NAMI ★ The Nation's Voice on Mental Illness

Campaign For The Mind Of America

Partnerships For Recovery

ANSWERING THE CALL

Reducing the Costs of Untreated Mental Illness in Illinois While Improving Care

NAMI ILLINOIS AND PARTNERS OF THE CAMPAIGN FOR THE MIND OF AMERICA

April 13, 2005

Presented by NAMI Illinois
www.nami.org

EXECUTIVE SUMMARY

With almost 1,000,000 citizens of Illinois suffering from a serious mental disorder in any given year, mental illness touches almost every family in the state. The direct and indirect costs of mental illness total more than $2.6 billion a year for the state of Illinois. State and county governments are forced to pay millions of dollars in emergency medical care, education interventions, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs. Everyone is affected.

That said, mental illness poses challenges with proven solutions. The U.S. Department of Health & Human Services (HHS) and experts in the field are promoting proven interventions that may lead to recovery—including the use of new and improved psychotropic medications, and implementation of evidence-based practices (EBPs).

Sadly, despite such advances, nearly 50 percent of all people with a severe mental illness do not get the treatment they need. In Illinois and other states, people with severe mental illnesses face many barriers to treatment, such as inadequate health insurance coverage, stigma, financial disincentives to treatment and a lack of qualified mental health professionals.

i. An Action Plan for Illinois

To close these gaps and decrease the costs of untreated mental illness, NAMI Illinois and the Campaign for the Mind of America recommend:

- **Jail Diversion:** *Every citizen of Illinois should have confidence that the state's correctional institutions are reserved for criminals, not for those whose only transgression is having an illness.*

    1. Proven programs such as Crisis Intervention Teams and Mental Health Courts must be available statewide.
    2. The state must expand the quality, evidence-based services that have sharply reduced the number of people with severe mental illnesses who fall into the criminal justice systems, saving taxpayer dollars.

- **Investments in Core Services:** *Illinois must fulfill its promise to its most vulnerable citizens and fully fund the community mental health care system. These investments would yield significant savings by preventing unnecessary incarcerations, chronic homelessness, and overcrowding in emergency departments, while helping people with severe mental illness live independent lives and contribute to their communities.*

    1. In changing to a fee-for-service payment model, care must be taken to ensure a quality system of care where people receive evidence-based care, while providing more accountability to taxpayers of the state.
    2. The House should pass HB1451, which will strengthen community-based mental health services for people with severe mental illness.

- **<u>Mental Health Parity</u>:** *Illinois must protect its current parity law, while taking steps to join other states in enacting parity legislation that includes broader benefits for state residents.*

  1. The legislature should pass HB 59 this year. This bill would extend Illinois' existing mental health parity law, which is due to expire on December 31, 2005. NAMI Illinois also supports SB 770, a bill that would expand the existing law to include parity coverage for anorexia, bulimia, and post-traumatic stress disorder (PTSD). Consideration should also be given to broadening the existing language because it exempts small employers and Employee Retirement Income Security Act (ERISA) plans, leaving many employees in the state without parity coverage.
  2. The existing law also only addresses adults with severe mental illness, leaving no parity benefit for children and adolescents with serious emotional disturbances.

ii. New Approaches to Reducing Costs and Improving Care

In a time of difficult choices, this report also offers economically sound solutions to protect services for the state's most vulnerable citizens. In particular, Illinois should learn from other states such as Michigan, Missouri, Vermont and others that are facing similar budget pressures and have developed innovative programs to care for people with mental illness.

iii. Conclusion

Given current budgetary difficulties in Illinois, meeting patient needs through an array of services appears to be challenging. The truth is, however, that drastic budget cuts will ultimately cost taxpayers more, while putting individuals already at risk in greater jeopardy.

NAMI Illinois and the Campaign for the Mind of America are prepared to work with all stakeholders. We want to develop common goals and solutions to ensure that systems of care and social supports efficiently and effectively aid recovery, so people with mental illness can be productive members of their community.

I. INTRODUCTION

Severe mental illnesses are extremely common; they have an impact on almost every family in Illinois. They affect people from every background and occur at any age. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 7.7 percent of adults in Illinois had a severe mental illness in the past year. This translates into approximately 950,000 citizens of Illinois. Approximately 240,000 of those affected are children and adolescents. Nationally, the estimate for severe mental illness is 8.76 percent of the population.

Without treatment, people living with mental illnesses are rarely able to achieve school success, secure employment, maintain adequate housing, and ultimately live a quality, productive life in the community. With treatment, however, a life of dignity and productivity is indeed possible.

II. UNTREATED MENTAL ILLNESS: IMPACT ON ILLINOIS

In the United States, mental illnesses account for more than 15 percent of the overall burden of disease from all causes—slightly more than that of cancer. ("Report of the U.S. Surgeon General," 2003). In Illinois, mental illnesses are major barriers to school success, employment, housing and quality of life, and a leading contributing factor to poverty.

Failure to provide timely treatment can destroy individuals and families. Untreated mental illness is the leading cause of disability and suicide, and imposes high costs on state and local government. Many people left untreated or with insufficient care see their illnesses worsen. Children left untreated become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail.

For too many in Illinois, mental health treatment and supports remain fragmented, disconnected and inadequate—frustrating the opportunity for recovery. The grim reality is that in many communities in the state, treatment is non-existent and in others, it is extremely difficult to access.

For most people with severe mental illnesses, treatment is not available until they go into crisis. Then, the costs become prohibitively expensive. Nationally, direct treatment (public and private) costs are estimated at $69 billion in 1996, translating into over $2.75 billion in Illinois alone. Indirect costs for untreated mental illnesses, such as lost productivity were estimated at $79 billion nationally. In Illinois, indirect costs were estimated at more than $3.2 billion.

Overall, the total national cost of mental illness was estimated at $148 billion annually. In Illinois, that figure translates to nearly $6 billion per year.

Untreated mental illness also involves other costs that are shifted to multiple sectors of society, including county systems and budgets. State and county governments are forced to pay millions of dollars each year in emergency medical care, education interventions, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs. Everyone ends up being adversely affected.

Spending $$ in All the Wrong Places:
The Unintended Consequences of Untreated Mental Illness

- **Untreated mental illness impacts negatively on educational achievement. Approximately 50% of children with emotional and behavioral disturbances drop out of school. ("Report of the Surgeon General's Conference on Children's Mental Health," 2003).**

- **Lost productivity robs dignity and reduces the community tax base. Between 85 and 90 percent of adults with severe mental illness end up unemployed. ("U.S. Department of Health and Human Services," 1999).**

- **Individuals with severe mental illness frequently become homeless. More than one-third of homeless individuals in Illinois suffer from a severe mental illness.**

- **Adults with untreated mental illness are often put in jails and prisons. The Illinois Department of Corrections does not appear to collect information about the prevalence of inmates with severe mental illness in state prisons. However, based on national estimates that 16 percent of jail inmates suffer from severe mental illnesses, it can be estimated that 7,100 of the total 44,379 adults in Illinois state prisons suffer from schizophrenia, bipolar disorder or another severe mental illness. (U.S. Department of Justice, 1999).**

  The prevalence of mental illnesses among youth in Illinois juvenile justice facilities is much higher. Research on youth detained in Cook County juvenile justice facilities revealed that 58.8% of males and 66.4% of females had one or more psychiatric disorders. These rates are even higher among minority youth. (Teplin, L. *Archives of General Psychiatry*, December 2003).

- **90 percent of suicides are the result of mental illness, with impacts that extend throughout families and communities. (Institute of Medicine, 2002 and Surgeon General, 1999). Among young people ages 15 to 24, suicide is the third leading cause of death. (Anderson, et. al., National Vital Statistics Report, 2003).**

- **In 2001, 12,700 families in the U.S. were forced to give up custody of their child to the child welfare and juvenile justice systems for the sole purpose of accessing mental health services. This unthinkable practice, which forces families to choose between maintaining custody of their child or securing vitally necessary mental health services also occurs in Illinois, where state officials reported that families in DuPage County were forced to place their child in the juvenile justice system to secure mental health services. The state did not provide data to the Government Accounting Office (GAO) on the number of families that were forced to place a child in child welfare to secure mental health services. (U.S. GAO, 2003).**

III. EVIDENCE-BASED PRACTICES IN ILLINOIS: AN UNDERUTILIZED OPPORTUNITY

"Evidence-based practices" (EBPs) are clinical and administrative practices that have been proven, through randomized clinical trials and "real-world" observations, to consistently produce specific, intended results. For youth and adults with severe mental illnesses, these results entail recovery, as well as the prevention of the most damaging consequences of untreated mental illnesses, such as homelessness, criminalization, hospitalization, or suicide.

SAMHSA has identified the following six services for adults that constitute EBPs:

- Assertive Community Treatment (ACT) programs
- Integrated mental health and substance abuse treatment for people with co-occurring mental illness and substance use disorders
- Supported employment
- Medication management protocols
- Family psycho-education programs
- Illness self-management programs

Over the past year, NAMI collected data from the 50 states and the District of Columbia about the extent to which each EBP is available to adults with severe mental illnesses. Additionally, NAMI has collected data on jail diversion programs and supportive housing programs. In terms of resources, the state of Illinois ranks 32nd nationally in per capita funding for the treatment of mental illness, spending $63.54 per person. A snapshot of the data provided by the Illinois Division of Mental Health for fiscal year 2004 follows immediately below.

In collecting data on the availability of EBPs for adults with severe mental illnesses, NAMI used the very conservative estimate that 1 percent of Illinois' adult population, or 124,192 adults according to 2000 Census data, suffer from severe mental illnesses. In actual fact, the number of people with severe mental illnesses in the state is probably significantly higher.

Assertive Community Treatment (ACT) – ACT is one of the best-documented services that helps individuals with severe mental illnesses live in the community and avoid hospitalization. It consists of a diverse team of mental health providers who together, using a triage type approach, provide comprehensive and integrated services for people with severe mental illness, reaching out to them in their own communities and providing the full range of services needed.

In Illinois, 59 ACT programs serve individuals with severe mental illnesses. The Division of Mental Health reported that 3,568 people were served by these programs, with 3,234 individuals receiving ACT case management services and 334 in ACT supervised residential programs. The State invested a total of $17,634,429 in ACT programs—$14,378,709 for case management and $3,255,720 for supervised residential programs. At the current levels of service, ACT programs have only begun to scratch the

surface of need in Illinois. Many improvements are necessary to bring ACT to all those who could benefit from this intensive and highly effective service

NAMI Expectations: 18,628 persons should be served by ACT programs in Illinois.

Integrated mental health and substance abuse treatment for people with co-occurring disorders – This optimal form of treatment for people with co-occurring disorders combines mental health and substance abuse treatment in one setting, with effective coordination and ongoing communications between treatment providers in both areas.

The Illinois Division of Mental Health is in the beginning stages of bringing integrated treatment to those in need. Approximately 17 agencies across the state are engaged in planning and staff training to implement integrated treatment using a federal grant of $300,000. No information is available on the number of individuals expected to be enrolled in services once the programs are operational. NAMI is pleased to see this initiative taking root in Illinois and calls for the rapid and widespread implementation of these critically important services.

NAMI Expectations: The Illinois mental health system should have the capacity to offer integrated treatment to 62,096 individuals.

Supported Employment – This employment service is the most effective in helping people with severe mental illnesses obtain and maintain competitive employment. Departing from the traditional "train-place" model of vocational rehabilitation, supported employment programs help people with severe mental illness find jobs and provide job-coaching and ongoing supports on the job-site to maximize the chances of success.

The Division Of Mental Health (DMH) reported that three agencies in the state offer supported employment services. Based on data from two of those agencies, 221 individuals participated in these programs in fiscal year 2004. However, the DMH did not have a separate grant for supported employment programs in fiscal year 2004 and did not report the funding source for these programs.[1] At the current levels of implementation, Illinois' supported employment programs are not nearly sufficient to meet the need of individuals with severe and persistent mental illness who could become productive, working citizens of Illinois.

NAMI-Illinois calls upon the DMH, working in coordination with the Illinois Division of Rehabilitation Services, to significantly increase supported employment services for individuals with severe mental illness.

NAMI Expectations: 62,096 persons served by supported employment programs.

Medication Management – Various mechanisms can help translate the latest available knowledge about medications into practice by helping physicians and patients choose the

[1] It should be noted that the role of the DMH is generally to fund extended employment supports. The Division of Rehabilitation Services is responsible for initial funding of these services.

appropriate medication. Decisions about medication must be made at the individual level, with the full support of scientific evidence.

Illinois is currently implementing two community medication management programs with training in progress in several other sites. To support these programs the state invested $40,000, but the state has not been able to track the numbers of individuals served to date through medication management programs. While NAMI applauds the state's move towards implementing programs in the community, there is still a major unmet need for these programs to ensure the best use of medication for people with severe mental illness and to allow the state to achieve greater efficiencies in its reimbursements for prescription drugs for mental illnesses.

NAMI Expectations; All prescribers of medication for individuals with severe mental illnesses should utilize medication management programs.

Family Psychoeducation – Since family members of individuals with severe mental illnesses often provide support and care for their loved one, services that help them understand mental illness have been shown to help family members cope better and help people with mental illness avoid psychiatric crises. An estimated 50 percent of family members provide intensive care for individuals with severe mental illness—and thus could benefit significantly from family psycho-educational services.

The DMH was not able to provide any data on the high fidelity family psychoeducation programs that are considered an EBP. However, in 2004, NAMI Illinois was able to fill this gap by educating more than 550 family members about mental illness through the free, community-based *Family-to-Family* Education Program, and an additional 311 primary caregivers of children and adolescents through its *Visions for Tomorrow* program. The DMH must make a stronger commitment to reaching out to families in need to help ease the burden on the state's mental health system and on consumers and families throughout Illinois.

NAMI Expectations: A minimum of 62,096 family members should receive family psychoeducation services.

Illness Self-Management – Interventions that help people with severe mental illness better understand their illness and take charge of their treatment decrease psychiatric symptoms and improve outcomes. All people with severe mental illnesses should have access to illness self-management.

For this intervention, the DMH was also not able to provide any data on the high fidelity illness self-management programs that are considered an EBP. Again, NAMI Illinois has stepped in to serve 189 people with mental illness in 2004 through the free, community-based Peer-to-Peer Education Program. Additionally, we are aware that the state is providing a program called *Wellness Recovery Action Planning (WRAP)* for individuals living with mental illnesses. While these are positive steps, the DMH should expand access to these programs with proven effectiveness in helping to facilitate recovery.

NAMI Expectations: Illness self-management programs should be accessible to all persons in the state with severe mental illnesses.

Jail Diversion (An emerging best practice) – Throughout the country, a variety of pre-booking and post-booking programs have emerged as alternatives to incarceration to link people with severe mental illnesses with needed services. A growing body of evidence shows that these programs are frequently successful in reducing criminal justice involvement and enhancing public safety.

Illinois has made some progress in establishing alternatives to incarceration for people with severe mental illnesses. In fiscal year 2004, the state reported that two Mental Health Courts served 232 individuals and two more are in the process of opening their doors. Additionally, the state has invested $1,248,917 in six jail diversion programs in the state that have served 967 individuals in the past year. Illinois is moving in the right direction in establishing and funding programs to ensure that individuals with mental illness do not become unnecessarily entangled in the criminal justice system, but there is still much to be done as described in a later section of this report.

Overall, Illinois has implemented a variety of evidence-based services in the community for people with severe and persistent mental illnesses. However, much more can and should be done to bring these practices to those most in need. Illinois must also do a better job of collecting accurate data on these most important practices so that programs and their outcomes can be tracked and evaluated. At a time of fiscal constraints and budgetary restrictions, improved information of this kind is critical to protect and expand the implementation of EBPs.

V. PRIORITIES FOR THE STATE OF ILLINOIS

PRIORITY ISSUE:
INCREASED PENETRATION OF JAIL DIVERSION PROGRAMS

In Illinois, as in the rest of the country, the police have become the front line respondents to youth and adults with severe mental illnesses who are in crisis. Municipal jails and state prisons have become de-facto psychiatric treatment facilities. In fact, the Cook County jail vies with the Los Angeles jail for the dubious distinction of being the country's largest "psychiatric hospital!"

The true shame of the tragedy of the criminalization of people with severe mental illness is that it is frequently easily preventable. As discussed throughout the text of this report, the provision of quality evidence-based practices such as ACT, integrated mental health and substance abuse treatment, and others, have demonstrated effectiveness in sharply reducing the involvement of people with severe mental illnesses with criminal justice systems.

Criminal justice systems are frequently not equipped to respond to people with significant psychiatric treatment needs. Studies have shown that people with severe mental illnesses spend far more days in jail than individuals who have committed comparable offenses who do not have mental illnesses. (Butterfield, F. , 1998).

Furthermore, offenders with severe mental illnesses are far more expensive to incarcerate than other inmates, due to heightened treatment needs, the need for specialized treatment units, and other factors. (Criminal Justice/Mental Health Consensus Project, 2005).

In Chicago, a jail diversion program operated by Thresholds is a shining example of the positive outcomes that can be accomplished through effective collaboration between criminal justice and mental health systems. This program has achieved remarkable successes both in reducing criminalization and in saving public dollars. A comprehensive study of this program showed dramatic reductions in jail and hospital costs after individuals with severe mental illness began receiving services. (*Psychiatric Services*, 2001).

Cost Savings Realized by Jail Diversion Programs				
Program	**Number of Participants**	**Prior to Involvement**	**During Involvement (Plus Program Cost)**	**Cost Savings per Person**
Thresholds Jail Program (Cook County, IL)	**30 (Two Years)**	**$53,897**	**$35,024**	**$18,873**
Project Link (Monroe County, NY)	**44 (One Year)**	**$73,878**	**$34,360**	**$39,518**
***Source*: Criminal Justice Mental Health Consensus Project.**				

A number of innovative approaches to jail diversion have emerged throughout the country. Examples of these include:

- **Police Crisis Intervention Team (CIT) programs,** an approach that combines police training about effective responses to people experiencing psychiatric crises with the development of specialized mental health/law enforcement triage mechanisms designed to effectively link people with needed mental health services in lieu of arrest and incarceration;

- **Mental Health Courts,** specialty courts created specifically to facilitate treatment alternatives to incarceration for non-violent offenders with severe mental illnesses. More than 100 of these courts have been established throughout the country, including one in Cook County; and

- **Post-Booking Diversion Programs**, involving innovative partnerships between mental health, court systems, and parole and probation. An example of such an approach is the statewide post-booking diversion program that is being operated in all arraignment courts in Connecticut.

As demonstrated by the successes of Thresholds and other similar initiatives, the development of services designed to reduce the unnecessary use of criminal justice systems for psychiatric treatment need not result in significant public expenditures. In the long run, these services lead to significant cost savings through reductions in hospitalizations, incarceration, and other costly services associated with lack of appropriate mental health treatment. These services also reduce burdens on law enforcement, courts, and corrections, freeing them up to serve their essential crime-fighting responsibilities. Start up costs associated with jail diversion programs in various communities have been financed through a variety of sources, including:

- The Byrne Formula Grant program—federal monies filtered through states to fund a variety of innovative criminal justice initiatives in communities. Information about this program can be found at http://www.ojp.usdoj.gov/BJA/grant/byrne.html

- The SAMHSA Targeted Expansion Capacity Jail Diversion Program—has provided seed funding for a number of community-based jail diversion programs in recent years. Information about this program can be found at http://www.samhsa.gov/grants/2005/nofa/sm05011_jaildiversion.aspx

- The Federal Mental Health Courts Grant Program administered by the U.S. Department of Justice, Bureau of Justice Assistance—More information about this program can be found at http://www.consensusproject.org/mhcourts/about

In November, 2004, President Bush signed into law the "Mentally Ill Offender Treatment and Crime Reduction Act," a new federal program designed to award grants to states or communities for jail diversion, community reentry, or other services for individuals with severe mental illnesses who come into contact with criminal justice systems. It is hoped that funds from this program will be available for local communities in 2006.

In sum, while the costs of starting CIT programs, Mental Health Courts, or other jail diversion programs are relatively modest, the benefits, in terms of cost savings and enhanced public welfare are potentially tremendous. NAMI Illinois calls upon the state to assume leadership in helping local communities create these programs on a state-wide basis.

PRIORITY ISSUE:
STANDARDIZING CORE SERVICES

As it is all over the country, state support for the public mental health care system in Illinois has been under serious attack since 2001. While the situation in Illinois is no different than in the rest of the country, mental health advocates are in a markedly better position to defend against the disastrous cuts being threatened elsewhere. Dominating much of the discussion at the state capitol is dialog on the transition to a fee-for-service payment model for mental health treatments through the state's indigent care delivery model.

The transition to a fee-for-service model represents a significant adjustment for service providers. Historically, in Illinois, community providers have received a

lump sum grant from the state to provide services within their defined service area. The fee-for-service model requires the service provider to perform certain services and then request payment for the services delivered from the state.

Implementation of a fee-for-service model is not new. Several states have already transitioned their payment approach to take advantage of the built-in accountability of the fee-for-service model. NAMI Illinois believes that fee-for-service potentially enhances the chances that people with severe mental illnesses will receive services that are state of the art and evidence-based. Moreover, the change to a fee-for-service system will potentially better enable the state to monitor outcomes and therefore increase accountability to the taxpayers of the state. As the discussion on this topic progresses, the Campaign calls on the state to continue the focus on achieving the greatest possible return on its investment into services for citizens with severe mental illnesses.

The transition from a grant-based system of financing mental health services to a fee-for-service system is very complicated and poses significant challenges for all concerned. The implementation of a new payment system, if done improperly, could create significant cash flow problems for providers and even jeopardize the ability of some providers to remain solvent. Additionally, providers will have to develop new billing, systems, including methods for carefully tracking and documenting services received by their clients, something they might not have done under the old grants-based system. The transition is a positive development, but will take some time to properly implement.

Thus, NAMI Illinois calls upon the State to proceed systematically but cautiously in implementing the new system. The transition should occur over a designated period of time, with extensive technical assistance available for providers and others who must negotiate the new system. A phased transition, which may initially include a combination of grants and fee-for-service financing, should be considered. Finally, the state should continue to significantly involve people with severe mental illness and their family members in all aspects of the transition, including field-testing and evaluation.

As implementation of the change in payment methodologies approaches, the state must assure that payment rates are adequate to allow providers the flexibility to provide evidence-based services and attract top level, skilled staff. A fee-for-service model that does not provide adequate reimbursements is doomed to failure as skilled professionals leave the marketplace and remaining providers are left with inadequate resources to provide high quality services.

Most importantly, NAMI-Illinois and the Campaign assert that core community-based mental health services must be available to all citizens of the state with severe mental illness - those who receive services through the public mental health system and those who receive privately funded services. Essential core services must include crisis intervention, inpatient and residential treatment, psychiatric medication, detoxification, integrated mental health and substance abuse treatment, ACT and the other EBPs delineated earlier in this report.

The spirit of this recommendation is partially addressed in HB 1451, a bill pending in the Illinois legislature. HB 1451 would amend the Mental Health and Developmental Disabilities Administrative Act and establish minimum standards for the provision of high-quality services to people with severe mental illness.

Eligibility for core services should be based on functional assessments, so scarce resources are allocated to individuals with the most severe disabilities. Multiple funding streams should be crafted into a seamless system of care for this priority population, allowing for consistent service provision, quality assurance and cost effectiveness.

These basic investments could yield significant savings by preventing unnecessary incarcerations, chronic homelessness, overcrowding in emergency departments and reliance on social services, and help people with severe mental illness live independent lives and contribute to their communities.

PRIORITY ISSUE
Mental Health Parity in Illinois

The state of Illinois first passed mental health parity in 2001. The original bill that provided parity for six core mental illnesses included a sunset provision that allows the law to end on December 31, 2005.

Since the law's enactment, there has been no public outcry from industry about the costs of the benefit. Currently pending before the Illinois legislature is HB 59. The state of Illinois should take prompt action and pass this bill which would permanently codify mental health parity for the state.

Legislators must take the following facts into consideration as they contemplate HB 59.

- There is no medical or economic reason for health insurance plans to discriminate between mental illnesses and other illnesses.
- Mental illnesses such as schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder and severe anxiety disorders are real illnesses.
- There is simply no scientific or medical justification for insurance coverage of mental illness treatment to be on different terms and conditions than other diseases.
- Discriminatory insurance coverage of mental illness bankrupts families and places a tremendous burden on taxpayers.
- Parity is affordable—the Congressional Budget Office (CBO) estimates that S 543 will increase insurance premiums by less than 1% (a finding that is consistent with numerous previous studies that demonstrate how non-discriminatory coverage is economical and results in better treatment outcomes).
- 36 states have enacted parity laws.

VI. FUNDING STRATEGIES FOR IMPROVING MENTAL HEALTH SERVICES

NAMI Illinois believes that the core community-based services described in the previous section are critically important so that people who have serious mental illness are able to live in and become productive members of their communities. To fund these services and programs involves implementing new approaches to control the rate of escalation in health care spending while simultaneously ensuring quality of care for those being served.

Examples of strategies incorporated in other states to generate revenues for mental health services include the following: (McKinsey and Company, Feb. 2004).

Kentucky

In 2004, Kentucky passed legislation, HB 157, authorizing court fees collected in DUI cases to be used to create a triage system for screening jail inmates for mental illnesses and to provide mental health services in local jails throughout the state. More information about this legislation can be found at http://www.lrc.state.ky.us/record/04rs/HB157.htm

Louisiana

A 22-page "plan for immediate action" by the Department of Health and Hospital is calling for a change in the way nursing homes are paid under Medicaid. The plan advocates for one long-term Medicaid unit that will oversee all services for the elderly, disabled, nursing home residents and people covered by waivers who want home and community-based care. Home and community-based care services are currently handled by separate agencies with separate budgets.

The state currently collects a provider tax from nursing homes that is based on the number of patients they serve. Proposals have been made to charge a tax on the number of beds, rather than the number of patients, as an incentive for nursing homes to cut back on their number of beds and to steer nursing homes into the business of providing community-based services.

Michigan

A 75-cent-a-pack increase has been added in the state's cigarette tax, which generates an additional $300 million annually into the state's Medicaid program.

Missouri

Missouri formed the Missouri Mental Health Medicaid Pharmacy Partnership (MHMPP) in March of 2003. MHMPP retained the services of Comprehensive Neuroscience, Inc. (CNS) to evaluate mental health medication prescribing practices. The evaluation focused on improving patient care by educating doctors regarding best practices standards of mental health medications and reviewing, identifying and analyzing problematic prescribing patterns of physicians who frequently deviate from those guidelines (Alternatives to Restricting Access to Mediations).

This program analyzes pharmacy claims data on a monthly trend basis for better behavioral pharmacy management, identifies prescriber outliers based on deviations from nationally recognized best practice guidelines, engages prescriber outliers through targeted educational messages, benchmarking and peer review consultations, tracks changes in outlier prescribing practice over time, tracks high-risk patients' failure to refill antipsychotic medications and reports findings to physicians, and identifies patients receiving current same-class medications from multiple prescribers and alerts all involved prescribers.

It is estimated that Missouri saved nearly $9 million under the first year of the program.

NAMI Illinois recognizes the significant budget pressures experienced by the state of Illinois. This year, NAMI Illinois supported legislative language that would have preserved access to life saving medications for people living with mental illness. NAMI Illinois and its partners must remain vigilant to ensure that current restrictions to mental heath medications do not suppress opportunities for recovery or proliferate adverse events.

New York
The Health Care Reform Working Group proposed reducing Medicaid reimbursements to hospitals on certain "high end" treatments like transplants and cardiac care, and giving savings to more basic services like emergency room care and treatment for asthma.

Vermont
About two-thirds of Vermont's Medicaid spending is financed from their Health Access Trust Fund (HATF). Revenues for the trust fund come from tobacco (taxes, as well as part of the settlement from cigarette manufacturers), provider taxes on hospitals, nursing homes and home health agencies, and an annual transfer from the General Fund.

Washington
The state's Department of Social and Health Services has created a "No Wrong Door" program to coordinate services across various programs. Three specific groups were recognized as key targets for program coordination: people with multiple disabilities including mental illness; troubled youth and their families; and long-term welfare recipients, many of whom were dealing with chemical dependency or mental illness.

VII. RECOMMENDATIONS

1. **Illinois must invest in criminal justice interventions that steer youth and adults with severe mental illnesses away from incarceration and into treatment. Models with proven effectiveness such as the Thresholds jail diversion program should be implemented on a statewide basis. Additionally, the state should provide assistance and help communities find resources to develop Police Crisis Intervention Team (CIT) programs and Mental Health Courts for both juveniles and adults.**

2. **The Illinois Division of Mental Health must fulfill its promise to its most vulnerable citizens with severe mental illnesses and fully fund the community**

mental health care system in the state. Funding should flow through a payment model that promotes investment in EBPs, ensuring the greatest return on investment for the taxpayers of Illinois.

3. **NAMI Illinois and the Campaign support the conversion of public mental health financing from the traditional grants-based system to a fee-for-service system. If done properly, this will both enhance the availability of core services for people with severe mental illnesses and promote accountability in the provision of these services. However, the state must implement the conversion carefully and deliberately, with extensive technical assistance for providers and an adequate period to ensure a smooth transition. NAMI Illinois and the Campaign also urge the continuing involvement of consumers and families in all phases of this conversion.**

4. **The Illinois Legislature should reauthorize the state's mental health insurance parity law, thereby ensuring that mental illness will be covered equally with all other medical disorders in health insurance policies subject to state regulation.**

5. **Doctors must be allowed to utilize the latest breakthroughs in medical science to treat people with severe mental illnesses without bureaucratic restrictions in access to psychiatric medications. Failure to pass protective language earlier in the session potentially places consumers in harm's way. As the state looks to the future and the implementation of the Medicare drug benefit, close scrutiny of medication access is warranted.**

VIII. CONCLUSION

The state government continues to face acute financial pressures. However, caring for people with mental illnesses is also a critical issue for state government. Understanding mental illness, patient needs, and how services are currently provided are important steps in determining what actions the state of Illinois can take to improve access to quality treatment and services. Because of the nature of severe mental illness, individuals often require a multi-faceted approach to care. Meeting the needs of people with severe mental illness means addressing their "total care" needs, and that includes job training, access to medications and other services described as part of a "core services" strategy.

Given current budgetary difficulties in Illinois, ensuring that patient needs are met through an array of services can appear challenging. Yet, the fiscal risks to the state of drastic cost containment actions, or inaction—i.e., not addressing the medical and social needs of people with severe mental illness—can result in greater financial costs, and most notably, can ultimately put individuals at risk.

NAMI Illinois and the Campaign for the Mind of America are prepared to work with all stakeholders to develop common goals and solutions to help ensure that systems of care and social supports are designed efficiently and effectively and to aid recovery and life in the community for people with severe mental illness.

In this report, we have highlighted strategies that the state of Illinois can incorporate to improve services for people with severe mental illnesses, while ensuring greater accountability in the provision of these services. Also discussed are strategies that can be utilized to end the shameful use of the criminal justice system for mental health treatment needs and diverting, whenever possible, people with severe mental illnesses into appropriate treatment programs instead of incarceration. Finally, we have described the benefits of covering mental illness equitably in health insurance in urging the Illinois legislature to reauthorize the state's mental health parity law.

All concerned with the welfare of people with mental illness, must develop strategies to provide quality health care that is both medically sound and cost-effective. Working together we can improve patient outcomes and save money in the short and long run.

REFERENCES

American Psychiatric Association, "Gold Award: Helping Mentally Ill People Break the Cycle of Jail and Homelessness—The Thresholds State, County Collaborative Linkage Project, Chicago", *Psychiatric Services*, 2001 Oct; 52(10), 380-382.

Anderson, RN, Smith, BL; "Deaths: Leading Causes for 2001," National Vital Statistics Report, 2003; 52(9): 1-86.

Butterfield, F., "Prisons Replace Hospitals for the Nation's Mentally Ill," New York Times, March 5, 1998, A1.

Council of State Governments, Criminal Justice/Mental Health Consensus Project. New York: June 2002, http://www.consensusproject.org/the_report/.

Ditton, P., "Mental Health and Treatment of Inmates and Probationers," U.S. Department of Justice, Bureau of Justice Assistance Special Report, July, 1999, www.ojp.usdoj.gov/bjs/pub.alp2.htm.

U.S. Government Accounting Office, "Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services," GAO-03-397, April 21, 2003; http://www.gao.gov/htext/d03397.html.

McKinsey and Company, "Achieving a Critical Mission in Difficult Times," February, 2004.

Teplin, LA, "Psychiatric Disorders in Youth in Juvenile Detention," *Archives of General Psychiatry*, 59(12): 1133-43 (December, 2002).

U.S. Department of Health and Human Services, *Mental Health*: *A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

U.S. Department of Health and Human Services, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*, 2003, www.surgeongeneral.gov/topics/cmh/childrenreport.htm.