

State Advocacy Update

Medicaid Waiver Policy Could Threaten Benefits

Department of Health and Human Services (DHHS) Secretary Tommy Thompson in August unveiled a new Medicaid and State Children's Health Insurance Program (SCHIP) demonstration waiver policy that gives states more flexibility in setting benefits and cost-sharing for some beneficiaries, which could adversely affect millions of Americans in need.

Under the new policy, states can apply for permission to waive Medicaid requirements (using section 1115 waivers) to cut benefits and increase cost-sharing for certain groups of Medicaid beneficiaries. States are then encouraged—but not required—to use the savings to expand coverage for uninsured individuals through the Medicaid and SCHIP programs.

NMHA is concerned that this new policy will cause dramatic reductions in coverage for millions of Medicaid beneficiaries and dramatically reduce their access to mental health and substance abuse services.

The policy, called the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, is modeled after the Medicaid demonstration waiver policy changes recommended by the National Governors' Association (NGA) earlier this year. The NGA proposal, however, called for additional federal funds to help finance program expansions to cover otherwise uninsured individuals. But the new HIFA initiative at issue would provide no additional funds and instead invites states to cut benefits to vulnerable Medicaid beneficiaries (for more information, visit <http://www.hcfa.gov/medicaid/hifademo.htm>).

Children, Older Americans at Risk

The new waiver process can be applied only to optional Medicaid populations—that is, individuals whom the federal law allows but does not require states to cover (e.g., individuals with disabilities above Social Security income limits or the medically needy who qualify by deducting medical expenses from income). Under the new policy, mandatory populations such as SSI beneficiaries must

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Advocates Call for Investment in Community-Based Services

Funding for community-based mental health services has declined in recent years. This widening deficit exists even though research demonstrates that mental health treatment is effective and benefits individuals, families and society as a whole. Despite profound unmet needs, communities across the country face funding cuts in mental health programs for FY 2002.

NMHA is deeply concerned about the outlook for mental health funding in the coming fiscal year. To demonstrate the need for community-based funding for mental health services, NMHA has identified resources to illustrate the ill effects of under-funded mental health services, and the benefits of sufficient mental health services to individuals and society. NMHA hopes that advocates find the following fact sheet useful in their ongoing initiatives for increased mental health funding. For more information, contact Lynn Bauer, policy analyst, at lbauer@nmha.org or 703-837-3371.

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Sept. 11 Reinforces Need to Improve Mental Health Infrastructure

Continued from the Dec. 2001 front page of The Bell

“The United States may face a major mental health crisis unless immediate attention is given to the lack of community-based programs and coordinated services throughout the country,” NMHA President and CEO Michael M. Faenza told a congressional committee in the wake of the attacks.

“The medical evidence is clear that unpredictable acts of malice along with protracted recovery efforts lead to a higher incidence of mental health problems,” Faenza said. “An uncertainty of what the future will hold adds to the nation's level of stress.”

Planning for the Future

Weaknesses in an already strained mental health system before Sept. 11 have become even larger concerns since the tragedy. Here are some areas that need special attention from advocates to help strengthen the mental health infrastructure in their communities and across the nation:

- Integrate mental health into crisis planning
- Promote prevention and long-term services

- Expand and coordinate children's mental health services
- Safeguard mental health and substance abuse budgets
- Protect current consumers of mental health services
- Analyze barriers in Medicaid and managed care

Formulating Crisis Response Plans

Many state and community crisis response plans may not include significant mental health components. And public mental health systems, which are accustomed to providing long-term services on a much smaller scale, may face

particular difficulty when devising response plans. MHAs, however, with connections to public social service agencies, are in a unique position to bridge the gap between agencies and



The Press Enterprise

NMHA Policy Conference Focuses on Sept. 11

Mental Health Programs May Face Budget Shortfalls

Participants of NMHA's annual Healthcare Policy Conference in Alexandria, Va., Oct. 13-15, examined the policy implications of the Sept. 11 crisis and analyzed strategies for averting potential state budget shortfalls for mental health programs.

Nearly every participant expressed significant concern about how to secure adequate funding for mental health in 2002. Participants discussed the benefits of working more closely with Medicaid and mental health offices as well as legislators to emphasize the importance of mental health. Council of State Governments (CSG) representatives also provided ideas on how to reduce the number of people with mental illness currently warehoused in our nation's justice system. The CSG is working with stakeholders across the country to draft a model language document for state officials.

During the advocacy presentation, representatives from the MHA in California and the MHA of Los Angeles County explained how they successfully passed the Integrated Services Agency law (AB 34), which provides intensive services for people with mental illness who are homeless or at risk of being homeless (for more information on the Integrated Services Agencies, please see www.village-isa.org). Attendees also addressed a range of pressing issues, including school-based mental health services, housing and employment, culturally competent advocacy coalition building, involuntary outpatient commitment, substance abuse parity issues and access to medications.

Each year, the policy conference brings together one person from each state to strategize with colleagues across the country on pressing mental health policy issues. For more information, please contact Erica deFur Malik, NMHA's project manager for Healthcare Reform, at 703-837-3360 or at emalik@nmha.org.

connect mental health to schools, hospitals and disaster relief organizations.

Focusing on Prevention and Long-Term Care

MHAs and other advocates should focus on prevention now, as people are realizing the impact of trauma on children and adults. Evidence-based programs that strengthen families can help enhance parents' and children's ability to cope with stress and help avoid the need for intensive clinical services later.

Because the implications of tragic events go far beyond crisis counseling, long-term care is also imperative. Crisis response plans, therefore, must determine how fragmented systems will come together to address long-term needs.

Integrating Children's Services

Children are particularly vulnerable during times of crisis, which calls for the expansion and coordination of children's mental health services. The children's mental health system suffers from a lack of financing; fragmentation among agencies serving the same children; a failure to invest in prevention; and an inability to reach out to the large numbers of children in need of mental health or substance abuse services.

In addition, the mental health needs of children in the child welfare system are often neglected. And children with mental health and substance abuse issues often find themselves entangled in the juvenile justice system with no access to care. At the very least, advocates must bring together child-serving agencies to develop systems to screen for mental health needs related to trauma or distress.

Prevention programs, including school-based services, should also be made part of both crisis response and long-term plans to help enhance and secure children's overall sense of well-being. To be prepared, systems must come together now rather than wait for the next crisis to bring them together.

Protecting Funding and Consumers

Mental health and substance abuse budgets were in jeopardy before Sept. 11, and the need for these services is growing. Factors will play out differently in each state or community: Some advocacy efforts may leverage new funding for children's programs, but funding for other

services may be jeopardized as resources go to security efforts or are lost due to decreased tax revenues. Although the crisis may have strained mental health and substance abuse budgets in some cases, advocates may be able to identify opportunities for new programs or increased appropriations because of the crisis.

But new resources must be appropriated and not shifted from already under-funded programs. If funds are simply taken from existing state budgets or grants, it would harm current mental health consumers.

Safeguarding Access

Likewise, mental health advocates must analyze barriers to Medicaid and managed care to help ensure consumer access to needed services. Healthcare companies have

seen dramatic increases in hotline calls and participation in group therapy sessions since Sept. 11. Unfortunately, managed care organizations are expected to continue restricting access to referrals, limiting access to practitioners, and capping the number of therapy sessions.

Mental health and substance abuse budgets were in jeopardy before Sept. 11, and the need for these services is growing.

In the coming months, NMHA will carefully analyze insurance company practices and gather information about consumers who are denied care or receive inadequate services. This information will be an invaluable tool in securing access to trauma-related services.

To prepare for crisis in the future, mental health advocates should review Medicaid plans and managed care contract language to look for potential pitfalls. NMHA is available to help in this area, and is creating tool kits to support appropriations and Medicaid advocacy campaigns in 2002. For more information or draft copies of these materials, contact NMHA at 800-969-NMHA or shcrinfo@nmha.org. **SAU**

Advocates Call for Investment in Community-Based Services

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Did You Know? . . .

Research Shows That Not Investing in Mental Health Is Expensive

- The total yearly cost for mental illness in both the private and public sector in the United States is \$205 billion—but only \$92 billion of that total comes from direct treatment costs. In fact, \$105 billion is due to lost productivity, and \$8 billion results from crime and welfare costs. *That means the total cost of untreated and mistreated mental illness to American businesses, the government and families has grown to \$113 billion annually.*¹
- Employees who are depressed are twice as likely to take time off for health reasons than employees who are not depressed, and are seven times more likely to be less productive on the job than their counterparts. The success rate for treating clinical depression, however, is about 80 percent.²
- Treating people in communities is far less expensive than treating them in institutions. In one recent study, the total treatment cost per person per year, including the cost of housing, was \$60,000 compared to \$130,000 for institutional care.³

Without Mental Health Services, Society Pays a Larger Bill

- Twenty percent of youths in juvenile justice facilities have a serious emotional disturbance and most have a diagnosable mental disorder. Up to an additional 30 percent of youths in these facilities have substance abuse disorders or co-occurring mental health and substance abuse disorders.⁴
- On any given night, more than 600,000 people are homeless in the United States, one-third of which have a serious mental illness.⁵
- The World Health Organization estimates that depression and substance abuse are associated with more than 90 percent of all suicide cases.⁶

Research Shows That Treatment Offers a Powerful Return on Investment

- A study conducted by the *American Journal of Psychiatry* noted that antidepressant treatment reduces overall healthcare costs by more than 70 percent.⁷
- Comprehensive community-based mental health services for children and adolescents can cut public hospital admissions and lengths of stay.⁸
- In 1996, the average cost of incarcerating an individual in a New York City jail was approximately \$63,000. In contrast, the cost of providing community-based housing to an individual in New York City was only \$12,000 per year or \$33 a day.⁹

Research Shows That Mental Health Is Under-Funded

- In 1997, mental health and substance abuse expenditures represented only 7.8 percent of the more than \$1 trillion of all U.S. healthcare expenditures. This is a decrease from 8.8 percent in 1987.¹⁰
- The overall real purchasing power for state mental health appropriations between 1955 and 1997 declined from \$16.5 billion to \$ 11.5 billion.¹¹
- Mental illness is the second leading cause of disability in the United States¹², yet only 7 percent of all healthcare expenditures are designated for mental health disorders.¹³ SAU

Sources:

- ¹ Rice, P. Dorothy, & Leonard, S. Miller. (1998). Health economics and cost implications of anxiety and other mental disorders in the United States. *British Journal of Psychiatry*, 173(34): 4-9.
- ² *The Chicago Tribune*. August, 2001.
- ³ Rothbard, B. Alieen (1999). Service utilization and cost of community care for discharged state hospital patients: A three year follow up study. *American Journal of Psychiatry*, 156: 920-927.
- ⁴ U.S. Department of Justice. (2000). Youth with Mental Health Disorders: Issues and Emerging Responses. *Juvenile Justice*, 7(1): 3-31.
- ⁵ Center for Mental Health Services, Homeless Programs branch. <http://www.mentalhealth.org/publications/allpubs/KEN95-0015/>.
- ⁶ World Health Organization, 2000. <http://www.befrienders.org/info/statistics.htm>.
- ⁷ Thompson, D., Hylan, T., McMullen, W., Romeis, M., Buesching, D., and Oster, G. (1998). Predictors of a Medical-Offset Effect Among Patients Receiving Antidepressant Therapy. *The American Journal of Psychiatry*, 155: 824-827.
- ⁸ Coalition for Fairness in Mental Illness Coverage, 1998.
- ⁹ Kolbert, Elizabeth. Housing Hope of Mentally Ill is Fading Away. *The New York Times*, 1998 (B1).
- ¹⁰ U.S. Department of Health and Human Services. (2000). *National Expenditures for Mental Health and Substance Abuse Treatment*, 1997.
- ¹¹ Under Court Order: What the Community Integration Mandate Means for People with Mental Illness. The Supreme Court Ruling in *Olmstead v. L.C.* Bazelon Center for Mental Health Law, 1999.
- ¹² World Health Organization, 1990. www.who.int/msa/mnh/ems/dalys/intro.htm.
- ¹³ Substance Abuse and Mental Health Services Administration, 1997.

New Medicaid Waiver Policy Could Threaten Benefits

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continue to receive the same benefit package specified in the state's Medicaid plan.

Optional Medicaid beneficiaries, who total 11.7 million people, constitute more than one-quarter of those covered by the program and include 4.2 million children, 3.7 million adults, 2.3 million older Americans and 1.5 million people with disabilities. Many individuals in these optional groups have family incomes at or below the poverty level (\$8,590 for an individual, \$14,630 for a family).

For those vulnerable optional populations, states are permitted, under this new policy, to reduce Medicaid benefits to the level required under SCHIP and, in some cases, even lower. The new policy also no longer requires states to provide federal mandatory benefits to all optional beneficiaries, and states no longer have to provide the same optional benefits to all qualified populations.

Benefit Cuts and Cost-Sharing

Under the new waiver policy, the most basic package could be quite limited, and exclude long-term care and Early Periodic Screening Diagnosis and Treatment benefits, and impose restrictive caps on mental health services. Many of the Medicaid benefits that people with mental disorders or substance abuse problems rely on could be cut, including prescription drugs, rehabilitation services, practitioner services (including therapy for a range of services), clinic services, case management services, inpatient psychiatric services for those under age 21, institutions for mental disease services for those over 64, nursing facility services, and home health services (see related article on page 7-a).

States can also use the new waiver process to greatly increase the amount of cost-sharing imposed on optional beneficiaries. Current law permits only nominal cost-sharing, in most cases, whereas the new waiver policy sets no limit on the level of cost-sharing. In light of concerns about rising drug costs, states will likely target Medicaid

prescription drug benefits for greater cost-sharing. Long-term care is another costly benefit that could be subject to higher cost-sharing.

NMHA's Response

This increased cost-sharing and cuts in benefits may prevent millions of people with disabilities—including those with mental disorders—from accessing the supports they need to live in their communities. In response, NMHA sent Secretary Thompson a letter expressing its concern about the new policy and urged the administration to provide meaningful opportunity for public comment on HIFA waiver applications received by the DHHS before their approval. NMHA also asked the administration to enforce the requirement that states provide residents with public notice of section 1115 waiver applications before submitting them to DHHS.

NMHA is calling on affiliates and other advocates to contact their state Medicaid agencies, governors, and other state officials and legislators to express concern about the new federal waiver policy. Affiliates should also alert other mental health advocates and related groups in their states—including children's, elderly, legal services, disability rights and general low-income advocates—about this policy change and urge them to express concern to state officials about the HIFA initiative. For more information, call Kristen Beronio, senior director of Government Affairs, at 202-675-8413. [SAU](#)

Find Timely Policy Updates On NMHA's Web Site

Visit NMHA's Web site at <http://www.nmha.org> for regular updates on pressing policy issues, and timely reports on federal and state advocacy efforts.

The screenshot shows the NMHA website with a navigation bar at the top including links for 'About Us', 'News', 'Advocacy', 'Mental Health Information', 'Bookstore', 'Calendar', and 'Affiliate Network'. The main content area features a large article titled 'Mental Health Parity Defeated' with a sub-headline 'While approving increases in funding for mental health services and for NIMH research, House Republicans defeated a motion to adopt the Senate-passed mental health parity legislation on a roll call vote of House/Senate conferees. Following the demise of the parity provision the conferees quickly agreed to reauthorize the 1996 Mental Health Parity Act for an additional year. Sen. Domenici vowed to reintroduce S.543, the Domenici-Wellstone parity legislation and NMHA will be back to fight for full parity early next year. [more](#)'. Below this article are three smaller sections: 'Did You Know? December 19, 2001' about the Oklahoma City bombing, 'Mental Health in Troubled Times... Coping During This Holiday Season', and 'NMHA Ranked Top Health Charity' with a 'Worth 100 Best Charities' badge.

New NMHA Tools Support Public Policy Advocacy

To help support affiliates' public policy activities, NMHA is developing advocacy resources on several key topics. Below is a preview of materials being drafted in two issue areas: access to medications and investment in community-based mental health services. These materials will be available soon for a minimal fee. For copies of the full documents or for more information, please contact NMHA's Advocacy Resource Center at 800-969-NMHA (6649), (select option 6), or via email at shcrinfo@nmha.org.

Access to Medications

Many states across the country are mistakenly seeking to control Medicaid costs by restricting access to medications. Studies show that such efforts not only jeopardize consumer care but also fail to reduce overall expenditures. The excerpts below are taken from a new NMHA publication, *Protecting Consumer Access to Psychotropic Medications: Examples of Model Policies Considered in 2001*, that offers legislative language used by state advocates to block or blunt efforts to restrict access to psychotropic medication. As a compromise, language from states such as Florida and Oregon seeks to exempt psychotropic medications from restrictive laws. In other cases, legislative options attempt to prevent Medicaid offices from imposing restrictions in the first place. Note that NMHA opposes restrictions on access to all types of needed medications. Exemptions for psychotropic medications are intended only as a final compromise.

Preempting Restrictions on Medication Access

In 2001, the Mental Health Association of Indiana led an innovative effort to prevent formulary restrictions. Anticipating state efforts to impose a restrictive formulary on the Indiana Medicaid program, mental health advocates proposed the following policy provision [at left] to prevent the application of any restrictive requirements on psychotropic medications for a two-year period.

Indiana S.B. 471

SECTION 1. IC 12-15-26-3 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS

Sec. 3 (a) A recipient under the Medicaid program may not be denied access to or restricted in the use of a prescription drug for the treatment of a mental illness.

(b) This section expires December 31, 2002.

SECTION 2. IC 12-15-26-4 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS

Sec. 4 (a) The office and any entity that provides prescription drugs to a Medicaid recipient shall make available to Medicaid recipients prescription drugs that are used for the treatment of mental illness without any restrictions or limitations, including prior authorization, when the prescription drug is used for the treatment of mental illness.

(b) This section expires December 31, 2002.

Though the legislation (S.B. 471) won overwhelming legislative support, Governor Frank O'Bannon ultimately vetoed it. The state is now seeking input from the Mental Health Association of Indiana during the promulgation of regulations to ensure that cost-saving policies do not adversely affect access to medications for treatment of mental illness.

Antidepressant treatment reduces overall healthcare costs by over 70 percent.

Thompson, D., Hylan, T., McMullen, W., Romeis, M., Buesching, D., and Oster, G. (1998). Predictors of a Medical-Offset Effect Among Patients Receiving Antidepressant Therapy. The American Journal of Psychiatry, 155: 824-827.

Example Definition of Mental Health Medications*

Any drug prescribed for the purpose of stabilizing or improving mood, mental status, or behavior, which is interfering with a person's quality of life. This includes medications typically classified as antipsychotic or neuroleptic, anti-anxiety, antidepressant, anti-manic, stimulant, or sedative hypnotic. It also includes other medications not typically classified as psychotropic when such medications are given to stabilize or improve

mood, mental status, or behavior (e.g., anti-epileptics, antihistamines, thyroid medications). For purposes of this policy, this definition does not include those cases in which a medication typically classified as psychotropic is given to treat other conditions (e.g., spasticity).

**Example definition of Psychotropic Medications used by State of Tennessee*

New NMHA Tools Support Public Policy Advocacy

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Investment in Community-Based Mental Health Services

Media and public policy organization analyses of state fiscal situations paint an unmistakable portrait of economic decline and mounting budget strain. These reports have once again portrayed Medicaid as the burden of state budgets. All factors point to the potential for across-the-board budget cuts in numerous states and a growing national trend in statehouses across the country toward cutting Medicaid expenditures. Of particular concern are optional Medicaid services now in danger of being cut. The following excerpt is from a forthcoming NMHA document titled *Advocating for Mental Health Services Under Medicaid in Times of Fiscal Uncertainty: An Advocacy Guide*:

Optional Medicaid Services for Mental Health

Virtually all community-based mental health services of any significance for children and adults with serious mental disorders are financed through optional Medicaid services (that is, they are subsidized directly by the federal government). Under new Health Insurance Flexibility and Accountability (HIFA) demonstration initiative rules, these benefits can be limited and made vulnerable to cost-sharing requirements that effectively curtail access to such services [see related article on the cover of *State Advocacy Update*]. States traditionally have selected from among the following optional services:

■ Clinic services

These services must be furnished by or under the direction of a physician. Many services provided by community mental health centers (CMHCs) are reimbursed under the clinic option.

■ Other practitioner services

These services include treatment by state licensed psychologists, psychiatric social workers, occupational therapists and other mental health professionals.

■ Prescription drugs

Every state exercises the option to cover prescription drugs and provide antipsychotic medications through drug formularies, which allows states to determine which drugs will be covered. States can also impose prior authorization and fail-first requirements that impede access to medications. (See the NMHA publication *Protecting Consumer Access to Psychotropic Medications* for discussion of these restrictions and a state-by-state comparison of formulary policies. This publication is available for \$5 by calling the Advocacy Resource Center at 800-969-NMHA (6642), select option 6.)

■ Targeted case management

This refers to services that help people gain access to necessary medical, social, educational and other services. Case management emphasizes coordinated service delivery, and ensures the continuous and integrated services.

■ Psychiatric rehabilitation

This benefit and other wraparound services are typically covered under the category “other diagnostic, screening, preventive and rehabilitative services.” Such services may include individual and group therapies, psychosocial services, and physical, occupational and speech therapies. A physician must recommend these benefits.

■ Psychiatric inpatient hospital and nursing facility services for people age 65 and older in an Institution of Mental Disease (IMD)

States may finance psychiatric inpatient hospital and nursing facility services for eligible Medicaid beneficiaries over the age of 65. As defined by statute, an IMD is “a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.” Federal law prohibits Medicaid reimbursement for any person over the age of 21 and under the age of 65 who resides in an IMD. This prohibition is commonly referred to as the “IMD rule” or “IMD exclusion.” State and private psychiatric hospitals are IMDs as are nursing homes that specialize in caring for individuals with severe mental illness.

■ Inpatient psychiatric services for people 21 years old and younger

States use this option to finance residential treatment for children with serious mental and emotional disturbances.

■ Group homes

Medicaid law specifically excludes coverage for services in psychiatric institutions for adults age 22-64, yet group homes are not subject to the IMD rule. Under section 1905(I) of the Social Security Act, services provided in small community residential programs (less than 16 beds) can be billed to Medicaid. States may not claim reimbursement for room and board in these facilities, however.

Healthcare Reform Advocacy Trainings Continue to Produce Results

Spring/Summer Update

NMHA continues to offer trainings in coordination with state and local affiliates to meet the specific advocacy needs and priorities of state mental health coalitions. Trainings conducted this summer and fall include:

Vermont—The Vermont Association for Mental Health in July convened state advocates to analyze strategies for coordinating transitional services for youth between the ages of 18 and 22. Participants examined Vermont's existing systems of services and explored how eligible young adults could more effectively move from the children's mental health systems into adult mental health services. Efforts underway include considering alternative funding to support a broad-based initiative that will involve collaboration among child, adolescent and adult service agencies throughout the state.

Pennsylvania—The MHA in Pennsylvania met with mental health consumers and other advocates in September to make key decisions about their preferences for psychiatric advance directives legislation. Advocates hope that such legislation will reduce the need for involuntary treatment. (Advance directives are legal documents that allow mental health consumers to make choices about their care in advance should their decision-making ability become compromised.) Participants probed existing state statutes regarding "instruction-driven" directives (living wills) and "agent-driven" directives (which grant proxy or power-of-attorney), and outlined objectives to determine the most feasible ways to address mental health consumers' needs.

Rhode Island—The MHA of Rhode Island held a training in September to discuss various ways in which the state could improve the delivery of mental health services to its children and adolescents. Instead of creating an independent planning initiative focused solely on children, participants chose to support and influence the comprehensive planning initiative being conducted by Rhode Island's Department of Children, Youth and Families. A facilitated discussion about the Supreme Court's *Olmstead* decision highlighted the importance of addressing the lack of community-based services for adults and children in the state.

North Dakota—In October, the MHA of North Dakota met with a range of coalition members to devise strategies for moving the *Olmstead* planning process forward in the state. Participants also discussed a legislative strategy for 2003 to protect and expand North Dakota's children's health insurance program, Healthy Steps.

Missouri—The MHA of St. Louis in October brought together state advocates to analyze current advance directive statutes and to prepare for the next legislative session. During the training, advocates developed an action strategy to protect access to mental health medications in the face of expected attempts to impose restrictions to access. They also decided to begin drafting new legislation to make it clear that Missouri will honor psychiatric advance directives.

Illinois—The MHA in Illinois in October convened a two-day training with the state's mental health coalition, called the Illinois Mental Health Summit, to explore measures to enhance and strengthen the mental health service system for children and adolescents.

If you anticipate problems regarding legislation or regulatory policy, or if you need to create or expand a mental health coalition, please feel free to contact us for assistance. NMHA is ready to help.

For more information, contact Dave Nelson, vice president of Healthcare Reform at 703-797-2594 or dnelson@nmha.org, or Terri Odom, director of Healthcare Reform Training, at 703-838-7554 or todom@nmha.org. 

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State Advocacy Update

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