



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

May 2008

FROM THE PRESIDENT

We are roughly midway through the presidential season and healthcare reform is in the air once again, just like in 1992 and the early years of the Coalition. That was a much more hopeful time or perhaps a more naïve time. Once again, a Clinton may be responsible for putting together a healthcare plan for the nation. Come to think of it, it could be the *same* Clinton! The challenges facing us today are at least the same as they were when the Coalition was founded. It will not come as a surprise to our members, however, that the Coalition's resources in money and manpower have been substantially reduced over the last few years. This is the first newsletter we have published in a year and our efforts have been largely confined to electronic communications with colleagues and organizations. I would like to take stock of where we are as an organization and where we as professionals and consumers are in the struggle to preserve privacy, quality, access and choice in mental health and substance abuse care.

WHAT HAVE WE ACCOMPLISHED?

Many of you know what we accomplished in the early years of opposition to managed care intrusions into health care. The National Coalition educated, alerted and energized many of us to fight for our profession and our craft. We were (and are) the only mental health organization that speaks to the needs of both professionals and consumers and we had a powerful impact on our professional associations. Sometimes subtle, sometimes strident, our voices were heard in our professional groups. The American Psychological Association, for example, had to shelve plans to set up a Division of Managed Care.

Over the last two decades, our professional organizations have come closer to recognizing the importance of the core values of the National Coalition. The American Psychoanalytic Association (APsaA) has been particularly supportive and was a major supporter of the lawsuit against implementation of the HIPAA privacy rules. The Coalition continues to be an active member of the Mental Health Liaison Group (MHLG), an association of all major mental health organizations that tracks legislation affecting mental

WILLIAM A. MACGILLIVRAY, PHD, ABPP

health treatment and funding.

Although our efforts have resulted in mixed success, our organization is the only one, to my mind, that consistently addresses issues of privacy and confidentiality in mental health treatment. Almost without exception, our professional groups are willing to compromise on this issue. As noted above, only the American Psychoanalytic supported the lawsuit against HIPAA regulations. The American Psychological Association (APA) reviewed the lawsuit and refused to join, calculating that the lawsuit would fail and would only alienate the Republican majority in Congress. When asked about this failure to protect privacy, Russ Newman (of APA's Practice Directorate) assured us that privacy protections in the individual states would continue to "trump" HIPAA disclosure rules. The American Psychiatric did issue a position paper that was quite helpful in emphasizing the privacy of psychotherapist's notes, but declined to support the lawsuit that was intended to support full guarantees for privacy for all citizens.

Our professional organizations have been reluctant to challenge health information technology (HIT) laws meant to set up nationwide databases for health records, falling in line with the idea that these systems can somehow be made secure and holding out only for "guarantees" of security, when the only guarantee of security would be to have each citizen give permission to have records placed in such a database. While it is hard to accurately assess our impact, I do find that APA and other organizations have at least become more sensitive to the issues of privacy over the last few years (after bowing down to HIPAA). MHLG did issue an alert to member organizations to protest the Health Insurance Marketplace Modernization and Affordability (HIMMA) law, which was defeated (see May 2006 President's Column).

WHAT HAVE WE LEARNED?

I think the most important thing we have learned is to focus much more narrowly on what is truly at stake. In the early years of the Coalition, our efforts were often directed toward all mental health professionals, and indeed, all

healthcare professionals and consumers. We viewed the assaults of managed care as raining down equally on us all; and in many ways this was, and is, correct. Over the years, however, it is clear that there remains a significant difference between medicine, broadly conceived, and psychotherapy and psychosocial interventions. For reasons too complicated to address here, professionals who focus on physical treatment, that is drugs and surgery, have a fundamentally different position in the healthcare system and remain far less vulnerable to managed care than psychotherapists and others who focus on psychotherapeutic treatments.

The National Coalition certainly welcomes the support of other professional and grassroots organizations and seeks way to align our organization with them. Dave Byrom, chair of our Liaison Committee (as well as former president), has been tireless in reaching out to healthcare activists in New York as well as across the country and has been a powerful voice for mental health care in these groups, groups that frequently overlook or even dismiss the need to incorporate mental health treatment as a core part of healthcare reform. His role, however, is often an educative one, keeping mental health treatment “on the table.”

Our professional organizations have tended to be more concerned with guild concerns that other professions might want to “poach” on their turf; or in the case of APA, want to “poach” on psychiatry’s turf by expanding prescription privileges to psychologists. The Coalition remains focused on the need to protect all psychotherapists and the right of consumers to seek out any psychotherapist who offers privacy, choice, access and quality in mental health treatment. This has resulted in our strategic alliance with American Mental Health Alliance (AMHA) and other groups that promote self-pay and other ideas for supporting independent practice of psychotherapy.

Another major thing we have learned is that it is damned hard to come to any consensus on the one best way to pay for mental health treatment. From the beginning, our organization refused to endorse any specific plans for healthcare reform for two important reasons. First of all, we found that there was no plan being proposed that came close to incorporating the four principles of our organization. Although our founder, Karen Shore, and board member Kathie Rudy both developed model plans (available on our web site), and former board member Ivan Miller has a recent book, *Balanced Choice*, detailing his ideas (reviewed in *Coalition Report*, March 2007), we have yet to see a plan proposed by a political party or healthcare advocacy group that fully incorporates our core principles. These principles have recently been restated and worked into a model document called Essential Elements of Mental Health and Substance Abuse Care and is available in this issue (pages 8-9) and on our web site.

We have planned to use this document as a “template” to review the healthcare plans of the presidential candidates, although one problem at this stage is that their plans, however ambitious, tend to be rather short on details, making it difficult to directly compare and contrast their plans based on our core principles. More on this later.

Secondly, the Coalition has been made up from the beginning both with those who strongly favored government funding as well as those who strongly critiqued any third-party involvement as a threat to our core principles. Their thoroughgoing critiques of third party reimbursement has been an important contribution of the Coalition to the healthcare debate. For me, if not for most of us, before managed care came to town, insurance and insurance reimbursement were seen more or less as a simple affair and the only task for a clinician was to have access to patients with the “good insurance;” and the main task for our pro-

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professional organizations was to promote their profession's right to access insurance reimbursement (and to keep other professions locked out of same). As managed care made inroads into our communities and practices, our main goal was to get back to where we were.

This is where many of our board members in the Coalition served an important role in educating us about the role of third-party reimbursement and the impact any such arrangement has on the therapeutic relationship. Already noted above were Karen Shore and Kathie Rudy's ideas on "fixing" insurance plans. Peter Gumpert's proposals with the establishment of the AMHA was another set of valuable ideas about how to structure the clinician's relationship with insurance reimbursement. Of course there were always psychotherapists who refused third-party reimbursement, insisting that the patient had to deal directly with his/her insurance company rather than involve the therapist in the arrangement.

Ivan Miller and current Coalition vice-president Michaele Dunlap have provided important alternative voices within the Coalition, addressing the questions of entrepreneurship and patient self-pay as a model for practice and practice development. AMHA is the national organization that best represents this model and asks psychotherapists to see their work and craft as one that is best developed and promoted in a collegial association of likeminded clinicians who offer affordable services with little or no third-party involvement. This model is the only one so far that does meet the core principles of the Coalition, since it is only by jettisoning third-party involvement that patients can be assured that their privacy, access, and choice is guaranteed. This model obviously leaves out many who cannot afford psychotherapy services, but the important challenge of this model is to unrealistic assumptions, often shared by patients (and therapists), that *someone else* should pay, just as *someone else* is to blame for their problems. Many years ago, the chief psychiatrist at a local psychiatric hospital would lecture patients before leaving the hospital on their need to continue individual therapy, insisting that quality psychotherapy was at least worth the price of a good car and that a good car cost \$10,000 (this was many years ago) and two years of therapy would not cost that much.

Another important thing we have learned is to stay open-minded about who are your friends and who are your enemies. (There is an unfortunate lesson about this on page 12 describing the plight of former board member Harold Eist's struggle to maintain patient privacy.) We have found, for example, that libertarian and conservative members of Congress are far more likely to be on our side on issues of privacy and that liberal and progressive politicians have tended to look favorably on programs such as TeenScreen and HIT legislation that seriously compromise privacy.

WHERE ARE WE GOING?

Our organization continues to be seen as valuable and important by many professional and grassroots organizations. Through our liaison work and our clear message, the Coalition does have an impact on policy development and position statements. We have recently had more active involvement from members and colleagues on NCTalk, the Coalition list. It is encouraging that members are bringing issues, questions and energy to bear on important questions of mental health and substance abuse treatment. We plan to track the healthcare reform debate as the presidential campaigns heat up. Perhaps there will even be real debates on this issue. More realistically, we hope to use the "Essentials" document to educate our political leaders and to encourage our members and colleagues to distribute this document widely as a way to promote a consensus in the mental health community on the need for privacy, quality, access and choice in mental health and substance abuse treatment.

Please continue to read the rest of this issue and to respond to the ideas and concerns expressed by directly contacting me (drmacg@comcast.net) or starting a discussion on NCTalk.

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And in the News...

SAVING PRIVATE INSURANCE

TOMPAINÉ.COMMONSENSE

PHILIP MATTERA

FEBRUARY 22, 2007

This article reviews the healthcare reform ideas that have been emerging since the start of the campaign season and the continuing reliance upon private healthcare plans as the basis for our system. The author notes, “Public officials across the political spectrum are, in effect, seeking to expand the customer base for a highly profitable industry.” His criticism of private plans, however, lumps together for-profit and not-for-profit, in contrast to government run plans, concluding, “the U.S. political class seems to be on a mission to save private insurance.”

He also adds a useful bit of history with which I was unfamiliar. He states that there was a movement early in the last century to have the U.S. adopt healthcare programs similar to Germany and other countries. AFL President Samuel Gompers, fearing that government-run healthcare would dilute the power of unions to provide for its members, opposed this movement of the Progressive Party. The rest of the history is fairly standard, pointing out that government healthcare plans, as well as private insurance plans, were cobbled together based upon the exigencies of the Second World War. By the time Harry Truman proposed a national system of healthcare insurance, the Cold War was on us and “socialized medicine” became a shibboleth to scare away proponents. Once again, however, labor unions played an important part in supporting private healthcare insurance as a benefit for its members, rather than a right for all Americans. He concludes,

The failure once again to create a system of universal care left the American people at the mercy of the market. The ranks of the uninsured swelled as many employers solved their health finance problems by eliminating coverage or by shifting premium and co-payment costs to workers to such an extent that they opted out. Many of those who tried to obtain individual coverage found themselves priced out of the market or rejected because of a pre-existing condition. Those workers who retained workplace coverage increasingly had to confront HMOs and other purveyors of “managed care,” whose business plan depended on restricting the use of medical services. A 1994 *Wall Street Journal* article stated: “Health maintenance organizations are all about penny pinching, yet they

are so awash in cash that they don’t know what to do with it all.”

The author then goes on to a lengthy history of attempts to rein in HMOs’ and other healthcare industries’ attempts to limit service and increase profits. Much of this should be familiar to National Coalition members. He summarizes, “These lawsuits may have shaken the industry somewhat, but they did not put an end to the abuses that characterize managed care.”

One major trend is the increasing consolidation of the healthcare marketplace. In 2006, UnitedHealth was worth \$64 billion, with 28 million “covered lines.” WellPoint, that same year, reached \$52 billion and 34 million “covered lines.” The next three (Aetna, Cigna and HealthNet) combined control \$59 billion and 33 million “covered lines.” The combined profits from all six? \$10 billion. And what about marketing and administration? WellPoint paid out \$9 billion in 2006 to run its enterprise. Life at the top of these companies is good. Chief executive William McGuire (UnitedHealth) earned \$10 million, although stock options increased his return 100 times over that figure.

The author concludes, “Public officials should abandon the mission of saving commercial insurance and devote themselves instead to creating a healthcare system that substitutes the public interest for private profit.” Since he doesn’t differentiate between for-profit and not-for-profit, his arguments seem weaker, especially without an equivalent look at the actual universal system (at least for seniors) we do have in this country. Critics of private healthcare insurance often seem to compare what exists in this country to an idealized system of universal care. Of course, any system will not look as good as a “perfect” system that provides universal access, quality treatment, and reasonable remuneration to healthcare professionals and workers. The entire article can be found at http://www.tompaine.com/print/saving_private_insurance.php

THE HEALTH INSURANCE MAFIA

WALL STREET JOURNAL

JONATHAN KELLERMAN

APRIL 14, 2008

Since this article was written by a novelist, as well as a psychologist, it is difficult to summarize and I encourage you to read it for yourself at http://online.wsj.com/public/article_print/SB120813453964211685.html I will attempt to provide the gist of it, however, since I believe he articulates a position not often heard. He begins by taking the counterintuitive proposition that the problem is that there are too many people insured rather than too few. Although he leaves this idea to go on to analyze the insurance racket, what he is really proposing is that there are a wide range of services that do not require third party payers and that we have become too dependent upon the concept that insurance for all and everything is the solution.

Kellerman's take on the insurance industry is provocative, comparing health insurance tactics unfavorably with Mafia protection rackets, since the racketeer is only interested in getting your money and not likely to actually tell you how to run your business.

Insurance companies provide nothing other than an ambiguous, shifty notion of "protection." But even the Mafia doesn't stick its nose into the process; once the monthly skim is set, Don Whoever stays out of the picture, but for occasional "cost of doing business" increases. When insurance companies insinuate themselves into the system, their first step is figuring out how to increase the skim by harming the people they are allegedly protecting through reduced service.

The healthcare industry, in contrast, has insured itself against possibility of loss (or less than obscene profits) through putting the lien/lean on both the patient and the physician, making both ends of the payment equation work for their benefit. "Insurance is all about betting against negative consequences and the insurance business model is unique in that profits depend upon goods and services *not* being provided."

The consequences of any insurance-based healthcare model, be it privately run, or a government entitlement, are painfully easy to predict. There will be progressively draconian rationing using denial of authorization and steadily rising co-payments on the patient end; massive paperwork and other bureaucratic hurdles, and steadily diminish-

ing fee-recovery on the doctor end.

His solution is fee-for-service, which he believes is possible for most people for most procedures. He suggests that insurance should be reserved only for procedures that are prohibitively expensive for most people. He suggests that low cost or no-cost clinics should be established for those that cannot afford out-of-pocket costs. "Physicians and other providers need to liberate themselves from the Faustian bargain they've cut with the Mephistophelian suits who now run their professional lives."

There is a great deal of appeal in Kellerman's proposal; and a great deal more absurdity in the healthcare system when it comes to insurance than he points out. It is more difficult in some ways to find a physician who accepts cash payments. I had a difficult time finding an internist who would accept money rather than an insurance card. With every office visit I am met with a skeptical secretary or nurse who looks upon me with suspicion for failing to produce the needed insurance card. It is also true that costs for services could decline markedly without the mark-up of insurance. I paid out-of-pocket for cataract surgery and was given a substantial discount for doing so. At the same time, I am also quite certain that the insurance companies that paid for other patients' surgeries exacted an equal (or larger) cutback in charges. I do not believe that a fee-for-service system would work for as many people or for as many services as Kellerman seems to assume. I don't think that paying out-of-pocket for diabetes care would reduce the costs to a level with the budget of many middle class people. In any event, I would need to see more than anecdotal evidence to be convinced.

My second concern is that Kellerman's proposal for low-cost and no-cost clinics cannot be a practical answer. One of the rationales for promoting Social Security and Medicare has been that these government perquisites are available to all, regardless of income level. This has had two purposes: to rid beneficiaries of the stigma of charity and to ensure a large middle class investment in these programs. When health care services are delivered in clinics for those unable to pay, there is both a lack of active (voting) constituency to press for quality services, and an active perception that both the services and the patients in these clinics will be second-class.

Finally, Kellerman's endorsement of fee-for-service in one that many National Coalition members have adopted and embraced as a way out of the insurance racket. We have endorsed the efforts of groups such as the American Mental Health Alliance who promote this as one way to protect the integrity of psychotherapy and preserve the key goals of the National Coalition to insure privacy, access, quality and choice in mental health and substance abuse

treatment. These clinicians have been willing to tailor their practices in exchange for the increased freedom from insurance company controls. One consequence of this, of course, is that this actually benefits the insurance company. Every time a patient with insurance pays out-of-pocket, the insurance company benefits and the system stays the same. While this solution works well for the clinician and the patients, those outside the system continue to struggle. When clinicians opt out of the system, there are fewer left “inside” the insurance racket to take action to change the system. Opting out of the insurance racket inevitably means that there are many who will not be able to access your services and will have to rely upon the shrinking choices offered, including the “dumbed-down” services and drug regimens that are the increasing stock in trade. In the end, this means that fewer and fewer people even know what quality psychotherapy is about, and that in turn reduces the ability of patients to recognize that there are ways to get effective help for problems.

Clearly, Kellerman’s editorial was not meant as a comprehensive plan to revamp the healthcare system; and his provocative reframing of the problem of insurance deserves a fair hearing and understanding. An insurance-based system will almost certainly continue to squeeze both patients and doctors in a system that will be “gamed” by Big Pharma and Big Hospitals and other players in the system with access to money and political influence. At the same time, a fee-for-service model will almost certainly apply to a limited range of services and individuals. His article reminds us that the range of services and individuals may be much greater than assumed with far more benefits than possible under the insurance racket. How to take care of what is “left over” remains an important challenge.

**POLL FINDS AMERICANS SPLIT BY POLITICAL PARTY
OVER WHETHER SOCIALIZED MEDICINE BETTER OR
WORSE THAN CURRENT SYSTEM**

HARVARD SCHOOL OF PUBLIC HEALTH

PRESS RELEASE

FEBRUARY 14, 2008

This is part of a continuing series on health and the upcoming presidential campaign. This article describes interesting survey results on how Americans view the phrase “socialized medicine” and assess healthcare plans based on these assumptions. Although the phrase has often been used to attack national healthcare plans, especially those proposed by Democrats, the recent poll conducted by Harvard Opinion Research Program at the Harvard School of Public Health (HSPH) and Harris Interactive finds “Americans are split on whether a socialized

medical system would be better or worse than the current system,” with a plurality (45%) approving and 39 percent disapproving. I was somewhat troubled with their assertion that 82% of those surveyed were able to understand the concept of socialized medicine. This seems an overly optimistic finding. The more interesting finding is that “Seventy percent of Republicans say that socialized medicine would be *worse* than our current system;” while Democrats say a socialized system would be better by the same margin of 70 percent.

Robert J. Blendon, Professor of Health Policy and Political Analysis at the Harvard School of Public Health concludes from this, “These results suggest how polarizing the issue of health care will be in the general election. The phrase ‘socialized medicine’ really resonates as a pejorative with Republicans. However, that so many Democrats believe that socialized medicine would be an improvement is an indication of their dissatisfaction with our current system.” Humphrey Taylor, chairman of The Harris Poll concludes just the opposite, “No doubt some Republicans will continue to use the words ‘socialized medicine’ to attack Democratic health care proposals before and after this November’s elections, but these attacks are unlikely to do much damage . . . Clearly socialized medicine is not the scary bogeyman it used to be.”

I suspect that Dr. Blendon is more likely to be right, since the issue is not likely to be resolved on the basis of an accurate assessment of the benefits and drawbacks of the various healthcare proposals, but the degree to which these proposals can be labeled as “socialized medicine” to stir up the opposition. The vast discrepancy between self-described Republicans and Democrats on the issue of socialized medicine, does not suggest to me the result of well thought out policy positions but a response to the emotional appeal that often determines political opinion, as Drew Westen points out in his latest book, *The Political Brain* (Public Affairs, 2007). I would conclude only that the Democrats may be more susceptible to the emotional appeal of “the left” than in recent years, not that their judgment of healthcare proposals have markedly changed. The clearest reason for my conclusion is that neither Clinton’s or Obama’s healthcare reform plans do anything to challenge the central problems facing healthcare and the willingness of big business, big government, big pharma and big insurance companies to be complacent about the faltering quality of healthcare in this country. The present system serves their interests and it is unlikely to be challenged by either the Democratic or Republican nominee.

ACCESS TO HEALTH RECORDS BOLSTERED FOR EMPLOYERS
HOUSTON CHRONICLE
L.M. SIXEL
MARCH 15, 2008

The article begins with a chilling assertion: “Medical privacy has been protected for years by the most unlikely guardians: insurance companies. Now, the Texas Legislature has become the first in the nation to force insurance companies to pass along sensitive employee health records to their companies, a practice permitted under federal law.”

The law will allow companies to access information on employees whose healthcare costs exceed \$15,000 during the previous year. This information will include diagnoses, dates of service, amounts paid, prognoses, future costs and treatment plans for each. Get this! To protect the employees’ privacy, the employee or family member will only be identified by a number, not by name. That should make everyone feel assured that the information will not be abused, correct?

Of course, as highlighted in the article “*Federal privacy laws already allow companies to access their employees’ protected medical information under the Health Insurance Portability and Accountability Act.*” Isn’t it refreshing to have the bald truth stated so succinctly? This is the truth that the National Coalition and others tried to bring out in our recent lawsuit, a lawsuit that was dismissed not because our allegations were proven incorrect, but because the court held that no harm could be attributed to government action based upon HIPAA provisions. In other words, if the employer uses the information provided by HIPAA disclosure to discriminate against an employee that is certainly not the government’s business.

The article quotes Deborah Peel of Patient Privacy Rights as pointing out the exceeding ease involved in matching a number to an actual employee. “It appears to give employers the power to find out who is expensive and fire them,” according to Peel. In contrast, Sam Francis, a board member of the Texas Association of Benefit Administrator, says “he trusts employers to do the right thing. Besides, said Francis, companies often know when employees are sick because of the time they take off.” The rationale for the law is to allow benefit managers to make accurate decisions as to the actual costs of the plans they subscribe to. The curious aspect to this issue is that insurance companies, posing as protectors of this information and opposed to the new law, may be more interested in keeping their costs a mystery than in protecting privacy.

There are further paradoxes in the entire issue and the core problem is that employer-paid healthcare is inher-

ently corrupting to all concerned. In the “good old days” this may have appeared to be less of an issue, with insurance companies acting in the “old-fashioned” way and not attempting to manage cost and increasing profits solely through competitive rates. Employers enjoyed the tax benefits; employees saw healthcare insurance as a benefit. This system has collided with increasing healthcare costs, largely because, truth be told, there is a whole lot more that medicine and surgery can do to help people in the last 30 years than at any time in the past. It is time to get employers out of the healthcare system entirely! The entire article can be read at <http://www.chron.com/disp/story.mpl/headline/metro/5623062.html>

DATA MINING SHOULD GET THE SHAFT
SEATTLE TIMES
NICOLE BRODEUR
FEBRUARY 26, 2008

That it’s called ‘data mining’ is bad enough. So begins this exploration of the practice of data mining by Big Pharma: “pharmaceutical companies have been doing it for years: buying data that track what doctors prescribe to us, then using that information to push their products on our docs.” There is a bill before the Washington legislature, the Prescription Privacy Bill, that is meant to address this practice and prevent drug companies from accessing information about patients’ prescriptions. At present, it is very easy to track patient information through insurance claims. As a result, drug company representatives are able to know which drugs a physician is prescribing and to tailor their pitch to the particular prescription patterns.

Drug companies are fighting the bill, pointing out that this practice saves them marketing money, savings, which they then pass along to consumers, of course! “Getting rid of the data makes it less efficient for the pharmaceutical industry to have targeted marketing campaigns,” said Julie Corcoran, of the Pharmaceutical Research and Manufacturers of America. “We’d need to blanket 10,000 doctors to make sure 1,000 get that information. It could make it less efficient, and more costly.”

There is something uniquely perverse about the assault on privacy represented by data mining and the hand-wringing explanation that these practices save consumers money is remarkable. It is similar to the grievance of a mugger who insists the victim should not resist handing over his money without a struggle, since it will only result in a greater harm to the victim if he fights and loses.

WHITE PAPER: ESSENTIAL ELEMENTS OF

The mission statement of the Coalition has been refined over the years, but the four key concepts of Access, Choice, Privacy and Quality have been central to our vision of what a mental health system, indeed a health care system, should promote and embody. As we gear up for another presidential election, it appears that, once again, health care reform will be on the agenda of many candidates for office. At a recent board meeting of the Coalition, we discussed the issue of what impact our organization could have on the upcoming campaigns and came to the conclusion that we might best advance the debate on health care reform by fleshing out what we mean when we invoke our four key concepts. Michael Dunlap agreed to take on this project and come up with a draft. We intend that the final document we develop will serve as a template against which we can compare the various plans offered by candidates, as well as other organizations. We hope this will serve to both inform and educate candidates and the general public concerning the important aspects of mental health care that are left on the cutting room floor in the service of promoting programs that sound good but are weak on details and even counter-productive in assuring good mental health care. We invite our members to look over this document and provide advice and criticism of this working document. If we are going to make a difference in the coming election, it will be up to our entire membership, not simply the Coalition board, to find ways to inform the candidates and electorate on these vital issues.

As professionals and consumers we are enmeshed in a context of many dysfunctional US health care payment plans. These plans require major changes to allow services and financing that meet human and economic need without overregulation, waste, fraud, or excessive profit-taking. Proposals to change U.S. healthcare economics must include specific elements that protect **access, choice, privacy** and **quality** in the area of mental health and substance abuse services. The changes must be both pro-consumer and pro-clinician while being mindful of costs.

ACCESS

There must be no discrimination between availability of physical and mental health care. Availability and continuity of services should not be contingent on people's place of employment. Any barrier or process that denies people access to mental health and substance abuse services drives up medical care spending, destroys lives, hurts families, damages workplace productivity and increases crime. Pro-

posals for improvement in health care **must assure** that mental health and substance abuse services include:

- Consumer choice of professionals, treatment settings, types of treatment.
- Wide range of services for all populations.
- High quality, coordinated care for vulnerable populations via integrated community networks, and local community control of these networks.
- Consumer choice of forms of payment for mental health and substance abuse services,
 - No discrimination against those who self-pay; no insurance contract, or government regulation should prohibit people from private purchase of mental health and substance abuse services.
 - If people use insurance to help cover the cost of mental health and substance abuse services the provisions of those insurance contracts should be explicit and have full medical parity, i.e. not subject to reviewers' definitions of "medical necessity" or any management, limitation or restriction that does not also apply to other medical benefits under that contract. To prevent discrimination between physical and mental health services, there should not be any separation in terms of annual or lifetime limits.
 - Third party payments to providers of mental health and substance abuse services should be equitable for the services rendered. Driving down payment for mental health and substance abuse services results only in limiting consumer choice when practitioners and facilities either leave third party payment systems or are driven out of business. Payments based on diagnoses without regard for their severity often lead to under-treatment. A system that does not allow for extended treatments based on severity of diagnoses hurts the consumer.

Choice

Effective mental health and substance abuse care requires an informed population, qualified practitioners and facilities and treatment choices that are appropriate to the individual, or family seeking services. Proposals for improvement in health care **must assure** that mental health and substance abuse services include:

- Strategies to inform consumers about mental health and substance abuse treatment alternatives; the effectiveness and limited risk of talk therapies and

MENTAL HEALTH AND SUBSTANCE ABUSE CARE

psychosocial interventions; effectiveness and risks of prescription medications.

- Consumer choice over all aspects of mental health and substance abuse services including the treatment setting, the type and length of treatment and the treating practitioners and facilities.
- Consumer choice about whether to seek mental health and substance abuse services.
- Provisions that, when mental health and substance abuse services are mandates of courts, government agencies or the criminal justice system, the involuntary consumer should have as much choice as possible over the treatment setting, the type of treatment and the treating practitioners and facilities.

Privacy

People own their personal health information. Proposals for improvement in health care **must assure** that mental health and substance abuse services include:

- Consumers' right to control who has access to their information, wherever and however it is kept. Exercise of the right to privacy should not effectively result in denial of services.
- Regulation that personal details about mental health and substance abuse services which may be disclosed for purposes of payment shall not be maintained in the record or further disclosed by the payer.

Quality

Quality of mental health and substance abuse services is primarily based in the training of the professionals and paraprofessionals providing service. Adequate local and regional facilities for intensive out-patient and inpatient treatment of mental health and substance disorders are also essential. Proposals for improvement in health care **must assure** that mental health and substance abuse services include:

- Treatment methods and processes that are informed by qualified professional education, training and research, not invasively regulated by legislators or third party payers.
- Availability of a range of clinicians qualified by appropriate training in mental health and substance abuse specialties and sub-specialties.
- Recognition that payment systems that are based on clinician's degrees reward those who end formal training and punishes those who continue to improve their

skills and knowledge base. A system that discourages advanced training eventually hurts the consumer. A relatively fair system to encourage clinicians to continue advanced training would set reimbursement by health plans at a fixed amount for specific services with co-pays negotiated by clinicians and patients on a sliding scale basis.

- No "fail-first" requirements or excessively high co-payments before consumers can use the newest or most effective medications. (This can be dangerous for people with serious mental illnesses.)
- Availability of inpatient and intensive-outpatient settings appropriate to the care of those who cannot function safely in the community; separate units or programs for adults, children, adolescents, the elderly, and those with addictions and physical disabilities which complicate treatment. Such settings should be situated locally, to facilitate support of family and friends.
- Availability of the full range of mental health and substance abuse treatment methods, without restriction to artificially brief, symptom-focused or problem-focused models. As with innovations in medical care, quality of mental health and substance abuse services requires respect for new understanding in human development, behavior and functioning.
- Policies that encourage innovation and improvement of services and service delivery.
- Recognition that claims for specific treatments as "evidence based" frequently fail meta-analytic scrutiny and may be biased by their source of funding and the limitations of the research process itself. (For decades, the brief, solution-focused therapies have gotten grants for research since those therapies fit into the most used research protocols while several forms of therapy supported by patients and the community of therapists are not given grants because they cannot be manualized or standardized and because they would require long term studies.)
- All funding sources for research, authors, and journals that support claims for the benefits of specific treatments must be fully disclosed.

WHY HAS HEALTHCARE REFORM FAILED?

LOS ANGELES TIMES

HENRY AARON

NOVEMBER 6, 2007

Henry Aaron is a senior fellow at the Brookings Institution in Washington. He writes about the cycle of healthcare reform failures and describes the reasons for these failures and what might be done about it. “Each time, supporters of reform believed, popular clamor would drive elected officials to end the national embarrassment of millions of uninsured and rein in health expenditures that were needlessly high and bought less than they should. Each time, reformers were right in their indictment and wrong in their political judgments.”

We are facing a new election season and a new round of healthcare reform proposals. There are many reasons to indict the system, especially the high cost of care compared to the low coverage compared with other countries. At the same time, there remain the same barriers to change that have defeated other attempts at reform. He concludes, “We need to understand the barriers that prevented reform in the past:

- Elites remain deeply divided on what to do.
- Eighty-five percent of Americans are insured and fear change.
- Large-scale health reform is large-scale income redistribution, and the politics of redistribution is the politics of trench warfare.
- Healthcare reform involves huge financial stakes. The potential losers from any reform—insurers, hospitals, doctors—can and will marshal enormous resources to block action.
- The U.S. political system is exquisitely structured to frustrate action on large and controversial matters on which there is not overwhelming agreement.
- Healthcare varies greatly across the United States, making consensus hard to come by.

He concludes that the best that can happen is through piecemeal reform that attacks only small aspects of the problem without disturbing the rest of the system, without alerting the constituencies and political and business interests that can otherwise combine to defeat change. He finally concludes that reforms on a state-by-state basis hold the most promise and that the Congress might well support this through financial support and relaxation of rules and regulations. At the same time, these suggestions seem to promote “more of the same” since the various interests that cannot be challenged, such as for-profit insurance companies, are in large part responsible for the problem.

LAWMAKER GETS FIRSTHAND VIEW OF MH SNAFUS *VERMONT PRESS BUREAU*

DANIEL BARLOW

APRIL 15, 2008

This article was sent in by Russ Holstein, who has researched the problem of so-called “phantom panels,” that is, provider lists that have lots of names of professionals who are no longer on the panel, never were on the panel, or are deceased. The article focuses on the efforts of one Vermont legislator, Mike Fisher, to access a list of mental health professionals on his BC/BS provider panel. He first discovered that the company, Magellan, promised but failed twice to send him a list. In calling back to obtain the list, he was told Magellan had no records he had even contacted them. When he finally obtained the list, over half on the list were no longer on the provider panel. Fisher generously concluded, “I don’t believe that the insurance companies are evil or that they are trying to be dishonest, but I do believe that there are parts of our system right now that end up being real barriers to treatment.”

Contacted to comment on the story, the spokesperson, Erin Somers, more or less blamed Fisher for the problem. “We know it is not a positive experience for consumers or providers to call us back and give us the same information all over again,” Somers said. When asked about the provider list, that too was not Magellan’s fault. This time, the providers were to blame for not making sure their names were not on the list!

Ken Libertoff, the executive director of Vermont Association for Mental Health, said he will hold forums later this spring focusing on phantom networks. And he urged state health care regulators to get tougher with the insurance companies. He commented, “We believe that organizations like Magellan and Cigna have frequently had phantom treatment panels, meaning that consumers are offered lists of treatment providers for mental health and substance abuse care when in fact only a few of them are active participants in the provision of care.”

The article addresses the issue as a curiosity and as an issue in debate on a parity bill before the Vermont legislature. The issue of phantom panels, however, is far more serious than stated. These panels are used to assure benefits managers and employee representatives making decisions regarding insurance companies that there are enough professionals to deliver services to patients. Magellan and other companies have every investment in maintaining phantom panel lists to provide the “assurance of care.” When they are caught in the act, the insurance company can simply blame the provider or the patient, without any penalty or consequence.

About the Petition

The Academy, along with the American Mental Health Alliance and the National Coalition of Mental Health Consumers and Professionals is co-sponsoring a petition on privacy in psychotherapy. Privacy in the consulting room is threatened with extinction due to decisions that have been made by the federal government, corporate medicine, and the insurance industry.

The purpose of this petition is to give voice to practicing professionals who uphold their ethical obligation to protect clients' privacy because they know trust and privacy are essential elements of psychotherapy.

This petition campaign is one step toward a "registry" of professional opinion—a strategy to reclaim the healing arts as a collaborative endeavor of professionals and the culture, rather than letting corporations define healing modalities! The Registry uses the legal principle of "respectable minority" as a basis for affirming practice standards endorsed by a community of educated therapists rather than imposed by the legal and legislative forces of managed care, insurance, and pharmaceutical companies.

Read Bernard McDowell's "*Reasons to Support the Petition on Confidentiality*" at http://www.academyprojects.org/reasons_doc.htm

Read Bernard McDowell's *Proposal for an Archive for the Preservation of Psychotherapy* in which he proposes that psychologists develop an archive of healing practices by joining their voices into a legally acknowledged "respectable minority" at <http://www.academyprojects.org/mcdowarchive.htm>



Sign and Return Petition to
Licensed Psychotherapists' Petition On Confidentiality
AMHA-USA
PO Box 4075
Portland, OR 97208-4075

Licensed Psychotherapists Petition on Confidentiality

This petition is co-sponsored by AMHA-USA, The National Coalition of Mental Health Professionals and Consumers, and the Academy for the Study of the Psychoanalytic Arts To sign the petition, go to AMHA website, <http://www.americanmentalhealth.com/media/pdf/natpetitiononconfcospon.pdf> which houses the printable copy of the petition. We are not petitioning anyone or any institution at this time. All petition signers are placed in a registry on the web open for all to view.

Petition Text

To Whom It May Concern:

We, the undersigned psychotherapy professionals:

- support client confidentiality as a fundamental principle of psychotherapy and as a basic right of our clients
- object to the decline in protections for confidentiality under new federal regulation,
- object to unquestioning adoption of corporate medicine's standards of practice.

We therefore:

- object to the idea that all records must be kept in a manner to be reviewed by third parties,
- object to any standard requiring psychotherapists to give every client a diagnosis.

Such requirements provide little consumer protection or service, may stigmatize people, prevent people from seeking treatment or obtaining insurance in the future, unnecessarily invade privacy, and compromise patient trust.

When a psychotherapist and a client both agree, it is appropriate 1) for the therapist to keep no records at all of the therapy process or to keep them under a pseudonym and/or 2) for a therapist to forgo giving the client a diagnosis.

This petition is not intended to circumvent laws that require report of threats to human safety.

**Eleventh Annual Conference of the
International Center for the Study of Psychiatry and Psychology, Inc. (ICSPP)**
in collaboration with Amedco, LLC

**To take place in Tampa, Florida
1:00 P.M., October 10th, thru 1:00 P.M., October 12th, 2008**

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- 6. Helping Seniors Cope with the Difficulties of Life**

The Conference committee is seeking papers (45 min.), workshops (90 min.) and panel presentations (1-2 hr.) on the aforementioned conference topics. Please submit your proposals for presentations in Microsoft WORD format by e-mail before June 30, 2008 to:

jeffreylacasse@mac.com
Jeffrey Lacasse, MSW
Visiting Lecturer
FSU College of Social Work
Tallahassee, FL 32306-2570
Phone number (850) 645-5769

Presentations may include among others:

- Intervention strategies for problems in child development: birth to adolescence
- Critiques of mental health screening: practice realities
- Critical evaluations of parents and children's rights in schools
- Critical evaluations of aging issues: psychological, social and economic
- Critical evaluations of studies of non drug treatment protocols for children and adults
- Surveys and descriptions of existing and/or planned non drug treatment programs
- Comparisons of efficacy of drug and non drug treatments
- Political and economic considerations

For registration forms and information see our website: www.icspp.org or call 212 861-7400

THE HEIGHT OF ARROGANCE

ROBERT L. PYLES

“A shocking case” that was “the height of administrative arrogance” so said one of the three judges at Maryland Board of Appeals v Eist. He told the state’s attorney “How- ever this case is decided, you should go back and tell your bosses that this is how the Court of Special Appeals views their actions.”

This was Harold Eist’s fifth court appearance to defend his patient’s right to privacy and his duty to practice ethically. As you may recall, Eist is a psychoanalyst and child psychiatrist practicing in Bethesda, MD. His ordeal began in 2001 when the estranged husband of his patient submitted a complaint against him to the Board. Eist had been treating a mother and two children, and attested to her fitness as a parent during a bitter divorce. Soon after that, the complaint was filed, charging him with overmedicating the mother and children.

Since that time, the complaint was repeatedly found to be without merit both by two courts and peer review. Nevertheless, the Board persists in its prosecution of Eist, charging him with failure to cooperate with their investigation.

The American Psychoanalytic Association was among twenty-eight amici, representing professional organizations, patient advocacy groups and privacy watchdog groups supporting Eist’s commitment to professional ethics. Representatives from many of the groups filled the courtroom, and were heartened by the judges citing the amicus brief.

THE JUDGES DID THEIR HOMEWORK

The judges’ thorough knowledge of the details of this five-year saga impressed the courtroom. They had scrupulously reviewed every twist and turn in this tortuous ordeal, reviewing the primary materials as well as the subsequent legal documents submitted by the attorneys. The judges were confident that the initial complaint was a transparent effort to influence a domestic dispute over custody, and thought it had little or no face validity. They challenged the Board on their repeatedly “absolutist” actions in demanding the entire medical record regardless of the merit of the complaint, and over the patient’s objection.

The judges pointed out that much of the record was in fact made public at the child custody hearing, and that there was no need to obtain the patient record, since the court transcript was public. The state’s attorney defended the Board’s demand for the entire record in every case by saying that the Board is busy and understaffed. When asked, the state’s attorney reported that of the 970 complaints received in one year, approximately 3% were found

to have merit. The judges found it “frightening” that the Board demanded the release of the entire record in all these cases for so small a yield, and questioned the Board’s judgment in demanding entire records before any preliminary investigation was done.

A TOUGH ROW TO HOE

The judges were so familiar with the material and the process that they succinctly asked the state’s attorney to demonstrate how Eist might have both protected his patient’s rights and cooperated with the Board.

The state’s attorney said that he could not think of anything that Dr. Eist could have said and that the doctor “had a tough row to hoe.” In spite of the judges clarifying that the Board placed Eist in an impossible position, the state’s attorney showed no interest or curiosity in how the Board might proceed differently in the future. The state’s attorney was indifferent to the fact that this false complaint produced a witch hunt, wasting the taxpayers money, and costing Eist thousands of dollars and years of anguish.

A SOBERING NOTE

As gratifying as it was to hear the judges take the state’s attorney to task, there is no guarantee of victory. The judges raised the question as to whether this court was the valid forum to decide on issues concerning the U.S. Constitution and its application to state law and procedures. As we saw in the HIPAA suit, where the judges seemed equally favorable to our arguments, they ruled against us on narrow legal grounds. We hope that these judges will have the courage and wisdom to uphold the principles of professional ethics and Constitutional rights to privacy embodied in this case. Regardless of the outcome, there is likely to be one more court hearing, at the highest court in Maryland.

A CASE OF NATIONAL SIGNIFICANCE

Although the key issue in this case is the privacy of mental health records, it is of national importance for another reason, as well. In state after state, renegade professional boards are operating without oversight, without checks and balances. For both these reasons, the decision in this case will be a significant precedent in Maryland and a persuasive precedent, throughout the country. By participating as an amicus in this case, the American Psychoanalytic Association is working to protect our patients and our profession.

This article was originally published in The American Psychoanalyst, the newsletter of the American Psychoanalytic Association and is published here with permission.

THE NECKLACE AND THE NOOSE

MICHAEL ZAMPARDI, PHD

PPsychologists, as well as others, deal not only with events but with perception of events. Psychologists particularly often strive to understand various perceptions of events by various parties surrounding an issue. This paper will attempt to understand the needs/issues of the other side as well as to recognize our needs/issues. This paper will discuss issues surrounding the New Jersey Postpartum Depression Law.

THE NECKLACE

The NJ Postpartum Depression (PPD) screening law aims to deal with serious issues. From what I understand, a driving force behind the development of the law has been Mrs. Mary Jo Codey, wife of previous New Jersey governor, Richard Codey. I recently attended a conference sponsored by Valley Hospital in Ridgewood on the topic of PPD. Both Mrs. Codey and Mrs. Kristine Johnson, anchor of WCBS News, presented very moving and poignant narratives of their experiences with postpartum reactions.

Perhaps the painful and turbulent experiences of Mrs. Codey have propelled her to become a type of Helen Keller who was moved to raise awareness and concern to deal with the issues of the blind, the deaf, and the mute. Significant legislation in the past has been created by political leaders and their families. The Kennedys have spurred legislation related to mental retardation and learning disabilities. If Mrs. Codey seeks to be a type of Helen Keller regarding pre- and post-birth reactions, we can support her altruistic aims. Her aim in effect is to present new mothers with a precious necklace. However, there are serious implications.

THE NOOSE

Although the aims of the New Jersey PPD screening law are laudable, its formulation and the procedures to be carried out under the law are fraught with difficulties. The major defect of the law is the absence of adequate informed consent provisions. The lack of these protections can actually do more harm than good for the new mother. In the current medical data landscape with technological capabilities to rapidly access and transmit highly sensitive data, the woman who is diagnosed depressed in this required screening can face a record having been created which she cannot retrieve, created by an encounter with a stranger in a time of unique physical and emotional vulnerability.

The current New Jersey PPD law is like a well-built house that has had its roof, doors, windows, and curtains removed. There is virtually no privacy and protection from harmful consequences for the woman patient. This entire situation is a noose around the neck of the new mother.

POSTPARTUM DEPRESSION SCREENING

This law mandates that all pregnant women and new mothers be psychiatrically screened for PPD and have records to that effect kept on file. This law mandates mental health/psychiatric screening for adults and is very likely a precedent and potentially a very dangerous and harmful one. This law could be viewed in effect as part of a national universal health screening initiative which also includes Teen Screen. From a privacy and confidentiality point of view, this law is the straw that broke the camel's back. We must draw the line. Hopefully we can reverse some pernicious trends and elements.

MEDICAL ANALOGIES AND METAPHORS

If one uses medical analogies and metaphors, one could characterize the NJ law as being affected by two legal/regulatory diseases: a remote disease that proceeds from the national level and a proximate disease that proceeds from the local level. Both of these diseases interact with each other.

At the national level, a major component of the disease consists of HIPAA (Health Insurance Portability and Accountability Act) regulations that purportedly were designed to protect patient privacy but virtually have destroyed patient privacy. This is in part due to regulations of the HHS (Health and Human Services) Department that have vitiated confidentiality. Another component of the national disease are ERISA (Employee Retirement Income Security Act) regulations that allow managed care/cost organizations to override confidentiality laws for people whose insurance coverage is not traditional indemnity insurance coverage. The net effect is to destroy confidentiality and privileged communication protections for the vast majority of people who have insurance coverage. The dynamics and development of this national level disease are aptly described by the National Coalition for many years.

At the local level, the current NJ law and rules and regulations do not appear to give pregnant women and new mothers sufficient information about the screening process and the implications and consequences of the process. Thus, there is lack of full disclosure of the limits of the confidentiality relationship and lack of a document or process of informed consent. If one combines the effects of the national disease and the local disease, one could consider the New Jersey PPD law to be attempted surgery by a surgeon using contaminated surgical instruments. Put another way, this is a situation where the attempted cure is worse than the disease.



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The National Coalition of Mental Health Professionals & Consumers Inc.
<http://www.TheNationalCoalition.org>

AN ADVOCACY AND EDUCATION ORGANIZATION WORKING TO

- Promote a mentally and emotionally healthy nation.
- De-stigmatize the treatment of mental and emotional distress.
- Inform America about the need for adequate mental health and substance abuse services.

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\$5001 - 10,000 Super Hero	\$176 - 250 Challenger
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\$1001 - 2,500 Champion	\$35 - 99 Supporter
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