

Letters

Mental Health Parity

I read with interest and hope an article titled “Mental Health Parity at Last?” by Martin Sipkoff in the journal *Managed Care* (April 2008). While it painted a potentially exciting picture of equating coverage of mental health disorders with that of biomedical disorders, I’ve learned that—like in the investment fraud world—“if it looks too good to be true, it can’t be true.” But if there is a potential for this model to actually be implemented, then I think physicians better do a number of things to forestall occurrence of those inequities that led to managed care in the first place and the eventual lack of any workable reliable model of behavioral health care at all.

Because workable, reliable, accessible mental health coverage is lacking—due in part to inadequate numbers of consultant physicians—primary care physicians (PCPs) like me have been asked to become proficient in the diagnosis and management of such disorders as panic, anxiety, obsessive-compulsive disorder, post-traumatic stress disorder, phobias, mood disorders like seasonal affective disorder, reactive and endogenous depression, bipolar disorders with their subset of problems, psychotic disorders such as schizophrenia, and those psychoses born out of organic dementia. I’m not saying this is a bad thing, given my belief and custom that these rightfully belong in the PCP bin of care, that doctors like me should become as proficient with managing these as we do diabetes, hypertension, chronic back pain, chronic obstructive pulmonary disease, migraine, prostate and gynecologic disorders, and common infectious diseases. The problem is that we have been persuaded to become the caregivers because so few others are available

Mental Health among Older Adults

Congress recently passed 2 bills requiring group health plans to offer mental health coverage benefits, including deductibles, copays, and annual ceilings, that are equivalent to those provided for other medical conditions. The legislation would reduce copays for outpatient mental health services from 50% to 20% of the cost over 5 years. At present, there are 2 versions of the legislation (H.R. 1424 and S. 558) that differ at several key points. Legislators are working on resolving the differences so 1 bill can be sent to President Bush for signature.¹

According to Mental Health America (formerly known as the National Mental Health Association), “One in 4 American adults have a diagnosable mental illness, but less than one-quarter of older adults with mental illness get any type of mental health attention, let alone appropriate treatment.”² Older women are particularly affected by mental health disorders: 1 in 8 women will become depressed sometime throughout their lives. The highest rate of depression in women is among middle-aged Hispanic women, and African-American women have the second highest rate. Furthermore, as caregivers, midlife and older women are often left to deal with undiagnosed and untreated mental health disorders in others.²

Older adults have the highest suicide rate in the country. Those aged 85 and over have the highest suicide rate; those aged 75 to 84 have the second highest. For those 65 and older, there is 1 suicide for every 4 attempts compared to younger age groups (among other age groups, the rate is 1 suicide for every 20 attempts).² Older adults have changing bodies and chemistry, changes in family and friendships, and changes in living situations—all of which can impact mental health. Polypharmacy among older adults can also cause drug interactions and side effects that change mood and behavior.²

Although Medicare covers 80% of a physical health problem, it currently covers only 50% of costs associated with treatment of a mental health problem. Researchers estimate that as many as 63% of older adults with a mental disorder do not receive the services they need. Three-quarters of those who commit suicide visited a PCP within 1 month of their suicide.²

References

1. *Congressional HealthBeat Quarterly*. www.cq.com/corp/products_cqhealthbeatnews.html.
2. Older Americans' Mental Health Week. Owl The Voice of Midlife and Older Women. www.owl-national.org/Older%20Americans%27%20Mental%20Health%20Week.html. Accessed June 13, 2008.

to provide this care. (Can you imagine the amount of money being spent on detailing Abilify (aripiprazole), an atypical antipsychotic with a limited therapeutic niche, to PCPs?) Just as we need specialty partners to manage complicated heart, lung, gastrointestinal, and especially oncologic cases, we must have access to reliable mental health consultants.

And should I, in my lifetime, be given access to that specialist, via a workable mental health parity system, I think the following might be considered desirable (no, make that necessary):

1. Referring PCPs like me should provide the consultant with a referral form, noting the following:
 - The reason for referral
 - Biomedical problems: a list of comorbidities
 - A list of medications and allergies
 - Diagnosis data such as findings on magnetic resonance imaging or computed tomography, when appropriate
 - A concise family history and the patient's psychosocial resources
2. Psychiatry and psychology consultants should be mandated to provide a consultation report (not unlike those received from cardiology, gastrointestinal, urology, orthopedics, and other specialty physicians) noting their findings, their DSM-IV diagnoses, their recommendations, and their prognosis for resolution.
3. Should a consultant recommend, or elect to "follow" the patient, they should be required to indicate the number of planned visits and the measurable outcome(s) they hope to achieve.
4. Consultants should not use "confidentiality" as a reason to deny issuing a consultation report. Neuropsychiatric assessment should be made available (currently affordable, it appears from a verbal communication I recently had with a consultant, only to those patients injured in an accident, or who have suffered neurologic consequences from a workman's comp-covered incident).

5. Access to consultants providing electroshock therapy would be a blessing.
6. There should be psychiatric and psychology consultants available for consultation. Right now, finding a psychiatrist is like fishing for whales in a bathtub. (I suspect reimbursement is one barrier. I recently spoke with a private geriatric psychiatrist who indicated that if a patient were covered by Medicare in an extended care facility setting, he would be reimbursed \$25 for his consultation.)
7. Neuroleptic medications, chronic pain medications, and opioid medications must be made available at affordable prices. A patient of mine, during the donut-hole curse of her coverage, was forced to pay close to \$400 for 3 weeks of risperidone (Risperdal) to manage delusions and hallucinations, avoid relapse, and allow independent living. She and I were told that the copay for the generic would be \$5. There is no generic risperidone. (I'm reminded of the story of the shopper asking the deli owner, "Why is your corned beef \$14 a pound? Across the street, they charge only \$6 a pound." The deli owner replied, "Then buy it across the street." To which the shopper stated, "But, they don't have any more!" The deli owner retorted, "When I don't have any more, you can have it for \$3 a pound.")

My letter may be getting long. But I recall a letter that Gilbert K. Chesterton, the English author, penned to a friend, "Dear George, please excuse the length of this letter; I didn't have time to write a short one." *MPM*

Marvin Herring, MD
Clinical Professor of Family Medicine
UMDNJ School of Osteopathic Medicine
Stratford, NJ