable of efficiently delivering and financing effective treatments—such as medications, psychotherapies, and other services—that have taken decades to develop. Responsibility for these services is scattered among agencies, programs, and levels of government. There are so many programs operating under such different rules that it is often impossible for families and consumers to find the care that they urgently need. The efforts of countless skilled and caring professionals are frustrated by the system’s fragmentation. As a result, too many Americans suffer needless disability, and millions of dollars are spent unproductively in a dysfunctional service system that cannot deliver the treatments that work so well.

A fragmented services system is one of several systemic barriers impeding the delivery of effective mental health care. Our interim report describes other problems, including our failure to serve those with the most serious illnesses, our failure to intervene early in childhood, and our Nation’s failure to recognize mental health care as a national priority. We are optimistic that our Commission, in its final report, can offer you many solutions for improving the serious problems we have uncovered. In this interim report we identify several stellar community-based models—models that illuminate how services can be innovatively and effectively delivered in spite of these overwhelming barriers. We are awestruck at what can be learned from the people who pioneered these programs, from educators in Dallas all the way to Air Force Generals. Their inspiring example can lead the Nation in mental health system reform.

Sincerely,

Michael F. Hogan, Ph.D.
Chairman, President’s New Freedom Commission on Mental Health

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Interim Report of the President's New Freedom Commission on Mental Health

The President's New Freedom Commission on Mental Health was established as part of the President's agenda to ensure that Americans with mental illness not fall through the cracks, that lives not be lost, and that recovery be a realistic goal of treatment. The Commission is essential to the President's commitment—embodied in the New Freedom Initiative—to eliminate inequality for Americans with disabilities.

President George W. Bush asked the Commission in April of 2002 to recommend improvements in the U.S. mental health service system for adults with serious mental illness and for children with serious emotional disturbances. He requested a review of both public and private sectors to identify policies that could be implemented by Federal, State, and local governments to maximize the utility of existing resources, to improve coordination of treatments and services, and to promote successful community integration.

While the Commission's recommendations will be presented in its final report in April 2003, this document responds to the legal requirement for an interim report (Executive Order 13263):

Sec. 6 (a) Interim Report. Within 6 months from the date of this order, an interim report shall 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 Commissioners are highly motivated to respond to the President's charge. Through monthly meetings, the Commission has reached out to consumers of mental health care, families, advocates, public and private providers, administrators, and researchers. The Commission has received public comments by personal testimony, letters, and an Internet web site. Individuals throughout the country have shared their experiences and offered suggestions on ways to improve mental health service delivery. The Commission held a meeting in Chicago to grasp firsthand the challenges that youth and families face,

and it plans to hold meetings elsewhere in the United States. The Commission has asked experts in mental health care to evaluate various aspects of mental health services and to offer recommendations for improvement.

After several months of hearing from the public, the Commission affirms the President's position that Americans deserve a health care system that treats their mental illnesses with the same urgency as it treats their medical illnesses. In an ideal system, all individuals would receive prompt, high quality, effective care with the same priority, regardless of diagnosis.

The Commission is united in the belief that the mental health service delivery system needs dramatic reform. It is becoming clear that the mental health services system does *not* adequately serve millions of people who need care. While many consumers do receive effective treatments and services, many others do not. The system is fragmented and in disarray—not from lack of commitment and skill of those who deliver care, but from underlying structural, financing, and organizational problems. Many of the problems are due to the “layering on” of multiple, well-intentioned programs without overall direction, coordination, or consistency. The system's failings lead to unnecessary and costly disability, homelessness, school failure, and incarceration.

This interim report first describes the Commission's findings about the extent of unmet needs and the barriers to care. For each barrier, the Commission then spotlights one or more community-based models with proven success in coordinating services and producing desired outcomes. The Commission will further examine these models as part of potential solutions for the mental health system.

Unmet Needs and Barriers to Care

Mental illness is shockingly common, affecting almost every American family—directly or indirectly. It can strike a child, a brother, a grandparent, or a co-worker. It can strike someone of any background—white, African American, Asian American, Pacific Islander, Hispanic American, or

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Native American. It can strike at any stage of life, from childhood to old age. No community is unaffected, no school or workplace untouched.

About 5-7 percent of adults, in a given year, have a serious mental illness, according to several nationally representative studies (DHHS, 1999; Kessler et al., 2001; NHSDA, 2002). “Serious mental illness” is a term used in federal regulations for any diagnosable mental disorder that affects work, home, or other areas of social functioning. A similar percentage of children, about 5-9 percent, have a “serious emotional disturbance,” or SED. This term also comes from Federal regulations, and it refers to any diagnosable mental disorder (in a child under age 18) that severely disrupts social, academic, and emotional functioning.

The annual prevalence figures translate into millions of adults and children disabled by mental illness. *The disability toll can be quantified in a way that cannot be ignored:* when compared with all other diseases (such as cancer and heart disease), mental illness ranks *first* in terms of causing disability in the United States, Canada, and Western Europe, according to a study by the World Health Organization (WHO, 2001). This groundbreaking study found that mental illness (including depression, bipolar disorder, and schizophrenia) accounts for 25%

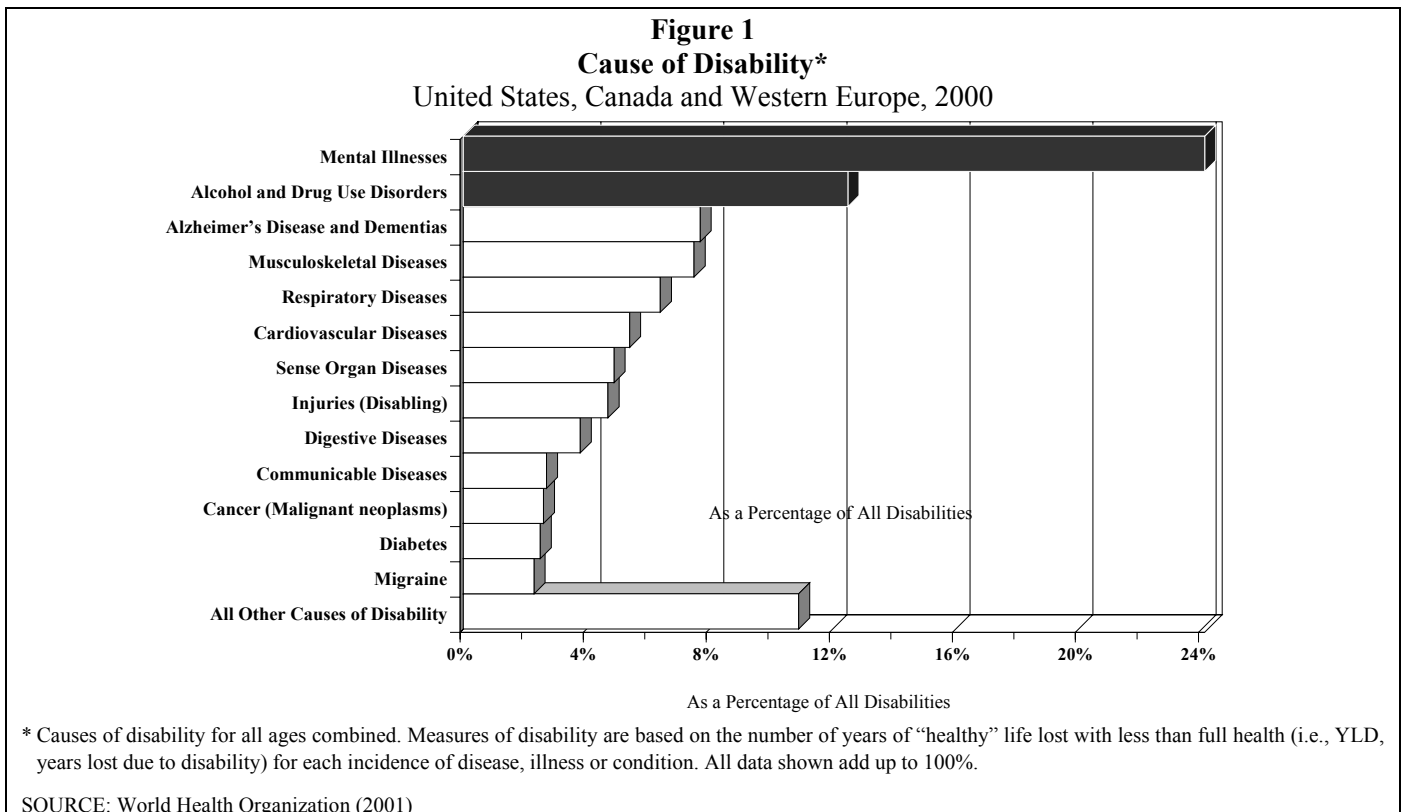
of all disability across major industrialized countries (Figure 1). In the US, the economy’s loss of productivity from mental illness amounts to \$63 billion annually (DHHS, 1999).

The bottom line is that mental illness is very common and very disabling—and *not* to be dismissed as a character flaw or weakness. In the speech launching this Commission, the President said, “...Americans must understand and send this message: mental disability is not a scandal—it is an illness. And like physical illness, it is treatable, especially when the treatment comes early.”

There are many effective treatments for mental illness, according to the landmark 1999 report, *Mental Health: A Report of the Surgeon General*. With effective treatment, services, and the support of families, friends, and communities, the possibility of recovery is no longer elusive.

“My experience was very positive. ...I feel that my recovery from depression was due to the provider’s flexibility in services.”

—Ohio parent with depression



While many people are given good care and manage to recover, the reality is that about one out of every two people who needs mental health treatment does not receive it (Kessler et al., 2001; NHSDA, 2002). The individual who reaches care may find that many treatments and services are simply unavailable, especially in rural areas. Also, the quality of care may be inadequate. A diagnosis may sometimes be missed, the dose of medication may be insufficient, or the length of treatment too short (DHHS, 1999; Young et al., 2001). For ethnic and racial minorities, the rate of treatment is even lower than that for the general population, and the quality of care is poorer. After thorough study of the problem, the Surgeon General's report concluded that minorities, in comparison to whites, bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity (DHHS, 2001).

“Mental illness is an equal opportunity disease. Yet we are the expendable ones. If you are poor and female and minority – I’m African American ... the system isn’t operating as it should.”

—Hikmah Gardiner, Older Adult Consumers Mental Health Alliance, Mental Health Assoc. of Southeastern Pennsylvania

The stigma of mental illness is also a major barrier to treatment. Many people are reluctant to seek care because of the shame our society attaches to mental illness. Societal stigma leads to ridicule, ostracism, and inexcusable discrimination in housing and employment. Stigma is often internalized by individuals with mental illness, leading to

hopelessness, lower self-esteem, and isolation. Even more tragically, stigma deprives them of the social support they need to recover.

“Stigma leads to isolation, and discourages people from seeking the treatment they need.”

—President George W. Bush, April 28, 2002

This Commission has been charged to focus on the service system and to identify the barriers to getting services. Through its activities, the Commission has identified *five* barriers (Exhibit 1) that needlessly impede access to care within the mental health system. These barriers do not stand in isolation; tearing down any one of them has the potential to bring down some others.

The heartening news is that the Commission has found creative, community-based programs that begin to circumvent the barriers. These programs carry a track record of success at achieving desired outcomes. Our review indicates that the best results are often achieved *despite*—not because of—financing systems and bureaucracies that often create fragmentation instead of focus and reward dependency instead of recovery. *The system should foster recovery, resilience, and independence, not thwart them by limiting access to effective treatments.* After a short description of the fragmented system, the Commission describes each of the exemplary programs. They range from school-based mental health care in Dallas to suicide prevention by Air Force generals. The Commission will consider the programs' implications and opportunities, along with other solutions, in its final report.

Exhibit 1 Barriers to Care Within the Mental Health System

- **Fragmentation and Gaps in Care—for Children**
- **Fragmentation and Gaps in Care—for Adults with Serious Mental Illness**
- **High Unemployment and Disability for People with Serious Mental Illness**
- **Older Adults With Mental Illnesses Are Not Receiving Care**
- **Mental Health and Suicide Prevention Are Not Yet National Priorities**

A Fragmented Mental Health System

The mental health services system defies easy description. Loosely defined, the system collectively refers to the full array of programs for anyone with mental illness. The programs deliver or pay for treatments, services, or any other types of supports, such as disability, housing, or employment. These programs are found at every level of government and in the private sector. They have varying missions, settings, and financing. The mission could be to offer treatment in the form of medication, psychotherapy, substance abuse treatment, or counseling. Or it could be to offer rehabilitation support. The setting could be a hospital, a community clinic, a private office, or in a school or business. The financing of care, which amounts to at least \$80 billion annually,¹ could come from at least one of a myriad of sources—Medicaid, Medicare, a state agency, a local agency, a foundation, or private insurance. Each funding source has its own complex, sometimes contradictory, set of rules. Taken as a whole, the system is supposed to function in a coordinated manner; it is supposed to deliver the best possible treatments, services, and supports—but it often falls short.

Consider the daunting scenario for someone with both a serious mental illness and a substance use disorder, the most disabling sets of disorders according to the study by the World Health Organization (Figure 1). Three million adults have this combination of conditions (NHSDA, 2002). Mental illness is often treated in one setting (e.g., a mental health clinic or a psychiatric hospital), while substance abuse treatment is often given in another (e.g., a detox program or a methadone program). The rules governing eligibility for care often vary across those settings. And the rules governing payment vary too, depending on which funding sources apply. Many rules also differ for children and adults, a precarious problem for adolescents whose benefits may be lost as they enter adulthood. Because mental illnesses and substance use disorders are often long-term in nature, the inconsistencies of the system play out day-to-day, week-to-week, and year-to-year.

“When I turned 18, I lost all my services.”

—Student from Chicago

The reasons for fragmentation of the mental health system are complex and driven by historical forces (DHHS, 1999). The milestone carrying the greatest significance traces back to the 1950s, with the move away from care in institutions to care in communities. Long-term institutional care was expensive, neglectful, ineffective, and sometimes harmful. But the care was provided under one roof. The movement away from institutions, known as de-institutionalization, was motivated by reformers' desire to bring services to people in their communities. The unintended consequence is that responsibility is scattered across levels of government and across multiple agencies. New programs created to fill gaps in care added to the complexity and fragmentation. The Federal government pays for most services for people with a serious mental illness, while responsibility for providing them rests with states and localities. Compounding this problem, most Federal resources are in mainstream programs (e.g., Medicaid, Medicare, Vocational Rehabilitation, housing) that are not tailored to the requirements of good mental health care. While many providers are very dedicated and make valuable contributions despite the disorganization of the system, no one is ultimately responsible. Tragically, consumers and families are left with the struggle to find services, all the while coping with disorders that strike the mind and often cripple the ability to plan, manage, and advocate for care.

It is no wonder that people with mental illness, by the very nature of the illness, are the least equipped to navigate their way through the complexities of the mental health system.

“When my son first became ill we were totally adrift ... help from the ‘system’ was difficult to obtain ... he was unable to remember appointments. Confidentiality was given as the reason why we, as his parents, could not be advised of date and time for appointments. Therefore, he did not receive needed help. Any other illness would have been treated quite differently. When he was released from a hospital, local wrap-around services were almost impossible to obtain. Case management was fragmented, case managers seemed to have no training ... some really tried and cared, but they soon burned out and left ...”

—Parents from Ohio

¹ This figure represents the 1996 expenditures for direct treatment of mental disorders and addictive disorders (DHHS, 1999).

The reality is that the mental health system looks more like a maze than a coordinated system of care. When the system fails to deliver the right types and combination of care, the results can be disastrous for our entire Nation: school failure, substance abuse, homelessness, minor crime, and incarceration. While there are 40,000 beds in state psychiatric hospitals today (NASMHPD, 2001), there are hundreds of thousands of people with serious mental illness in other settings not tailored to meet their needs—in nursing homes, jails, and homeless shelters.² The rates of serious mental illness among incarcerated persons are about three to four times those of the general U.S. population (Teplin, 1990).³ Something is terribly wrong, terribly amiss, with the mental health system.

The unmet needs are likely to deepen with the aging of the population and the demographic growth of minority populations (DHHS, 1999; DHHS, 2001). Fulfilling even the existing unmet needs means addressing fragmentation, as well as inadequate capacity to train personnel, monitor quality of care, and give information to consumers, families, and providers about best practices.

Fragmentation and Gaps in Care—for Children

“No one should be needing to play hide and seek to locate appropriate mental health treatment while watching a relative deteriorate. After one year, we have not found one resource to help us coordinate mental health care...it is a full time job for me to coordinate all the appointments with psychiatrists, counselors, blood work, social services, and special education ...We hope that our 1992 van will weather the winter without major work.”

—Parent from Wisconsin

The “mental health maze” is more complex and more inadequate for children. The most seriously affected children are defined, under Federal regulations, as having “serious emotional

disturbance,” which means that they have a diagnosable disorder that severely disrupts social, academic, and emotional functioning. About 7-9 percent of all children (ages 9 to 17) have serious emotional disturbance, or SED (DHHS, 1999). *That means one or two kids with serious emotional problems in virtually every classroom.* The Commission has heard from families whose children could not get an accurate diagnosis for years and for whom the maze of “helping” programs is “opaque,” in the words of a father from Chicago. The potential sources of help may include teachers, school counselors, pediatricians, family physicians, psychiatrists, clinics, psychologists, and courts. Families do not know where to turn, and the first choices may not be able to help. The service system in many communities is *more fragmented* for children than that for adults, with even more uncoordinated funding streams and differing eligibility requirements. This problem is partly the unintended result of good intentions: there are more programs set up to serve children than adults. But this leaves coordination up to families who are coping with their children’s behavioral problems and who may not have the knowledge to navigate the maze. All of the problems are disproportionately worse for children who are ethnic and racial minorities (DHHS, 2001).

Intervening with good services can help to prevent the worst nightmares for families: school failure, juvenile delinquency, substance abuse, and suicide. Yet only a fraction of children with SED has access to school-based or school-linked mental health services. The failure to reach many SED children in schools is partly the result of an approach to special education that also needs reform, as the President’s Commission on Excellence in Special Education has recommended. Those children with SED who are identified for special education services have higher levels of absenteeism, higher drop-out rates, and lower levels of academic achievement than students with other disabilities.

Model Programs

The Commission has identified several exciting community-based models that make tangible differences for our children and adolescents. They range from prevention in infancy all the way to treatment of the most severe problems in adolescence. They focus on tailoring services to children at the greatest risk, particularly minority youth.

² About 250,000 inmates in U.S. prisons have mental illness (Psychiatric Services, 1999).

³ The elevated rates are determined by using standardized diagnostic instruments and similar time-frames.

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One model program starts early, indeed before birth. It is one of the few proven methods of preventing our children from tumbling into the juvenile justice system. The program is almost too simple to contemplate: it sends a trained nurse to the home of a high-risk woman during her first pregnancy and extending through the first year of her child's life. The nurse helps the young, typically unmarried, woman learn how to parent and to avoid risky behavior. The benefits are tangible for children a remarkable 15 years later: more than 50 percent reduction in their arrests and convictions, less risky behavior, and fewer school suspensions and destructive behaviors (Box 1). The less risky behavior entailed fewer sexual partners, less running away, and less use of illegal substances. These benefits were documented by the most rigorous type of study—a randomized clinical trial—after which children were tracked for 15 years. The results have been published in the most prestigious medical journals and have been replicated in several cities, including an inner city, urban population.

Our review indicates that this program, the *Nurse-Family Partnership*, is so impressive that it is being used in 270 cities in 23 states. It could be expanded further, except for one obstacle: the service does not fall under any traditional category of Federal or state program jurisdictions. Federal programs typically do not provide reimbursement without waivers of existing rules. The system is simply not organized in a way that readily rewards effective innovations and promotes proven methods of prevention.

The mental health service system also needs to consider new ways to deliver care to children in a place long overlooked, our Nation's schools. Almost a decade ago, in 1993, a school principal in Dallas partnered with a physician to build the Nation's first comprehensive school-based program in mental health. The partners bridged two distinct systems, the school system and the mental health system, by creating a new access point for mental health care in the schools, using both school district and mental health funds. The story of this union is inspiring (Box 2). The program has ushered in improvements in

Box 1

Example of Intervening Early to Prevent Mental Health Problems

- **Program: Nurse-Family Partnership**
- **Goal:** To improve pregnancy outcomes by helping mothers to adopt healthy behavior, to improve child health and development, to reduce child abuse and neglect, and to improve families' economic self-sufficiency.
- **Features:** A nurse visits the homes of high-risk women beginning in pregnancy and continuing for the first year of children's lives. The nurse adheres to visit-by-visit protocols to help women adopt healthy behaviors and to responsibly care for their child. In many States, Nurse-Family Partnership programs are funded as special projects or via state appropriations.
- **Outcomes:** For mothers: 80% reduction in abuse of their children, 25% reduction in maternal substance abuse, and 83% increase in employment. For children (15 years later): 54-69% reduction in arrests and convictions, less risky behavior, and fewer school suspensions and destructive behaviors. This is the only prevention trial in the field with a randomized, controlled design and 15 years of follow-up. The program began in rural New York 20 years ago, and its benefits have been replicated in Denver and in minority populations in Memphis (Olds et al., 1997; Olds et al., 1998; Kitzman, 2000).
- **Biggest Challenge:** To preserve the program's core features as it grows nationwide. The key feature is a trained nurse, rather than a para-professional, who visits homes. A randomized, controlled trial found para-professionals to be ineffective (Olds et al., 2002).
- **How Other Organizations Can Adopt:** Modify requirements of federal programs, where indicated, to facilitate adoption of this effective, cost-effective model.
- **Contact Point:** Dr. David Olds, University of Colorado
- **Sites:** 270 communities in 23 states

Box 2
Example of School-Based Mental Health Program

- **Program: Dallas School-based Youth and Family Centers**
- **Goal:** To establish the first comprehensive school-based program in mental health care in the 12th largest school system in the Nation. The program overcomes stigma and inadequate access to care.
- **Features:** Integrates physical and mental health care at nine locations. The mental health component features partnerships with parents and family, treatment (typically 6 sessions), and follow-up with teachers. Trains school nurses, counselors, and principals to identify problems and make changes in the classroom tailored to each child's needs. Annually serves 3,000 mostly poor, Hispanic, and African American children and families.
- **Outcomes:** Improvements in attendance, discipline referrals, and teacher evaluation of child performance (Jennings et al., 2000). Preliminary evidence reveals improvement in children's standardized test scores in relation to national and local norms.
- **Biggest Challenge:** To sustain financial and organizational support of collaborative partners in spite of resistance to change or jurisdictional barriers. Program's \$3.5 million funding comes from the school district and an additional \$1.5 million from Parkland Hospital.
- **How Other Organizations Can Adopt:** Recognize the importance of children's mental health for school success. Rethink how state and Federal funding streams can be more efficiently partnered and utilized by school systems to deliver these services.
- **Contact Point:** Jenni Jennings, Dallas Independent School District
- **Sites:** Dallas and Fort Worth, Texas

children's attendance, discipline referrals, and teacher evaluation (Jennings et al., 2000). There is even preliminary evidence showing that standardized test scores of children served by the program improve relative to their peers, nationally and locally. The program serves a high number of minority children. The staff are ethnically diverse, with almost 70 percent African American or Hispanic. Having staff who share cultural backgrounds with children and families naturally helps to engage them. It also illustrates a key component of what has been called "cultural competence."

Another exemplary program expressly targets children with serious emotional disturbance. The program, called *Wraparound Milwaukee*, strives to integrate services and funding for the most seriously affected children and adolescents (see Box 3). Most are minorities in the child welfare and juvenile justice systems. *Wraparound Milwaukee* demonstrates that the seemingly impossible can be made possible:

children's care can be seamlessly integrated. The services given to children not only work, in terms of better clinical results, reduced delinquency, and fewer hospitalizations, but the services are also cost-effective.

"This is an ordinary miracle."

—Bruce Kamradt, Director, *Wraparound Milwaukee*

For the average child in the program, the cost is almost 40 percent lower than the cost of traditional approaches that emphasize residential treatment, juvenile correctional placements, and psychiatric hospitalization. These traditional approaches had been funded largely by the child welfare and juvenile justice systems, and by Medicaid's mental health benefit. The results of *Wraparound Milwaukee* are eye-opening: after enrollment in the program, the rates

Box 3

Example of Integrated System of Care for Children with Serious Emotional Disturbance

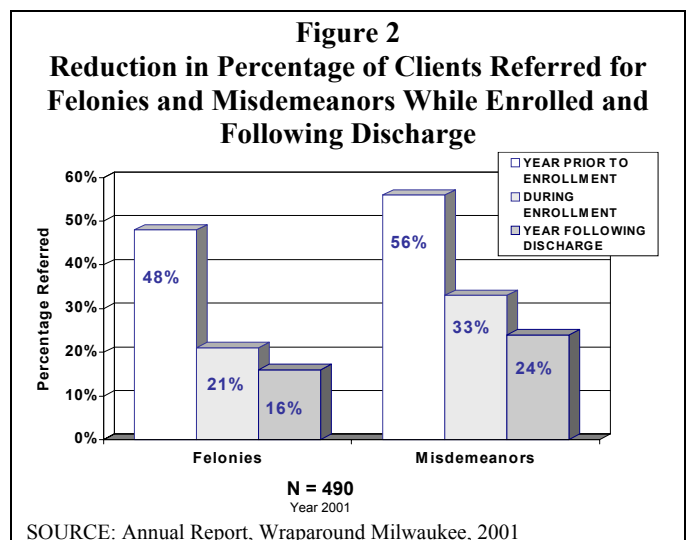
- **Program: Wraparound Milwaukee**
- **Goal:** To offer cost-effective, comprehensive, and individualized care to children with serious emotional disturbance and their families. The children and adolescents served by the program are under court order in the child welfare or juvenile justice system, and 64% are African American.
- **Features:** Provides coordinated system of care through a single public agency (*Wraparound Milwaukee*) that coordinates a crisis team, provider network, family advocacy, and access to 80 different services. The program's \$30 million budget is funded by pooling child welfare and juvenile justice funds (previously spent on institutional care) and by a set monthly fee for each Medicaid-eligible child (the fee is derived from historical Medicaid costs for psychiatric hospitalization or related services).
- **Outcomes:** Reduced juvenile delinquency (Figure 2), higher school attendance, better clinical outcomes, lower use of hospitalization, and reduction in cost of care (Annual Report, 2001). Program costs \$4,350 versus \$7,000 per month per child for residential treatment or juvenile detention.
- **Biggest Challenge:** To expand the program to children with somewhat less severe needs who are at risk for worse problems if they are not recognized and treated.
- **How Other Organizations Can Adopt:** Encourage integrated care and more individualized services by ensuring that funding streams can support a single family-centered treatment plan for children whose care is financed from multiple sources.
- **Contact Point:** Bruce Kamradt, Project Director, Wraparound Milwaukee
- **Sites:** Milwaukee and Madison, Wisconsin; Indianapolis, Indiana; and the State of New Jersey

of felonies and misdemeanors have been cut by about half (see Figure 2). Imagine the nationwide impact on our juvenile justice system if this program were implemented in every community. An astounding 80 percent of children entering the juvenile justice system have mental disorders (Cocozza and Sowyra, 2000). If other states wish to emulate *Wraparound Milwaukee*, they would need waivers from Medicaid and child welfare requirements. Federal programs should be structured to support proven effective models as the standard approach, not as the alternative, which requires such local ingenuity.

Fragmentation and Gaps in Care—for Adults with Serious Mental Illness

Adults with serious mental illness, one of our Nation's most vulnerable groups, suffer greatly from the fragmentation and failings of the system. The evidence of our failure to help them is most apparent and most glaring on our Nation's streets, under our bridges, and in institutions like nursing homes and jails. Some are homeless, and some are dependent on

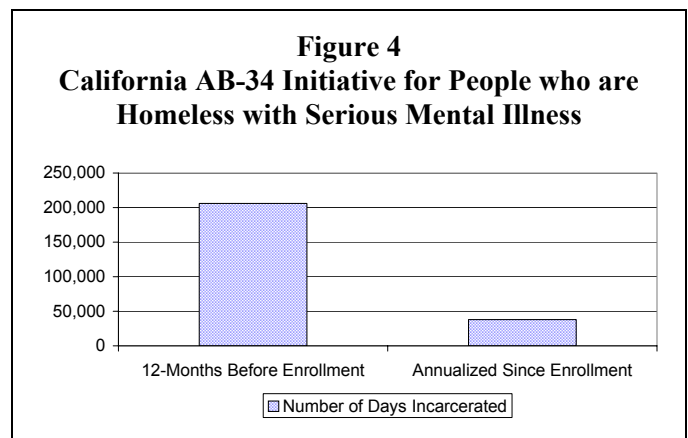
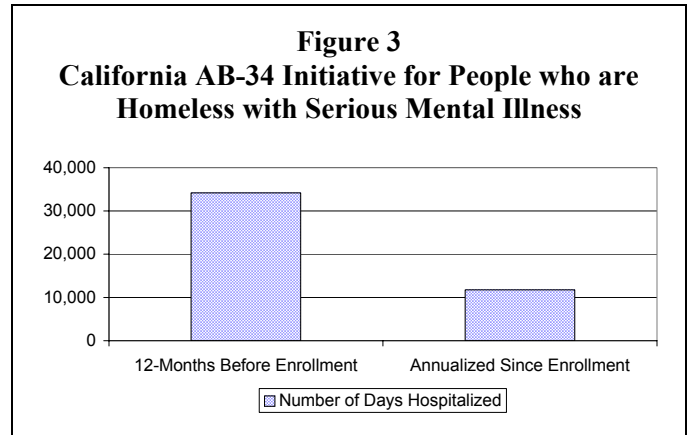
alcohol or drugs. Many are unemployed, and many go without any treatment. Most strikingly, less than 40 percent of those with serious mental illness receive stable treatment (Kessler et al., 2001). An estimated 25 percent of homeless persons have a serious mental disorder and, for the most part, do not receive any treatment (Dickey, 2000). Among those who are



“chronically homeless,” the prevalence of mental illness is even higher. Providing them with quality treatment and flexible supports leads to symptom relief, recovery, employment, less homelessness, less substance abuse, and less incarceration.

Model Programs

Efforts begun in California, Texas, and other states offer a glimpse of solutions that other communities could adopt. In California, mental health leaders realized that a lack of flexibility and focus in existing programs meant that homeless people with severe mental disabilities regularly slipped through the cracks. For example, funding for treatment programs—often based in clinics on the assumption that clients would readily come for care—was not flexible enough to support the months of outreach sometimes needed to convince homeless mentally ill individuals to accept care (see Box 4). Building on successful pilot programs, California created a network of efforts known as AB-34 projects (after the Assembly bill that created them). The AB-34 projects emphasize outreach to homeless individuals where they are. Their goals are to arrange safe and flexible housing and to work assiduously to engage people in care. The projects have yielded a remarkable 80 percent drop in homelessness and 82 percent drop in incarceration (Figures 3 and 4).



Box 4

Example of Integrated Services for Homeless Adults With Serious Mental Illness

- **Program: AB-34 Projects - Named after California Legislation of 2000**
- **Goal:** To “do whatever it takes” to meet the needs of homeless persons with serious mental illness, whether on the street, under a bridge, or in jail.
- **Features:** Outreach (often by formerly homeless people), comprehensive services, 24/7 availability, partnerships with community providers, and real-time evaluation. Flexible funding, not driven by eligibility requirements.
- **Outcomes:** 66% decrease in number of days of psychiatric hospitalization, 82% decrease in days of incarceration, and 80% fewer days of homelessness (Figures 3 & 4).
- **Biggest Challenge:** To change the culture, attitudes, and values around treating difficult populations with different strategies. Traditional services and providers tend to want to continue “business as usual” and follow funding streams rather than integrate services or share responsibility.
- **How Other Organizations Can Adopt:** Change infrastructure to integrate services. This concept is a different way of doing business and requires linkage to a broader array of services, not just mental health.
- **Contact Point:** Dr. Stephen W. Mayberg, Director, California Dept. of Mental Health
- **Sites:** 38 California counties

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Unfortunately, not all states can count on the substantial new resources that California devoted to this problem, and many of the major Federal and state programs that fund mental health care do not provide the flexibility and focus that has been the key to the AB-34 success. Community leaders seeking to provide integrated care must either painstakingly knit together disparate funding sources with sometimes conflicting requirements, or seek major new appropriations of “flexible” dollars. Bureaucracies should not block integrated, effective care for such needy populations, while easily reimbursing ineffective approaches.

Another program shows that high quality, research-based care can be delivered to people with serious mental illness. The Texas Medication Algorithm Project (TMAP) has been so successful it has been adopted in Nevada and at least five other

states (Box 5). Launched in 1996 through a public-university collaboration and funding from the Robert Wood Johnson Foundation and Meadows Foundation, TMAP fills a critical link in the system: it provides up-to-date and research-based procedures—and expert advice—for doctors to consider when prescribing medications. The quality treatment facilitated by TMAP, including information for consumers and families, leads to improved consumer satisfaction and adherence with recommended care, greater symptom relief, and fewer side effects. With the focus and accountability provided by TMAP, both Texas and Nevada also made efficient state-level investments to provide medications to those consumers ineligible for Medicaid or whose only insurance is Medicare. Given that many individuals with serious mental illness are uninsured—yet ineligible for Medicaid—coverage for medications is of great importance.

Box 5 Example of Quality Care for Serious Mental Illness

- **Program: TMAP - Texas Medication Algorithm Project**
- **Goal:** To ensure quality care for serious mental illness through the development, application, and evaluation of medication algorithms. An algorithm is a step-by-step procedure, in the form of a flow chart, to help clinicians deliver quality care via the best choice of medications and brief assessment of whether they work. The target population is serious and chronically ill people served by public programs.
- **Features:** Development of algorithms by research physicians, as well as development of consumer education materials and other tools for treating serious mental illness. Public sector-university collaboration with support of stakeholders, education and technical assistance, and administrative supports to serve the most medically complex patients. Early phases of the project developed and tested the benefits; the program's latest phases are to be implemented everywhere in the state of Texas.
- **Outcomes:** The algorithm package, implemented by Texas, was more effective than treatment-as-usual for depression, bipolar disorder, and schizophrenia (Rush, 2000; Rush, 2001). It reduced symptoms, side effects, and improved functioning. The package's benefit for reducing incarceration is being studied.
- **Biggest Challenge:** To ensure that the entire algorithm package—patient education, frequent medical visits, medication availability, and consultation—is properly implemented in other states and localities.
- **How Other Organizations Can Adopt:** Conduct an active planning process, including meetings with stakeholders, to examine what organizational changes are needed to make the algorithm work best.
- **Contact Point:** Dr. John Rush, Prof. of Psychiatry, Univ. of Texas Southwestern Medical Center, Dr. Steve Shon, Medical Director of the Texas Department of Mental Health and Mental Retardation; Dr. M. Lynn Crismon, University of Texas at Austin
- **Sites:** States of Texas, Nevada, Ohio, Pennsylvania, South Carolina, New Mexico; Atlanta and Athens, Ga.; Louisville, Kentucky; Washington D.C.; San Diego County; and private sector in Denver, Colorado

Every policymaker—and nearly every citizen—knows that many people with mental illness are at risk for homelessness. Contributing factors include the lack of appropriate and affordable housing and the lack of access to medications and rehabilitation supports. These are necessary to help people achieve the personal stability that is key to housing stability. Our review finds that ending chronic homelessness—as the Administration has proposed—requires special attention to the adults with serious mental disabilities who are over-represented among the most needy homeless.

The ACCESS program is oriented to address chronic homelessness. It is a 5-year demonstration program in nine states, funded and administered by SAMHSA,⁴ designed to show that homeless people with serious mental illness can be served by pulling together disparate programs that span mental health, housing, drug and alcohol, benefits and entitlements, and medical treatment (Box 6). Over 5 years, the program demonstrated its mettle: it improved symptoms and everything else that flows from better mental health—quality of life, income, and, of course, housing. It can be done.

“ACCESS took 7,200 chronically homeless, seriously mentally ill, addicted persons off the streets in this country and gave them back their lives.”

—ACCESS Program Director of West Philadelphia, May 2001

Other communities can emulate the three special programs described here—TMAP, AB-34, and ACCESS—to serve people with serious mental illness. However, reform in Federal programs is needed to help states and communities adopt and sustain improved efficiencies. Model programs with flexible funding (e.g., ACCESS at the community level, and AB-34 at the state level) are useful to propel innovation and galvanize change, but the process must exist to translate proven models into more widely adopted services. In order to achieve the goal of ending chronic homelessness, the successes in pilot

programs must be widely replicated. The needed changes may include flexibility to enroll individuals who are not yet disabled enough by a mental illness to qualify under current requirements. Changes may also include requiring the promotion of more timely access to housing certificates and placements. The Commission will study these programs more closely and make specific recommendations for change.

High Unemployment and Disability for People with Serious Mental Illness

The Commission finds that undetected, untreated, and poorly treated mental disorders interrupt careers, leading many into lives of disability, poverty, and long-term dependence. Our review finds a shocking 90 percent unemployment rate among adults with serious mental illness—the worst level of employment of any group of people with disabilities. Strikingly, surveys show that many of them want to work and report that they *could* work with modest assistance (Drake et al., 1999). Instead, our Nation’s largest “program” for people with mental illness is disability payments. The cost of disability is unacceptable in both human and economic terms. The situation is similar in many ways to the old welfare system. Our mental health, rehabilitation, and disability programs unintentionally trap millions of individuals—who want to work—into expensive, long-term dependency.

“... I cannot emphasize enough how important the ability to work in a real job has been to [my daughter’s] self-esteem and therefore to her continued stability.”

—Mother of a woman with bipolar disorder

Model Program

There is new evidence that serious mental illness need not lead to “disability dependency.” Thirty states and several foreign countries are implementing an innovative supported employment program called IPS, or Individual Placement and Support. Pioneered by researchers in New Hampshire, the program is designed to obtain jobs quickly and efficiently for

⁴ The U.S. Substance Abuse and Mental Health Services Administration.

Box 6

Example of Program for Homeless Adults with Serious Mental Illness

- **Program: ACCESS—Access To Community Care And Effective Services And Supports**
- **Goal:** To demonstrate that the most vulnerable Americans—homeless people with serious mental illness—can be served through fresh approaches that bring together five distinct service sectors: mental health, drug and alcohol, housing, benefits and entitlements, and medical treatment.
- **Features:** Outreach, often by formerly homeless people in recovery, to bring services to where homeless people are: on the street, in missions, soup kitchens, shelters, and drop-in centers. Provides them with intensive case management through the highly regarded Assertive Community Treatment. Permits each community, with stakeholder input, to develop its own innovative ways to coordinate services.
- **Outcomes:** Over 5 years, the pooled findings from more than 7,000 homeless people reveal significant improvements in housing, income, and quality of life, and significant reductions in symptoms and substance use (Randolph et al., 2002).
- **Biggest Challenge:** To coordinate services across five independent service sectors and to recognize that homeless people do not readily come to traditional settings for services.
- **How Other Organizations Can Adopt:** Develop innovative ways to deliver services and coordinate existing services for homeless people with mental illness.
- **Contact Point:** Dr. Frances Randolph, SAMHSA
- **Sites:** 18 communities in nine states

people with serious mental illness (Box 7). The program has achieved an employment rate of 60-80 percent (Drake et al., 1999). Productive careers and economic independence are replacing “disability welfare” for many people recovering from serious mental illness. IPS starts with the individual’s career priorities and, through personal support, helps people recovering from mental illness to choose, get, and keep a paying job.

Many nationwide barriers keep other people with mental illness from achieving these positive employment successes. The Vocational Rehabilitation (VR) system often fails people with a mental illness. They are one of the largest disability groups referred to VR, but they achieve the worst employment outcomes relative to other disability groups. Medicaid is the largest public payer for mental health care, but it does not reimburse for vocational training and support for individuals with a mental illness, although many individuals with developmental disabilities receive such services under Home and Community Based Services programs.

The success of the research-based IPS program highlights another problem: Federal agencies have not

proven adept at helping communities implement effective programs on a large scale. The National Institute on Mental Health and the Substance Abuse and Mental Health Services Administration helped research the supported employment model and demonstrate its effectiveness. However, there are not yet tested models to help communities adopt such “evidence-based” services, and to develop service models that are feasible for communities to implement. The Commission will study and make recommendations to improve this “Science to Services” cycle, to make the benefits of research real.

Nationally, our failure to help people with mental illness achieve productive work is not only a personal tragedy, but staggeringly costly. People with mental illness are both the largest and fastest growing group of people with disabilities receiving Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) disability payments. The numbers are immense. An estimated \$25 billion is spent annually for these disability payments (SSA, 2001). Despite the high total cost, the benefits paid to individuals are not adequate to ensure safe housing. Instability in housing contributes to cycles of relapse and poor job success.

Box 7

Example of Supported Employment for People with Serious Mental Illness

- **Program: IPS - Individual Placement and Support**
- **Goal:** To secure employment quickly and efficiently for people with mental illness. An alarming 90% of them are unemployed, yet most wish to be working.
- **Features:** An IPS employment specialist on a mental health treatment team. The employment specialist collaborates with clinicians to make sure that employment is part of the treatment plan. Then the specialist conducts assessments, rapid job searches, and provides ongoing support while the consumer is on the job.
- **Outcomes:** In general, 60-80% of those served by IPS obtain at least one competitive job, according to findings from three randomized controlled trials in New Hampshire, Washington, DC, and Baltimore (Drake et al., 1999). Those trials find IPS far superior to traditional programs that include prevocational training. The cost of IPS is no greater than that for traditional programs, suggesting that IPS is cost-effective.
- **Biggest Challenge:** To move away from traditional partial hospital programs, which are ineffective at achieving employment outcomes yet still reimbursable under Medicaid.
- **How Other Organizations Can Adopt:** Restructure state and federal programs to pay for evidence-based practices like IPS that help consumers achieve employment goals, rather than pay for ineffective, traditional day treatment programs that are not effective in supporting employment.
- **Contact Point:** Dr. Robert E. Drake, Dartmouth Medical Center
- **Sites:** 30 States in the United States, Canada, Hong Kong, Australia, and 6 European countries

Another problem is the link between disability payments under SSI and SSDI and eligibility for health care coverage under Medicaid. Many people with a mental illness find that they *cannot afford to go back to work* because they would lose their Medicaid coverage. The high costs of health care and the unavailability of employer-based health care for people with a “preexisting condition” means that thousands of people with a mental illness make a conscious choice to stay on disability assistance because it provides Medicaid coverage for their expensive medication and treatment needs. Although reforms have been initiated, such as the option for states to extend Medicaid to working disabled individuals, the current economic downturn means that many states cannot afford to implement this option. People with mental illness live in a kind of “disability welfare system” that badly needs reform. The Commission will study this problem and make recommendations for change.

Older Adults with Mental Illnesses Are Not Receiving Care

Depression is alarmingly common among older adults. About 5-10 percent of older adults have major depression, yet most are not properly recognized and treated (DHHS, 1999). Untreated depression causes distress, disability, and, most tragically, suicide. Older men have the highest rates of suicide in the Nation (IOM, 2002). Most worrisome is that the growing number of older Americans will soon magnify and expose existing problems.

“The US population will look like Florida very soon.”

—Stephen Bartels, M.D., M.S., Dartmouth Medical School

Older adults (age 65 or above) manifest depression in different ways than do younger adults, and they are reluctant to get care from specialists (DHHS, 1999). Instead, older people feel more comfortable going to their primary care doctor. Still, they are often more sensitive to the stigma of mental illness, and do not readily bring up their sadness and despair, their feelings of hopelessness and loss. If they acknowledge problems, they are more likely than young people to describe physical symptoms. Primary care doctors may see their suffering as “natural” aging, or treat their reported physical distress instead of the underlying mental disorder. What is often missed is the deep impact of depression on older persons’ capacity to function in ways that are seemingly effortless for others.

Model Program

A novel research project, known as IMPACT, is designed to help primary care doctors spot depression and stop it in its tracks (Box 8). IMPACT⁵ is a multi-site clinical trial that delivers treatment in primary care settings to older people with major depression. In most settings, primary care doctors are on their own to detect and treat mental illness—as well as other ailments—in older adults. With IMPACT, a mental health professional (nurse, social worker, or psychologist) is added to the medical team. IMPACT gives older people the treatment they need—a choice of medications and/or psychotherapy. If those older people receiving their choice of care do not get better, a stepped up approach is offered, supervised by a psychiatrist. The study’s preliminary findings are that the intervention, compared with usual care, leads to reduced prevalence and severity of symptoms, or complete remission. The Commission will examine whether existing reimbursement mechanisms are adequate to support broader use of this cost-effective approach.

Mental Health and Suicide Prevention Are Not Yet National Priorities

Our Nation’s failure to prioritize mental health is a national tragedy. So many lives are at stake, so many

families and communities struggle to stay afloat. This interim report has focused, for the most part, on the shattered lives of adults and children who suffer from mental illness. However, no loss is more devastating than suicide. Over 30,000 lives are lost annually to this largely preventable public health problem. About ninety percent of those who take their life have a mental disorder (IOM, 2002). Many have not had the care in the months before their death that would help them to affirm life. The families left behind live with shame and guilt—a “half-stitched scar,” in the words of poet Elizabeth Jennings (cited in Jamison, 1999).

Model Programs

Put simply, there is no airtight method of preventing suicide. As intractable as suicide may seem to be, some organizations have chosen to confront it. They have tried to change steadfast attitudes that suicide is somehow inevitable. They have taken a stand to stop suicide the best way they can.

One of those organizations comes literally from out of the blue: the U.S. Air Force. In 1996, the Air Force’s Chief of Staff created a suicide program that doesn’t even have a name, a logo, or a brochure. He and his organizers rolled up their sleeves and asked why, why on earth, one-quarter of their Air Force deaths in the early 1990s were from suicide. Their answer: Air Force personnel were reluctant to get help. The Chief of Staff sent not one, but many, hard-hitting messages to personnel worldwide, encouraging them to seek help in times of emotional pain and trauma. Messages were sent from the top of the command structure, from those who embodied the most uplifting ideals of American fortitude, resolve, heroism, and commitment to life.

“Suicide poses a threat to the health and well-being of our community. This is not the time to put this program on autopilot. The loss of a single airman is a loss to us all.”

—General Michael Ryan, Air Force Chief of Staff, in a service-wide electronic message, 2000

⁵ The project was funded by the John A. Hartford Foundation and the California HealthCare Foundation.

Box 8

Example of Program for Treating Late-Life Depression in Primary Care

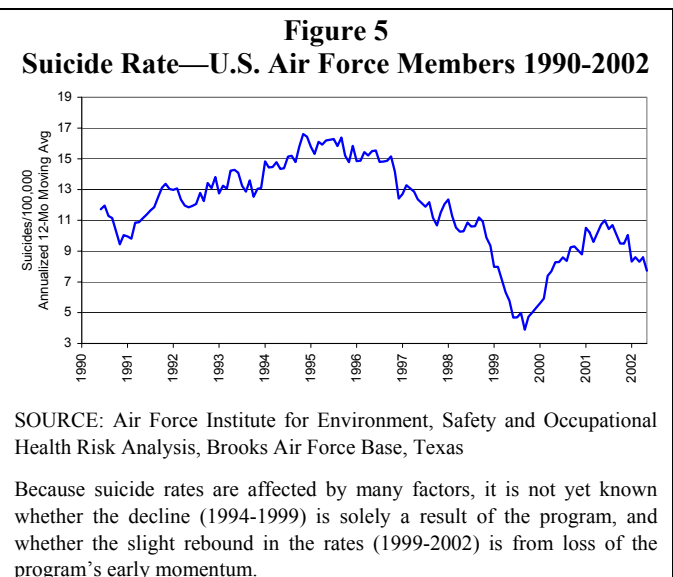
- **Program: IMPACT - Improving Mood: Providing Access To Collaborative Treatment For Late Life Depression**
- **Goal:** To recognize, treat, and prevent future relapses in older patients with major depression in primary care. About 5-10% of older patients have major depression, yet most are not properly recognized and treated. Untreated depression causes distress, disability, and, most tragically, suicide.
- **Features:** A multi-site clinical trial delivering depression care, in the primary care setting, to older people with major depression. Mental health professionals added to the team give older adults a choice of medications or psychotherapy. If they do not get better, a stepped up approach is offered via supervision by a psychiatrist.
- **Outcomes:** The study's preliminary findings are that the intervention, compared with usual care, leads to higher satisfaction with depression care and reduced prevalence and severity of symptoms, or complete remission (Unutzer, 2002).
- **Biggest Challenge:** To ensure that the intervention is readily adapted from the research setting into the practice setting.
- **How Other Organizations Can Adopt:** Be receptive to organizational changes in primary care and to finding new methods of reimbursement.
- **Contact Point:** Dr. Jurgen Unutzer, Principal Investigator, UCLA
- **Sites:** Study sites in California, Texas, Washington, North Carolina, Indiana

The Air Force program has many features (Box 9), but none as inspiring as messages from its leader to change a military culture, to reverse centuries of stoicism in the face of hardship—to encourage going for help. What is known so far is that the suicide rate in the Air Force dropped, from 1994 to 2002, by about 50% (Figure 5). This is a dramatic decline, saving the lives of many in uniform. Because suicide rates are affected by many factors, it is not yet known whether the decline is solely from the program itself, and whether the recent rebound in the rates is from the loss of the program's early momentum. While the program's impact is under study, the Air Force has set an awe-inspiring example. Strong leadership from the top with a comprehensive approach has the potential to save lives in many other settings where leaders can step up to the plate: in colleges and universities, faith communities, businesses, and schools.

Conclusions

Research and personal testimony confirm that recovery from mental illness is real: there are a range

of effective treatments, services, and supports to facilitate recovery. Medical science has devised treatments and services that work, but the system cannot efficiently deliver them. The mental health system is fragmented, in disarray, and in need of dramatic reform.



Box 9

Example of Suicide Prevention & Changing Attitudes about Mental Health Care

- **Program: Air Force Initiative To Prevent Suicide**
- **Goal:** To reduce the alarming rate of suicide—one in every four deaths, 1990-1994—among active duty U.S. Air Force personnel. Suicide was the second leading cause of death, after unintentional injuries, in the Air Force.
- **Features:** The Air Force Chief of Staff, in 1996, initiated a community-wide approach to combat suicide through hard-hitting messages to all active duty personnel. The messages recognized the courage of those confronting life stress and encouraged them to seek help from mental health clinics—moves once regarded as career-hindering, but now deemed “career-enhancing.” Other features of the program: education and training, improved surveillance, critical incident stress management, and integrated delivery systems of care.
- **Outcomes:** From 1994 to 1998, the suicide rate dropped from 16.4 to 9.4 suicides per 100,000 (Litts et al., 2000). By 2002, the overall decline from 1994 was about 50 percent (Figure 5). The University of Rochester is also conducting an external evaluation of the program.
- **Biggest Challenge:** Sustaining the enthusiasm by service providers as the program has become more established.
- **How Other Organizations Can Adopt:** “The program’s principles should be transferable to any community. Every community has leaders and the most basic elements of organization,” said Dr. David Litts.
- **Contact Point:** Dr. David Litts, Advisor to the Surgeon General and Executive Director of the Air Force Program on Suicide Prevention (1996-1999)
- **Sites:** All U.S. Air Force locations throughout the world

The system is not oriented to the single most important goal of the people it serves—the hope of recovery. Many more individuals could recover from even the most serious mental illnesses, if they had access to treatment tailored to their needs, to support, and to services in each of their communities. State-of-the-art treatments, based on decades of research, are not being transferred from research to community settings. Meanwhile, many outdated and ineffective treatments are currently being actively supported.

Our Nation needs to replace the institutions it began to empty 50 years ago with efficient and effective community services that people can count on. It needs to integrate programs that are fragmented across levels of government and among many agencies within every level. It should increase its capacity to fulfill unmet needs. It must prevent people from slipping through the cracks.

Tragically, many of the system’s failures result in needless personal suffering and disability that carry a heavy societal toll. Mental illness, in comparison with

all other diseases and health conditions, is the greatest cause of disability in North America and Western Europe. That was the finding of an authoritative study by the World Health Organization in 2001.

The barriers to mental health care can and must be overcome, and this interim report points to many innovative ways to do so. Across the Nation, many communities have developed and tested programs that blend the wisdom of modern science with the compassion of skilled professionals. These are oases of excellence, and they convince the Commission that excellent care and recovery can become the norm, not the exception. But change will be needed for such exemplary models to become commonplace in our communities. In the coming months, the Commission plans to propose bold new directions for the mental health service delivery system. The President’s charge and the hopes of many families struggling with these disorders allow no less.

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PRESIDENTIAL DOCUMENTS

Title 3 --**Executive Order 13263 of April 29, 2002****The President****President's New Freedom Commission on Mental Health**

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve America's mental health service delivery system for individuals with serious mental illness and children with serious emotional disturbances, it is hereby ordered as follows:

Section 1. *Establishment.* There is hereby established the President's New Freedom Commission on Mental Health (Commission).

Sec. 2. *Membership.* (a) The Commission's membership shall be composed of:

(i) Not more than fifteen members appointed by the President, including providers, payers, administrators, and consumers of mental health services and family members of consumers; and

(ii) Not more than seven ex officio members, four of whom shall be designated by the Secretary of Health and Human Services, and the remaining three of whom shall be designated--one each--by the Secretaries of the Departments of Labor, Education, and Veterans Affairs.

(b) The President shall designate a Chair from among the fifteen members of the Commission appointed by the President.

Sec. 3. *Mission.* The mission of the Commission shall be to conduct a comprehensive study of the United States mental health service delivery system, including public and private sector providers, and to advise the President on methods of improving the system. The Commission's goal shall be to recommend improvements to enable adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate fully in their communities. In carrying out its mission, the Commission shall, at a minimum:

(a) Review the current quality and effectiveness of public and

The President's New Freedom Commission on Mental Health

private providers and Federal, State, and local government involvement in the delivery of services to individuals with serious mental illnesses and children with serious emotional disturbances, and identify unmet needs and barriers to services.

(b) Identify innovative mental health treatments, services, and technologies that are demonstrably effective and can be widely replicated in different settings.

(c) Formulate policy options that could be implemented by public and private providers, and Federal, State, and local governments to integrate the use of effective treatments and services, improve coordination among service providers, and improve community integration for adults with serious mental illnesses and children with serious emotional disturbances.

Sec. 4. Principles. In conducting its mission, the Commission shall adhere to the following principles:

(a) 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;

(b) 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;

(c) 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;

(d) The Commission shall consider how mental health research findings can be used most effectively to influence the delivery of services; and

(e) 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.

Sec. 5. Administration. (a) The Department of Health and Human Services, to the extent permitted by law, shall provide funding and administrative support for the Commission.

(b) To the extent funds are available and as authorized by law for persons serving intermittently in Government service (5 U.S.C. 5701-5707), members of the Commission appointed from among private citizens of the United States may be allowed travel expenses while engaged in the work of the Commission, including per diem in lieu of subsistence. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(c) The Commission shall have a staff headed by an Executive Director, who shall be selected by the President. To the extent permitted by law, office space, analytical support, and additional staff support for the Commission shall be provided by executive branch departments and agencies.

(d) Insofar as the Federal Advisory Committee Act, as amended, may apply to the Commission, any functions of the President under that Act, except for those in section 6 of that Act, shall be performed by the Department of Health and Human Services, in accordance with the guidelines that have been issued by the Administrator of General Services.

Sec. 6. *Reports.* The Commission shall submit reports to the President as follows:

(a) *Interim Report.* Within 6 months from the date of this order, an interim report shall 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.

(b) *Final Report.* The final report will set forth the Commission's recommendations, in accordance with its mission as stated in section 3 of this order. The submission date shall be determined by the Chair in consultation with the President.

Sec. 7. *Termination.* The Commission shall terminate 1 year from the date of this order, unless extended by the President prior to that date.

George W. Bush
The White House,
April 29, 2002.

The President's New Freedom Commission on Mental Health

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