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Issue Brief

Trends in Mental Health Care

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Introduction

In the last few years, a number of major government reports have placed mental health care at the center of health policy and public health. *Mental Health: A Report of the Surgeon General,* released in December 1999, summarized the findings of a vast body of scientific literature on the prevalence and treatment of mental disorders.[1] Evidence amassed in this report indicated that a variety of efficacious treatments are available for most mental disorders. The Surgeon General's office also released a supplement to this report entitled *Mental Health: Culture, Race and Ethnicity,* addressing the disparities in access to mental health services and their toll on overall health and productivity, and *A Call to Action to Prevent Suicide,* providing a blueprint for reducing suicides in the U.S.[2] Most recently, the New Freedom Commission appointed by President Bush to study the mental health delivery system released its final report, *Achieving the Promise: Transforming Mental Health Care in America,* in July 2003.[3] The report recommended a fundamental transformation in mental health care delivery. Together with prior research, these four publications provide a valuable framework for assessing how public policies affect care for those with mental illnesses.

Delivery of Mental Health Care

Striking changes have occurred in the delivery of mental health care over the past few decades. Fifty years ago, most individuals receiving care for mental disorders obtained treatment from a specialty provider in an inpatient setting. Of the 1.7 million psychiatric patient-care episodes in 1955, 77 percent were in 24-hour hospital services.[4] At that time, government-owned psychiatric hospitals and specialty mental health clinics accounted for 84 percent of mental health spending.[5] Today, most individuals receive mental health care on an outpatient basis and live in a community setting. Services delivered in public psychiatric hospitals account for less than 15 percent of total spending.[6] Instead, delivery of mental health care in general hospitals and nursing homes, and by primary care clinicians, psychologists, psychiatrists, and social workers provides a broader array of treatment options. Likewise, the development of insurance-based financing (including Medicaid and Medicare) has fostered the emergence of markets providing greater autonomy and choice to individuals with mental illnesses as consumers of health care. Even the most severely ill individuals are able receive community-based care financed through public insurance.

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However, this transformation has also fragmented care across a patchwork of public and private insurance programs and delivery settings. New policy concerns have also emerged through enhanced civil rights to individuals with mental disorders. Advocates view the dramatic rise in homelessness and incarceration of individuals with mental disorders as unintended, troubling consequences of the evolution of the mental health system.

Prevalence, Service Use, and Social Costs

The National Comorbidity Survey (NCS) constitutes the primary source of data on prevalence of mental disorders in the U.S.[7] The NCS reported that about 19 percent of the population have a diagnosable mental disorder.[8] About 15 percent of Americans use mental health services each year, yet only half of these individuals have a specific disorder. Therefore, only about 37 percent of individuals with a disorder actually receive mental health treatment. These data signal that problems of both under- and over-treatment for mental disorders exist.[9] Diagnosis might not always be an appropriate measure of need for services. Mental health experts suggest that treatment decisions should be made on the basis of diagnosis in conjunction with other indicators of need, such as persistent or recurring symptoms, comorbidity, and impaired functioning.

Untreated mental disorders can lead to decreased work productivity, family disruptions, significant personal distress, and disability. Mental disorders constitute a major cause of disability in the U.S. and one of the top ten leading causes of disability worldwide.[10] Anxiety and mood disorders are the most prevalent diagnoses.[11] Poor mental health is more common among the poor than among higher income individuals, though causality may run in both directions.[12]

The indirect costs of mental illness represented a $112.3 billion loss to the U.S. economy in 1994.[13] This estimate included $88 billion in morbidity costs reflecting loss of productivity in usual activities due to illness, as well as $16.5 million in mortality costs from lost productivity due to premature death and $7.8 billion in productivity losses for incarcerated individuals and caregiving family members.[14] Suicide also constitutes a major, preventable public health problem and is a consequence of under-diagnosed and undertreated mental illnesses. In the U.S., suicide results in 30,000 deaths each year. It ranked as the eleventh leading cause of death in 2000 and the fourth leading cause of death among those 25 to 44 years of age.[15]

Efficacy of Treatments for Mental Disorders

Mental Health: A Report of the Surgeon General highlighted the extraordinary pace and productivity of scientific research on the etiology and treatment of mental illness with particular focus on the brain and behavior. Significant gains in pharmaceutical technology have led to the development of a range of effective treatments with fewer side effects. Both the pace of medical discovery and faster approvals of new drugs in recent years by the U.S. Food and Drug Administration have contributed to the increasing use of these therapies. Various psychotherapies, such as psychodynamic, interpersonal, and cognitive-behavioral therapy also are available.

Many Americans with disorders do not benefit from the effective treatments now offered.[16] The Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century,* noted that the lag between treatment discovery and incorporation into routine patient care tends to be unnecessarily long across health diagnoses.[17] The Surgeon General's report specifically highlighted the challenges associated with translating the best scientific knowledge about mental health treatment into everyday clinical practice. In an effort to improve quality, the mental health field has developed evidence-based practices defined as treatments and services where effectiveness is well documented. In contrast, emerging best practices are mental health treatments and services that are promising but less thoroughly documented.

Given the complexity of mental health care delivery and financing, a primary challenge involves disseminating evidence on treatment efficacy and coordinating care across a range of service settings. For example, most people suffering from depression seek care in primary care settings, so it is helpful to create linkages between primary and special mental health care providers. Furthermore, the delivery system for dispensing psychotropic drugs has expanded. Currently, psychiatrists prescribe only a third of psychotropic medications, while primary care physicians and other specialists prescribe the remaining two-thirds.[18] Yet, evidence has shown that primary care clinicians often lack the necessary training, time or financial incentives for appropriate detection and treatment of mental conditions.[19] Diffusion also appears hampered by uncertainty among private and public payers regarding how to cover evidence-based services.

Spending on Mental Health Care

National expenditures for the treatment of mental health and substance abuse totaled $82.2 billion in 1997, with 86 percent ($70.8 billion) spent on treating mental illness and 14 percent ($11.4 billion) spent on treating substance abuse.[20] Mental health and substance abuse expenditures constitute about 8 percent of the more than one trillion dollars spent on all U.S. health expenditures in 1997. Specialty mental health providers received

71 percent of mental health and substance abuse expenditures, while general health care providers received 14 percent. The remaining 15 percent covered prescription drug costs and administrative expenses of insurers.

Mental health care spending grew more slowly than overall health expenditures over the last decade. While real health care spending increased by 5 percent annually between 1987 and 1997, real mental health spending grew by only 4 percent.[21] Notably, these trends are reversed for prescription drug spending. The annual 9 percent inflation-adjusted increase in spending for prescription drugs to treat mental illness exceeds the annual 8 percent increase in spending on drugs for all health-related diagnoses. Outpatient psychotropic drugs now constitute the fastest growing mental health care cost. Prescription drug use grew from 22 percent of total behavioral health spending in 1992 to 48 percent in 1999 among people with employer-based health insurance.[22] Growth in the use of psychotropic drugs is attributable both to the increased availability of effective medications to treat mental disorders and to the comparatively generous coverage for this portion of the mental health benefit.

The primary explanation for lower relative growth in overall mental health and substance abuse spending is the reduction in hospital expenditures, which in turn resulted from widespread adoption of specialty managed behavioral health carve-outs in part due to price competition among health plans. Carve-out companies use specialized expertise to establish networks of mental health providers (including psychiatrists, psychologists, social workers, and psychiatric nurses), negotiate volume-related discount contracts, identify evidence-based treatment protocols, and develop other incentive programs to manage use of services and costs. According to an annual survey, the managed behavioral health care industry has experienced a substantial increase in enrollment over the decade, from 70 million in 1993 to 164 million in 2002.[23] Studies have produced relatively consistent evidence that contracting with behavioral health carve-out companies reduces mental health and substance abuse costs by around 30 to 48 percent in the private sector.[24] Most of these savings result from decreases in use and spending for inpatient care. Most often, the proportion of enrollees using outpatient care increased while the number of outpatient visits decreased under carve-outs. Fewer studies have examined the effects of carve-outs on quality of care. Carve-outs do not appear to increase rates of re-hospitalization,[25] however studies have produced mixed results on their effects on continuity of care,[26] adherence to treatment guidelines,[27] and clinical outcomes.[28]

Disparities in Mental Health Services

Substantial disparities exist in access to mental health services. According to the Surgeon General's report, *Mental Health: Culture, Race and Ethnicity,* racial and ethnic minorities are less likely than whites to seek out or access services, and they receive poorer quality mental health care despite having similar community rates of mental disorders.[29] While use of mental health care among Asian American groups has been difficult to accurately measure, a number of studies found that they use fewer services per capita than other groups.[30] After controlling for sociodemographic characteristics and differences in need, another study found that African Americans receiving mental health treatment from any sources was about half that of whites.[31] Most studies of Latino mental health care access also reported low service use.[32] Also, in geographically remote areas, people with mental illness encounter more trouble accessing services due to limited availability of providers, lower family income, and possibly greater social stigma.[33]

The Role of the Public Sector

Federal, state, and local governments contribute substantially to the financing and delivery of mental health care. Public payers funded 58 percent of mental health and substance abuse spending in 1997, a much larger share than the 46 percent of total health expenditures paid for through the public sector.[34] Historically, state and local governments have assumed a particularly large role in financing mental health services. In 1997, state and local governments provided 28 percent of all mental health and substance abuse expenditures, while funding only about 13 percent of health care services overall.[35]

Among all payers, Medicaid is currently the largest single payer for mental health services. In 1971, Medicaid represented only about 12 percent of national spending for mental health treatment. By 1997, this share had increased to nearly 20 percent, totaling $14 billion.[36] Expenditures through the Medicaid and Medicare programs constitute 35 and 21 percent, respectively, of total public sector expenditures on mental health services.[37]

Medicaid pays for mental health care primarily for two distinct populations: people enrolled in Temporary Assistance to Needy Families (TANF) and in Supplemental Security Income (SSI). TANF recipients have somewhat higher rates of treatment for mental disorders than the general population[38] and an estimated 28 percent of enrolled adults report very poor mental health scores.[39] With regard to depression, Medicaid provides a vital source of access to services given that rates are particularly high among low-income women. For example, a recent study found that mothers of young children experience rates of depression ranging from 12 to 50

percent, with the highest levels among women who are poor or homeless or have a chronic health problem. Their children are at increased risk of developmental, behavioral, and emotional problems.[40] Adolescent girls also experience high rates of depression and report relatively high rates of suicidal ideation.[41]

In addition to Medicaid and Medicare, the federal government provides resources through the Community Mental Health Block Grant, community support programs, the PATH program for services to the homeless mentally ill, and Comprehensive Community Mental Health Services for Children. Income supports for individuals unable to work due to mental illness include SSI, TANF, and Social Security Disability Insurance (SSDI). Thirty-five percent of SSI beneficiaries and 27 percent of SSDI beneficiaries were disabled by mental illnesses in 2001, including a large proportion with schizophrenia.[42]

Stigma and Mental Health

The New Freedom Commission Report and Surgeon General's Report both emphasized the importance of changing public attitudes to eliminate the stigma associated with mental illness. Advocates for the mentally ill identify stigma and discrimination as major impediments to treatment. Stigma prevents individuals from acknowledging these conditions and erodes public confidence that mental disorders are treatable. A plurality of Americans believe that mental illnesses are just like any other illness; however, 25 percent of survey respondents would not welcome into their neighborhoods facilities that treat or house people with mental illnesses, suggesting that some level of lingering stigma persists.[43] Sixty-one percent of Americans think that people with schizophrenia are likely to be dangerous to others[44] despite research suggesting that these individuals are rarely violent.[45]

The Surgeon General's report viewed increasingly efficacious treatments for mental disorders as the most effective long-range antidote to stigma, noting that "effective interventions help people to understand that mental disorders are not character flaws but are legitimate illnesses that respond to specific treatments, just as other health conditions respond to medical interventions."[46]

Mental Health Insurance Coverage

Under most health insurance plans, coverage for mental disorders is more limited than coverage for general medical care. Plans commonly require higher cost sharing and more stringent limits on inpatient hospital days and outpatient visits for mental health treatment. Until recently, special lifetime and annual dollar limits were often used. A recent study reported that 74 percent of privately insured workers were subject to special annual outpatient mental health visit limits and 64 percent were subject to special annual inpatient mental health day limits in 2002.[47] In the Medicare program, outpatient psychotherapy services are covered with a 50 percent beneficiary co-payment requirement, compared with 20 percent enrollee cost-sharing on other Medicare outpatient services.[48] A 1998 survey by the Robert Wood Johnson Foundation reported that 83 percent of uninsured and 53 percent of privately insured individuals listed cost concerns as the principal reason for not seeking mental health care.[49]

In the 1990s, states began to enact parity laws as a policy response to mental health coverage limitations. The objective of parity is to require insurers to provide the same level of benefits for mental health (and sometimes substance abuse) as general medical care. Thirty-four states have enacted some form of parity legislation. In 1996, Congress passed a law addressing one aspect of mental health coverage limits. The Mental Health Parity Act (P.L. 104-204) took effect in 1998 and prohibits the use of annual or lifetime dollar limits on coverage for mental illnesses. Unlike state parity laws, it extends to all self-insured companies exempt from state mandates under ERISA. The law does not apply to other kinds of benefit limits, such as special day or visit limits and higher cost sharing. Companies with fewer than 50 employees and those that offer no mental health benefit are exempt from the federal parity law. Payers experiencing more than a 1 percent increase in premiums as a result of federal parity can apply for an exemption. In 2000, the General Accounting Office reported that two-thirds of compliant employers had made at least one other aspect of their mental health benefits more restrictive, raising concerns about circumvention of this law.[50]

Insurers have traditionally limited coverage for mental disorders out of concern that generous benefits could lead to high costs due to long-term or intensive psychotherapy and lengthy hospital stays. In fact, there is evidence that in fee-for-services settings consumers are more sensitive to changes in the price of mental health services than other health care services. The RAND Health Insurance Experiment demonstrated that increased use of services by consumers in response to decreased out-of-pocket costs was twice as great for outpatient mental health services than for ambulatory health services as a whole under indemnity insurance.[51] However, contracting with carve-out companies eases these concerns since cost-control efforts no longer rely exclusively on limiting benefits. Importantly, some evidence suggests that plans may structure mental health benefits to avoid selection of unfavorable or high-risk consumers.[52] Mental health is an area where economic research has also identified particularly strong selection incentives. Inefficiently low levels of insurance coverage

may result if health plans narrowly limit benefits to discourage enrollment by consumers with high expected mental health use.

In the 108th Congress, Senator Pete Domenici and Representative Patrick Kennedy have introduced the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003 (S. 486/H.R. 953) to provide more comprehensive parity for mental health benefits. This legislation is patterned on an executive order issued in 1999 mandating comprehensive mental health and substance abuse benefit parity for the nine million enrollees of the Federal Employees Health Benefits Program (FEHBP).[53] The Office of Personnel Management and the Department of Health and Human Services are evaluating the impact of the FEHBP benefit change on cost, access, and quality. Like the FEHBP parity policy, this legislation would prohibit the use of special mental health day or visit limits and higher cost sharing. Employers remain concerned about the cost of enacting broader federal parity. The Congressional Budget Office estimated in 2001 that an identical version of the bill introduced in the prior Congress would increase premiums for group health plans by 0.4 percent after accounting for the responses of health plans, employers and workers.[54]

In addition, Sen. Jon Corzine and Rep. Pete Stark introduced the Medicare Mental Health Modernization Act of 2003 (S. 646/H.R. 1340). This legislation would eliminate the lifetime limit on inpatient mental health services and require parity in coverage for outpatient mental health services in the Medicare program. S. 853 introduced by Senator Olympia Snowe specifically addresses the issue of reducing the outpatient coinsurance rates for mental health services in the Medicare program from 50 percent to the 20 percent level for general outpatient medical services.

Other Current Mental Health Policy Issues

Recent federal policies encourage those with mental disorders to re-enter the workforce. People disabled by mental illness have the lowest rates of employment among all disabled groups. Only one in three mentally disabled individuals has a job.[55] The federal Welfare-to-Work initiative created a strong financial incentive for beneficiaries to obtain training and employment by placing time limits on income support. Likewise, the Ticket to Work Incentives Improvement Act of 1999 (P.L. 106-170) sought to encourage SSI and SSDI beneficiaries to enroll in employment training and obtain jobs. However, the New Freedom Commission Report raised a concern that its rules do not create enough of an incentive for vocational rehabilitation providers to take on clients with more severe mental illnesses.[56]

Through the Balanced Budget Act (BBA) of 1997 (P.L. 105-33) and the Ticket to Work Act, the Congress has addressed the related issue of loss of Medicaid as a disincentive to employment. Under the BBA, states are permitted to extend Medicaid coverage to disabled individuals with incomes up to 250 percent of poverty. Under the Ticket to Work program, states can set higher income and resources levels for receiving Medicaid coverage, including for those whose health and functioning has improved enough through the use of psychotropic medications to enable a return to work. Most states have not opted to implement these Medicaid buy-in programs.

Increasing attention has focused on the troubling issue of trading custodial rights for access to children's mental services. The General Accounting Office examined the issue of parents placing children with mental health issues in welfare or juvenile justice systems solely to obtain treatment after exhausting savings and health insurance.[57] The GAO reported that state child welfare officials in 19 states and juvenile justice officials in 30 counties estimated that parents placed over 12,700 children in welfare or juvenile justice systems to receive mental health care treatment in 2001. Nationwide, this estimate is likely to be higher since 32 states, including the five largest states, and many counties were unable to provide data on the number of affected children. No formal federal or state tracking of these placements occurs.

In the 1999 *Olmstead v. L.C.* decision, the U.S. Supreme Court held that unnecessary institutionalization of people with disabilities is discriminatory under the Americans with Disabilities Act (ADA).[58] This decision requires that services to those disabled by mental illness be delivered in the most integrated setting possible. While states are required to develop comprehensive work plans for placing disabled people in appropriate treatment settings and to "maintain a waiting list that moves at a reasonable pace," some have been slow to comply.[59] Four years after the Olmstead ruling, 42 states and the District of Columbia have set up task forces, commissions or state agency working groups to develop implementation plans.[60]

Finally, President Bush appointed the New Freedom Commission to study the mental health delivery system citing major barriers to the provision of high quality mental health care including stigma, inadequate insurance coverage, and a fragmented service delivery system. Noting problems with the evolution of community mental health care over the intervening decades since deinstitutionalization, Commission members proposed six goals aimed at fundamentally transforming mental health care delivery:

- Americans should understand that mental health is essential to overall health. The report recommended

developing national campaigns to reduce stigma and prevent suicide. It noted that mental health should be addressed with the same urgency as physical health.

- Mental health care should be consumer and family driven. The report urged patient and family-centered care through the development of individualized treatment planning, improved care integration and accountability, and a focus on consumer rights and protections.
- Disparities in mental health services should be eliminated through improving access to culturally competent care and increasing services to geographically remote areas.
- Early mental health screening, assessment and referral to services should become common practice. The report stressed the importance of screening by primary care clinicians, expanding school mental health programs, and improving detection and treatment of co-occurring mental health and substance abuse disorders.
- Excellent mental health care should be delivered and research should be accelerated. Specific understudied areas include developing a knowledge base in mental health disparities, long-term effects of medication, and trauma and acute services for those in crisis.
- Technology should be used to better access mental health information and coordinate service delivery. Information technology can minimize mental health delivery problems in rural and other underserved areas, and electronic medical records can facilitate the adoption of and adherence to evidence-based practices.

Conclusion

Dramatic changes have occurred in mental health over the last 50 years, including significant advances in the diagnosis and treatment of mental illness, positive shifts in public attitudes about mental disorders, and a transformation in the delivery of mental health services. Yet, fragmented systems of care, insurance and reimbursement issues, and barriers to evidence-based treatments prevent some Americans from receiving quality care for mental disorders.

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