Folks,

Below my name the highlights of the bill, Helping Families in Mental Health Crisis Act of 2015, that passed a House Committee this week. It still has high hurdles to clear in the House and Senate before it would become law. Reading it, one realizes how short of nondiscrimination ["parity"] we still are. Yes, title has "2015."

Years ago WPS had a motion to use “nondiscrimination,” not “parity,” which made its way through the APA’s governance, but “nondiscrimination” was not pursued vigorously with other organizations. So the moral aspect of treating the mentally ill differently is not as strong as it could be if we were using “nondiscrimination” rather than “parity.”.

The Orlando horror has been attributed, as we know, to mental illness, more specifically to schizophrenia, bipolar I, bipolar II, substances, and so on. “Committing mass homicide” is not part of the definition of any DSM-5 condition, of course, but people with those conditions are being stigmatized by many this week as violent.

This week’s JAMA:

1] A number of medical leaders have “articulated the concern that the issue of medical technology has dehumanized the practice and stolen our attention, our time, and our presence away from patients.”

2] For patients with noncancer pain, those treated with long-acting opioid had a mortality that was 1.64 times greater than patients treated with an anticonvulsant or low-dose antidepressant [e.g., amitriptyline].

Not something plaintiff lawyers want to hear: In June 10th’s POLS One: A review of 37 studies concluded that clinicians still “do not have effective diagnostic tools to predict suicide.”

This week, the American Medical Association decided to urge medical schools to include telemedicine training as “a core competency.”

Those of you unhappy with FDA’s decision to cap citalopram at 40mg/d have a reference to support keeping patients at the higher level if they are doing well. A study published in this month’s AJP found that a FDA safety warning advising clinicians not to prescribe the antidepressant citalopram at dosages higher than 40 mg/day resulted in worsening depressive symptoms and more psychiatric hospitalizations among patients whose conditions had previously been stabilized with higher doses of the drug but the dosage had been lower after the FDA announcement.

Back to nondiscrimination. SAMSHA has a sheet you or your patients might find useful in challenging a third-party denial you suspect is discriminatory: samhsa.gov/shin/content//SMA16-4971/SMA16-49

Not everyone is happy with SAMSHA. Bethesda's Fuller Torrey writes, see site infra, that SAMHSA fails to assess the prevalence of schizophrenia, but quoting him, "I find it remarkable that we have good data on pigs, milk cows, and turkeys but no data on individuals with schizophrenia."

http://www.nationalreview.com/article/436484/mental-health-mental-illness-schizophrenia-federal-government-health-human-services-samhsa

The only rebuttal I have seen is a claim that they don't have good data on pigs either. Fuller says that the problem is basic, that SAMSHA does not believe schizophrenia exists.

Roger

Helping Families in Mental Health Crisis Act of 2015

1] This bill creates the position of Assistant Secretary for Mental Health and Substance Use Disorders to take over the responsibilities of the Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA). Mental health programs are extended and training regarding mental health is expanded.

2] SAMHSA must establish the National Mental Health Policy Laboratory and the Interagency Serious Mental Illness Coordinating Committee. {Sorel brought this paragraph to my attention, an issue that goes back about 35 years when St Es's Richard Jet Wyatt had an editorial in "Science" pointing out that there was a lot of research on many topics in psychiatry, but research that meaningfully measured the impact of health care policies before they were implemented were lacking. Jed wrote, "science policy lacks science."}

3] This bill amends the Public Health Service Act to require the National Institute of Mental Health to translate evidence-based interventions and the best available science into systems of care.

4] Certain mental health care professional volunteers are provided liability protection.

5] Pediatric mental health subspecialists are eligible for National Health Service Corps programs.

6] An underserved population of children or a site for training in child psychiatry can be designated as a health professional shortage area.

7] The protected health information of an individual with a serious mental illness may be disclosed to a caregiver under certain conditions.

8] This bill amends title XIX (Medicaid) of the Social Security Act (SSAct) to conditionally expand coverage of mental health services.

9] Part D (Voluntary Prescription Drug Benefit Program) of title XVIII (Medicare) of the SSAct is amended to require coverage of antidepressants and antipsychotics.

10] If it will not increase Medicare spending, Medicare's 190-day lifetime limit on inpatient psychiatric hospital services is eliminated.

11] Health information technology activities and incentives are expanded to include certain mental health and substance abuse professionals and facilities.
This bill restricts the lobbying and counseling activities of protection and advocacy systems for individuals with mental illness. These systems must focus on safeguarding the rights of individuals with mental illness to be free from abuse and neglect.