APPENDIX A

TO

MHLAC COMMENTS ON ANNUAL HEALTH COST TRENDS

2019

Need for Confidentiality of Psychiatric Information Beyond HIPAA – Patient Concerns, Implicit Bias and Inadequate Physical Health Care:

Otto F. Wahl, *Mental Health Consumers' Experience of Stigma*, 25 SCHIZOPHRENIA BULLETIN 467, 467-78 (1999). In a survey of 1,301 mental health consumers, the majority tried to conceal their illnesses due to associated stigma and "worried a great deal that others would find out about their psychiatric status and treat them unfavorably."

Carol A. Ford, et al., *Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care,* 278 J. AM. MED. ASSOC. 1029 (1997).

Debra J. Rickwood, et al., *When and how do young people seek professional help for mental health problems?*, 187 MED. J. AUSTL. S35 (2007) ("Confidentiality remains of utmost importance when engaging young people, and this is particularly important in the context of accessing alcohol and other drug services.")

D. Rosen, et al., *The impact of computer use on therapeutic alliance and continuance in care during the mental health intake*, 53 PSYCHOTHERAPY 117 (2016) (The mere use of an EHR system by a mental health therapist during intake both impairs the therapeutic alliance and reduces the likelihood the client will continue care.)

William A. Yasnoff, *The Health Record Banking Model for Health Information Infrastructure, in* HEALTHCARE INFO. MGT. SYSTEMS: CASES, STRATEGIES, AND SOLUTIONS 336-37 (C.A. Weaver et al. eds., 2016) (Disclosure of sensitive medical information may lead adults to avoid care or withhold information from providers.)

C. Campos-Castillo and D. Anthony, *The double-edged sword of electronic health records: implications for patient disclosure*, 22 J. Am. Med. Inform. Assoc. e130, e137(2015).

Ronald M. Salomon, et al., *Openness of Patients' Reporting With Use of Electronic Records: Psychiatric Clinicians' Views*, 17 J. AM. MED. INFO. ASS'N, 54-60 (2010) (Majority of mental health clinicians surveyed said they would not want their own personal psychiatric record included with their general medical record.)

45 C.F.R. § 164.501 Privacy Rule permits disclosure to any person providing health care to a patient, *without the patient's authorization*, of the following mental health medication prescription and monitoring, counseling session start and stop times, modalities and frequency of

treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

H. Fernandez Lynch, *Discrimination at the Doctor's Office*, 368 N. Engl. J. Med. 18 (2013) (Despite prohibitions against discrimination in professional ethics, as well as state and federal laws that make overt discrimination rare, implicit biases affect care. "[W]e should be particularly vigilant against the sort of subtle discrimination that can fly under the radar.")

E. Glicksman, *Your diagnosis was wrong. Could doctor bias have been a factor?*, Washington Post (Nov. 18, 2019) (People with mental illness may be affected the most by implicit assumptions overall...." Physicians focused on mental health may not notice a heart problem or may tie abdominal pain to depression or anxiety without testing.)

Graham Thornicroft et al., *Discrimination in Health Care Against People with Mental Illness,* 19 INT'L REV. PSYCHIATRY 113 (2007).

M. De Hert, *et al.*, *Physical illness in patients with severe mental disorders*, 10 World Psychiatry 52(2011) (Patients with SMI do not receive adequate risk screening for metabolic syndrome, obesity, or blood pressure. Even oral health is affected by the attitudes of dental health teams. Integration of physical and mental health care will not solve the problem of inferior care: "...stigmatization, discrimination, erroneous beliefs and negative attitudes associated with SMI will have to be eliminated to achieve parity in health care access and provision.")

S. Jeffery, *Psychiatrists Not Immune to Mental Health Bias,* Medscape (May 21, 2013)(report on inferior physical health care delivered to persons with serious mental illness delivered as Abstract NR12-12, American Psychiatric Association's 2013 Annual Meeting).

C. Peckham, *Medscape Psychiatry Lifestyle Report 2016: Bias and Burnout 2016*, Slide 7, available at http://www.medscape.com/features/slideshow/lifestyle/2016/psychiatry (last accessed Dec. 30, 2019) (Among all physicians who said bias affected treatment, 72% said that emotional problems had a negative effect on treatment.)

D Khullar, *The Largest Health Disparity We Don't Talk About*, N.Y. Times (May 30, 2018) (Disparity in life expectancy of Americans with serious mental illnesses compared to those without mental illness is *larger than for race, ethnicity, geography or socioeconomic status.* Clinician bias contributes to disparity. Therapeutic pessimism results in tests and treatments not offered or pursued. Diagnostic overshadowing attributes physical symptoms to mental illness.)

E. McGinty, *et al.*, *Quality of medical care for persons with serious mental illness: A comprehensive review,* 165 Schizophrenia Research 227 (2015) (Medicaid programs, including health homes and ACOs, should be required to collect and report standardized quality indicators for care of somatic (physical) conditions for enrollees with serious mental illness, since disparity in quality of care greater among Medicaid recipients with SMI.)

SAMSHA, Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings, http://www.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.pdf (Stigma-related concerns were cited by 28% of respondents for not obtaining mental health treatment.)

S. Eskelinen, *Physical health of patients with schizophrenia: Findings from a health examination study* (2017) https://www.researchgate.net/publication/318787232_PHYSICAL_HEALTH_OF_PATIENTS_WITH_SCHIZOPHRENIA_FINDINGS_FROM_A_HEALTH_EXAMINATION_STUDY (last accessed 12/30/19) (Individuals with schizophrenia less often admitted to hospital care or receive invasive procedures for heart disease than those without mental illness. Prescription rates for basic preventive medications for cardiac conditions inferior in patients with schizophrenia. Visiting a doctor within 12 months did not reduce the need for somatic interventions.)

Allison L. Smith & Craig S. Cashwell, *Stigma and Mental Illness: Investigating Attitudes of Mental Health and Non-Mental Health Professionals and Trainees,* 49 J. HUMANISTIC COUNSELING, EDUC. AND DEV. 189, 189-202 (2010)

A. Llerena et al., *Schizophrenia stigma among medical and nursing undergraduates*, 17 EUR. PSYCHIATRY 298, 298-99 (2002)

H. Rao et al., *A Study of Stigmatized Attitudes Towards People with Mental Health Problems Among Health Professionals,* 16 J. OF PSYCHIATRIC AND MENTAL HEALTH NURSING 279, 279-84 (2009)

M. Hugo, *Mental Health Professionals' Attitudes Towards People Who Have Experienced a Mental Health Disorder,* J. OF PSYCHIATRIC AND MENTAL HEALTH NURSING, 419, 419-25 (2001).

C. A. Ross & E.M. Goldner, *Stigma, Negative Attitudes and Discrimination Towards Mental Illness within the Nursing Profession: A Review of the Literature,* 16 J. OF PSYCHIATRIC AND MENTAL HEALTH NURSING 558, 558-67 (2009).

Patrick Corrigan, *et al.*, *Mental health stigma and primary health care decisions*, 218 Psych. Res. 35 (Aug. 2014) (doctors less likely to refer patients with mental illness to specialists or renew prescriptions).

Babak Roshanaei-Moghaddam & Wayne Katon, *Premature Mortality From General Medical Illnesses Among Persons With Bipolar Disorder: A Review*, 60 Psychiatric Services 147, 147-54 (2009) (discussing recent evidence which has shown an increased risk of premature mortality for bipolar patients).

Joseph Hayes, *et al.*, *A systematic review and meta-analysis of premature mortality in bipolar affective disorder,* 131 Acta Psych. Scandinavia 417 (2015) (study found persons with bipolar

disorder had double the all-cause risk of death than the general population, and natural deaths are 1.5 times greater, although data from 1935 to 2010 showed that all-cause mortality for persons with bipolar disorder has improved over time).

N. Liu, *et al.*, *Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas*, 16 World Psychiatry 30 (2017) ("Although [persons with SMD] have two times as many health care contacts, they receive less physical check-ups and screenings, less prescriptions and procedures, and less cardiovascular and cancer diagnoses, even though they have a higher risk of dying from these conditions." Persons with severe mental disease die of respiratory diseases at two to six times the rate of the general population, even after controlling for tobacco smoking and substance abuse." "[S]tudies clearly demonstrate the role of factors beyond disorder-specific and lifestyle behaviours in excess mortality") While the authors attribute this to many intersecting causes, including failure to address medication side effects and poverty, they note that "poorer health outcomes could be related to providers' negative beliefs and attitudes towards persons with SMD, including beliefs about the causes of illnesses, ability of persons with SMD to maintain an active and health lifestyle, or other beliefs about functioning. Mental health and primary care providers' attitudes towards patients with SMD appear related to treatment...." Authors also now that there are few randomized trials on the impact of mental and physical care coordination on aspects of physical health care for persons with SMD.)

'Diagnostic overshadowing': worse physical health care for people with mental illness, 118 ACTA PSYCHIATR. SCAND. 169 (2008).

BEHAVIORAL HEALTH INTEGRATION TASK FORCE, REPORT TO THE LEGISLATURE AND THE HEALTH POLICY COMMISSION 69, 82, 85-86 (2013) (listing Behavioral Health Integration Task Force forums, including April 30, 2013 communication and privacy forum). The task force was established under Chapter 224, Section 275 of the Massachusetts Acts and Resolves of 2012 to provide recommendations to the legislature on behavioral and mental health care treatment and service delivery. Act of Aug. 6, 2012, ch. 224, § 108, 2012 Mass. Acts 901. (Task Force held forums for public testimony, including April 30, 2013 communication and privacy forum. Numerous persons with psychiatric challenges recounted their inability to get appropriate physical health care because their providers were aware of their psychiatric histories.)

S. Jones, *'Diagnostic overshadowing': worse physical health care for people with mental illness*, 118 ACTA PSYCHIATR. SCAND. 169 (2008).

H. Stuart, *What we need is person-centred care,* 6 PERSPECT. MED. EDUC. 146 (2017) ("Psychiatric labels may also get in the way of appropriate physical care as clients are triaged as 'psychiatric' regardless of their physical needs and presenting complaint.")

S. Parle, *How does discrimination affect people with mental illness?* 108 NURSING TIMES 28:12-14 (2012).

B. Osumili, *The economic costs of mental health-related discrimination,* 134 ACTA PSYCHIATR. SCAND. Sup. 446, 34 (2016).

S. Evans-Lacko, *et al.*, *How much does mental health discrimination cost: valuing experienced discrimination in relation to healthcare care costs and community participation.* 24 EPIDEMIOL. AND PSYCHIATR. SCI. 423 (2015)(Cost of health services used for individuals who reported previous experiences of discrimination in a healthcare setting was almost twice as high as for those who did not report any discrimination during the last 12 months and this was maintained after controlling for symptoms and functioning.)

J.E. Tintinalli, et al., *Emergency Medical Evaluation of Psychiatric Patients,* 23 ANN. EMERGENCY MED. 859, 859-62 (1994) (Eighty percent of those "medically cleared" by emergency department for psychiatric hospitalization an illness should have had a physical illness identified.)

R.R. Reeves et al., *Inappropriate Psychiatric Admission of Elderly Patients with Unrecognized Delirium*, 103 SOUTHERN MED. J. 111–15 (2010) (finding patients in psychiatric rather than medical units less likely to undergo full diagnostic assessment).

Roy R. Reeves, *et al., Unrecognized physical illness prompting psychiatric admission*, 22 ANNALS OF CLINICAL PSYCH. 180, 184 (2010), *available at* https://www.aacp.com/pdf%2F0810%2F0810ACP_Reeves.pdf (The vast majority (85%) of inappropriate admissions to psychiatric facilities due to missed physical diagnoses were people who already had a psychiatric diagnoses in their medical records. Researchers concluded physical symptoms of patient with mental-illness history are more likely attributed to psychiatric-illness).

R. Hall, *Physical Illness Manifesting as Psychiatric Disease*, 37 ARCH. GEN. PSYCHIATRY 989 (1980) (Forty-six percent of patients evaluated for study suffered from physical, medical illnesses previously undiagnosed by their physician and which physical, medical illnesses either directly caused or greatly exacerbated their psychiatric symptoms. An additional 34% of patients were found to be suffering from at least one other undiagnosed physical, medical illness requiring treatment though unrelated to their psychiatric symptoms.)

S. Wattenberg, *Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange,* SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. HEALTH AND HUMAN SERVICES 1, 13, *available at* http://www.samhsa.gov/healthprivacy/docs/ehr-faqs.pdf (describing stricter confidentiality provisions for sharing mental health information, including with other providers, could accommodate exceptional circumstances using a "break the glass" provision whereby physician overrides patient consent requirement to access medical records).

Talya Miron-Shatz, et al., *To Serve and Protect? Electronic Health Records Pose Challenges for Privacy, Autonomy and Person-Centered Medicine,* 1 INT'L. J. PERS. CENTERED MED. 405 (2011) ("…the system needs to secure patients' consent to transfer records or data to a third party, *even if it is another medical caretaker*. One recommendation we adopt from

the custodianship approach is that patients should have the ability to control the flow of their clinical data and to grant access to it.")

Reducing Stigma - Peers as Colleagues and Open Notes:

G. Thornicroft, et al., *Evidence for effective interventions to reduce mental-health-related stigma and discrimination*, 387 Lancet 1123 (2016) (Review indicated that social contact most effective intervention in reducing stigma in the short-term.)

S. Knaak, *et al., Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions,* 30 Healthcare Management Forum 111(2017) (With social contact, persons with lived experience of mental illness are seen as educators, not patients. Social contact has been shown to disconfirm stereotypes, heighten empathy, and improve understanding of recovery.)

N. Sartorius, *Iatrogenic stigma of mental illness: Begins with behavior and attitudes of medical professionals, especially psychiatrists,* 324 BMJ 1470 (2002) (Doctors must communicate mental health diagnoses in a careful and restrained manner due to prejudices of healthcare professionals.)

C. Walsh, *Revising the language of addiction*, Harvard Gazette (Aug. 28, 2017) (Terms used to describe person or condition can elicit implicit bias.)

L. Kowalezyk, *Doctors' Notes on Mental Health Shared with Patients,* Boston Globe, April 8, 2014, *available at* http://www.bostonglobe.com/lifestyle/health-wellness/2014/04/07/beth-israel-deaconess-mental-health-providers-share-visit-notes-with-patients/2nVs4SSYCzh2ABleJgbCYK/story.html.

OPEN NOTES, www.myopennotes.org (last visited 12/31/19).

Kahn, *et al., Let's Show Patients Their Mental Health Records,* 311 J. AMER. MED. ASSOC. 1291 (2014).

Fosa, *et al., OpenNotes and share decision making: a growing practice in clinical transparency and how it can support patient-centered care*, 25 J. Am. Med. Info. Assoc. (June 2018) (finding OpenNotes improved patient satisfaction, adherence and medical decision making). Health and Human Services recently published guidelines concerning patient access stating that access may only be denied if it is "reasonably likely to endanger the life or physical safety of the individual or another person." This standard ought to be "narrowly construed."

Health and Human Services, HIPAA Guidance at http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html (last accessed Jan. 21, 2016). ("General concerns" about patients' reactions to data (e.g. they "will not be able to understand the

information or may be upset") are insufficient to withhold medical records, as is the "mere possibility" of harm. Access may only be denied if it is "reasonably likely to endanger the life or physical safety of the individual or another person." This standard ought to be "narrowly construed." NOTE: In practice, this standard is not narrowly construed and psychiatric information is regularly withheld from patients.)

T. Esch, *et al., Engaging patients through open notes: an evaluation using mixed methods,* 6 BMJ Open (2016) at https://bmjopen.bmj.com/content/bmjopen/6/1/e010034.full.pdf (last accessed 12/31/19) (fully transparent medical records led to better relationships with doctors, better adherence to treatment, improved self-care, and improved understanding of health information).

S. O'Neill, *et al., Embracing the new age of transparency: mental health patients reading their psychotherapy notes online*, 28 J. Mental Health 527 (2019) (Nearly all survey respondents (94%) agreed having open therapy notes were a good idea and 87% wanted it to continue, reporting that access was very important to self-care, trusting their providers, and feeling in control of their treatment. There were minimal adverse effects.)

R. Cromer, *et al., Online access to Clinical Notes Affects Patients' Trust of Mental Health Clinicians,* 68 Pysch. Serv. 520 (2018) (Accurate documentation of session, respectful notes that documented patient strengths, and lack of diagnoses that clinician had not revealed to patient were key factors in whether access to clinic notes strengthened the therapeutic relationship. NOTE: Requirements that clinicians write notes that are accurate, respectful, and strength-based, and that clinicians do not withhold pertinent information from their clients, effectively change how medical professionals perceive people with psychiatric challenges.)

J. Walker, *et al., OpenNotes After 7 Years: Patient Experiences With Ongoing Access to Their Clinicians' Outpatient Visit Notes*, 21 J. Med. Internet Research (2019) at https://www.jmir.org/2019/5/e13876/ (last accessed 12/31/19) (Of the 20,982 patient respondents, over 72% found it very important for helping take care of their health, over 69% feeling in control of their care and over 65% in remembering the plan of care. Very few were confused (3.3%) or more worried (4.83%) after reading the notes. Hispanic patients, and individuals who usually did not speak English at home, were most likely to report major benefits. Nearly all respondents (98.46%) thought web-based access to visit notes were a good idea. Mental health specialties were included in the provider groups that shared clinical notes.)

Integrating Care – Varied Outcomes and Independent Variables:

R. Capp, *Coordination Program Reduced Acute Care Use and Increased Primary Care Visits Among Frequent Emergency Care Users*, 36 Health Aff. 1705 (2017) (While six-month program reduced emergency department use and increased primary care visits, study excluded persons with serious mental illness and persons with substance use disorder, as well as persons with a psychiatric hospitalization during the previous 180 days. Model of care included up to eight

home visits within first 60 days of ED visit or hospital discharge, including a community health worker who interviewed patient to determine patient's goals. Plans are individually tailored and addressed social determinants like housing and transportation. Study did not examine clinical outcomes or patient-reported outcomes, although 70% of graduates agreed to advocate for the program. Hospital use data was from two hospitals and did not account for use of nearby hospitals. Primary care data limited to one federally qualified health center that served more than half of Medicaid and uninsured patients using hospital that referred patients to program.)

Financial burdens on insureds and harm to care:

C. Girod, *et al., The 2018 Milliman Medical Index* (May 2018), http://www.millimanriskadjustment.com/uploadedFiles/insight/Periodicals/mmi/2018-milliman-medical-index.pdf (last accessed 12/31/19) (Employee share of health care costs have grown compared to employer share in nine of the past 10 years.)

eHealth, *Average Individual Health Insurance Premiums Increased 99% Since 2013, the Year Before Obamacare, & Family Premiums Increased 140%, According to eHealth.com Shopping Data* (Jan. 23, 2017) (Excludes shoppers receiving government subsidies under the ACA from November 1 through December 31, 2016. Plans chosen vary from year to year. Authors note that prior to the ACA, plans offered more limited benefits and coverage and were not required to cover pre-existing conditions.)

SAMSHA, Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings, http://www.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.ppf (Costs or lack of insurance coverage most cited reasons for not receiving mental health treatment (65%)).

G. Shaw, *Studies Rebut Anthem's Retrospective ED Denials*, 41 Emergency Med. News 8 (2019) (Anthem Blue Cross Blue Shield denies coverage for emergency department visits retrospectively classified as nonemergent. Legislator noted denials caused families stress due to potential bills and appeal paperwork. Harvard Pilgrim will require insureds treated at an emergency room for nonemergent conditions to pay a deductible and 50% coinsurance after the deductible is met. Doctors noted that patients do not have perfect information and that these policies require patients to be their own doctors. NOTE: MGL ch. 175 §47u limits the ability of insurers to deny coverage to insured.)

Limited networks and tiering:

The National Council on Disability repeatedly emphasizes the need to protect continuity of care when designing health care systems. http://www.ncd.gov/publications/2013/20130315/20130315Ch3

(last accessed Nov. 16, 2015) (NOTE: Limited networks disrupt the therapeutic alliance when the network or the patient's insurance changes. Limited networks also hamper an individual's ability to find a geographically accessible provider in a timely manner with whom the person can establish a therapeutic relationship. The same is true for tiering when it makes providers unaffordable.)

J. Safran, et al., *Alliance, Negotiation and Rupture Resolution,* in Handbook of Evidence Based Psychodynamic Therapy, at 208 (2009) (the quality of the patient-therapist relationship is more important than the treatment modality).

J. Sharf, et al., *Dropout and Therapeutic Alliance: a Meta-Analysis of Adult Individual Psychotherapy,* 47 Psychotherapy Theory, Research, Practice, Training, 637-645 (2010).

B. Arnow, et al., *The Relationship Between the Therapeutic Alliance and Treatment Outcome in Two Distinct Psychotherapies for Chronic Depression*, 81 J. Consulting and Clinical Psychol. 627 (2013).

J. Norcross, ed., Evidence-Based Therapy Relationships (2011) at 8 ("Alliances with both youth and their parents are predictive of treatment outcomes."; outcomes and patient well-being is considerably enhanced with a better collaborative relationship and goal consensus).

J. Browne, *et al.*, *The relationship between the therapeutic alliance and client variables in individual treatment for schizophrenia spectrum disorders and early psychosis: Narrative review*, 71 Clin. Psych. Rev. 51 (2019)(recovery, less severe symptoms, and better functioning, insight, and social support were all related to better provider/client alliance).

G. Tryon and A. Kane, *The Helping Alliance and Premature Termination,* 3 Counseling Psychology Quarterly 233-238 (1990).

J. Ross and A. Werbart, *Therapist and relationship factors influencing dropout from individual psychotherapy: A literature review*, 23 J. Psych. Research 394 (2013).

R. Kluft, et al., *Treating the Traumatized Patient and Victim of Violence,* in Psychiatric Aspects of Violence: Issues in Prevention and Treatment (2000) ("Continuity of care is an important aspect of long-term treatment, and the object constancy and reliability of the therapist may be one of the most important factors in treatment success.")

R. Capp, *et al., Coordination Program Reduced Acute Care Use and Increased Primary Care Visits Among Frequent Emergency Care Users*, 36 Health Aff. 1705 (2017) (Authors cited continuity of care in the outpatient setting was one of the three reasons for success of the program.)

H. 907/S. 555, *An Act Relative to the Continuity of Care of Mental Health Treatment*, 191st Mass. General Court (2019).

J. Adams & S. Paddock, *Misclassification Risk of Tier-Based Physician Quality Performance Systems,* 52 Health Serv. Research 1277 (2017) (concluding that tiering

methodology may produce misleading results as number of eligible events is typically small).

N. Bhandari, *et al., Why Do So Few Consumers Use Health Care Quality Report Cards?,* 76 Med. Care Research and Rev. 515 (2019) ("Consumers tend not to use CQI to any great extent, mostly relying on a wide array of informal sources for provider quality information.")

Problems with Traditional Medical Model of Treatment:

S. Eskelinen, *Physical health of patients with schizophrenia: Findings from a health examination study* (2017) (Treatment with antipsychotic medications increase risk of obesity, metabolic syndrome, T2D (insulin resistance – a risk factor for kidney failure, blindness, and mortality) and bone fracture, among other somatic conditions. NOTE: Conventional treatment models can exacerbate health problems.)

N. Liu, *et al.*, *Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas*, 16 World Psychiatry 30 (2017) (Risk for suicide is highest within a year following discharge from a psychiatric hospitalization, with 25% of cases occurring within the first 30 days; peer support and peer-led programs improve health status.)

Cosgrove, Lisa and Emily E. Wheeler. "Drug Firms, the Codification of Diagnostic Categories, and Bias in Clinical Guidelines." *The Journal of Law Medicine & Ethics*, 41(3): 644-653. September 2013.

Cosgrove, Lisa et al. "Tripartite Conflicts of Interest and High Stakes Patent Extensions in the DSM-5." *Psychotherapy and Psychosomatics*, 83(2): 106-113. January 2014.

Falk, Neil, Daniel B. Fisher, and Will Hall. "Optimizing Medication in the Service of Recovery: Is there A Path for Reducing Over-Utilization of Psychiatric Medications?" In *Modern Community Mental Health: An Interdisciplinary Approach*. 358-375. Oxford: Oxford University Press. 2013.

Whitaker, Robert. *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. New York: Broadway Paperbacks. 2010.

Patient Choice and Engagement vs. Involuntary Treatment:

National Association of State Mental Health Program Directors, Medical Directors Council Technical Report, 2001, http://www.nasmhpd.org/docs/publications/archiveDocs/2001/Involuntary_Outpatient_Commitment.PDF (concluded failure to provide a continuum of appropriate services designed to promote consumer and family participation responsible for lack of mental health treatment; Medical Directors Council did not endorse forced community-based treatment).

Campbell, J. and Schraiber, R. *In Pursuit of Wellness: The Well-Being Project.* California Department of Mental Health, Sacramento, CA (1989) (Slightly more than half of a group of Californians diagnosed with serious mental illness avoided voluntary treatment, even when they believed it might benefit them, for fear of drawing the attention of treatment providers that might petition to force treatment.)

Michael Rowe, *Alternatives to Outpatient Commitment*, J. Am. Acad. Psychiatry & Law, 41: 3: 332-336 (Sept. 2013), http://www.jaapl.org/content/41/3/332.full (Clinician working in a shelter said that when he informed his male clients of their potential eligibility for outpatient commitment, almost all fled the shelter and were not seen again.)

Massachusetts Department of Mental Health Task Force on Staff and Client Safety in the Community, Majority Report (2011), http://www.mass.gov/eohhs/gov/departments/dmh/dmh-task-force.html (Task Force determined that safety issues were best addressed by providing "access to a broad spectrum of services along with delivery of care by well-staff, fully-resourced, and highly trained interdisciplinary teams.")

SAMSHA, Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings, http://www.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.pdf (Fear of commitment or forced treatment one of the reasons respondents listed for not obtaining mental health treatment.)

National Coalition for Mental Health Recovery, *Enhancing the Effectiveness of Psychiatric Care and Other Services and Supports: Guidelines for Promoting Recovery Through Choice and Alternatives* (April 2011), at http://www.ncmhr.org/press-releases/4.28.11.htm (last accessed 12/31/19)(Supporting choice from a wide array of services and supports, including alternatives to traditional medical options as a means to promote recovery.)

Faulty Foundations for "Evidence-Based" Care, Protocols, and Practice Guidelines:

Andrew Admon, *Appraising the Evidence Supporting Choosing Wisely® Recommendations*, 13 J. Hosp. Med. 688 (2018) (Study showed that only 22% of recommendations relied on primary research, while 7.8% cited case series, review articles, editorials, or lower quality data. The majority of recommendations relied on Clinical Practice guidelines.)

J. Kung, *Failure of clinical practice guidelines to meet institute of medicine standards: two more decades of little, if any, progress,* 172 Arch. Intern. Med. 1628 (2012, correction for competing interests of guidelines on alteplase, BMJ (2013) at https://www.bmj.com/content/346/bmj.f3998) (survey found that 71% of chairs of clinical policy committees and 90.5% of co-chairs had financial conflicts).

J. Lenzer, *Why we can't trust clinical guidelines*, 2013 BMJ

Funding of Alternatives:

K. Gooch, *20 proposed billing codes for nonmedical health needs,* Beckers Hosp. Rev. (July 31, 2019), at https://www.beckershospitalreview.com/finance/20-proposed-billing-codes-for-nonmedical-health-needs.html (last accessed 12/31/19) (American Medical Association and UnitedHealthcare submitted proposed codes addressing social determinants of health to the ICD-10 committee. Codes include inability to pay for utilities, transportation, and clothing, inadequate social interaction, housing, and unemployment.)

California Health Facilities Financing Authority, *Peer Respite Care Grant Program* (2016), at https://www.treasurer.ca.gov/chffa/imhwa/peer.asp (last accessed 12/31/19).

Wisconsin Department of Health Services, *DHS Awards Grant to Fund New Peer-Run Respite for Veterans* (March 27, 2019), at https://www.dhs.wisconsin.gov/news/releases/032719.htm (last accessed 12/31/19).

R. Capp, *Coordination Program Reduced Acute Care Use and Increased Primary Care Visits Among Frequent Emergency Care Users*, 36 Health Aff. 1705 (2017) (No billable codes exist for providing services in program to ensure long-term funding.)

Alternative Modalities of Care:

Exercise

S. Harvey, *et al., Exercise and the Prevention of Depression: Results of the HUNT Cohort Study*, Am. J. Psychiatry (Oct. 3, 2017), at https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2017.16111223 (last accessed 12/31/19) (Exercise could reduce population burden of mental illness.)

Arts

D. Fancourt and S. Finn, *What is the evidence on the role of the arts in improving health and well-being?* World Health Organization, Health Evidence Network Synthesis Report 67 (2019) (Referencing over 900 publications, including 200 reviews covering over 3,000 further studies, report concluded that the arts contributed to core determinants of health and to prevention of mental illness and age-related physical decline. Arts also supported the treatment or management of the aforementioned health issues, noncommunicable diseases, neurological disorders, and acute and end-of-life care. Policy recommendations included implementation of art interventions and further research on scaling art interventions to larger populations.)

Griffiths, S., & Corr, S. (2007). The use of creative activities with people with mental health problems: A survey of occupational therapists. *The British Journal of Occupational Therapy*, *70*(3), 107-114.

Meditation/Mindfulness

S. Naragatti, *et al.*, *Effects of Meditation on Health*, 3 Int. J. Med. And Biomed. Stud. 38 (2019) (As compared to the control group, study showed significant improvement in meditation group in physical health, as well as psychological and social relationship domains.)

Coffey, Kimberly, A., Marilyn Hartman, and Barbara L. Fredrickson. *Deconstructing Mindfulness and Constructing Mental Health: Understanding Mindfulness and its Mechanisms of Action.* 1 Mindfulness 235 (Dec. 2010)

-Godfrin, K.A. and C. van Heeringen. *The effects of mindfulness-based cognitive therapy on recurrence of depressive episodes, mental health and quality of life: A randomized controlled study.* 48 Behaviour Research and Therapy 738-746 (2010).

-Grossman, Paul et al. "Mindfulness-based stress reduction and health benefits: A meta-analysis." *Journal of Psychosomatic Research*, 57(1): 35-43. July 2004.

-Kabat-Zinn, Jon et al. "Alterations in Brain and Immune Function Produced by Mindfulness Meditation." *Psychosomatic Medicine*, 65(4): 564-570. July 2003.

Peers

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The Appendix is a partial list of sources supporting MHLAC's comments and recommendations.