# FORGOTTEN POLICY

## An Examination of Mental Health in the U.S.

*A Series of Community Voices Publications*


BY

Marguerite Ro, MPH, DrPH • Lucy Shum, MHS



Community Voices

HEALTHCARE FOR THE UNDERSERVED

www.communityvoices.org

# FORGOTTEN POLICY
## An Examination of Mental Health in the U.S.

***A Series of Community Voices Publications***

***MAY 2001***

**BY**

Marguerite Ro, MPH, DrPH • Lucy Shum, MHS

Prepared for

**W.K. KELLOGG** FOUNDATION

## About the Authors

Marguerite Ro, MPH, DrPH is an Assistant Professor at Columbia University's School of Public Health and School of Dental and Oral Surgery. Dr. Ro works primarily on improving access and utilization of health services by vulnerable populations. With the W.K. Kellogg Foundation's Community Voices initiative, she works with 13 community collaborations on informing policy to improve access to oral health, mental health, and general health services. Addressing the social determinants of health, including social capital, class disparities, and racial/ethnic disparities, is a major component of her research and the policy technical assistance that she provides. In addition, Dr. Ro provides program management for the American Legacy Foundation/Community Voices tobacco cessation initiative and is a principal in Columbia's Oral Health Disparities and Policy Center.

Lucy Shum, MHS is a student in the Law and Health Care Program at the University of Maryland, School of Law. Through the school's Disability Law Clinic and the Maryland Disability Law Center, Ms. Shum has advocated for children's access to community-based mental health services. As an administrator in the Department of Psychiatry at the New England Medical Center and Tufts University School of Medicine, her responsibilities included quality assurance, compliance, and staff supervision. Ms. Shum served on the Public Mental Health Working Group during her graduate studies in the Department of Mental Hygiene at Johns Hopkins University's School of Public Health, where her training focused on mental health policy and services research.

## ABSTRACT

Mental health is fundamental to general health and well-being. Mental health is the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Yet in an era of technological and scientific advances, most Americans who suffer from mental health and/or substance abuse disorders go untreated. Approximately 20% of the population is affected by mental health or substance abuse disorders during any given year. Less than one-third of those affected will receive any type of treatment. Barriers to treatment include the lack of health insurance coverage, high cost of pharmaceuticals, and stigma surrounding mental illness.

While mental health and substance abuse disorders affect the entire population, there are subgroups of the population that disproportionately lack access to quality care and treatment. Among these subgroups are vulnerable populations, including the working poor, low-income populations, racial and ethnic minorities, and rural communities. In addition to the barriers to care that the general population faces, these vulnerable populations also face barriers due to lack of culturally and linguistically appropriate providers or geographically accessible providers, as well as transportation and child-care problems. These individuals may have a greater need for health and social support.

In order to ensure healthy and productive lives for all Americans, efforts must be directed to support good mental health and to provide quality mental health services for those who need it. This paper presents strategies and recommendations for improving the current system so that it better addresses the mental health needs of vulnerable Americans. The 15 strategies are to:

- Reduce stigma as a barrier to access.
- Eliminate financial barriers to access.
- Address prescription drug coverage issues.
- Integrate services for co-occurring mental health and substance dependence disorders.
- Support the mental health workforce.
- Target the needs of vulnerable populations.
- Enhance school-based health and mental health services.
- Support school-based violence prevention programs.
- Address the needs of children in the foster care system.
- Expand insurance coverage for adults with mental disabilities.
- Address the housing needs of adults with mental illness.
- Tackle the employment needs of adults with mental disabilities.
- Address issues involving the criminalization of adults with mental illness.
- Promote mental health among the elderly.
- Address deficiencies in nursing homes.

## EXECUTIVE SUMMARY

Despite the scientific and technological advances, numerous people still suffer needlessly from mental health and substance abuse disorders. Less than one-third of adults and children who suffer from these disorders receive any kind of treatment. This report provides an overview of the barriers to access and utilization of behavioral health services and offers a brief overview of the financing and coordination of mental health services. It presents strategies and policy recommendations to improve access to and utilization of mental health and substance abuse services, particularly for underserved populations.

### THE ISSUES

Poor mental health affects every American—whether it is by individual experience or by knowing a family member, friend, or colleague who suffers from a mental health or substance abuse disorder. Effective treatments are available; however, most individuals who suffer from mental health or substance abuse disorders do not get treated often because of the cost or due to the stigma associated with these disorders. For vulnerable populations—low income, uninsured, and rural and minority populations—these barriers to care are compounded with the lack of insurance coverage, problems with transportation and childcare, and a lack of culturally competent and geographically accessible care.

The cost of untreated mental health and substance abuse disorders is high. Individuals who go untreated are often less productive in their work/school life and lead less satisfactory social and family lives. Society pays due

to lost productivity and by having to spend more for potentially avoidable health and social services.

For vulnerable populations, the current mental health safety net is a fragile net of state and local mental health programs. These programs, together with social services, the public education system and justice system, provide piecemeal services to those with limited financial resources and those without insurance. Lack of coordination just between mental health, substance abuse, and general health services is a major problem. It becomes more complicated with the additional need to coordinate housing, employment, and other social services. It is clear that changes in behavioral health policy and programming are urgently needed.

The challenge of improving access to and utilization of mental health and substance abuse services will, therefore, require all sectors of society. Federal and state governments, health care providers, social service providers, educators, the justice community, employers, families and consumers have a role in reshaping the mental health system to better serve all Americans. The challenge is to create a mental health system that recognizes the importance of mental health to general health and one that can serve a diverse and growing population.

The following strategies and recommendations suggest ways to begin to improve the current system so that it better addresses the mental health needs of vulnerable Americans. Presented are strategies that address the broader structural issues with the mental health system and then strategies that address specific periods of the lifespan.

## *Broad Strategies to Improve Mental Health*

### Strategy 1: Reduce Stigma as a Barrier to Access

Stigma prevents individuals from recognizing and/or addressing mental health disorders. The stigma of mental disorders may lead to unnecessary suffering due to lack of treatment. Public perceptions of mental disorders do not reflect the realities of mental health as fundamental to health. Reducing stigma is important to ensure that those who need treatment can seek it without recrimination or remorse.

*Policy Recommendations*

- Integrate stigma awareness training into the education curriculum and continuing education requirements of health care providers.
- Require dissemination of stigma awareness literature for consumers and providers in the Medicaid contracting process.
- Increase awareness at community-based points of entry through professional associations, institutions, and employers.
- Train culturally competent and culturally diverse health and social service providers.

### Strategy 2: Eliminate Financial Barriers to Access

Mechanisms to address financial barriers to access include parity legislation and oversight of managed care and managed behavioral health care organizations.

*Mental Health Parity*

In theory, mental health parity would ensure consumers insurance coverage for mental health services that is subject to the same benefits and restrictions as coverage for other health services. However, due to other limitations such as caps on inpatient days or outpatient visits, true mental health parity has yet to be achieved in most states.

*Policy Recommendations*

- Expand the federal mental health parity act by requiring that all limitations on the coverage for mental illnesses be equal to those for medical and surgical benefits. This provision would prohibit an insurance plan's ability to impose arbitrary caps on spending limits, inpatient days and outpatient visits, and co-payments and other deductibles.
- Advocate for state legislation that achieves full and comprehensive parity that includes protections for treatment for alcohol and substance abuse. These pro-visions would require public and private health insurance plans to provide treatment for mental illness and substance abuse commensurate with that provided for other major physical illnesses and would require health plans to offer access to all effective and medically necessary medications.

*Oversight of Managed Care and Managed Behavioral Health Care*

By 1999, 41 states and the District of Columbia had some form of public sector managed behavioral health care. The managed behavioral health care programs vary widely from state to state. While it is important that these systems are efficient, it is critical to ensure that these systems operate in a manner that best serves their clients. Quality, accessibility, appropriateness, and accountability are key components to good managed health care.

*Policy Recommendations*

- Require fair internal and external appeals processes.
- Adopt regulations and standards to ensure compliance with Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) requirements.
- Require routine data and performance reports in managed care contracts to hold systems accountable.
- Provide incentives for managed care contractors who are responsible for targeted case management to facilitate linkages and the coordination of care between the mental health, general medical, and social service systems.

## Strategy 3: Address Prescription Drug Coverage Issues

The lack of or limited coverage for prescriptions is a significant treatment barrier. This is particularly true for treating mental illnesses because effective treatments are often newer and do not have generic counterparts.

*Policy Recommendations*

- Require pharmaceutical companies to base the direct-to-consumer cost of prescription drugs on an average of the costs negotiated with insurance companies.
- Require prescription drug coverage in plans regulated by state insurance commissioners.
- Require insurance companies to review and revise their formularies on a routine basis to ensure that newer, safer, and more effective drugs may be included.
- Support prescription drug coverage for all Medicare recipients.

## Strategy 4: Integrate Services for Co-Occurring Mental Health and Substance Dependence Disorders

For those suffering from co-occurring mental health and substance dependence disorders, the obstacles to appropriate care are considerable. The mental health and substance dependence treatment systems exist separately, and coordination between them is inadequate.

*Policy Recommendations*

- Encourage the detection and treatment of co-existing mental disorders and substance dependence disorders by coordinating funding streams to allow mental health and substance abuse treatment into integrated plans.
- Require that inpatient and emergency treatment for either condition involve screening of the other, as well as discharge and follow up with both conditions.
- Roll out requirements for integrated treatment of co-existing mental disorders and substance dependence disorders.
- Roll out incentives for integrated mental health, general medical, and social services systems.

## Strategy 5: Support the Mental Health Workforce

To support an increasingly diverse population, it is important to have a culturally competent and geographically well-distributed workforce. To address the needs of the underserved and uninsured populations, states should consider the distribution and diversity of practitioners, scope of practice laws, reimbursement policies, and the shape of the mental health delivery system.

*Policy Recommendations*

- Maintain flexible use of non-physician providers via "any-willing-provider" laws and expanded state practice acts that allow professionals to maximize the use of demonstrated skills and competencies.
- Require or increase reimbursement rates for mental health services provided by mental health and primary care practitioners.
- Standardize mental health quality indicators across provider types.
- Support programs for the continuing education of primary care professionals in the delivery of mental health care.

## Strategy 6: Target the Needs of Vulnerable Populations

*Ethnic Minorities*

Ethnic minorities face linguistic and cultural barriers to treatment for mental illness. These barriers include the

somatization of mental disorders, e.g., expressing mental disorders as a physical ailment, and problems finding linguistically and culturally competent providers.

*Policy Recommendations*

- Require third-party payers to adopt and implement a "Cultural Competence Report Card" that measures the extent that linguistically and culturally appropriate care is being delivered.
- Require that state and local mental health and general medical systems data is stratified by race, ethnicity, and diagnoses to detect undertreatment and underutilization.
- Require providers to meet cultural competence standards in order to participate in the Medicaid Program.

*Rural Populations*

Rural populations face issues of availability and access to mental health services. Most rural areas have fewer mental health services than urban areas. Due to the stigma associated with mental disorders, people living in rural areas may also be less likely to visit a mental health practitioner in a rural setting.

*Policy Recommendations*

- Require managed care entities to contract with primary care physicians for the provision of mental health services in rural areas.
- Support effectiveness research of alternative delivery options for rural mental health services such as the use of licensed professional counselors and pastoral counselors.
- Support additional funding to increase the number of interdisciplinary practices, internships, and residency placements currently available.
- Expand the use of telemedicine and e-health to provide continuing education for providers in rural settings.

*People with Serious Mental Disabilities*

In most cases, community-based integrated settings are recommended for persons with mental disabilities. For those with serious mental disabilities, there is an even greater need to assure coordinated health and social services. Plans and systems to integrate persons with serious mental disabilities into community-based settings require input from all key stakeholders, including people with disabilities, providers, policymakers, and community members.

*Policy Recommendations*

- Convene a task force of legislators, public and private agencies, providers, people with disabilities and community members to study the current issues surrounding the access to and utilization of community-based services and to provide recommendations.
- Include people with disabilities in the development of state plans to address integrating qualified individuals with disabilities into community-based settings.

## *Strategies To Improve Mental Health Services Across The Lifespan*

### CHILDHOOD AND ADOLESCENCE

One in 10 U.S. children suffers from some sort of mental disorder, but only 20% of them are receiving treatment.

#### Strategy 7: Enhance School-Based Health and Mental Health Services

Schools are the primary location where children or adolescents seek services. Mental health services in schools may be offered within or separate from school-based health clinics (SBHCs).

*Policy Recommendations*

- Support training initiatives for teachers to identify and respond to individuals with mental illness and to raise awareness about available mental health services.
- Maximize use of available Medicaid funds for outreach, enrollment, and preventive services.
- Support state Medicaid policy that, at a minimum, encourages managed care entities to coordinate services with SBHCs and provides incentives to contract with SBHCs.
- Examine methods and options to provide better case management and to reduce administrative inefficiencies through coordinating school-based mental health programs, school-based health programs, special education, and EPSDT services.
- Support IDEA requirements that schools provide free

and appropriate public education during a period of expulsion as a result of serious emotional disturbance.
- Advocate for federal funding to enforce IDEA mandates, including psychotherapy and family therapy, for seriously emotionally disturbed children.
- Adopt policies and programs that support seamless, integrated, comprehensive services.

### Strategy 8: Support School-Based Violence Prevention Programs

Recognizing and treating mental disorders at an early stage is critical to maintaining the health and well-being of children and communities. Schools offer a unique opportunity to reach all children in promoting violence prevention.

*Policy Recommendations*

- Use funding streams to foster interagency collaboration and service linkages for children and adolescents at the onset of mental disorder and serious emotional disturbance.
- Increase the availability of mental health services in schools and school-based health clinics.
- Develop standards and mechanisms for schools to integrate violence prevention interventions into the curriculum.
- Encourage and facilitate community and family involvement to reinforce the values and expectations of preventive efforts.

### Strategy 9: Address the Needs of Children in the Foster Care System

Compared with other children, those in foster care suffer from higher rates of serious emotional and behavioral problems, developmental delays, and overall poor mental health. In order to assure the well being of these children, it is critical to address their developmental and mental health problems.

*Policy Recommendations*

- Convene a task force of legislators, child welfare agencies, health care providers, Medicaid representatives, managed care organizations, foster parents, biological parents, and community members to study and provide recommendations on addressing the developmental and mental health needs of children in foster care.
- Develop state guidelines that outline the process and regulations for providing children in foster care with adequate general and mental health care.
- Ensure that comprehensive developmental and mental health assessments are performed during initial and routine health assessments of children in foster care.

## ADULTS

### Strategy 10: Expand Insurance Coverage for Adults with Mental Disabilities

As a result of The Ticket to Work and Work Incentive Improvement Act of 1999, states have the ability to expand coverage for workers with disabilities. The following recommendations can be administratively implemented through an amendment to a state's Medicaid plan. These expansions do not require a Medicaid waiver.

*Policy Recommendations*

- Expand Medicaid eligibility to working individuals at least 16 but less than 65 years of age who, except for their income and resource levels, are eligible to receive Social Security Income (SSI).
- Expand Medicaid coverage to employed individuals with a medically improved disability who lose Medicaid eligibility under the group described above because they no longer meet the SSI definition of disability.
- Utilize federal funds available through the Medicaid Infrastructure Grant Program to improve health care service delivery to disabled workers. Utilize the Medicaid Demonstration to Maintain Independence and Employment funds to provide early delivery of Medicaid benefits to working people with potentially severe, disabling conditions.

### Strategy 11: Address the Housing Needs of Adults with Mental Illness

For individuals with mental illness, social support is as critical as receiving medical treatment. Housing, particularly supported- and supervised-living settings, is a basic need that is often difficult to arrange.

*Policy Recommendations*

- Support independent living arrangements, supported-living settings (such as apartments and condominiums), and supervised-living arrangements (such as group homes and halfway houses) for people with mental illnesses.
- Provide incentives for neighborhoods to accept supervised-living arrangements.

### Strategy 12: Tackle the Employment Needs of Adults with Mental Disabilities

The unemployment rate for the population with mental illness was three to five times higher than for the rest of the population (Sturm et al., 1999). Due to advances in treatment and community-based rehabilitation, adults with serious mental illnesses are able to work. To help individuals reach their full potential, support is needed for specialized services designed for people with mental illnesses that enhance sustained employment.

*Policy Recommendations*

- Provide incentives for vocational rehabilitation programs to address the needs of adults with severe mental illnesses.
- Provide supported employment, transitional employment, and psychosocial rehabilitation programs for people with mental illnesses.
- Develop innovative employment programs, e.g. small business/entrepreneurship ventures supervised by mainstream businesses.

### Strategy 13: Address Issues Involving the Criminalization of Adults with Mental Illness

In addition to law enforcement efforts, reducing risk factors, such as untreated mental illness and/or substance abuse that may lead to unintentional criminal acts, is important. Particularly for those who are poor and who suffer from severe mental illness, the criminal justice system may act as a revolving door resulting in inadequate and sporadic treatment for mental disorders and substance abuse disorders.

*Policy Recommendations*

- Support applied violence risk assessment research for use in law enforcement and community settings.
- Increase the assessment and treatment of mental disorders in jails and prisons.
- Enhance referral and follow-up mechanisms from the criminal justice system to the mental health and substance abuse systems.
- Provide legal identification and documentation for individuals to ease the transition out of the criminal justice system into society and mental health and substance abuse systems.
- Use diversion programs to channel individuals with mental illness into treatment, rather than jail, to minimize the risk that they will be returned to the community without treatment.
- Ensure that people entering jails are not automatically disenrolled from Medicaid. Medicaid benefits should be immediately available to those who are eligible upon leaving the criminal justice system.

## ELDERLY

### Strategy 14: Promote Mental Health Among the Elderly

The mental health of the elderly is often secondary to their physical ailments. However, there is as great a need to address mental health as there is their physical health.

*Policy Recommendations*

- Encourage screening for depression in primary care and monitor referrals and outcomes as a quality assurance process.
- Require training in primary care clinician curriculums and continuing education for the recognition, diagnosis, and treatment of mental disorders in the elderly.

### Strategy 15: Address Deficiencies in Nursing Homes

Most primary care and nursing home settings are not equipped to manage older adults with mental illness. Major barriers persist in the delivery of appropriate care to nursing home residents with mental illness.

*Policy Recommendations*

- Provide incentives to nursing home providers and health, mental health, and human service providers to develop innovative programs, such as co-location, that increase the coordination of care and geographic access to services, and minimize costs.
- Train nursing home providers (e.g., physicians, nurses, and nurses' aides) to identify symptoms of mental disorders and to make referrals to mental health providers.
- Develop quality assurance guidelines on mental health for nursing home facilities.

Mental health is fundamental to general health and well-being. Improving access to mental health services benefits all Americans. As Kenneth Moritsugu, Deputy Surgeon General, stated, "Mental health is critical to the

overall health of the nation, and we believe it is time we adopted a new approach to mental illnesses, one that is based on caring and nurturing and not clouded by the blame and the stigmatization that has characterized our society's attitude toward this all too prevalent malady."

The following are definitions outlined in the Surgeon General's Report on Mental Health:

Mental Health – The successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.

Mental Illness – This term refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood or behavior (or some combination thereof) associated with distress and/or impaired functioning.

## *INTRODUCTION*

More than one in four U.S. adults (28%) experience a mental health or substance abuse disorder in any given year. Less than one-third of those adults with a mental disorder and less than half of those suffering from substance abuse will receive treatment (Zuvekas, 1999). More than one in five children and adolescents between the ages of 9 and 17 experience a mental or addictive disorder in any given year. Only 30% of those children and adolescents will receive treatment (Surgeon General, 1999). Although effective treatments are available, the majority of individuals with mental health or substance abuse disorders will go untreated.

**Less than one-third of adults with a mental disorder receive treatment.**

**Approximately 70% of children and adolescents in need of treatment do not receive mental health services.**

While mental health and substance abuse disorders are recognized as a leading cause of disability, inadequate resources, financial and non-financial, have been dedicated to addressing the issues of behavioral health. Compound this with general problems of access and utilization by vulnerable populations—low-income, uninsured, rural, and minority populations—and it is clear that changes in behavioral health policy and programming are urgently needed.

Barriers to quality behavioral health care are exacerbated in vulnerable populations with special needs. Ethnic minorities face both linguistic and cultural barriers to care. Rural populations face additional obstacles with the scarcity of providers in rural areas. In addition, the fear of stigmatization from close knit rural communities is often a barrier to care. Adults with mental disability and children with mental disability identified as seriously emotionally disturbed are vulnerable to shifts in public coverage. For populations that need consistent treatment, coordinated services, and continuity of care, the loss or disruption of benefits may result in severe consequences over the long term.

The direct and indirect costs of untreated mental health and substance abuse disorders to society are high. Employers and educators are faced with diminished work/learning productivity and lost days from work or school. Taxpayers are faced with the burden of cost shifting associated with charity and safety net care for both social welfare and health care related services. Families suffer from the stress and burden of caring for individuals with mental disorders that are often treatable.

In 1996, the direct cost of mental health and substance abuse treatment, including Alzheimer's and dementia, exceeded $99 billion. The indirect costs of mental illness imposed approximately a $79 billion loss on the U.S. economy in 1990, with $63 billion in morbidity costs—lost productivity due to disease; $12 billion in mortality—loss of productivity due to premature death; and almost $4 billion in the productivity losses of incarcerated individuals and the loss of productivity by caretakers of individuals with mental illness (Rice & Miller, 1998).

This report provides an overview of the barriers to access and utilization of behavioral health services. Also provided is a brief overview of financing and coordination of mental health services. Given the need to improve access to behavioral health services, particularly for vulnerable populations, broad strategies and policy recommendations are presented. In addition, strategies and

policy recommendations targeting mental health over the lifespan are included.

## The Course Of Mental Health And Substance Abuse Disorders

Recognizing the need for treatment is the first step to addressing mental health and substance abuse disorders. However, even this first step is fraught with barriers such as stigma and lack of knowledge. Often individuals who experience symptoms delay and/or reject treatment due to the stigma associated with mental disorders. It is commonplace to hear that "if one were simply stronger [willed]" or "one just needs to tough it out," mental disorders would disappear. Opportunities for effective and appropriate treatment are lost when individuals, families, friends, and colleagues do not recognize mental disorders as acceptable and treatable in the same manner as other illnesses or health problems. Thus, it is important for individuals and communities to learn that mental health and substance abuse disorders can be treated and where and how to access the services.

As with general health problems, there may be considerable obstacles to obtaining care. The primary barrier is financial—lack of insurance or financial resources is a major deterrent to receiving needed care. In 1998, more than 44 million Americans lacked health insurance. The lack of insurance coverage often results in the delay or lack of preventive or routine visits that further result in preventable emergency room visits or inpatient hospitalizations. For adults and juveniles, lack of treatment, particularly for serious mental disorders, may also result in having to deal with the social welfare or justice system. Other barriers to care include transportation or childcare issues, or lack of appropriate and acceptable providers.

Entry into the mental health system can be difficult and alienating, even for those who have private coverage. Particularly for vulnerable populations, obtaining appropriate care requires considerable skill at navigating the mental health system. For instance, determining the availability of services, e.g., locating an appropriate and available provider, can be time consuming and difficult given the lack of coordination between the general health, mental health, substance abuse, and social welfare systems. Moreover, the process of obtaining authorization for services from the insurance company can be inhibitory, requiring numerous calls and patience for the waiting time involved with telephone trees and being placed on hold.

Another significant treatment barrier is the lack of or limited coverage for prescriptions. Insurance companies often limit access to pharmaceuticals by restricting their formularies. To contain costs, managed care companies may charge higher out-of-pocket rates to patients for specific drugs, and exclude coverage for some drugs altogether. This is especially a problem for drugs used to treat mental illnesses because safer, more effective treatments are often newer and do not have generic counterparts. Lack of prescription drug coverage is costly and short sighted, particularly for those with severe mental illness, perpetuating a revolving door into emergency and inpatient services.

Upon entering the mental health system, limits on treatment visits become a constant issue. These visitation limits present dilemmas for consumers and providers alike on how to budget the visits allotted per year while addressing treatment needs. These arbitrary limits, like restrictive pharmaceutical formularies, are expensive because they raise barriers to appropriate treatment. For instance, a recent study demonstrated that smaller increments in which care is authorized, e.g. authorization for five visits instead of 10, might actually increase the number of patients who terminate treatment prematurely (Liu, Sturm, & Cuffel, 2000). For various reasons, individuals may not seek additional care and providers may not apply for re-authorization. Even if providers do seek re-authorization, there are generally limits placed on the total number of visits per year. When the provider is unable to continue services without coverage, and if the consumer is ineligible for public mental health services, consumers must pay out-of-pocket or go without services.

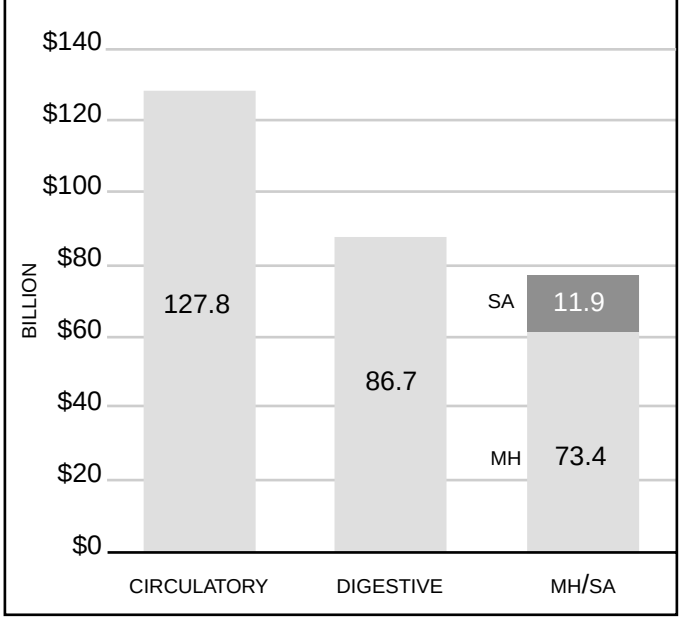
## Financing of Mental Health Services

Particularly for those with limited financial resources and those without insurance, state and local mental health programs serve as the primary "safety net." Federally funded programs such as Medicaid, the State Children's Health Insurance Program, and Medicare serve as the "catastrophic insurer" for those who have no access to

private insurance and for those who have the most severe problems. However, 16% of the U.S. adult population—primarily the working poor—continue to have no health insurance and are ineligible for public insurance coverage. With the move to managed care, growing attention is being placed on mental health; and due to charges by advocates that the current mental health system provides "inadequate care" for mental health problems of underserved communities, more and more states are examining strategies to improve their public mental health systems. There remains a clear need to improve the access to quality mental health services for uninsured and underserved communities.

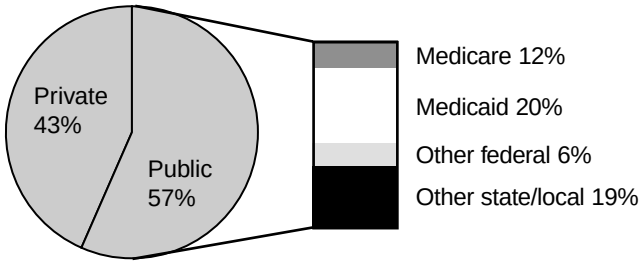
- In 1997, $85.3 billion ($73.4 for mental health, $11.9 for substance abuse) was spent on mental health and substance abuse treatment. By disease, mental health and substance abuse spending is only exceeded by spending on circulatory diseases and on digestive system diseases (Mark et al., 2000).

**Spending by Disease Category, 1997**




- In 1997, the U.S. spent more than $85 billion for the treatment of mental disorders, not including Alzheimer's disease and other dementias, and for the treatment of substance abuse. More than two-thirds, or $73 billion, was spent on mental health services and $11 billion for substance abuse services alone. In 1996, an additional $18 billion was spent on Alzheimer's disease and related dementias. Overall in 1997, mental health and substance abuse spending made up 7.8% of total personal health care and government public spending (Surgeon General, 1999, and Mark et al., 2000).
- More than half of the funding for mental health and substance abuse treatment comes from public sector payors (Mark et al., 2000).

**Mental Health and Substance Abuse Spending by Source of Payment, 1997**




- In 1997, approximately 57% ($48 billion) of funding came from public expenditures, and 43% ($37 billion) from private expenditures. Of the expenditures from public sources, federal and state/local spending was about equal (assuming that 60% of Medicaid spending was attributed to federal spending and 40% to state spending) (Mark et al., 2000).

## *Coordination of Mental Health, General Health, and Social Services*

The public mental health system, consisting of loose networks of hospitals, community behavioral health organizations, community health centers and social welfare and justice agencies, is chronically underfunded and poorly coordinated. Coordination between mental health and social welfare services is critical, especially for those with severe mental disorders. People with severe mental disorders often have social service needs, such as foster care, education, housing, and employment. Currently, the mental health system and social service systems work

together in a fragmented and inefficient manner. To best serve people with mental illnesses, providers must have the resources to coordinate mental health care with the provision of social services.

Ten to 12 million Americans have co-occurring mental health and substance abuse disorders. However, the treatment systems exist separately, coordination between them is inadequate, and providers within each system are not trained to treat both conditions. People who access services generally receive sequential treatment, one disorder, then the other, or parallel treatment, where two providers at separate locations use separate treatment plans to address each condition separately but at the same time. Although research demonstrates that the most effective services integrate treatments for each condition, federal funding streams do not promote policies that facilitate the development of such programs. In addition, people with co-occurring disorders have difficulty accessing social services such as supported living arrangements because they are designed for one disorder or the other but not co-existing conditions.

***New Mexico Community Voices*** **and its sponsor, the University of New Mexico Health Sciences Center, received a national award for its UNM Care Plan for 15,000 uninsured county residents. The UNM Care Plan features accessible neighborhood-based care and one-stop shopping, including social services, case management, community outreach, and behavioral health (Pratt, 2000).**

## *Broad Strategies to Improve Mental Health*

Strategies to address the issues with the mental health system exist both at the aggregate and functional level, as well as by lifespan. The strategies that address the broader, structural issues with the mental health system provide the context for those focused within the stages of life.

### Strategy 1: Reduce Stigma as a Barrier to Access

Stigma is the root of issues with access to the mental health system. Public perceptions of mental illness do not reflect the realities of biologically based disorders that are treated as effectively and sometimes more effectively than general medical conditions.

In a survey regarding the causes of mental illness, 71% of respondents believed that mental illness is caused by emotional weakness, 65% believed that mental illness is caused by bad parenting, 35% believed that mental illness is caused by sinful or immoral behavior, and 43% believed that mental illness is in some way caused by the individual (Hinckley, 1999). Stigma perpetuated by popular culture and sensationalism in the press has disastrous consequences. Just as social attitudes against cancer patients have changed over the last fifty years, the stigma against mental illness must change.

Stigma perpetuates the inability of individuals to recognize the need for treatment in themselves and the inability of friends and family to recognize that need. Vulnerable individuals heavily rely on the competence of community-based professionals. Educational efforts to increase awareness of the problem by providers in the specialized medical services sector, primary care sector, and social services are critical to support individuals in obtaining and maintaining mental health treatment.

Individuals working in the community play a vital role in detecting and facilitating treatment of mental disorders. Community-based points of entry into the current system include the primary care sector, churches and other faith-based organizations, school-based health centers, the juvenile justice system, social welfare agencies, job assistance programs, community mental health centers, community-based health clinics, and the adult criminal justice system.

Community health and social service professionals, including educators and police officers, are on the front lines. They may be the first to recognize illness among community members, may offer treatment directly through counseling, or assist individuals by making referrals to mental health providers. Increasing training and awareness of mental health issues and destigmatizing mental illness among community-based professionals is a key to early detection, treatment, and the prevention and early treatment of relapses.

*Policy Recommendations*

- Integrate stigma awareness training into the education

curriculum and continuing education requirements of health care providers.
- Require dissemination of stigma awareness literature for consumers and providers in the Medicaid contracting process.
- Increase awareness at community-based points of entry through professional associations, institutions, and employers.
- Train culturally competent and culturally diverse health and social service providers.

## Strategy 2: Eliminate Financial Barriers to Access

Mechanisms to address financial barriers to access include parity legislation and oversight of managed care and managed behavioral health care organizations. Oversight of state-level public mental health systems by state mental health departments should work hand in hand with oversight of private insurers through insurance commissioners with the common goals of access and appropriate treatment. Public and private systems must be held accountable to address the need for continuity of care and coordination of services.

### *Mental Health Parity*

In accordance with the idea that "mental health is fundamental to health," there has been a push to assure adequate coverage for mental health services. In response, at the federal level, the Mental Health Parity Act of 1996 imposed new federal standards on mental health coverage offered under most employer-sponsored group health plans. Specifically, the law prohibits employers from imposing annual or lifetime dollar limits on mental health coverage that are more restrictive than those imposed on medical and surgical coverage. However, the law does not affect employers who do not offer mental health coverage and employers are also exempt if the law would result in excessive costs to them.

Thus, it remains to be seen whether access to mental services will be truly improved as a result of the new law. Current research (Pacula & Sturm, 2000; General Accounting Office [GAO], 2000) suggests that because of its narrow scope and reductions in mental health benefits that employers have made to offset the required enhancements, compliance with the Mental Health Parity Act may have little effect on employees' access to mental health services.

A GAO report (2000) showed that:
- 87 percent of those that comply contain at least one other plan design feature that is more restrictive for mental health benefits than for medical and surgical benefits;
- About 65 percent of plans restrict the number of covered outpatient office visits and hospital days for mental health treatment beyond those for other health treatment; and
- Many employers may have adopted newly restrictive mental health benefit design features since 1996 specifically to offset the more generous dollar limits they adopted as a result of the federal law.

The states have also made efforts to improve access by passing state mental health parity acts or laws that address mental health coverage in employer-sponsored group plans or individual plans. As of March 1, 2000, 32 states have some form of mental health parity.

Mental health parity acts fall within the scope of a broader set of laws that address mental health coverage. A review by the National Conference of State Legislatures (NCSL) found that 43 states and the District of Columbia have passed laws addressing mental health coverage in employer-sponsored group plans and, to a lesser extent, coverage sold in the individual market (GAO, 2000).

There is considerable variation in mental health parity acts and mental health coverage laws. According to NCSL, more than half, or 29, of the state laws affecting group plans are more comprehensive than the federal law in that they require parity not only in dollar limits but also in service limits or cost-sharing provisions. In addition, many of these also mandate that mental health benefits be included in all plans sold. Laws in 6 states essentially parallel the federal law. Laws in 8 states and the District of Columbia are more limited than the federal law, while 7 states have no laws addressing mental health benefits. Unlike the federal law, most states, or 41, and the District of Columbia either explicitly include substance abuse within the scope of their mental health benefit laws or have separate statutes addressing substance abuse coverage. However, only 13 of these state laws cover only alcoholism (GAO, 2000).

*Policy Recommendations*

- Expand the federal mental health parity act by requiring that all limitations on the coverage for mental illnesses be equal to those for medical and surgical benefits. This provision would prohibit an insurance plan's ability to impose arbitrary caps on spending limits, inpatient days and outpatient visits, and co-payments and other deductibles.
- Advocate for state legislation that achieves full and comprehensive parity that includes protections for treatment for alcohol and substance abuse. These provisions would require public and private health insurance plans to provide treatment for mental illness and substance abuse commensurate with that provided for other major physical illnesses and would require health plans to offer access to all effective and medically necessary medications.

*Oversight of Managed Care and Managed Behavioral Health Care*

In 1999, managed behavioral health plans covered 78% of the population, or 177 million people (Surgeon General, 1999). In the public sector, 42 states have managed behavioral health care programs funded primarily through Medicaid (SAMHSA, 2000).

Public sector managed behavioral health programs are either integrated with general health services or "carved out," meaning that mental health services are provided through a specialty organization independent from general medical services. The mental health services provided vary by program design. Integrated programs generally provide traditional care such as inpatient, outpatient, and pharmacy services. Carve-outs are more likely to provide specialized benefits, including residential, rehabilitation, and support services. Increasingly, states are adopting the carve-out model as a result of the chronic nature of mental illness and in an effort to control costs.

By 1999, 41 states and the District of Columbia adopted some form of managed behavioral health care. States that operate Medicaid managed care programs have done so through 1915(b) waivers (20 states), 1115 waivers (16 states), and non-waiver Medicaid programs (14 states). Twelve states have non-Medicaid managed care programs (SAMHSA, 2000).

Whether a state chooses to adopt or not adopt some form of managed behavioral health care, mental health services are guaranteed to children participating in Medicaid, through Early Periodic Screening Diagnosis and Treatment (EPSDT). EPSDT was the result of legislation enacted in 1989 providing a broad mandate for children. EPSDT requires states to provide any medically necessary, federally recognized Medicaid service, regardless of whether the state covers the service under its state plan. Despite EPSDT and managed care, it is clear that children are still not getting the care they need.

Although managed care has been widely adopted in both the public and private sector, there is no one correct approach in the design or implementation of managed care programs. There has been tremendous variation in managed care approaches among the states to address capitation and risk sharing, case management, and utilization review (McAlpine & Mechanic, 1998). States' experience with managed behavioral health care has been mixed. Positive aspects of managed care include an expanded array of services, less use of inappropriate inpatient care, more goal-directed treatment, and increased emphasis on accountability and outcomes while containing costs. Problems noted by state and local officials include the lack of incentives to serve people with serious mental disorders, an undue emphasis on emergency and acute care, neglect of rehabilitation and other services with longer-term payoff, cost shifting between state agencies, billing and payment difficulties, discrepancies between regions, inequities between services for Medicaid and non-Medicaid populations, and the lack of reporting and accountability (Bazelon & Milbank, 2000).

Managed behavioral health care continues to evolve. It will be necessary to continue to research and analyze how states can best shape their managed care system to satisfy the needs of consumers, providers, advocates and policymakers. Managed care can be a useful tool in providing quality care in a cost-effective manner. Efforts to involve all stakeholders in the planning and reform of managed care systems supports the likelihood of a successful program.

*Policy Recommendations*

- Require fair internal and external appeals processes.
- Adopt regulations and standards to ensure compliance with Medicaid EPSDT requirements.
- Require routine data and performance reports in

managed care contracts to hold systems accountable.
- Provide incentives for managed care contractors who are responsible for targeted case management to facilitate linkages and the coordination of care between the mental health, general medical, and social service systems.

## Strategy 3: Address Prescription Drug Coverage Issues

The lack of or limited coverage for prescriptions is a significant treatment barrier. For individuals with insurance coverage, access to pharmaceuticals is often restricted by formularies that carry limited name brand pharmaceuticals and generic drugs. For individuals with mental disorders, this is especially problematic because safer, more effective treatments are often newer and do not have less expensive generic counterparts. So even with health insurance and prescription drug coverage, individuals can still have no coverage for the drug that their doctors find most appropriate. Uninsured individuals must pay out-of-pocket and do not receive any discount for their prescriptions.

For the low-income population with coverage, access to the appropriate drugs may be further limited due to cost-sharing measures, e.g., co-payments for drugs. The issue of prescription drug coverage particularly affects the elderly without Medigap coverage, the uninsured, and consumers whose plans have very limited drug formularies.

*Policy Recommendations*

- Require pharmaceutical companies to base the direct-to-consumer cost of prescription drugs on an average of the costs negotiated with insurance companies.
- Require prescription drug coverage in plans regulated by state insurance commissioners.
- Require insurance companies to review and revise their formularies on a routine basis to ensure that newer, safer, and more effective drugs may be included.
- Support prescription drug coverage for all Medicare recipients.

***Washington D.C. Community Voices* is working with Unity Health Care and Catholic Charities to develop a pharmacy program for the District's uninsured residents. The project will include a Perscription Drug Resource Center and centralized distribution center (Pratt, 2000).**

## Strategy 4: Integrate Services for Co-Occurring Mental Health and Substance Dependence Disorders

Studies indicate that people with mental disorders are at least twice as likely to abuse alcohol and other drugs as people with no mental disorder. Ten to 12 million Americans have co-occurring mental health and substance dependence disorders. Fifty-two percent of individuals who have abused or become dependent on alcohol within their lifetime have also had a mental disorder in their lifetime. Thirty-six percent also had a lifetime non-alcohol drug use disorder. Of those with a lifetime history of drug abuse or dependence, 59% had a lifetime mental disorder. Seventy-one percent also had a lifetime alcohol use disorder.

The mental health and substance dependence treatment systems exist separately, coordination between them is inadequate, and providers within each system are not trained to treat both conditions. Although research demonstrates that the most effective services integrate treatments for each condition, funding streams do not promote policies that facilitate the development of such programs.

Furthermore, states have various limitations on payment by service, and policies that support the most effective integrated services are virtually non-existent. In addition, federal matching funds are not available to states through the Institutions for Mental Diseases (IMD) exclusion and "room and board" exceptions of Title XIX, the Medicaid statute. Under these broad exclusions, no federal matching funds are available for services provided either in or outside the facility for IMD patients between 21 and 65.

The effectiveness of the mental health and substance abuse treatment settings relies on systems' abilities to address the disorders as they co-exist and facilitate points of entry as well as the continuity of care. The systems should enable individuals with both conditions who need services for each to access them efficiently.

States setting the standards for integrated treatment for co-occurring mental and substance dependence disorders should also include long-term objectives that address social service needs in one place. People with these conditions are more likely to need housing and employment services, and are at risk for falling through the cracks of the social services systems.

*Policy Recommendations*

- Encourage the detection and treatment of co-existing mental disorders and substance dependence disorders by coordinating funding streams to allow mental health and substance abuse treatment into integrated plans.
- Require that inpatient and emergency treatment for either condition involve screening of the other, as well as discharge and follow up with both conditions.
- Require integrated treatment of co-existing mental disorders and substance dependence disorders.
- Provide incentives for the integration of mental health, general medical, and social services systems.

## Strategy 5: Support the Mental Health Workforce

The mental health workforce is a diverse group of professionals trained in the fields of medicine, psychiatry, clinical psychology, education and counseling, and clinical social work. Providers include physicians, nurse practitioners, social workers, and counselors.

It is difficult to estimate the number of practitioners providing mental health services, though it is clear that the number of providers is small. One indication is that only 3 to 4 percent of graduating medical students choose psychiatry as their specialty (Sierles & Taylor, 1995). Although the number of medical graduates choosing psychiatry is falling, there has been an increase in the non-physician workforce. The impact of this trend is an increase in the numbers of minorities and female health non-physician providers (Ivey et al., 1998). While this may be viewed as positive, it is important to ensure the availability of highly trained professionals for more complex cases. In addition, as the population becomes more culturally diverse, it is also critical that this diversity is reflected in the physician workforce.

**Estimates of population ratios for clinically trained personnel (per 100,000)**

**Psychiatrists 12.5***
**Psychologists 26.7****
**Clinical Social Workers 36.0****

***1995 **1996**
**Source: Ivey et al., 1998**

Estimates of the provider-to-population ratio mask the regional variation in the availability of providers. For instance, the 1996 ratio of psychiatrists in New England was 21.3 per 100,000, compared to 6.8 per 100,000 in the East South Central region—Alabama, Kentucky, Mississippi, and Tennessee. The ratio of clinically trained social workers in New England was 76.4 per 100,000 to 17.6 per 100,000 in the East South Central region (Ivey et al., 1998).

To address the needs of the underserved and uninsured populations, states should consider the distribution and diversity of practitioners, scope of practice laws, reimbursement policies, and the structure of the mental health delivery system, e.g. managed care penetration. More flexible practice acts and reimbursement policies will encourage a more even distribution of providers and will allow states to offer better incentives to attract providers to underserved communities.

*Policy Recommendations*

- Maintain flexible use of non-physician providers via "any-willing-provider" laws and expanded state practice acts that allow professionals to maximize the use of demonstrated skills and competencies.
- Require or increase reimbursement rates for mental health services provided by mental health and primary care practitioners.
- Standardize mental health quality indicators across provider types.
- Support programs for the continuing education of primary care professionals in the delivery of mental health care.

## Strategy 6: Target the Needs of Vulnerable Populations

Vulnerable populations include ethnic minorities, those with mental illness in rural areas, and individuals with mental disability. These people are especially susceptible to disparate treatment.

*Racial and Ethnic Minorities*

Racial and ethnic disparities in health status and access to health care have been well documented (Brown et al., 2000; Satcher, 2000). Racial and ethnic minorities bear a disproportionate amount of overall mortality and morbidity and experience reduced access to care. A major barrier to care is the lack of health insurance. Minorities are much more likely than non-Latino Whites to be uninsured. Latinos (37%), African Americans (23%), Asian Pacific Islanders (21%), and Native Americans (17%) are all more likely to be uninsured than non-Latino Whites

(14%) (Current Population Survey, March 1998).

Racial and ethnic minorities face additional linguistic and cultural barriers in accessing mental health treatment. Cultural identity imparts distinct patterns of beliefs and practices that have implications for the recognition of symptoms, and the ability to seek and respond to mental health services. Minorities are more likely to seek treatment for a general medical condition that in actuality is a mental illness. Communication is a key issue with the general lack of interpreters in provider settings, and the lack of cultural competence and sensitivity.

*Policy Recommendations*

- Require third-party payers to adopt and implement a "Cultural Competence Report Card" that measures the extent that linguistically and culturally appropriate care is being delivered.
- Require that state and local mental health and general medical systems data be stratified by race, ethnicity, and diagnoses to detect undertreatment and underutilization.
- Require providers to meet cultural competence standards in order to participate in the Medicaid program.

***North Carolina Community Voices*** **and its sponsor, FirstHealth, provide training to health providers about Latino culture, give a one-day Spanish class to their employees and other providers, and conduct workshops in the Latino community about navigating the health and social service system. They employ a bilingual patient representative in a hospital emergency department and operate a Telephone Language Line that provides interpreters for multiple languages (Pratt, 2000).**

*Rural Populations*

Rural populations face issues of availability and access to mental health services. Most rural areas have fewer mental health services than urban areas. In 1990, 20.5% of rural counties had no mental health services. Researchers associate the lower availability of services with decreased access. While in some counties family practice physicians are available to provide mental health services, many rural areas exist with no mental health providers to provide mental health services.

Less than 20% of Americans live in non-metropolitan areas (U.S. Bureau of the Census, 1998). Since the early 1980s, such stressors as the farm crisis; the out migration of population, industry, and resources from rural areas; rising unemployment and poverty; and a shrinking tax base have contributed to the increased numbers of rural Americans "at risk" for mental health and substance abuse problems (Ortega et al., 1994).

**Across the 3,075 counties in the United States, 55% have *no* practicing psychiatrists, psychologists, and social workers, and *all* of these counties are rural (National Advisory Committee on Rural Health, 1993).**

Compared to their urban counterparts, rural areas have more serious shortages of appropriately trained professionals, service delivery alternatives are fewer, the array of support services is extremely limited, and the opportunities to acquire affordable health insurance that includes mental health and substance abuse benefits are limited. Additional barriers to accessing services also exist, such as increased costs associated with transportation and communication in sparsely populated areas and the perceived stigma surrounding the treatment of mental health disorders among some subgroups.

*Policy Recommendations*

- Require managed care entities to contract with primary care physicians for the provision of mental health services in rural areas.
- Support effectiveness research of alternative delivery options for rural mental health services, such as the use of licensed professional counselors and pastoral counselors.
- Support additional funding to increase the number of interdisciplinary practices, internships, and residency placements currently available.
- Expand the use of telemedicine and e-health to provide continuing education for providers in rural settings.

*People with Serious Mental Disabilities*

Psychiatric claims filed with the Equal Employment Opportunity Commission (EEOC) doubled from 1993 to 1998, to 2,917 a year, making them the single largest type of American Disability Act (ADA) claim, constituting 16.4% of all ADA discrimination cases. The courts have

applied strict definitions to ADA language when making decisions regarding workplace accommodations involving mental illness, finding that conditions that are correctable, such as depression correctable with medication, are not disabilities. In 1997, the EEOC issued enforcement guidelines for psychiatric disabilities, giving specific examples of who is covered and what accommodations might be reasonable.

The U.S. Supreme Court's application of the ADA to its decision in Olmstead provides an opportunity for states, communities, and advocates to create better access to community-based services for disabled individuals. The Olmstead decision requires States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities" within the state's budget constraints (HCFA, 2000).

With the continuing trend toward community-based services, policy makers and decision makers need to work with providers, consumers, and other community members to ensure that an adequate and reliable community-based service plan is developed and implemented. There is considerable variation in how states have chosen to address these issues and to what extent deinstitutionalization has occurred.

*Policy Recommendations*

- Convene a task force of legislators, public and private agencies, providers, people with disabilities, and community members to study the current issues surrounding the access to and utilization of community-based services and to provide recommendations.
- Include people with disabilities in the development of state plans to address integrating qualified individuals with disabilities into community-based settings.

## *Strategies to Improve Mental Health Services Across the Lifespan*

Mental illness manifests within the different stages of life, and targeted treatment approaches and service delivery systems have to be developed to address specific needs. As the Surgeon General's report states, "Different stages of life are associated with vulnerability to distinct forms of mental and behavioral disorders."

### CHILDHOOD AND ADOLESCENCE

Children and adolescents who receive treatment for mental health are likely to receive services through school-based health and mental health centers. Schools are a key component of the child and adolescent mental health services system. More than half of children and youth receiving mental health services in a year receive them exclusively from schools.

For children and youth with serious emotional disturbance needing intensive services, families face the issue of exhausting their insurance coverage and draining financial resources. If the family's income is too high for Medicaid eligibility, families face the decision of retaining custody or relinquishing it to the state child welfare agency so that their child will receive treatment.

The relationship between mental illness and juvenile delinquency illustrates the need for better preventive interventions and the coordination of care between the education, mental health, and juvenile justice systems. In a 1994 study conducted by the Office of Juvenile Justice and Delinquency Prevention, 73% of juveniles reported having mental health problems and 57% reported having prior mental health treatment or hospitalization upon admission to juvenile facilities.

Estimates indicate that 20% of individuals in juvenile facilities have a severe mental disorder and 50% have a substance dependence disorder. While interventions exist to minimize and prevent violence in at-risk youth, implementation of these interventions often requires creative use of traditional funding streams and interagency partnerships with shared objectives.

### Strategy 7: Enhance School-Based Health and Mental Health Services

Schools are the primary location where children or adolescents seek services. Eighteen percent of children ages 9 to 17 receive mental health services through school (Surgeon General, 1999). Between 1996 and 1997, more than 400,000 emotionally disturbed children and youth between the ages of 6 and 21 were served in public schools (U.S. Dept. of Education, 1997). Mental health services in schools may be offered within or separate from school-based health clinics (SBHCs). Schools without SBHCs may offer services through arrangements from community providers or may arrange with outpatient facilities to provide care. In addition, schools may hire

psychologists or social workers to provide mental health services to students in special education through the Individuals with Disabilities Education Act (IDEA).

School-based health clinics are often first-line providers of health and mental health services to adolescents and children. All but five states currently have at least one SBHC. There are more than 1,000 SBHCs nationwide, distributed mostly in urban areas, though there are increasing numbers being developed in rural areas. Services offered at SBHCs include an array of primary medical care, oral health, public health, and mental health services. Mental health services offered generally include comprehensive individual evaluation, case management, individual and group therapy, crisis intervention, and basic drug and alcohol prevention and treatment services.

Funding for school-based mental health programs is a mix of funding sources with heavy reliance on state general funds, private foundations, and federal grants. Increasingly there is an emphasis on funding school-based mental health services through third-party insurance reimbursement. Most states, 43, permit SBHCs to bill Medicaid and SCHIP, though three states—Arizona, Hawaii, and Oklahoma—explicitly do not. (Note, North Carolina does not allow SBHCs to bill SCHIP.) Twenty-eight percent of SBHCs have formed relationships with managed care entities.

*Policy Recommendations*

- Support training initiatives for teachers to identify and respond to individuals with mental illness, and to raise awareness about available mental health services.
- Maximize use of available Medicaid funds for outreach, enrollment, and preventive services.
- Support state Medicaid policy that, at a minimum, encourages managed care entities to coordinate services with SBHCs and provides incentives to contract with SBHCs.
- Examine methods and options to provide better case management and to reduce administrative inefficiencies through coordinating school-based mental health programs, school-based health programs, special education, and EPSDT services.
- Support IDEA requirements that schools provide free and appropriate public education during a period of expulsion as a result of serious emotional disturbance.
- Advocate for federal funding to enforce IDEA mandates, including psychotherapy and family therapy, for seriously emotionally disturbed children.
- Adopt policies and programs that support seamless, integrated, comprehensive services.

## Strategy 8: Support School-Based Violence Prevention Programs

Children with behavior disorders such as oppositional defiant disorder, conduct disorder, and attention deficit hyperactivity disorder are the most likely to be perpetrators or victims of violence. Forty percent of children between 8 and 12 diagnosed with conduct disorder still have the diagnosis four years later. Many of the most costly adult mental health problems and social issues—such as substance abuse, delinquency, and antisocial personality disorder—originate with conduct issues.

**50 - 70% of incarcerated young offenders are estimated to have diagnosable mental disorder**

**15 - 20% of incarcerated young offenders suffer from severe mental illness such as manic depression or schizophrenia**

**Source: Coalition for Juvenile Justice, 2000**

Since developmental risk factors are not disorder specific, researchers recommend the use of universal prevention programs targeting school-aged children. Such interventions promote social and emotional competencies through emotional skill building, i.e., teaching students to identify, understand, and self-regulate their emotions. The 1997 Department of Justice study, *Preventing Crime: What Works, What Doesn't, What's Promising*, made the following recommendations for school-based violence prevention interventions:

- Communication and reinforcement of clear, consistent norms about behavior through rules, reinforcement of positive behavior, and school-wide initiatives are needed.
- Social Competency Curricula when taught over a long period of time reduces delinquency, substance abuse, and conduct problems, and should include skills such as stress management, problem solving, self-control, and emotional intelligence.

*Policy Recommendations*

- Use funding streams to foster interagency collaboration and service linkages for children and adolescents at the onset of mental disorder and serious emotional disturbance.

- Increase the availability of mental health services in schools and school-based health clinics.
- Develop standards and mechanisms for schools to integrate violence prevention interventions into the curriculum.
- Encourage and facilitate community and family involvement to reinforce the values and expectations of preventive efforts.

Approximately 33 million U.S. adults, or 13% of the adult population, do not have health insurance. The majority of the uninsured are people in the workforce who are not offered work-based insurance coverage or cannot afford their share of the premiums. Uninsured individuals who are not in the workforce often are ineligible for publicly funded insurance coverage and cannot afford private insurance coverage. The lack of health insurance is a major barrier to mental health, as well as general health services.

Critical issues related to adult mental health include housing, employment, and other social support. Particularly for adults with severe or persistent mental disorders, the coordination and organization of health and social services are critical. This is particularly true with the delivery of community-based services.

### Strategy 9: Address the Needs of Children in the Foster Care System

In 1998, nearly 1.4 million children received preventive services due to child abuse or neglect (National Child Abuse and Neglect Reporting System). Children at the highest risk are placed in foster care for their protection. By 1999, an estimated 568,000 children were in foster care (ACF, October 2000). These children often suffer from chronic health, developmental, and psychiatric disorders that are accentuated by the trauma of being separated from their families (Perrin et al., 2000). Researchers have consistently found a high prevalence of mental health disorders—ranging from 29% to 96%—in this population. In one study, approximately 70% of children were found to have moderate to severe mental health problems (Kaveler & Swire, 1983).

Despite the high prevalence of mental disorders among these children, many children do not receive proper treatment or care. The lack of appropriate mental health services for these children is often a result of inadequate funding, planning, and coordination of services in addition to poor communication between the health and child welfare systems (AAP, 1994). Coordination is essential to ensuring that a child's mental health needs are met once a child enters the child welfare system, during foster care placement, and after leaving the child welfare system.

To achieve the national child welfare goals of safety, permanency, and well-being, federal and state efforts should address the mental and psychosocial needs of children and their families. Establishing cohesive systems of mental health support for children and their families is important to addressing and preventing problems that result in children being placed in foster care.

*Policy Recommendations*

- Convene a task force of legislators, child welfare agencies, health care providers, Medicaid representatives, managed care organizations, foster parents, biological parents, and community members to study and provide recommendations on addressing the developmental and mental health needs of children in foster care.
- Develop state guidelines that outline the process and regulations for providing children in foster care with adequate general and mental health care.
- Ensure that comprehensive developmental and mental health assessments are performed during initial and routine health assessments of children in foster care.

**Foster care children were 10 times more likely to use mental health services than other Medicaid children.**

**While foster care children only constituted 4% of California children on Medicaid, they accounted for 40% of all Medicaid mental health expenditures.**

**Source: Halfon et al., 1992**

## ADULTS

### Strategy 10: Expand Insurance Coverage for Adults with Mental Disabilities

The Ticket to Work and Work Incentive Improvement Act of 1999 (TWWIIA) makes it possible for Americans with disabilities to join the workforce without fear of losing their Medicare and Medicaid coverage. TWWIIA establishes new optional eligibility groups by creating two

new eligibility categories, extends the period of premium-free Medicare Part A eligibility, and requires consumer protection for certain individuals with Medigap coverage. The two new categories are: 1) individuals with a disability between the ages of 16 and 64 whose income and resources do not exceed a standard established by the state, and 2) employed individuals between the ages of 16 and 64 with a medically improved disability whose income and resources do not exceed a standard established by the state.

Importantly, as a result of TWWIIA, states have the ability to expand coverage for workers with disabilities. The following recommendations can be administratively implemented through an amendment to a state's Medicaid plan. These expansions do not require a Medicaid waiver.

*Policy Recommendations*

- Expand Medicaid eligibility to working individuals at least 16 but less than 65 years of age who, except for their income and resource levels, are eligible to receive Social Security Income (SSI).
- Expand Medicaid coverage to employed individuals with a medically improved disability who lose Medicaid eligibility under the group described above because they no longer meet the SSI definition of disability.
- Utilize Federal funds available through the Medicaid Infrastructure Grant Program to improve health care service delivery to disabled workers. Utilize the Medicaid Demonstration to Maintain Independence and Employment funds to provide early delivery of Medicaid benefits to working people with potentially severe, disabling conditions.

## Strategy 11: Address the Housing Needs of Adults with Mental Illness

About one-third of homeless people have a severe and disabling mental illness: 30-40% have alcohol problems, 10-20% have other drug problems, and 10-20% have dual diagnosis. With the move toward community-based care instead of institutionalized care, the individuals with severe mental illness are more likely to be homeless.

As Robert Drake and Kim Mueser of the New Hampshire-Dartmouth Psychiatric Research Center recently observed: "Patients with dual diagnoses of severe mental illness and AUD [alcohol use disorder] are particularly prone to unstable housing arrangements and homelessness...One reason for this increased risk appears to be that dually diagnosed clients often are excluded from housing and treatment programs designated specifically for people with single disorders." Compared with other homeless subgroups, those with co-occurring severe mental illness and AUD are more likely to experience harsh living conditions, such as living on the streets rather than in shelters; suffer from psychological distress and demoralization; grant sexual favors for food and money; be picked up by the police; become incarcerated; be isolated from their families; and be victimized.

*Policy Recommendations*

- Support independent living arrangements, supported-living settings (such as apartments and condominiums), and supervised-living arrangements (such as group homes and halfway houses) for people with mental illnesses.
- Provide incentives for neighborhoods to accept supervised-living arrangements.

## Strategy 12: Tackle the Employment Needs of Adults with Mental Disabilities

The unemployment rate for the population with mental illness was three to five times higher than for the rest of the population (Sturm et al., 1999). Due to advances in treatment and community-based rehabilitation, adults with serious mental illnesses are able to work. However, the unemployment rate remains high despite federal vocational rehabilitation services. These programs are designed for individuals with less serious disabilities and generally do not address the needs of individuals with serious mental illness, who commonly require more intensive services over longer periods of time to obtain and maintain employment.

Specialized services designed for people with mental illnesses that enhance sustained employment include supported employment, transitional employment, and psychosocial rehabilitation.

*Policy Recommendations*

- Provide incentives for vocational rehabilitation programs to address the needs of adults with severe mental illnesses.
- Provide supported employment, transitional employment, and psychosocial rehabilitation programs for people with mental illnesses.

- Develop innovative employment programs, e.g., small business/entrepreneurship ventures supervised by mainstream businesses.

### Strategy 13: Address Issues Involving the Criminalization of Adults with Mental Illness

Approximately 670,000 people with mental illnesses ended up in jail in 1996. At any given moment, 10% to 30% of jail and prison inmates are individuals with serious mental illnesses. Once they are there, these individuals are less likely to receive treatment. Furthermore, when they are released, the criminal justice system does not provide adequate linkages to treatment.

To address violence in incarcerated individuals with mental illness, the ongoing development of mental health services in the institutions and treatment as a condition of release and discharge planning are critical. Furthermore, mental health and substance abuse providers for this population need the resources to coordinate with the criminal justice system and need to partner in facilitating services.

*Policy Recommendations*

- Support applied violence risk assessment research for use in law enforcement and community settings.
- Increase the assessment and treatment of mental disorders in jails and prisons.
- Enhance referral and follow-up mechanisms from the criminal justice system to the mental health and substance abuse systems.
- Provide legal identification and documentation for individuals to ease the transition out of the criminal justice system into society and mental health and substance abuse systems.
- Use diversion programs to channel individuals with mental illness into treatment, rather than jail, to minimize the risk that they will be returned to the community without treatment.
- Ensure that people entering jails are not automatically disenrolled from Medicaid. Medicaid benefits should be immediately available to those who are eligible upon leaving the criminal justice system.

## ELDERLY

Mental health services for the elderly are provided in a range of settings. Both the primary care and nursing homes settings, however, demand special attention. While suicide rates are highest among American males aged 65 and older, elderly adult victims are likely to have visited a health care professional shortly before their suicide. Clinicians, ranging from physicians to social workers, need the training and resources to recognize, diagnose, and treat or refer elderly consumers vulnerable to mental disorder who seek assistance for general medical conditions.

**The number of California seniors with depression is expected to grow from 67,000 to 1.2 million by 2025.**

**Source: Sacramento Bee, 12/6/00**

Of the older adults living in nursing homes, two-thirds have a mental disorder. However, due to historical funding streams, the facilities have not been equipped to manage the older adults with mental illness. The inappropriate use of chemical and physical restraints in nursing homes has emerged as an issue attributable to the lack of resources.

### Strategy 14: Promote Mental Health Among the Elderly

Although the American population 65 and over makes up 13 percent of the population, they account for 20% of suicide deaths. Nearly 5 million of the 32 million Americans aged 65 and older suffer from some form of depression. Primary care practitioners are a critical link in identifying and addressing mental disorders in older adults, particularly depression. When mental disorders are not recognized in primary care and treated or referred to specialty mental health services, the opportunity to improve both general medical and mental health outcomes is lost. This under-recognition and under-treatment is fatal: 70% of elderly suicide victims visited their primary care physician in the month prior to committing suicide.

*Policy Recommendations*

- Encourage screening for depression in primary care and monitor referrals and outcomes as a quality assurance process.

- Require training in primary care clinician curriculums and continuing education for the recognition, diagnosis, and treatment of mental disorders in the elderly.

### Strategy 15: Address Deficiencies in Nursing Homes

Of the older adults living in nursing homes, two-thirds have a mental disorder. However, Medicaid policies have discouraged nursing homes from providing specialized mental health services, and Medicaid reimbursements for nursing home patients have been too low to provide a strong incentive for participation by highly trained mental health providers. The emphasis on community-based care, combined with inadequate nursing home reimbursement policies, has limited the development of innovative mental health services in nursing homes. Major barriers persist in the delivery of appropriate care to nursing home residents with mental illness. The facilities have not been equipped to manage the older adults with mental illness.

*Policy Recommendations*

- Provide incentives to nursing home providers and health, mental health, and human service providers to develop innovative programs, such as co-location, that increase the coordination of care and geographic access to services, and minimize costs.
- Train nursing home providers (e.g., physicians, nurses, and nurses aides) to identify symptoms of mental disorders and to make referrals to mental health providers.
- Develop quality assurance guidelines on mental health for nursing home facilities.

## *CONCLUSION*

Mental health is fundamental to health. Good mental health is critical to ensuring the well-being and full productivity of every American. Biological and scientific advances have made it possible to treat many mental disorders. With proper treatment and care, many individuals who suffer from mental health or substance abuse disorders can lead productive lives, have successful relationships with other people, and can cope and adapt to change and adversity.

Yet we have a long way to go in assuring good mental health for all. Vulnerable populations, in particular, face significant barriers to care. These barriers are financial and non-financial. The lack of insurance coverage or ability to finance care is a major barrier to the uninsured, working poor, and those living in poverty. Yet there are other significant non-financial barriers, including the stigmatization of mental health, the lack of knowledge regarding mental health and existing treatment, and the lack of geographically accessible or culturally competent providers.

This report presented a series of strategies and policy recommendations to improve access to mental health care. Broad strategies to improve mental health care, as well as strategies across the lifespan are presented. Included are recommendations that are geared toward expanding coverage for mental health and substance abuse services, integrating mental health with primary care, and targeting specific barriers of vulnerable populations, i.e., poor, low-income, minority and rural populations.

In many cases, these strategies require new funds. Yet it is clear that ignoring mental health problems is costly to individuals and to society. Many of these recommendations require the acknowledgement of mental health and a system of accountability toward insuring quality mental health services. Mental health impacts more than biological health; it is a component to social functioning and productivity. As such, the impact of mental health on education, employment, and well-being cannot be ignored.

This report by no means presents all the strategies or solutions to improving access to mental health. This report does, however, suggest that a multi-pronged approach will be necessary to ensure the mental health of all Americans. Improving access to mental health services will enhance the health and well-being of individuals and our society.

## *REFERENCES*


Alliance for Health Reform. (2000, June). *Mental health: A new century, a new era.* Washington DC: Author.

American Academy of Pediatrics. (1994). Health care of children in foster care. *Pediatrics, 93,* 335-338.

American Association of Homes and Services for the Aging & The Milbank Memorial Fund. (1997). *Linking housing and health services for older persons.* New York: Author.

Bazelon Center for Mental Health Law et al. (2000). *A factual and statistical review of mental health policy and a questionnaire for candidates for public office in 2000.* Washington DC: Author.

Bazelon Center for Mental Health Law et al. (2000). *Policymakers' fact sheet on the mental health system.* Washington DC: Author.

Bazelon Center for Mental Health Law & The Milbank Memorial Fund. (2000). *Effective public management of mental health care: Views from states on Medicaid reforms that enhance service integration and accountability*. New York: Author.

Brown, E.B., Ojeda, V.D., Wyn, R., & Levan, R. (2000). *Racial and ethnic disparities in access to health insurance and health care.* Washington, DC: Kaiser Family Foundation.

Burnam, M.A., & Escarce, J.J. (1999). Equity in managed care for mental disorders. *Health Aff (Millwood), 18(5),* 22-31.

Center for Mental Health Services. (1998). *Mental health: 1998.* Rockville, MD: U.S. Department of Health and Human Services.

Center for Mental Health Services. (1999). *A preview of the new CMHS school violence prevention program: Enhancing resilience.* Available online at http://www.medscout.com/mental_health.

Foote, S.M., & Etheredge, L. (2000). Increasing use of new prescription drugs: A case study. *Health Aff (Millwood), 19*(4), 165-170.

Forster, J. (2000, October). The workplace: Mental illness when workers just can't cope. *Business Week,* 100.

Gresenz, C.R., Stockdale, S.E., & Wells, K.B. (2000). Community effects on access to behavioral health care. *Health Serv Res, 35*(1 Pt 2), 293-306.

Grob, G. (1994). *The mad among us.* New York: The Free Press.

Halfon, N., Berkowitz, C., & Klee, L. (1992). Children in foster care in California: An examination of Medicaid reimbursed health services utilization. *Pediatrics, 89,* 1230-1237.

Hinckley, R.H. (1999). American opinions on mental health issues. *Mental Health Issues: National Monitor, i-99.*

Horgan, C., Hodgkin, D. (1999). Mental illness and substance abuse among low-income populations. In M. Lillie-Blanton, R.M. Martinez, B. Lyons, & D. Rowland (Eds.), *Access to health care: Promises and prospects for low-income Americans.* Washington DC: The Kaiser Commission on Medicaid and the Uninsured.

Ivey, S.L., Scheffler, R., & Zazzali, J.L. (1998). Supply dynamics of the mental health workforce: Implications for health policy. *Milbank Q,* 76(1), 25-58.

Kaveler, F., & Swire, M.R. (1983). *Foster child health care.* Lexington, MA: Lexington Books.

Liu, X., Sturm, R., Cuffel, B.J. (2000). The impact of prior authorization on outpatient utilization in managed behavioral health plans. *Med Care Res Rev, 57*(2), 182-195.

Mark, T.L., Coffey, R.M., King, E., Harwood, H., McKusick, D., Genuardi, J. et al. (2000). Spending on mental health and substance abuse treatment, 1987-1997. *Health Aff (Millwood), 19*(4), 108-120.

McAlpine, D.D., & Mechanic, D. (2000). Utilization of specialty mental health care among persons with severe mental illness: The roles of demographics, need, insurance, and risk. *Health Serv Res, 35*(1 Pt 2), 277-292.

Meadow, M. (2000, January). *Moving toward consensus on cultural competency in health care.* Washington DC: Office of Minority Health, U.S. Department of Health and Human Services.

Meyer, J.A., & Silow-Carroll, S. (2000, June). *Increasing access: Building working solutions.* Washington DC: Economic and Social Research Institute.

Miranda, J., Hohmann, A.A., Attkisson, C.C., & Larson, D.B. (Eds.). (1994). *Mental disorders in primary care.* San Francisco: Jossey-Bass, Inc.

National Mental Health Association. (2000). *Position statements and mental health facts.* Available online at http://www.medscout.com/mental_health.

Oehlmann, M.L. (2000). *Olmstead and the Ticket to Work Act: Implications for Medicaid managed care.* Princeton, NJ: Center for Health Care Strategies, Inc.

Olsson, K. (2000, November 27). Sorrow plain and hollow: Emotional disabilities are less likely to be seen and treated in rural America. *U.S. News & World Report.*

Ortega, S.T., Johnson, D.R., Beeson, P.G. et al. (1994, Winter). The farm crisis and mental health: A longitudinal study of the 1980s. *Rural Sociology, 59*(4).

Otten, A.L. (1998). *Mental health parity: What can it accomplish in a market dominated by managed care?* New York: Milbank Memorial Fund.

Pacula, R.L., Sturm, R. (2000). Datapoints: Mental health parity and employer-sponsored health insurance in 1999-2000: II. *Copayments and Coinsurance. Psychiatr Serv, 51*(12), 1487.

Pacula, R.L., Sturm, R. (2000). Mental health parity legislation: Much ado about nothing? *Health Serv Res, 35*(1 Pt 2), 263-75.

Perrin, J.M., Simms, M.D., Dubowitz, H., & Szilagyi, M.A. (2000). Health care needs of children in the foster care system. *Pediatrics, 106 suppl* (200), 909-918.

RAND. (2000). *Are people with mental illness getting the help they need?* (Report No., RB-4533). Santa Monica, CA: Author.

RAND. (2000). *Tracking changes in behavioral health services: How has managed care changed care?* (Report No., RB-4531). Santa Monica, CA: Author.

Rice, D.P., & Miller, L.S. (1998). Health economics and cost implications of anxiety and other mental disorders in the United States. *Br J Psychiatry Suppl, 34,* 4-9.

Ricketts, T.C., III (Ed.). (1999). *Rural health in the United States.* New York: Oxford University Press.

Rochefort, D.A. (1989). *Mental health policy in the United States.* Westford, CT: Greenwood Press.

Satcher, D. (2000). Eliminating racial and ethnic disparities in health: The role of the ten leading health indicators. *J. Natl Med Assoc, 92*(7), 315-318.

Sierles, F.S., & Taylor, M.A. (1995). Decline of U.S. medical student career choice of psychiatry and what to do about it. *American Journal of Psychiatry, 152(10),* 1416-1426.

Sturm, R., Gresenz, C.R., Pacula, R.L., & Wells, K.B. (1999). Datapoints: Labor force participation by persons with mental illness. *Psychiatr Serv, 50(11),*1407.

U.S. Department of Education. (1997). *To assure the free appropriate public education of all children with disabilities.* (Nineteenth Annual Report to Congress on the Implementation of the Individuals With Disabilities Education Act). Washington, DC: Author.

U.S. Department of Health and Human Services. (2000). *The AFCARS report: Estimates as of October 2000.* Washington, DC: Administration for Children and Families.

U.S. Department of Health and Human Services. (2000, May). *State profiles, 1999, on public sector managed behavioral health care.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Health and Human Services. (1998). *Child welfare outcomes 1998.* Washington, DC: Administration for Children and Families.

U.S. Department of Justice. (1994). *Conditions of confinement: Juvenile detention and correction facilities.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

U.S. General Accounting Office. (2000, May). *Mental Health Parity Act: Despite new federal standards mental health benefits remain limited (Report No., GAO/HEHS-00-95).* Washington, DC: Author.

U.S. General Accounting Office. (1995). *Child welfare: Complex needs strain ability to provide services.* Washington DC: Author.

Varmus, H.E. (1998, May). *Parity in financing mental health services: Managed care effects on cost, access, and quality.* Rockville, MD: National Institute of Mental Health, National Institutes of Health, U.S. Department of Health and Human Services.

Zuvekas, S.H. (1999). Health insurance, health reform, and outpatient mental health treatment: Who benefits? *Inquiry, 36*(2), 127-146.

W.K. KELLOGG
FOUNDATION

One Michigan
Avenue East
Battle Creek, MI
49017-4058
USA
616-968-1611
TDD on site
Telex: 4953028
Facsimile: 616-968-0413
Internet: http://www.wkkf.org

CVHCU3927
Item #501
5-014MCPA

Union Bug FPO