COALITION REPORT

The National Coalition Of Mental Health
Professionals & Consumers, Inc.

Committed to Preserving Choice, Confidentiality and Quality
and to Building a Pro-Consumer Health Care System

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We Won: HIMMA Goes Down to Defeat!

William A. MacGillivray, PhD, ABPP

It is not very often that we are able to recount a victory in our efforts to advocate for privacy, access, choice and quality in mental health and substance abuse services. Many of you were alerted to the dangers of a recent bill before Congress, the Health Insurance Marketplace Modernization and Affordability Act (HIMMA), sponsored by Senator Mike Enzi of Wyoming (also known as S. 1955). We were one of many organizations around the country to mobilize for a national call-in day on May 3 to encourage senators to defeat this bill. Although this bill represented a threat to medical coverage for all manner of health conditions mandated by various state legislatures, it posed a unique challenge to efforts to promote parity for mental health and substance abuse care. The law was promoted as a way to support small businesses to provide health care insurance for workers by allowing employers to come together to enlarge the risk pool and presumably hold down costs for coverage. Although this was a positive goal, the means were a direct threat to efforts across the country to ensure fair coverage for health conditions. According to analysis of American Psychological Association,

> If HIMMA is enacted, it would allow insurers to offer health plans that are exempt from state consumer protection laws, including mental health parity, psychology "freedom of choice," mental health benefit mandates and mandated offering laws. Without these state requirements insurers would be able to offer "barebones plans." The only condition is that they also offer employers an alternative plan based on the state employee benefits in one of the five most populous states, which could also be "barebones." As a result, the benefits in the alternative plan may still be inadequate.

As noted in extensive discussions tracked on various listservs, the ostensive purpose of the law was belied by its effect on mandated coverage and the real purpose was to strip states of there right to "interfere" in business's right to offer the least amount of coverage for the least amount of money. The result was a curious set of circumstances with mainly Republican legislators proposing a national law that would deprive the rights of states to devise their own rules in regulating insurance coverage. One of the particularly pernicious effects of such a law is that individuals would discover that their insurance plan did not cover their medical condition and the state would become the "last resort" for ill citizens who would end up relying upon state resources through Medicaid and Medicare, charity care and ER visits, the so-called "Wal-Mart effect," as employers would be able to shift medical costs for their employees onto the state. As we wrote to our listserv members,

> If this bill passes, it would eliminate vital insurance protections including benefits such as cancer screenings, maternity care, well child care, and mental health care. The bill would also enable health insurers to bypass existing state consumer protection laws, resulting in loss of critical health care for 83 million Americans. This bill will produce higher costs for many small businesses and harm vulnerable workers and families.

There is a sour note that we would acknowledge following this victory. First of all, it is only a defeat of particularly dangerous legislation and the problem of the uninsured worker remains an ever-growing concern. Its defeat does not address our continued reliance upon employer-based insurance system that creates an alliance of insurance industry with employers that is increasingly at odds with the actual needs of citizens. Perhaps in the past when a substantial proportion of wage earners worked all their life for one company, this system made sense. This situation applies to far fewer workers and will continue to do so in the future. It's time for a new system.

That should not take away from a rare and substantial victory. It is to be hoped that health care and mental health care organizations will continue to work together and begin to develop support for a health care system that works for all Americans.

FROM THE PRESIDENT: STANDING UP FOR OUR CRAFT

WILLIAM A. MACGILLIVRAY, PHD, ABPP

I recently attended the Division of Psychoanalysis Spring Meeting. One of the featured speakers was Jane Fonda. I initially was quite resistant to the idea of attending this talk and annoyed at the presenters for organizing a panel that included someone who was asked to attend because of her "star power." I was aware that she had recently written a memoir, which included a dramatic story of her investigation into her family history and the impact of her mother's suicide on her life. But, what could Jane Fonda have to say about psychoanalysis? Well, she had quite a lot to say, nothing terribly original, but she quoted all the right people and addressed reasonably well the importance of a feminist voice in psychoanalytic thinking. What was more fascinating and truly eloquent, was her tribute to her therapist and the impact of therapy as a voyage of discovery. She observed that all her life she would have called herself a feminist, but it was only after therapy that she could feel it in her bones.

There was a lot more to her talk, but what I want to convey that seemed so exciting to hear was her insistence that psychotherapy, the "talking cure," is a radical and life-changing experience. This simple observation struck me as quite novel in the context of the current crisis in our field. Psychotherapy is under assault. We all know that. What we are less aware of, I think, is the insidious nature of this assault on our work. Many therapists have internalized a negative view of the value of their work. I realize this is a strong statement and I can evade objection further by insisting that this devaluation operates on an unconscious as well as conscious level (after all, I am a psychoanalyst!).

Here is an example. Many of our professional organizations have tended to present our work in a more "positive" context, insisting that psychotherapy is not the only thing we do since we are involved in prevention and social action. My own Division of Psychoanalysis was recently featured in the *Monitor on Psychology* (the American Psychological Association monthly magazine) touting the outreach efforts of our members. The message seemed to be that we are good and valuable to the extent we are not "sitting behind the couch" and instead are out there working in other ways for social change.

I honor the efforts of psychotherapists who perform crisis work during disaster, who help out in homeless shelters, or who spend quality time with a foster child. These and countless other service activities are important and vital. But they are not psychotherapy and they cannot replace psychotherapy in the lives of our patients. Returning to Jane Fonda's "story," it was psychotherapy that radicalized her, that transformed her life in ways she is only now beginning to explore. That's what psychotherapy can do! Why are we not able to stand up for this core aspect of our identity? What keeps us from speaking out, from writing to our local papers, for example, whenever a new drug is touted as a cure, or whenever a quick technique is praised over the demands of time and patience?

In this article, I am going to suggest some of the external forces that have immobilized many of our colleagues, including the medicalization of emotional problems and, paradoxically, the very success of psychotherapy in the culture. In the next issue, Michaele Dunlap will address some of the internal forces especially the difficulty psychotherapists in collaborating with one another, with professional turf battles interfering with ability to work together. In that issue, I will also address another "internal saboteur" in the internecine battles between the practitioner and researcher.

MEDICALIZATION OF OUR SOCIETY

This should come as no surprise to any of us. Our patients, our society, have been saturated with the notion that our emotional difficulties are lodged in our brains and that once our "chemicals" are balanced all will be well. The recent movie, *A Beautiful Mind*, illustrates the power of the medical model. In the movie, the implication is quite clear that John Nash, the brilliant mathematician who had been diagnosed with schizophrenia and suffered for years with mistreatment at the hands of the medical profession, including involuntary hospitalization, was successfully treated with medications and his return to sanity was achieved when he finally became "medically compliant." In the PBS documentary, *A Brilliant Madness*, however, a markedly different story is told. We are informed that Nash stopped taking his medications long before he was "restored" to sanity and is still off drugs. More eloquent than that, the documentary ends with the words of John Nash on his cure: It was love that did it. Nash relates that throughout his illness it was the patient understanding of his wife and friends that eventually led him back to sanity. Even in this fine production, there was continued obeisance to the medical model; including stern warnings that Nash's "refusal" to take his medication was a dangerous, albeit successful, decision. There was a particularly (unintentionally) funny scene as the narrator describes the onset of Nash's delusions and the scene shifts to a picture of the brain, as if to insist, *there* are those pesky hallucinations!

There is little doubt that medicine has effected significant changes in people's lives and the ability of life-saving drugs to stave off and even reverse physical conditions associated with cancer, heart disease, vascular illness, diabetes, etc., is truly remarkable. I also think few psychotherapists would argue that medications to relieve crippling symptoms of fear, anxiety, and emotional distress should not be available to our patients. But the data is in, psychotherapy works, more therapy works better than less therapy; patients' controlling their therapy works better that others' controlling the therapy. Patients may not get the immediate relief of medications; but psychotherapy brings sustained benefits beyond relief. And even psychoanalysis ends, while a lifetime regimen of multiple medications is truly interminable. As you can read in an article in this issue, the devastating side effects of medication continue and the new "atypical antipsychotics" have all too typical side effects that are life limiting, if not life shortening.

Here is another example. I recently attended a conference at Harvard Medical School on child and adolescent psychopharmacology and lecturer after lecturer proceeded to define and delimit the various childhood disorders refreshingly unconcerned that the diagnostic system they rely upon is hopelessly inaccurate. And how do researchers reconcile the fact that the diagnostic categories are hopelessly jumbled up? By solemnly invoking the concept of "comorbidity": the disorder is in the patient and not in the language categories that define the same behavior as occurring in a range of diagnostic conditions. Worse was the routine tossed off line, "Of course, CBT will help with this condition." Worst was presenting research indicating that long-term depth psychotherapy works best for bulimia with the sad conclusion, "…but managed care doesn't pay for this." Remember, this was at Harvard!

As psychotherapists, we can bemoan our fate and blame "the media" or "Big Pharma" for the neglect of the value of therapy in our society. Many of our psychiatrist colleagues have given up practice of psychotherapy altogether, citing the lack of reimbursement. Some of our colleagues attempt to cope by gaining prescription privileges, insisting that they will not go the way of the psychiatry ("The right to prescribe is the right not to prescribe." Yea, yea). But the fault also lies with us, with our professional organizations and our own unwillingness to buck the tide and take a stand to protect psychotherapy.

THE DR. PHIL SYNDROME

Now, I don't want to pick on Dr. Phil. For all I know he's a great therapist. I have only seen him once. I do think, however, he is an exemplar of a particular mindset concerning psychotherapy. First, it should be fast, a sound bite between commercials. Secondly, it should be directive and superficial. Once again, I'm all for being directive and I cannot vouch for the profundity of my interpretations. The troublesome message that I think comes through with this commercialization of psychotherapy is that "anybody can do it." This certainly has been the mantra of managed care industry as it willingly pays the same rates for "practitioners," regardless of their level of training, their years of experience, and/or whether or not they have a mental health degree at all.

There is a peculiar confluence of interests with patients wanting a "quick fix," since the culture continually informs them that this is their "right" and a natural process of progress in all areas of their lives, and managed care, which preaches the same mantra for its own benefit. Even institutions that are not beholden directly to managed care have joined the zeitgeist that suggests that therapy can be both fast and delivered by "highly-trained" technicians.

RECLAIMING LOST GROUND

The National Coalition is the one organization that seeks to combat the external forces that devalue the practice of talk therapy in the name of both patients and therapists. We also maintain that all those who support the principles of privacy, access, quality and choice have a place in this struggle and we do not participate in organizational struggles and turf battles that can divide and weaken our message. If you are reading this article, you are already more or less committed to these goals. I want to challenge you, however, to put these goals into action. In the next issue of the newsletter, I will list some of the activities and projects I will ask you to get involved with. If we are to reclaim the lost ground and preserve the legacy given to us by Freud, Perls, Rogers and so many others, we need all of you to act.

ETHICS-BASED, PATIENT ORIENTED APPROACH

JAMES C. PYLES,

The following is the testimony Jim Pyles provided as he represented the position of the American Psychoanalytic Association at hearings on privacy and health information technology before the National Committee on Vital and Health Statistics

MEDICAL PRIVACY IS ESSENTIAL FOR QUALITY HEALTH CARE

As the Department of Health and Human Services has noted, "…the entire health care system is built upon the willingness of individuals to share the most intimate details of their lives with their health care providers….More than anything else, the relationship between a patient and a clinician is based on trust."[1] The "reason and experience" of the country shows that "[e]ffective psychotherapy…depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears." Even the "mere possibility" that a patient's information will be used or disclosed without permission destroys the patient's ability to obtain effective psychotherapy.[2]

The standards of medical ethics of the American Medical Association since at least 1847 have provided that:

> The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.[3]

The ethics standards of the American Psychoanalytic Association similarly provide

> The psychoanalyst should never share confidential information about a patient with nonclinical third-parties (e.g., insurance companies) without the patient's or, in the case of a minor patient, the parent's or guardian's informed consent.[4]

Similar privacy principles vesting control over the use and disclosure of identifiable health information in the individual are also reflected in the Hippocratic Oath which is taken by nearly every physician in the country and is applied to health care facilities through accreditation standards.[5] Further, the right of the individual "to be let alone" in non-emergency situations is protected by numerous provisions of the Bill of Rights to the United States Constitution including the First, Fourth and Fifth Amendments.[6]

Thus, the right of individuals to not have their personal health information used or disclosed without their consent is deeply rooted in the history and tradition of medical ethics and constitutional law. The failure to preserve and protect that right does not result in greater access to the information, but rather, results in the information not coming into existence.[7] In other words, it is possible for the nation to have one of the best health delivery systems in the world without a national electronic health information system, but it is not possible for the nation to retain a quality health delivery system if it fails to preserve and protect the traditional right to medical privacy.

Thus, preserving the individual's trust and medical privacy should be a top priority in an "ethics-based" approach to any electronic health information system.

THE PUBLIC'S EXPECTATION AND CONCERN

Historically individuals have had "a common belief" and "strong expectations" that their identifiable health information will not be used and disclosed without their permission.[8] This belief is particularly strong with respect to the results of medical tests.[9]

Numerous studies have shown that there is a growing public concern over the threat to medical privacy from the increasing use of interconnected (or "interoperable") electronic health information systems.[10] One study showed that 75% of consumers are concerned about the loss of medical privacy due to the use of electronic health information systems.[11] These concerns were recently confirmed in testimony before this Subcommittee by the Center for Social and Legal Research which found that 70% of the public is concerned that their health information will be leaked or shared without their permission by an electronic health information system.[12]

These growing concerns over the threat to medical

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[1] 65 Fed. Reg. at 82,467 (December 28, 2000).

[2] Jaffee v. Redmond, 116 S. Ct. 1923, 1928 (1996).

[3] Standards of Ethics, AMA, Section 5.05.

[4] Standards of Ethics, American Psychoanalytic Association, IV. 2.

[5] R. Orr and N. Pang, "The Use of the Hippocratic Oath: A Review of 20th Century Practice and a Content Analysis of Oaths Administered in Medical Schools in the U.S. and Canada in 1993"; "Protecting Confidentiality", Joint Commission on Accreditation of Healthcare Organizations, 1 and 106-107 (2001).

[6] 65 Fed. Reg. at 82,464.

[7] Jaffee v. Redmond, supra, at 1929; Swidler and Berlin v. U.S., 118 S. Ct. 2081, 2086 (1998).

[8] 65 Fed. Reg. at 82,472-73.

[9] Ferguson v. City of Charleston, 121 S. Ct. 1281, 1288 (2001).

[10] 65 Fed. Reg. at 82, 465.

[11] Ethics Survey of Consumer Attitudes about Health Web Sites, California Health Care Foundation, at 3 (January, 2000).

[12] Testimony of Dr. Alan F. Westin, Professor of Public Law & Government Emeritus, Columbia University at Hearing on Privacy and Health Information Technology before the NCVHS Subcommittee on Privacy, at 5, (February 23, 2005).

privacy have resulted in individuals either withholding information from their practitioners or avoiding seeking necessary health care altogether. According to the Center for Social and Legal Research, 65% of Americans would not disclose sensitive but necessary health information to doctors and health care providers because of worries that the information will go into an electronic health information system.[13] These findings are consistent with HHS' findings that

a) approximately 600,000 people annually do not seek early diagnosis and treatment for cancer,
b) more than 2 million people annually do not seek needed treatment for mental illness, and
c) many people do not seek treatment for sexually transmitted diseases due to privacy concerns.[14]

Sixty-three percent of those in a national survey indicated that they would not take a genetic test if insurers and employees could gain access to the results, and 32% of those who were offered a free genetic test for breast cancer by the National Institutes for Health declined to take it citing privacy concerns.[15]

MEDICAL PRIVACY PROTECTIONS HAVE BEEN ERODED BY THE HEALTH INFORMATION PRIVACY RULE

The Health Information Privacy Rule implemented by HHS on April 14, 2003, eliminated the right to medical privacy reflected in the nation's history and tradition with respect to identifiable health information for all individuals in most, or "routine", situations.[16]

The Rule authorized the use and disclosure of every type of health information by covered entities without the individual's permission. It authorized the use and disclosure of that information in identifiable form to hundreds of thousands of other members of the public. It rendered individuals powerless to prevent those uses and disclosures because they are made

1) without notice, thereby eliminating any opportunity of individuals to assert their privacy rights under state law;
2) regardless of whether the individual signs an acknowledgement of notice of privacy practices;
3) without any accounting;
4) even if the individual pays privately for the services;
5) even for health information created prior to April 14, 2003; and
6) even if the individual objects.[17]

The Rule also granted "regulatory permission" for covered entities to waive individuals' fundamental right to personal privacy against their will.[18]

The Amended Rule has led to the widespread practice of covered entities using and disclosing identifiable health information over the patient's objection and contrary to traditional principles of medical ethics and constitutional law. This is not surprising because the Amended Rule requires all covered entities to inform patients of the nonconsensual uses and disclosures that are authorized by the Amended Rule regardless of the privacy practices the covered entity has traditionally followed.[19] If the covered entity provides a traditional consent process by agreeing to a request for restrictions, it is subject to civil and criminal penalties if it fails to comply with the restrictions.[20]

These strong disincentives have resulted in few covered entities affording a consent process as provided under traditional principles of medical ethics as well as state and constitutional law. The approach taken by Kaiser Permanente in its notice of privacy practices is rapidly becoming the norm:

> You may request that we limit our uses and disclosures of your PHI for treatment payment, and health care operations purposes. However, by law, we do not have to agree to your request. Because we strongly believe that this information is needed to appropriately manage the care of our members/patients, it is our policy to *not* agree to requests for restrictions.[21]

Thus, covered entities are exercising their authority under the Amended Rule to deny summarily all requests for a consent process. This process is made further meaningless because there is no time limit by which covered entities must respond to a request nor is their any opportunity for any appeal or other recourse.[22]

THE SECURITY OF AN ELECTRONIC HEALTH INFORMATION SYSTEM CANNOT BE ASSURED

HHS has determined that "security and privacy are inextricably linked" and that protecting the privacy of information in an electronic information system "depends in large part" on adequate security measures.[23]

While the Amended Privacy Rule authorized the widespread use and disclosure of personal health information

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[13] Id.

[14] 65 Fed. Reg. at 82,778.

[15] 65 Fed. Reg. at 82,466.

[16] 67 Fed. Reg. 53,182 (August 14, 2002).

[17] 45 C.F.R. 164.506(a); 67 Fed. Reg. at 53,210-14.

[18] 67 Fed. Reg. at 53,211.

[19] 45 C.F.R. 164.520(b)(1)(ii)(A).

[20] 67 Fed. Reg. at 53,213.

[21] Kaiser Permanente—Northern California Region, Notice of Privacy Practices, III. Your Rights Regarding Your PHI.

[22] 45 C.F.R. 164.522.

[23] 68 Fed. Reg. at 8,335 (February 20, 2003).

for routine purposes effective April 14, 2003, the Security Rule issued by HHS does not have a final compliance date until April 21, 2005. As HHS noted "whether or not to implement [the Security Standards] before the compliance date is a business decision that each covered entity must make."[24]

Furthermore, the Security Rule does not cover all of the information covered by the Amended Privacy Rule. HHS states that "this final rule requires protection of the same scope of information as that covered by the Privacy Rule, except that it only covers that information if it is in electronic form."[25] By contrast, the Amended Rule authorizes the nonconsensual use and disclosure of identifiable health information transmitted or maintained in "any form or medium."[26] Thus, the Security Rule does not provide the protection that HHS has found is necessary to ensure medical privacy.

Also, HHS concedes that "there is no such thing as a totally secure [electronic information] system that carries no risk." [27] This appears to be an understatement in view of the recent findings of the President's Information Technology Advisory Committee.[28] This Committee found that the nation's electronic information systems, particularly those that are interconnected, are highly vulnerable to corruption by hackers and others. According to the Committee, "ubiquitous interconnectivity = widespread vulnerability".[29]

The Commission further found that "the threat clearly is growing" with attacks rising by "over 20 percent annually."[30] For example one survey showed that 83% of financial service organizations experienced compromised systems in 2003, more than double the percentage in 2001.[31] The Commission also found that the reported level of security incidents "almost certainly understates the actual level" because there are few incentives for organizations to report incidents in a public forum.

The percentage of organizations that have experienced virus disasters (those with a "major impact") has grown over the last decade "with 92 percent of organizations reporting such incidents during 2003."[32]

The Commission also noted that the number of network vulnerabilities has also risen with 3,780 new electronic vulnerabilities recently being reported which was a 20-fold increase from 1995.[33]

The Commission concludes that the current approach of "patching" the system by adding security measures is inadequate and that new fundamental research is needed "to design security into computing and networking systems and software from the ground up."[34]

The validity of the Commission's findings and conclusions are illustrated by the almost daily reports of privacy breaches with respect to large and sophisticated electronic information systems:

1. A disgruntled former employee posted information about Kaiser Permanente patients on a website reportedly "to make the point that anyone could have gained access to the information."[35]
2. LexisNexis reportedly had personal information about 30,000 consumers stolen by identity thieves.[36]
3. A national shoe retailer reported that credit card information on its customers was stolen from its data base over a three-month period.[37]
4. Bank of America reportedly lost the computer backup tapes containing personal information on about 1.2 million federal employees, including U.S. Senators.[38]
5. ChoicePoint Inc. is reportedly being investigated involving the theft of "more than 100,000 consumer profiles" from its data bases.[39]

Under these circumstances, it is simply not credible to believe individuals would retain the trust in the health delivery system necessary for quality health care if their personal health information were put into an interconnected electronic information system without their knowledge and consent.

ADEQUATE ENFORCEMENT OF HEALTH INFORMATION PRIVACY RULES CANNOT BE ASSURED

HHS has acknowledged that health information privacy cannot be assured unless there is "some form of sanction or punishment activity" for violations of medical privacy.[40] HHS, however, has failed even to propose enforcement regulations for the Amended Privacy Rule stating merely that "it is expected that enforcement provisions applicable to all Administrative Simplification rules will be proposed in a

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[24] 68 Fed. Reg. at 8,362.

[25] 68 Fed. Reg. at 8,342.

[26] 45 C.F.R. 164.501; 65 Fed. Reg. at 82,805.

[27] 68 Fed. Reg. at 8,346.

[28] "Cyber Security: A Crisis of Prioritization" (February 23, 2005) (PITAC Report).

[29] PITAC Report at 7.

[30] PITAC Report at 10.

[31] Id.

[32] Id.

[33] PITAC Report at 11.

[34] PITAC Report at 12.

[35] "Patients' Private Data Put Online," *San Jose Mercury News* (March 11, 2005).

[36] "Another Data Broker Reports a Breach," *The New York Times* (March 10, 2005).

[37] "Credit Card Information Stolen From DSW Stores," The Associated Press (March 9, 2005).

[38] "Bank Loses Tapes of Records of 1.2 Million With Visa Cards," *The New York Times* (March 3, 2005).

[39] "U.S. Probing ChoicePoint Over Data Theft," Reuters (March 4, 2005).

[40] 68 Fed. Reg. at 8,346.

future rulemaking.[41] A hastily issued rule on April 17, 2003 is admittedly not the Enforcement Rule required by HIPAA. [42]

Moreover, between the April 14, 2003 compliance date for the Amended Rule and December 31, 2004, individuals had filed 10,875 complaints of privacy violations under the Amended Rule and only one enforcement action had been taken. Many of these complaints were "resolved" because the privacy violations were authorized by the Amended Rule. Even this volume of complaints is remarkable considering the Amended Rule authorizes the use and disclosure of identifiable health information without notice to the individual.

ELECTRONIC HEALTH INFORMATION SYSTEMS MAY NOT REDUCE ERRORS

The few studies that have been conducted on electronic health information have focused on the errors that such a system can prevent. However, recent studies show that such systems can also add the capacity for new errors.[43] For example, 51% of physicians using such a system reported medication discontinuation errors, and 22% reported these errors occurring a few times weekly, daily, or more frequently.[44] Fifty-five percent of physicians reported difficulty identifying the patient for whom they were ordering medication. The author of this study reported that the errors resulting from the electronic health information system were "stunningly frequent".[45]

Further, a major West Coast hospital recently abandoned a $34 million computerized health informationsystem after three months.[46] The system reportedly became an impediment to the efficient delivery of health care and failed to provide timely and useful information.

THERE IS NO ACCEPTED STANDARD OF RELIABILITY

Informal surveys of electronic information vendors reveal that there is no generally accepted standard of reliability for electronic health information systems or for security measures.[47] For example, there is no accepted standard for how often an electronic health information system will be "inoperable". Are such failures acceptable if they occur once a month, once a week, once a day, or once an hour? How long is it acceptable for such systems to be inoperable? Is it a day, a half day, an hour or several minutes?

Further, there is no accepted standard of care for electronic health information security. To the contrary, the Security Rule states that it is intended to be "scalable".[48] While the individual's interest in medical privacy and the damage resulting from violations are relatively predictable, the security protection is infinitely variable.

As was recently observed, "[b]ehind the cheers and high hopes that dominate the conference proceedings, vendor information, and large parts of the scientific literature, the reality is that systems that are in use in multiple locations that have satisfied users, and that effectively and efficiently contribute to quality and safety of care are few and far between."[49] Recent surveys show that roughly 75% of all large IT projects in health care fail.[50]

With a lack of excepted standards of reliability and security, it is impossible to estimate the liability risk to health systems posed by electronic health information systems. In the absence of quantifiable risk, it is unlikely that medical liability insurance will be available for systems that rely heavily or exclusively on electronic health information systems to provide care.

CONCLUSION

Electronic health information systems should not be viewed as a "magic bullet" or a panacea for rising health care costs. They should be viewed, like any other medical device or procedure, as another possibly useful tool that should be carefully tested and cautiously implemented. Regardless of the system or its design, it should be applied in a manner that is consistent with traditional principles of medical ethics and practice. In the rush to implement "evidence based" medicine, we should first and foremost ensure that patients retain access to "ethics-based" medicine.

Under federal constitutional common law, the media has a right protected by the First Amendment to publish personal information about individuals in public life, including politicians, even if the information is unlawfully obtained.[51] Therefore, protection of medical privacy is not just essential for quality health care. It is also essential for quality government.

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[41] 68 Fed. Reg. at 8,363.

[42] 68 Fed. Reg. at 18,897.

[43] "Role of Computerized Physician Order Entry Systems in Facilitating Medication Errors,",*JAMA* 2005; 293:1197-1203 (March 9, 2005).

[44] Id. at 6.

[45] "Not Quite Fail-Safe, Computerizing Isn't a Panacea for Dangerous Drug Errors, Study Shows." *The Washington Post* (March 22, 2005).

[46] "Cedars-Sinai Doctors Cling to Pen and Paper," *The Washington Post,* A1 (March 21, 2005).

[47] "Computer Technology and Clinical Work, Still Waiting For Godot," *JAMA* 2005; 293 1261-1263 (March 9, 2005).

[48] 68 Fed. Reg. at 8341.

[49] "Computer Technology and Clinical Work," *supra* at 1261.

[50] "Evaluating Computerised Health Information Systems; Hard Lessons Still to be Learnt," *BMJ*, 2003; 326:860-863.

[51] "A Tale of Privacy Woe, If Protection of Medical Data Isn't Strengthened, the Future may Be Bleak," *Legal Times* (March 14, 2005) (Copy attached).

STATE PRIVACY PROTECTIONS THREATENED BY FEDERAL BILL

This first part is adapted from a flyer put out by the Association of American Physicians and Surgeons and addresses the problems with the so-called "Wired for Health Act" (where do they come up with these names?) Although many mental health organizations did an excellent job opposing the recent Enzi bill that would undercut state laws on parity and mandated coverage, there has been less alarm about the increased threat to medical privacy. The National Coalition continues to support efforts to protect medical privacy as key to protecting psychotherapy. The second part of the article is an update on congressional effort to pass this law and is a summary of an article in Congressional Quarterly Healthbeat *It is important for all who support privacy to be aware of the threats to psychotherapy posed by this law. As Jim Pyles writes in the article that appears elsewhere in this newsletter, the consequences of the loss of medical privacy cannot only be measured by what will be disclosed, and whether information will be misused, but also on the chilling effect on patients, who will choose not to seek help, or to refuse to disclose vital information due to the fears of misuse. I am also including the letter sent by the Coalition to House and Senate conferees in charge of this bill. Thanks to Roz Gilbert who compiled this letter as part of her work with our Legislative Committee. The editor.*

Congress could vote soon to pass H.R. 4157, deceptively titled the "Health Information Technology Promotion Act." A somewhat different Senate version, S. 1418 ("Wired for Health Care") has already passed, lead by sponsors Ted Kennedy and Hillary Clinton. H. R. 4157 would allow new federal officer to kill states' medical privacy policies. The bill purports to promote an interoperable health information technology system, with a promise of systems that can "talk" to each so that medical records can be easily shared, resulting in better patient care and cost savings. Sounds good, right? But the problem lies in what has to be done to get to that point, and our concern is that medical privacy with be the first casualty. We need to tell Congress to slow down. Here are the problems with this bill:

1. It overrules state laws: It allows the federal government to overrule any existing or future state privacy laws if they might interfere with the establishment of this national interoperable system;
2. It expands power of HHS Secretary: It gives power to only one person, the HHS Secretary, to decide what state laws are in the way of the new system.
3. There are no guarantees of patient consent: There is no requirement that any standards established by the federal government include patient consent for disclosure of medical records;
4. It concentrates power in one non-elected official: The bill grants massive powers to one individual, the National Coordinator for Information Technology, to be appointed by the President. He would oversee development of the national technology system, and will have authority to contract with private companies to do so.
5. It creates potential conflicts-of-interest that are enormous, as the electronic medical records business has become a multi-billion dollar industry. The same companies that gather the information make money by selling it.

This bill establishes a permanent committee of appointed industry representatives. We are likely to end up with the same dilemma we have with vaccine policy: those who stand to benefit financially are those who get to make the policy recommendations. The impact on patient privacy could be devastating. Since HIPAA, which eliminated patient consent for disclosure of medical records, went into effect, the only true protection available to patients has been state laws that set a higher standard than the federal law. But if this bill passes, these tougher state laws could be sacrificed in the name of efficiency. Many of you support the use of technology for medical records. But plain and simple, here is the problem as stated so well by a former director of information systems for CMS:

> You can build an information system to *share* information, or you can build an information system to *protect and store* information. But you cannot have one system do both. And even those (such as the Pentagon's) designed to protect information have been compromised. Until we solve that dilemma, a secure system is impossible, and your medical records are at risk. Tell congress to protect your privacy and kill H.R. 4157

PRIVACY CONCERNS DELAY ACTION ON HEALTH INFORMATION TECHNOLOGY LEGISLATION

Witnesses and lawmakers at a House Ways and Means Health Subcommittee hearing on Thursday, April 4, urged the House to act on a bill (HR 4157) that would

CONTINUED ON PAGE 20

National Coalition of Mental Health Professionals and Consumers, Inc.
Box 438,Commack, NY 11725,
Phone: 866-826-2548, E-mail: NCMHPC@aol.com
William A. MacGillivray, PhD, ABPP, President

April 24, 2006

Dear Representative:

We commend Congress for considering legislation to create a nationwide electronic health information sharing system that has the potential to improve safety and quality of health care, while reducing wasteful spending. However, we are gravely concerned that Congress is rushing to pass legislation that does not provide adequate privacy protections for the personal and sensitive information of patients who use their health insurance to help pay for mental health and substance abuse treatment.

Americans are worried about healthcare privacy. According to a recent Gallop poll 78 percent of Americans believe it is important to keep medical records confidential and 69 percent of adults surveyed by Harris Interactive in February of this year do not believe sufficient data security will be installed in new health IT legislation. According to the Electronic Privacy Information Center, 36 percent of women surveyed declined a DNA Breast Cancer Test because of fear that the information would be shared.

Suffice to say, Americans suffering from psychological problems, family problems and problems with alcohol and drugs have an even greater likelihood of not seeking needed treatment. Privacy in mental health and substance abuse treatment records is vital. The knowledge that the intimate disclosures made during psychotherapy, family therapy, or counseling sessions could find their way into public access is not overstated. The epidemic of financial database breaches last year that left tens of thousands of consumers vulnerable to identity theft is proof that poor information security measures cost consumers.

The U.S. Department of Health and Human Services eliminated patients' rights to control access to their medical records in a 2002 amendment to the privacy law, which permitted over 800,000 health-related businesses and government agencies to access personal health information without patient knowledge or permission. The amendment allows health care providers to share patient records with employers, drug and insurance companies, marketing firms, credit reporting agencies, accounts, banks, lawyers, and others without permission, and for business and other uses, unrelated to healthcare treatment or paying claims. HIPAA now grants access to private corporations, individuals and government agencies without patient consent.

We need strong privacy legislation that covers everyone who has access to individuals' health, mental health and substance abuse treatment records. We believe that the benefits of technology must not override the importance of preserving medical ethics and patient control of access to their sensitive identifiable records. The privacy standards in state and common law, Constitutional law, and medical ethics must be incorporated into the design of all regional and national health information technology systems and networks.

It is important that we preserve patients' right to consent, or refuse consent, to what healthcare providers in non-emergency situations can see in their records. America's Information Technology industry is capable of building a system that can permit qualified medical personnel complete access to a patient's medical record in an emergency, but limit access in other, non-emergency cases.

We urge you to support a patient-centered system with a foundation that assures privacy rights and protections in the health information technology legislation now under consideration by the House of Representatives. The patient should be in control of his or her healthcare information, not the drug, insurance or marketing industries.

The current House bill H.R. 4157 would allow unauthorized disclosure of medical records. Language of the bill calls for state and federal privacy and security laws, but does not assign new parameters for regulation. On November 18, 2005 the Senate passed an amended version of S.1418, which added security measures requiring data breach reporting, but patients' rights to privacy were not addressed. We urge the House to include strong privacy standards in any healthcare information technology bill, restoring patients' rights to control their medical records and paving the way for these standards to be included the House and Senate reconciliation legislation.

We urge you to build a foundation of medical information technology that is based on the following longstanding ethical and privacy principles and protections as outlined by the Coalition for Patient Privacy on April 5th:

- Restore the patient's right of consent
- Give patients the right to opt-out of having their records in any national or regional electronic health system
- Give patients the right to segregate their most sensitive medical records
- Require audit trails of all disclosures
- Deny employers access to medical records
- Require that all patients be notified of all suspected and actual privacy breaches
- Preserve stronger privacy protections in state laws
- Enact meaningful enforcement and penalties for privacy violators

William A. MacGillivray, PhD, ABPP
President, National Coalition for Mental Health Professionals and Consumers

ANALYSIS: MASSACHUSETTS BIPARTISAN HEALTH CARE REFORM

This article is adapted from an analysis prepared by Universal Healthcare Access network (UHCAN) of the recently passed legislation in Massachusetts mandating healthcare insurance by July 1, 2007 for all residents of that state.

On April 4, 2006, the Massachusetts Legislature overwhelmingly passed a set of measures designed to move towards near universal coverage in Massachusetts over the next three years. While other states have passed creative initiatives in recent years to improve access to affordable health care, Massachusetts stands out as the first to do so with divided government—a strongly Democratic legislature and a Republican governor with presidential aspirations. To understand its strengths and weaknesses, it is best to compare it against well-accepted principles

From 2000 to 2004, the Institute of Medicine (IOM) convened a Committee on the Consequences of Uninsurance which produced a series of six reports, concluding with Insuring America's Health: Principles and Recommendations, released in January 2004. The following conclusions and principles from the Executive Summary of the report can be used to evaluate the politics behind and policies in the Massachusetts package and other state and national proposals.

- The persistence of uninsurance in the United States requires a national and coherent strategy aimed at covering the entire population.
- Federal leadership and federal dollars are necessary, although not necessarily federal administration or a uniform approach throughout the country.
- Universal health coverage will only be achieved when the principle of universality is embodied in federal public policy.

COMMENTS ON THE MASSACHUSETTS PACKAGE

An individual state cannot "embody the principle of universality in federal public policy." Nor can it develop a "national strategy" aimed at covering the entire population. However, should a number of states enact coherent strategies to cover their own populations, this can put pressure on federal politicians to take the policy leadership and find the dollars necessary to achieve health care for all. State strategies, such as that from Massachusetts, need to be evaluated on how "coherent" they are when initially proposed, and how successful they are as they are implemented.

The Institute of Medicine (IOM) has promoted the value of several key principles in developing a healthcare system. The principles are:

1. Health care coverage should be universal.
2. Heath care coverage should be continuous.
3. Health care coverage should be affordable to individuals and families.
4. The health insurance strategy should be affordable and sustainable for society.
5. Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

1. HEALTH CARE COVERAGE SHOULD BE UNIVERSAL.

The most straightforward way to assure universal coverage is through mandatory government programs. Given Republican opposition to mandatory programs, the package had to be "voluntary." Thus, the challenge is to make the incentives to participate strong enough, and the disincentives to nonparticipation powerful enough, to get nearly everyone to voluntarily participate. One major concern about the package is the paltry penalty it imposes on employers who do not insure their workers. The maximum $295 penalty per worker for companies that don't provide insurance is less than 1/10 of the cost of annual insurance for a policy for one person, let alone a family policy. Some argue that such a low penalty provides financial incentives to companies to drop coverage.

2. HEATH CARE COVERAGE SHOULD BE CONTINUOUS.

Continuity of coverage is a precondition of continuity of care. This principle means that individuals should not have time periods of lost access to care when they go through major life events such as changing jobs, becoming a caregiver to a child or parent, etc. While the Massachusetts package does not address this directly, the potential for discontinuities remains high because so many different insurance packages for different income levels and health statuses can be offered.

3. HEALTH CARE COVERAGE SHOULD BE AFFORDABLE TO INDIVIDUALS AND FAMILIES.

This is by far the most contentious aspect of the Massachusetts package. The package expands the number of patients who will be covered under Medicaid and S-CHIP. While there are subsidies for the purchase of individual policies to individuals and families with the lowest incomes, these completely phase out at 300% of poverty. Thus individuals and small families with incomes barely over $30,000 will be entirely responsible to pay for their coverage under the "individual mandate." The average current cost of comprehensive family policies in Massachusetts is currently $12,000. Comprehensive coverage with reasonable co-payments thus becomes unaffordable for low to middle income families. These people may only be able to pay for hollowed-out bare bones policies with high deductibles, thus leading to financial disincentives to access care in a timely fashion.

4. The health insurance strategy should be affordable and sustainable for society.

The Massachusetts package does not address how the costs of health care coverage will be made sustainable for the state. It provides some increased payments to institutions that have been relatively underpaid, but does not set out any frameworks or mechanisms to restrain the growth of costs in the future.

5. Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

These six characteristics of care, that it be "effective, efficient, safe, timely, patient-centered and equitable" have been used by the Institute of Medicine to describe quality since 2000. Quality issues are not addressed in the Massachusetts package in the same way that they have been in other states, such as Maine.

UHCAN's Perspective on Coordinated and Comprehensive Health Care Reform

States are very different. The challenges facing New Mexico and the challenges facing Massachusetts have little in common. Their geographies are different; their health care institutions are different; their social values as expressed in their political cultures are different. Massachusetts, Maine, Illinois, and California have done the nation a service by enacting legislation that can take major steps towards affordable, quality health care for all.

No piece of legislation is going to be perfect. None are going to solve the problems of health care cost, access and quality completely and forever. The Institute of Medicine's principles serve as excellent benchmarks through which to evaluate state and federal proposals, since all legislation will embody compromises among competing interest groups and social visions.

Since the collapse of the Clinton's national health insurance process in 1994, the federal government has been outside of the action on comprehensive health care reform. As the Institute of Medicine states, ultimately the "principle of universality must be embodied in federal public policy." The legislation that achieves this goal can implement it through national measures that have learned from the experiences of the states or in ways that partner the state and federal governments to stimulate further state innovation.

Michaele Dunlap Comments

Having seen the collapse of the vaunted Oregon Health plan I am concerned about any governmental regulations that protect the profits of insurance companies, mandate the purchase of insurance products (from a limited number of insurors) and promise coverage free to those who have lower incomes than others. I think this analysis of the potential problems with the MA bill is incomplete in that it does not address the tax issues for individuals or the product quality issues for insurors—nor, apparently, does the MA legislation.

NATIONAL COALITION ADVISORY BOARD

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STUDY RESULTS CONTRADICT CURRENT CLINICAL PRACTICE & TREATMENT GUIDELINES

ALLIANCE FOR HUMAN RESEARCH PROTECTION (AHRP)

This, and the next article, might seem slightly out of place in this newsletter, and the advocacy implicit in this article does not reflect a policy position of the National Coalition. What is notable about the research findings reviewed in this article is that it challenges the central myth of psychiatric treatment over the last 30 years that medical science is developing safer and more effective treatments for emotional and psychiatric disorders. The misnaming of major tranquilizers as "antipsychotics" and description of Prozac as an "antidepressant" is an example of the corruption of langauge with a very specific aim of lulling the general public (and mental health professionals) into a mindset that these drugs actually function as treatments rather than palliatives and reinforce a disease paradigm that can justify coerced hospitalization, lifelong stigma of having an incurable condition and discourage troubled individuals from seeking lasting help. The editor

Newly published results (phase II) from the Clinical Antipsychotic Trials in Intervention Effectiveness (CATIE) schizophrenia treatment efficacy study sponsored by the National Institute of Mental Health comparing the most commonly used second generation drug treatments for schizophrenia and depression, is highly disturbing. The results contradict psychiatry's current clinical practice and treatment guidelines.

It is instructive to learn flat out that psychiatry's biological treatment paradigm—which relies solely on drugs—no longer mentions recovery nor even pretends to improve patients' ability to engage in normal daily life functions—i.e., work, study, interact, marry. Psychiatry's endpoint criteria for measuring treatment effectiveness for patients with schizophrenia, is "how long patients stayed with the new drug!" Is this because patients can no long tolerate taking them, or the severity of the adverse effects forces the physician to withdraw patient? Most significant, the findings provide evidence-based validation that these drugs cause severe, life-threatening side effects for a significant number of patients.

The evidence shows that Clozaril, the first of the so-called atypical (second generation) neuroleptics (now off patent), outstripped all other drugs of this class—i.e, Risperdal, Zyprexa, Seroquel, Geodon—in terms of efficacy, which is defined as time to discontinuation:

> Clozapine showed nearly a three-fold increase in time until drug discontinuation compared with the three new antipsychotics olanzapine, risperidone, and quetiapine (10.5 months for clozapine, compared with an average of 2.9 months for the others). Efficacy outcomes are consistent with the time-to-discontinuation measure. [1]

But Clozaril has a "significantly greater side effect burden": weight gain, increased metabolic measures, sialorrhea, sedation, and the agranulocytosis—reduction in disease-fighting white blood cells and a potentially fatal inflammation of heart muscle. Clozaril and its closest comparator, Zyprexa, have the worst toxic side effect profile: patients taking these drugs are at highest risk of early death. Dr. Carol Tamminga, a leading schizophrenia researcher who wrote the editorial accompanying the two CATIE trial reports in the *American Journal of Psychiatry*, acknowledges that psychiatrists will now have to assume far greater medical monitoring responsibilities for patients being treated with these proven toxic drugs:

> The metabolic and other somatic effects of olanzapine and clozapine also have implications for psychiatric practice. As long as psychotropic medications were considered relatively free of side effects, psychiatrists could practice in settings appropriate to other mental health counselors. However, medication treatments with high side effect burden demand clinical settings that are capable of detecting and managing serious side effects. This knowledge means that the clinician's office needs to be equipped to efficiently monitor antipsychotic drug side effects. Blood pressure cuffs, scales, body tape measures, a process for plasma chemistry monitoring and electrocardiograms, and qualified consultants for medical questions become important components of practice. Dynamic information of drug side effects needs to take a prominent place in a patient's psychiatric chart. Medical consequences of psychiatric drugs are real, preventable, and require focused monitoring. Clinicians will need to have systems for the effective monitoring of drug side effects to maintain and promote physical health among patients as well as psychiatric health. [2]

The evidence from this major comparison study validates patients' assessment of and dissatisfaction with the prescribed treatments they are offered:

> the side effect outcomes are staggering in their

CONTINUED ON PAGE 17

KIDS & PILLS: WHAT YOU DON'T KNOW ABOUT THE MEDS YOUR CHILDREN ARE TAKING COULD HARM THEM

MARKIAN HAWRYLUK

This article was published in an Oregon newspaper and I am including it here for several reasons. The National Coalition supports all quality mental health treatment and certainly believe that many modalities are needed, from hospital-based to community-based, from behavior interventions to depth psychotherapy, and from physical treatments to psychotherapy. What we are strongly against, however, is the increased reliance upon polypharmacy as the first, last and only answer to emotional problems and this article confronts this problem in work with children and families. The other reason why this article was included in this issue is that it ends with a decription of Mike Connor's important work on StepOne program that Michaele Dunlap has previously written about in the September issue of the newsletter. His work, and Michaele's, is firmly based in the conviction that emotional difficulties take place within a family system and cannot be addressed outside of that context. The editor.

No drug is completely safe. Whether it's a matter of known side effects or unforeseen consequences, every prescription drug carries risks as well as benefits. And as patients take more than one drug, the risks are multiplied. Yet, a recent analysis found an increasing number of children, some as young as 2 or 3 years old, are taking multiple prescription medications. And that has many child health experts concerned. "This is a critical issue," says Dr. Joseph Penn, a child psychiatrist with the Bradley Hasbro Children's Research Center in Providence, R.I. "It's not uncommon to find a child on an antidepressant, a mood stabilizer and a sleep agent all at the same time, but there's no research to see how these drugs interact with each other."

Penn and his colleague Dr. Henrietta Leonard recently reviewed 10 years of research about pediatric polypharmacy, publishing their findings in the journal Psychiatry. Every study they came across documented an increase in kids taking more than one drug. Data from two national surveys found that the percentage of children taking multiple prescription drugs increased from 0.03 in 1987 to 0.23 by 1996, an eight-fold increase. Among patients taking any medication, the rate of adding a second medication increased 25 times over that decade.

The most common combination was pairing medications for depression and attention-deficit/hyperactivity disorder. In 1996, more than a third of children using antidepressants also used another class of medications, most often stimulants prescribed for ADHD. Similarly, a fifth of children taking stimulants also took another class of drugs, most often antidepressants. Yet both classes of drugs may now include so-called black box warnings from the Food and Drug Administration. In 2004, the FDA issued a public health advisory suggesting the possibility of a link between the use of antidepressants in children and suicide. And in February, an FDA advisory committee recommended that ADHD drugs carry a warning of an increased risk of injury or death. The agency is now considering whether to adopt the committee's recommendation. "If there is so much concern over the effects of a single drug, how much riskier is it to prescribe multiple drugs?" Penn says.

Clinicians are concerned that the risk of side effects is exponentially higher when taking multiple drugs because those drugs can interact in unforeseen ways. While there have been isolated documented cases of sudden death of children taking multiple medications, the researchers said adverse-events data for single medications are limited. Trying to track the effects of multiple medications is even tougher.Taking multiple behavioral medications may carry a higher risk because many target serotonin levels. That can subject kids to serotonin syndrome, a serious and potentially fatal illness that can result from excessive serotonin levels.

OFF-LABEL USE

Many parents may be surprised to know that most of the behavioral medications on the market have not been tested or approved for use in children. Physicians use medications that have been approved for adults and are therefore on the market. But nothing precludes physicians from prescribing these drugs for children. "Atypicals like risperidone are sometimes used to symptomatically treat psychosis or aggression in children, but most of these medications don't have FDA approval for use on psychiatric symptoms in the pediatric age group," says Dr. Henrietta Leonard, a child psychiatrist with the Bradley Hasbro Children's Research Center and Brown Medical School. "We just don't have the efficacy or safety data to back up what is common clinical practice."

Because many of these medications cause fewer or better tolerated side-effects in adults than some of the older medications, clinicians have been turning to them at a higher rate. But there is evidence that children react to drugs differently than adults. Dr. Ronald Hines, professor of pediatrics and of pharmacology and toxicity at the Medical College of Wisconsin, found that as children develop, the types and levels of enzymes that react with chemical compounds in their bodies change. These enzymes can activate or deactivate the medications, changing their impact.

Unless drugs are specifically tested in children, there's no way to know whether they will be effective or even safe, Hines says."It's recognized as a fairly major problem," he says. "Up until the FDA Modernization Act of 1997, there were hardly any drugs tested in kids. It was considered unethical by many to do so. I think that whole attitude now has changed."

Still, only five psychiatric drugs are approved for use in children. The rest are being used "off-label." While progress has been made in increasing testing of pharmaceuticals in children, costs and other obstacles continue to limit research in this area. Children often end up on multiple medications when a single medication therapy has failed, or when they are diagnosed with multiple disorders or higher levels of social dysfunction. But some of the studies suggest that of late, prescribing multiple medications is becoming a lot more routine.

The National Ambulatory Medical Care Survey found that in pediatric office visits in 1993-1994 in which a stimulant was prescribed, less than 5 percent also included a prescription for a psychotropic drug. By 1997-1998, that rate had increased to nearly 25 percent. A study of office-based practices in Michigan examined the records of 223 children, 3 years old or younger, diagnosed with ADHD. Some 57 percent were on a psychotropic medication, and of those, 35 percent were being treated with multiple medications. And those studies didn't even consider whether those children were also on medications for such conditions as allergies or asthma. There is even less data available on potential interactions between those drugs and behavioral medications.

Symptomatic approach

Drugs and drug interactions can sometimes lead to additional prescriptions as new symptoms emerge, something physicians refer to as "chasing symptoms." A child may have problems focusing or paying attention and is prescribed a stimulant, such as Ritalin or Adderall, which in turn prevents him from sleeping, so a sleeping pill is added, which may cause him to become irritable or moody, so he's put on an antidepressant. "Before you know it, the kid's on three or four psych meds," Penn says. "If all you're treating is the symptom, you can become a dog chasing its tail very easily."

But Penn says doctors, particularly pediatricians, are under the gun from schools and parents to prescribe behavioral drugs. "This is a more complicated issue than just what doctors want to prescribe. There's increasing pressure on doctors to medicate," Penn says. "Bottom line, we're a quick-fix society."

Those pressures are accentuated by the economics of health care. Insurance companies may pay for antidepressant or ADHD medications, but often have strict limits on mental health care services such as counseling or therapy. "Many times more intensive behavioral interventions, such as counseling and therapy, and work with family aren't immediately available," Penn says. "Or you have to really pull teeth to get those kinds of services approved by insurance companies."

While difficult cases in the past could be admitted to hospitals for a complete evaluation, the realities of managed care now limit hospitals to crisis stabilization. What was once a two- or three-month stay is now limited to a week. "It's more like, get the kid under control, until they're safe, and then discharge them," Penn says.

A polypharmacy work group organized by the American Academy of Child and Adolescent Psychiatrists in 2003, concluded that the piecemeal approach to treating mental health issues exacerbates the problem. "Within child mental health service delivery, fragmentation is a way of life, resulting in service duplication and gaps in service coordination," Dr. David Pruitt wrote in a summary of the group's findings. "Children are treated in multiple settings and placed on medications by different providers with little coordination."

The group said even when physicians know children are taking multiple medications, they often are reluctant to discontinue a drug they didn't prescribe themselves. "With polypharmacy, there's little or no research on the benefits and there's no research on the interaction effects in pediatric population," says Dr. Michael Conner, a clinical psychologist in Bend. "We're literally experimenting with children."

Conner says he talks to parents whose kids take more than one medication and their moods and behaviors are still out of control. "They have tried multiple trials of medications and multiple combinations, and behaviorally, nothing seems to be working," he says. "And the long-term side effects are completely unknown."

Limited options

According to a report on psychiatric polypharmacy by the National Association of State Mental Health Program Directors in 2001, a shortage of child psychiatrists has increased pressure to treat psychiatric conditions in children with medications. Managed care plans, the report said, would rather deploy scarce resources towards medication treatment than consultation, which requires a greater amount of physician time and overall expense.

Despite research showing that the combination of medication and therapy is more effective at treating depression than either treatment alone, many children have access only to the meds, effectively sealing their fate.

"The problem is many people have medical benefits and not mental health benefits," Conner says. "And physicians are constrained in the amount of time they can diagnose and prescribe. With the proper information, physicians make excellent decisions. The challenge is that they have difficulty getting the information they need in the time they have available."

Conner has developed an online screening tool that parents can use to gather information about their child and give the physician a head start. Nancy Webb, a parent and foster parent from Gresham, used the tool recently when she brought a foster child in to see a psychiatrist for a medication check.

Based on a school report documenting explosive outbursts and other incidents that happened at school, the psychiatrist started writing out another prescription. Then Webb showed him the information she had collected. "When he was finished looking at that evaluation, he chose a very different course. He did not prescribe the medication for explosive outbursts. And he started decreasing and taking away some of the medications that he'd previously been on," Webb says. "The evaluation showed high levels of depression, anxiety and suicidal tendencies, and he felt those medications that the young man was taking were contributing to that. So we actually took him off several different medications and didn't add that new one."

Conner says parents need to advocate for their children and help ensure that they don't wind up on multiple medications without good cause. "I'm not saying that kids don't need these medications. Some kids can't function (without them.) It ends up being a life jacket for some kids," he says. "But the solution is not just to medicate these kids. That's the option you get when you only have a small piece of the picture."

Meanwhile, child psychiatrists are working on ways to help sort out when kids legitimately need multiple prescriptions and when more medication doesn't truly help. The child psychiatrists work group borrowed the economic concept of decreasing marginal returns. They proposed that certain medications might provide the vast majority of the benefit, and adding other medications provides only marginal benefits, while substantially increasing short and long risk, and using up valuable resources.

Based on that notion, the group has developed a review tool to help clinicians review a child's medication history and determine what drugs can or should be eliminated. The review tool is still being evaluated. For now, Penn says parents need to be extra vigilant about what drugs their kids are prescribed. "They really need to be educated consumers. The family really needs to know what the risks are and what the other alternatives are," Penn says. "We're not talking about M&Ms. These are real risks."

CONTINUED FROM PAGE 14

> magnitude and extent and demonstrate the significant medication burden for persons with schizophrenia.… Sky-high drug discontinuation rates were seen, suggesting rampant drug dissatisfaction and inefficacy. [2]

The evidence also confirms the validity of our continued criticism of psychiatry's current treatment guidelines which are influenced by industry, not: TMAP guidelines were formulated by a consensus panel of academic psychiatrists. The project was funded by the makers of the drugs recommended in those guidelines—Johnson & Johnson, Eli Lilly, Pfizer, et al. Those industry-influenced, TMAP guidelines were then recommended by the President's New Freedom Commission report which initiated new mental health policy initiatives. The confirmatory evidence from the NIMH $140 million studies raise serious doubt about the integrity of that Commission's entire report.

Given these drugs' inefficacy and admittedly "staggering side effect outcomes," the profession's continued avoidance of a scientific comparison between the effectiveness of drug treatments for schizophrenia patients with non-drug treatment, borders on, if not constitutes, outright professional negligence. This is especially so, given a recent report by Dr. John Bola in the *Schizophrenia Bulletin* that raises doubt about the validity of the current drug-centered treatment paradigm which dictates that all patients who present with psychotic symptoms of schizophrenia should be immediately put on antipsychotics and kept on them. His meta-analysis of published studies that included first or second-episode schizophrenia spectrum subjects, found that during the course of a year, between 10% and 40% of psychotic patients did better without drugs.

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2. Carol Tamminga, "Practical Treatment Information for Schizophrenia" Editorial, *AJP,* April, 2006, vol. 163:563-565.
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Psychologists' Views of Commercial Mental Health Care in Southeastern Pennsylvania

Thomas G. Bowers, PhD and Karen Gibson, BS

This article originally appeared on the Division 42 website and is reprinted here with permission. The editor.

Abstract

Psychologists have long expressed concerns in regard to how managed care impacts the quality of clinical health services. However, there is little systematic information available about the views of psychologists about managed health care. Because of this, a survey of licensed psychologists in Southeastern Pennsylvania (Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties) was conducted to obtain data on psychologists' experiences with managed health care. In the Southeastern Pennsylvania area, Magellan Behavioral Health (MBH) manages 99% of the health and indemnity contracts. The survey indicated frequent authorization delays, restrictive authorizations, as well as reports of many claims being unpaid after 45 days.

Introduction

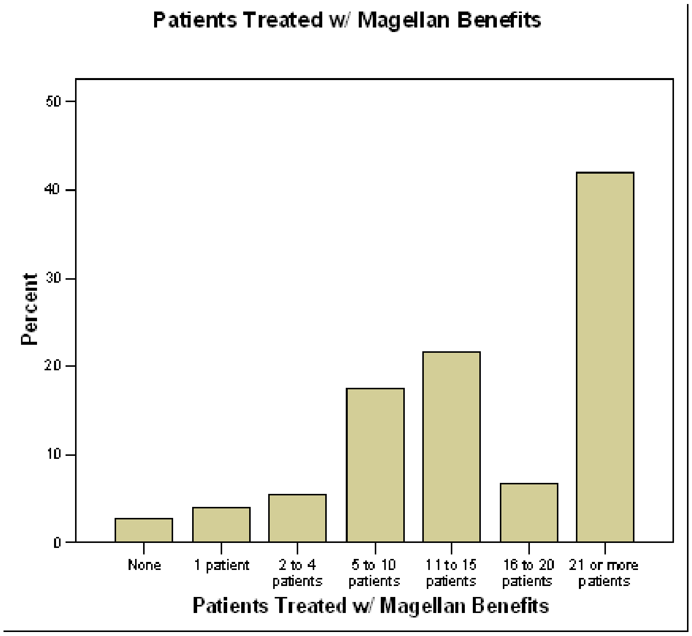
Given the rising influence of managed care within the field of mental health, as well as patients' resulting access to care and treatment, it does not come as a surprise that practicing psychologists may be troubled about the quality of the respective services they are providing. However, despite growing concerns on behalf of psychologists on the impact of managed health on the quality of clinical health services, there appears to be an overall lack of systematic research examining these views and concerns about managed care within the mental health field. As a result, the present survey study was conducted in an effort to collect data about Southeastern Pennsylvania psychologists' experiences with managed health care. In the Southeastern Pennsylvania area (Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties), Magellan Behavioral Health (MBH) handles 99% of the managed health care contracts (Pennsylvania Department of Health, 2003). Consequently, it would appear to be especially pertinent to examine the experiences and concerns of these psychologists in regards to managed care, given that such a large number of them (as well as their patients) are dealing with the same company.

Method

Surveys on the nature of psychologists' experiences with Magellan Behavioral Health (MBG) were sent to a sample of licensed psychologists in Southeastern Pennsylvania. Psychologists were randomly selected for participation via a list of licensed mental health professionals obtained from the Bureau of Professional and Occupational Affairs. Each survey consisted of 16 items and took an estimated 10 minutes to complete. Participants were advised to be both objective and impartial while completing the survey questions. In addition, in an effort to provide incentive for survey completion, for every survey returned, the Pennsylvania Psychological Association (PPA) indicated that they would be donating $1 for the Pennsylvania Alliance for the Mentally Ill.

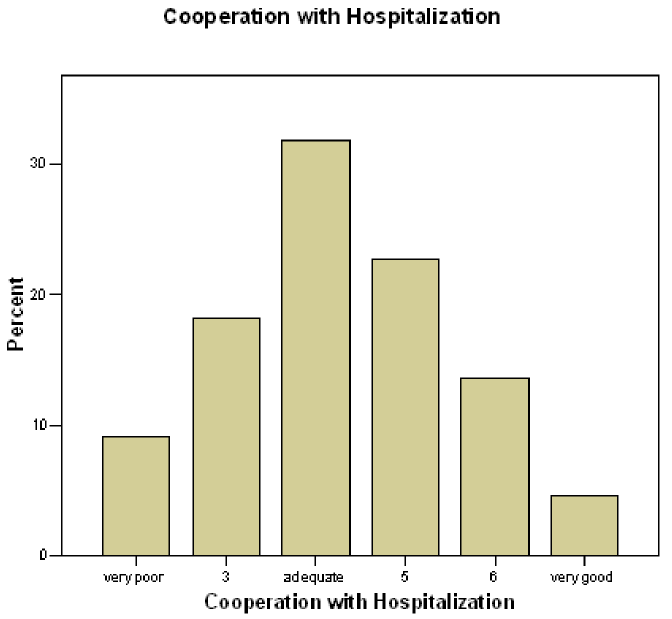
Results

Of the 458 surveys mailed, 11 were returned because of address changes, with a total of 215 responses returned. Seventy four (34.42%) of the responding psychologists were in the MBH network, and hence provided information about the nature of their experiences. The results of the survey indicated that most psychologists provided extensive services for patients who had benefits managed by MBH (50% reported 21 or more patients).

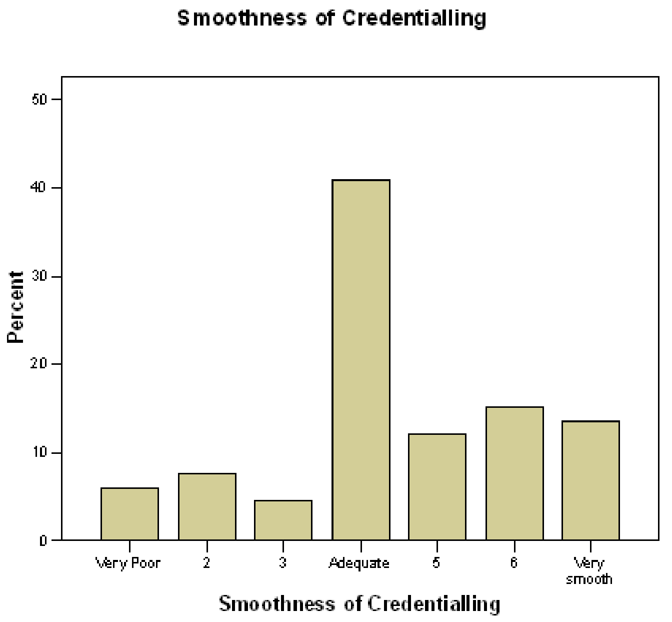


Thirty percent of respondents reported 6 to 10 % of authorization delays, while 20% of respondents reported more than 50% of authorization delays. Most practitioners (78%) provided services without authorization, despite delays in authorizations.

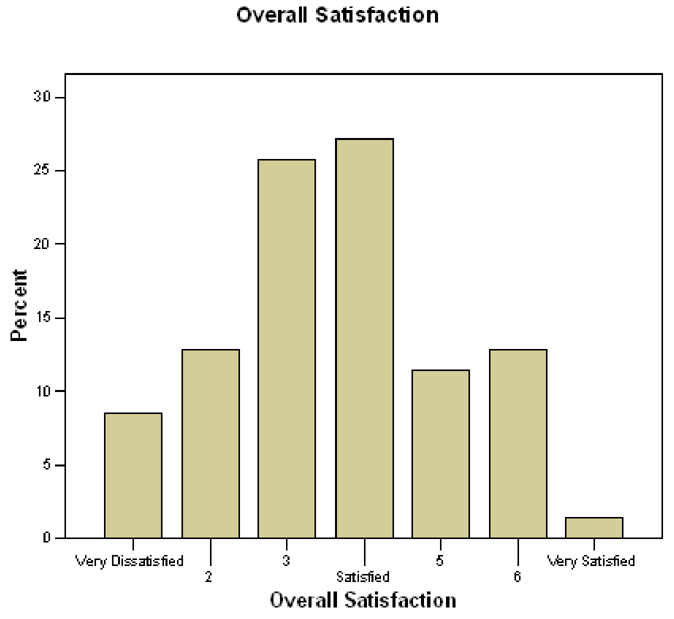
Twenty-seven percent of the responding psychologists reported more than 50% of patient authorizations were restricted in ways that appeared to be contrary to quality of patient care. However, relatively few psychologists indicated experiencing difficulty with cooperation with the approval or facilitation of hospitalization.



The average rating of 5.0 was on a scale of 1 to 7, with 1 indicating very poor and 7 indicating very good. In regards to claim payment, 10% of responding psychologists indicated that more than 50% of their claims remained unpaid 45 days after submission. Ratings on the smoothness of credentialing or recredentialing were found to be low, averaging 4.3 on a 7 point scale.



Finally, the psychologists' overall satisfaction with MBH was also low, with an average of 4.3 on a 7 point scale.



Conclusion

In summary, the views of psychologists on MBH in Southeastern Pennsylvania were often quite critical. Complaints included frequent authorization delays, frequent restricted authorizations, and frequent delays in claim payment. Overall satisfaction with MBH was only neutral, but mildly favorable with regards to cooperation with hospitalization. Other individuals (Knapp, Baturin and DeWall, 2005) have also detailed a critical analysis of this same date in Pennsylvania. Because MBH handles virtually all of the managed care contracts in Southeastern Pennsylvania, these difficulties appear to be serious.

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SEND ME YOUR HEALTH CARE HORROR STORIES: AN APPEAL FROM MICHAEL MOORE

How would you like to be in my next movie? I know you've probably heard I'm making a documentary about the health care industry (but the HMOs don't know this, so don't tell them. They think I'm making a romantic comedy). If you've followed my work over the years, you know that I keep a pretty low profile while I'm making my movies. I don't give interviews, I don't go on TV and I don't defrost my refrigerator. I do keep my website updated on a daily basis (there's been something like 4,000,000 visitors just this week alone) and the rest of the time I'm... well, I can't tell you what I'm doing, but you can pretty much guess. It gets harder and harder sneaking into corporate headquarters, but I've found that just dying my hair black and wearing a skirt really helps.

Back to my invitation to be in my movie. Have you ever found yourself getting ready to file for bankruptcy because you can't pay your kid's hospital bill, and then you say to yourself, "Boy, I sure would like to be in Michael Moore's health care movie"? Or, after being turned down for the third time by your HMO for an operation they should be paying for, do you ever think to yourself, "Now THIS travesty should be in that 'Sicko' movie"?

Or maybe you've just been told that your father is going to have to just, well, die because he can't afford the drugs he needs to get better and it's then that you say, "Damn, what did I do with Michael Moore's home number!"

Ok, here's your chance. As you can imagine, we've got the goods on these bastards. All we need now is to put a few of you in the movie and let the world see what the greatest country ever in the history of the universe does to its own people, simply because they have the misfortune of getting sick. Because getting sick, unless you are rich, is a crime a crime for which you must pay, sometimes with your own life.

About four hundred years from now, historians will look back at us like we were some sort of barbarians, but for now we're just the laughing stock of the Western world.

So, if you'd like me to know what you've been through with your insurance company, or what it's been like to have no insurance at all, or how the hospitals and doctors wouldn't treat you (or if they did, how they sent you into poverty trying to pay their crazy bills) ...if you have been abused in any way by this sick, greedy, grubby system and it has caused you or your loved ones great sorrow and pain, let me know.

Send me a short, factual account of what has happened to you and what IS happening to you right now if you have been unable to get the health care you need. Send it to michael@michaelmoore.com. I will read every single one of them (even if I can't respond to o, phDr help everyone, I will be able to bring to light a few of your stories).

Thank you in advance for sharing them with me and trusting me to try and do something about a very corrupt system that simply has to go. Oh, and if you happen to work for an HMO or a pharmaceutical company or a profit-making hospital and you have simply seen too much abuse of your fellow human beings and can't take it any longer and you would like the truth to be told please write me at michael@michaelmoore.com. I will protect your privacy and I will tell the world what you are unable to tell. I am looking for a few heroes with a conscience. I know you are out there.

CONTINUES FROM PAGE 8

encourage the adoption of health information technology. The Senate has passed similar legislation (S 1418), but the House has not yet acted on its bill, in part because of concerns from privacy advocates that the legislation does not provide adequate safeguards. At a press briefing Wednesday, 26 organizations urged House lawmakers to make strong privacy rights a large part of any health IT legislation approved by Congress. At the hearing, Rep. Nancy Johnson (R-Conn.), chair of the subcommittee and sponsor of the House bill, said the benefits of health care IT include improvements in safety and quality of care and reductions in wasteful spending. Rep. Pete Stark (D-Calif.) said Medicare payments should be increased and adoption of the technology should be a requirement for participation in Medicare. He said, "Let's raise the payment per procedure. I think we better be realistic and say it's going to cost something." Stark also said the federal government should expand use of the EHR system created for the Department of Veterans Affairs health system. Kenneth Kizer, a former VA official, said the VA system should be used across the U.S. adding, "It is unfortunate that this successful product developed by the government and taxpayer dollars cannot be made more available to benefit community, rural and public hospitals." Kizer added that code used in the VA system should be the basis of "open source development" to allow users to make improvements. He said, "[I]n an environment of collaboration, innovation is more rapid." Supporters of the House bill, which Johnson co-sponsored with Rep. Nathan Deal (R-Ga.), say it includes adequate privacy safeguards and would allow the advancement of a study to determine if state medical privacy laws created for paper-based records are outdated and could be replaced with more uniform national standards.

AND IN THE NEWS...

HEALTH CARE: AS MID-TERM ELECTIONS APPROACH, CONGRESS CONTEMPLATES 3 BILLS

NEW JERSEY STAR-LEDGER

ROBERT COHEN

APRIL 30, 2006

This article reviews efforts in Congress to address healthcare issues: "While Congress and the White House have been focused on the Iraq war and terrorism, immigration and gasoline prices, something else has been weighing heavily on the minds of most Americans: health care." The reporter reviews a variety of proposals meant to address various aspects of healthcare coverage, while pointing out that none of the initiatives are meant to be comprehensive, but are more likely going to be brought forward with an eye to the upcoming elections. "The proposals call for easing restrictions on small business health plans, limiting medical malpractice awards and expanding tax-free private health savings accounts." According to Paul Ginsburg, president of the nonpartisan Center for Studying Health System Change:

> The federal government clearly has not been focused on this issue, and the president has not made it a priority. There are some attempts now to show the Congress is doing something. But whatever the merits of President Bush's proposals, they should not be confused with an effort to substantially increase the number of people on health insurance.

The Kaiser Commission on Medicaid and the Uninsured, a bipartisan group of national leaders on health policy, reported this year that 45 million Americans under 65 lacked health insurance in 2004, an increase of 6 million since 2000.The Kaiser Commission also found "the uninsured come primarily from working families with low and moderate incomes, families for whom coverage is not available in the workplace or is unaffordable." In addition, the commission said employer-sponsored health insurance plans have "decreased markedly" during this decade.

Healthcare reform continues to suffer in comparison to the daily air of crisis brought on by the Iraq War. According to Robert Blendon, a Harvard University expert on health policy and public opinion, "You can't get people to think or talk about what should be done when all they read about is people in Iraq being blown up every day. But I expect health care to be huge in the 2008 presidential elections." One area of change has been the recent law passed in Massachusetts mandating that uninsured individuals purchase health insurance by July 1, 2007, with new and inexpensive policies developed to make this plan affordable. The article does not point out that mandated coverage is a gift to the insurance and managed care industries, locking the state into supporting private concerns that continue to be a primary cause of the problem of healthcare's increasing costs, rather than the solution.

There are three main initiatives planned in Congress:

- Restrict medical malpractice awards and shield drug and medical-device manufacturers from pesky lawsuits.
- Allow small businesses to pool risk, while also conveniently allowing them to evade state insurance mandates and guidelines.
- Expand Health Savings Accounts

The reporter allowed Ron Pollock of Families USA to have the last word:

> Real change will take presidential leadership and a bipartisan consensus. At some time, the tipping point will be reached, and it may be getting closer. But because of numerous failures to do major health-care reform in the past, there is a sense among policy makers that this is something that is intractable.

'HONEST ABE' WOULDN'T MAKE THE GRADE

CONNECTICUT LAW TRIBUNE

DOUGLAS MALAN

APRIL 24, 2006

This article begins, "If Abraham Lincoln were alive, he would encounter several difficulties gaining admittance to the Connecticut bar—assuming he deserved his reputation both for honesty and for 'melancholia.' That's because the state's Bar Examining Committee has reintroduced depression as one of the conditions listed on the mental health section of the bar application. Depression made the list in July 2000, but public outcry led to its removal—until now." There may be some slight satisfaction at seeing lawyers be on the receiving end of gross violation of privacy, but this article examines the frightening prospect of increased violations of medical privacy in all areas of work and life. Of course, the problem is not solely due to disclosure of private information, but the chilling effect the possibility of disclosure will have on those who need treatment and will not do so out of fear of disclosure.

Quoting Jon Bauer, a clinical law professor at the University of Connecticut, “I was really shocked when I saw these new questions. This could be a major disincentive for people to seek treatment for health matters, out of fear of repercussions following disclosure. It doesn’t make sense to ask about depression but not the physical ailments that affect people in a similar fashion. Depression affects energy level and mood. The same things are true of a lot of physical disabilities. Symptoms of major depression are not psychotic like manic disorders, bipolar disorder or schizophrenia.” This last observation is based on the fact that inquiry into severe mental health conditions has been standard for many state bar associations for years. In addition, the applicant is required to disclose history of treatment occurring within the last 10 years. The concerns raised by Jon Bauer have been dismissed by those on the Bar Exam Committee, who also claimed not to remember how and when the language requiring disclosure of “major depressive mood disorder” was included. The reporter also points out there is no such term as “major depressive mood disorder” in the DSM!

The article goes on to cite Lieutenant Governor Kevin B. Sullivan, “who has criticized the application questions in the past, wondered why ailments such as morbid obesity, consistent reckless behavior and narcolepsy aren’t on the list even though they could be equally detrimental to the practice of law. Sullivan said the amended phrasing is legally suspect, but doubts any applicants will make that risky power play.

“Will anyone who has standing seek admittance to the bar and sue at the same time? No,” Sullivan said. “The committee knows it’s in a position of power.”

JIM PYLES COMMENTS

This article from the *Connecticut Law Tribune* illustrates the controversy that would be generated by enacting a federal law that would preempt state laws and authorize the disclosure of sensitive mental health information without the patient’s consent and against the patient’s will. Not only would “Honest Abe” not be elected but neither would John Kennedy or Ronald Reagan. Of course, the strong disincentive to obtain needed mental health care is our greatest concern. Hopefully, Congress can create better public policy that is more in line with mainstream public expectations than the Connecticut Bar did. I suspect that the Connecticut Bar decision will not stand.

I would respectfully ask that you bring this to Mrs. Johnson’s[1] attention since she took issue with my observation that, in my experience, there is no end to the number of people who can come up with a good reason why they must have access to your identifiable health information without your consent or against your will. Now we can add the Connecticut Bar’s Examining Committee to that list.

Fighting for Privacy
Modernhealthcare.com
Matthew DoBias
April 10, 2006

Advocacy groups across the political spectrum—from the Christian Coalition to the American Civil Liberties Union—joined together last week to rally opposition to health information-technology legislation they claim could reduce patient privacy rights. The group also seeks to reverse some amendments they say have all but erased the effects of patients’ rights laws.

The coalition of 26 groups, called the Coalition for Patient Privacy and led by the Patient Privacy Rights Foundation in Austin, Texas, signed a letter to key members of the House arguing that the patient should be the sole owner of his or her healthcare information--not the drug, insurance or marketing industries. But the health IT juggernaut may be too big for the coalition to make much headway, with one of the member groups, Patient Privacy Rights, saying it doesn’t currently support any of the bills now in Congress. But the group does give a nod to a health IT bill co-sponsored by Rep. Patrick Kennedy (D-R.I.) and to subsequent legislation the congressman expects to introduce in May to update federal privacy rules.

In the letter dated April 5, the Coalition for Patient Privacy stated that the patient needs to be the point person when it comes to accessing electronic records and the data contained within. “Privacy violations will exponentially increase if patients cannot limit which healthcare businesses and government agencies can access our personal health data over an electronic network,” said Deborah Peel, chairwoman of the Patient Privacy Rights Foundation. The letter urges lawmakers to back legislation that gives patients the right of consent and the ability to opt-out of having their records in any national or regional electronic health system. Also, the group wants Congress to give patients the right to segregate their most sensitive medical records, require audit trails of all disclosures, deny employers access to medical records and require patients be notified of any suspected or actual privacy breaches.

Since 1996, Peel said she has watched as federal and private health agencies have chipped away at HIPAA regulations. Because any electronic health record could provide instant access to private patient information, she said any legislation would have to address privacy concerns.

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[1] Nancy Johnson (R-CT), Chair of the Health Subcommittee of Ways and Means and sponsor of the Health Information Technology Promotion Act of 2005 (H.R. 4157)

Many on Capitol Hill agree, even while they haggle over ways to ensure patient security. Kennedy, whose legislation goes the farthest in locking in data security, said there is bipartisan support for legislation, "But to realize its potential we also are going to have to ensure that healthcare privacy is rock-solid."

Mental Health Fees Stagnate

New York Times

Coeli Carr

March 26, 2006

The article begins with this story: "For more than three decades, Jessica Hinterman, a licensed clinical social worker who lives in Park Forest, a Chicago suburb, has had a fulfilling private practice, a part-time one so she could spend more time raising her children. But in 2005, she earned at least 10 percent less than the year before, while her practice-related expenses increased. Though her customary fee at the time was $90 an hour, she could charge only $68 to $72 for patients insured by the company she had contracted with. About two-thirds of her patients were insured by that company."

The article documents what many mental healthcare professionals know from firsthand experience: managed care continues to ratchet down reimbursements for psychotherapy. Quoting Richard G. Frank, a health economist with a specialty in mental health issues who is a professor at Harvard University, "Clearly, the earnings of mental health professionals—medical doctors, psychologists, social workers and counselors–have either been flat or been declining for the past five to eight years. It's not so much the number of visits allowed by managed care to mental health professionals has changed. It's that fees paid to the mental health professionals have not been rising."

What makes this article more significant, however, is that is also makes the point that psychotherapy is the target, rather than psychopharmacology and the reporter cites Frank's book, *Better but Not Well* (Johns Hopkins Press, 2006), as documentation that psychiatric care, in many instances, has become the sole treatment option for mental health patients. Quoting Ms Hinterman, "patients find prescription medicines a quicker fix than prolonged and thorough introspection. We just live in a culture that values speed and efficiency and wants to see complex problems resolved in half an hour." Ms Hinterman adds that she is starting a new line of work.

These problems, of course, affect all psychotherapists, regardless of mental health degree. Psychologists are facing the same downward pressure on their fees as social workers. Paul C. Berman, a licensed psychologist in Baltimore who serves as professional affairs officer for Maryland's psychological association, said, "Many psychologists in private practice have had their fees reduced year after year, requiring them to work many more hours to maintain the same income." As an example, Dr. Berman reports that his reimbursement rate was $85 in 1990 and it has fallen to $65 to $75. In addition to low fees, problems encountered include late payment and lengthy paperwork required in order to be reimbursed.

Not surprisingly, the "upbeat" answer for reduced fees touted by the article includes "diversifying your practice" and no longer doing psychotherapy but expand to coaching, forensic work, and so on. There was mention of the need to develop a practice outside of managed care altogether, and to join with colleagues in "selling" the value of our work. According to Dr. Berman: "First, many practitioners thought managed care would die. Then there was outrage. Then resignation. Then they felt overwhelmed. Where we are now is taking a proactive stance so we can meet the needs of the changing marketplace and survive financially and professionally." Implied in the article is the ongoing deprofessionalization of our field, with psychotherapy clearly seen as "less than" psychotropic medicines in treating patients, despite the clear evidence that psychotherapy is superior to medications for most mental health problems. Since this was the *NYT,* of course, Dr. Berman was described only as "Mr. Berman." So much for respect for our profession!

IN CASE YOU WERE WORRIED

The nation's health maintenance organizations reported a 21.2 percent higher profit during the first six months of 2005 than they did for the same period the year before. according to Weiss Ratings, reportedly basing its analysis on insurers that filed a National Association of Insurance Commissioners (NAIC) Health Statement or a California Health Care Service Plan statement.

The financial analysis firm said the profits reached $6.98 billion during the first six months of 2005, up from $5.76 billion during the same period in 2004. HMOs reporting the largest year-over-year dollar increases in profit include:

- Newark, N.J.-based Horizon Healthcare Services, which said it earned $137 million, up from $37.8 million
- New York City-based Oxford Health Insurance, which said it earned $98.1 million, up from $44.5 million
- Harrisburg, Pa.-based Advantage Insurance Co., which said it earned $32.3 million, up from a loss of $12.9 million.
- Detroit-based Blue Cross Blue Shield of Michigan, which said it earned $208.5 million, up from $163.4 million

CONTENTS

FROM THE BOARD

After many years of service to the National Coalition, including several terms as newsletter editor, treasurer and president of our organization, Dave Byrom announced his decision to step down from the presidency of our organization effective March 16, 2006. We are still in the middle of this important transition and Dave remains as a vital point person in his work as Liaison Committee chair. In this role, he will continue to coordinate collaboration with grassroots health care groups such as the Making Health Care Work For All Campaign, Citizens Healthcare Working Group, UHCAN, etc. The collaboration with the Medical Privacy Coalition always included Michaele Dunlap, our vice-president, and she will continue this work along with Bill MacGillivray, who has assumed office of the president. Other members of the Coalition remain at their posts, with Roz Gilbert as treasurer, Kathie Rudy as Publications Committee chair, and Gordon Herz as chair of Legislative Committee, and so on. Dave's leadership will be sorely missed; but his continued service on our board to the cause of privacy, quality and access to mental health care will remain as important contributions to the Coalition's efforts. Assuming the office of Past President, Dave will continue to provide valued counsel and guidance to our work. I hope every member of the National Coalition will join me in expressing heartfelt thanks for his years of service as our president.

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