CSR Research-In-Brief Series

Now is the Time: The Public Health Response to Improving the State of America's Mental Health System

by Wendy R. Ellis, MPH

The recent focus on America's mental health care system is timely and necessary. It addresses a critical gap in our public health safety net—the unmet need for mental health treatment. The public health community has been well aware of this issue for decades, but the implications for individual health and public safety have not always been fully understood by the general public or policymakers. A tragic series of shootings by individuals with identified mental illness highlights large gaps in our ability to identify *and* provide adequate mental health treatment at the community level. Understanding how to address this public health crisis to create a more efficient, accessible system of mental health care is a public health goal relevant to all states. To do so, we must first take a critical look at our mental health care delivery system. This brief will 1) identify issues most relevant to the framework of the mental health care delivery system, 2) make recommendations for future research to address these areas, and 3) suggest how health policy and practice may be informed through this research agenda.

Unmet Need for Care. Almost half of all Americans will experience symptoms of a mental health condition at some point in their lifetime. But as a GAO report released last month indicates, identification of mental illness does not guarantee adequate treatment.[1] This gap in mental health care affects patients across all insurance types but is especially acute for poorer Americans, who are known to have an increased risk for mental illness.[2,3] A recent study looking at utilization of mental health care among Medicaid-eligible children in Washington State found that while nearly 60,000 such children were identified with mental health care needs, barely half received any form of treatment in the state's system of care.[4] Washington State is not alone. The GAO national analysis found that 14 percent of all Medicaid-eligible children had an identified mental health need, but most did not receive mental health services. Another national study examining all insurance types found that less than 1 in 5 children and adolescents with diagnosable mental health problems receive the treatment they need.[5]

Why Early Treatment Matters. Poor mental health is strongly associated with other physical health and development concerns in young people, notably lower educational achievement, substance abuse, violence, and poor reproductive and sexual health.[6] Serious emotional disturbances in childhood interfere with emotional health, cognitive development, and interpersonal relationships. Longitudinal studies suggest untreated or inadequately treated disorders increase lifetime risk of developing serious mental illness.[7]

An estimated 11.4 million Americans (4.4%) have a serious mental illness (SMI) each year, including conditions such as major depression, schizophrenia, and bipolar disorder.[8] Moreover, half of all lifetime mental health disorders begin by age 14 and three-fourths by age 24.[9] A conservative estimate places direct and indirect costs of mental illness in the United States at more than $300 billion a year—the third most costly medical condition in terms of overall health care expenditure.[10,11] In 2010, hospitalizations for mood disorders ranked sixth out of the top 10 principal reasons for hospital stays.[12]

To better understand the prevalence of mental illness, we examined cross-sectional data on inpatient stays from the Healthcare Cost and Utilization Project (HCUP).[13] Analysis of HCUP data indicates that the proportion of individuals with one or more mental health diagnoses increases over time and peaks in middle age, with more than half of all patients reporting some form of mental illness (Table 1).[14,15] This corresponds with research indicating that individuals with serious mental illness (SMI) have chronic medical conditions leading to hospitalization at higher rates than those without SMI. These conditions and risk factors include heart disease, obesity, Type 2 diabetes, substance abuse, and smoking—all underlying factors in the nation's leading causes of death.[16]

Research to Inform Policy and Practice. Just as the public health approach has taught us to detect illness early and intervene quickly to prevent the progression of physical diseases, we must adopt a similar approach to mental health. With this in mind, several research questions should be addressed.

1 Report to Congressional Requesters: Children's Mental Health. Concerns remain about appropriate services for children in Medicaid and foster care. Washington, DC: U.S. Government Accountability Office. December 2012.

2 Bruce, M.L. et al. Poverty and psychiatric status: Longitudinal evidence from the New Haven Epidemiologic Catchment Area study. Arch Gen Psychiatry 1991; 48(5):470–274.

3 Sareen, J. et al. Relationship between household income and mental disorders: Findings from a population-based longitudinal study. Arch Gen Psychiatry 2011; 68(4): 419–427.

4 Ellis, W.R. et al. Washington State exhibits wide regional variation in proportion of Medicaid-eligible children who get needed mental health care. Health Affairs 2012; 31(5):990–999.

5 Katoaka, S.H. et al. Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. Am J Psychiatry 2002; 159:1548–1555.

6 Patel, V. et al. Mental health of young people: A global public health challenge. Lancet 2007; 369:1302–1313.

7 Costello, E.J. et al. Adolescent outcomes of childhood disorders: The consequences of severity and impairment. J Am Acad Child Adolesc Psychiatry 1999;38:121–128.

8 Substance Abuse and Mental Health Services Administration. Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings (Office of Applied Studies, NSDHU Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD: Substance Abuse and Mental Health Services Administration, 2010.

9 Kessler, R.C. et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005;62(6), 593–602.

10 Insel, T.R. Assessing the economic cost of serious mental illness. Am J Psychiatry 2008;165(6):663–665.

11 Soni, A. The five most costly conditions, 1996 and 2006: Estimates for the U.S. civilian noninstitutionalized population. Statistical Brief #248, July 2009. Rockville, MD: Agency for Healthcare Research and Quality. http://meps.ahrq.gov/mepsweb/data_files/publications/st248/stat248.pdf. Accessed January 27, 2013.

12 Pfuntner, A. et al. Most frequent conditions in U.S. hospitals, 2010. HCUP Statistical Brief #148. January 2013. Rockville, MD: Agency for Healthcare Research and Quality. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb148.jsp. Accessed January 28, 2013.

13 From Healthcare Cost and Utilization Project–Agency for Healthcare Research and Quality database. The 2010 Nationwide Inpatient Sample of community hospital inpatient databases. *Unpublished data*.

14 Sokal, J. et al. Comorbidity of medical illnesses among adults with serious mental illness who are receiving community psychiatric services. J Nerv Ment Dis 2004; 192(6) 421–427.

15 Dickey, B., et al. Medical morbidity, mental illness, and substance use disorders. Psychiatr Serv 2002; 53(7). doi: 10.1176/appi.ps.53.7.861

16 FastStats. Leading causes of death 2010 data. Atlanta: Centers for Disease Control and Prevention. http://www.cdc.gov/nchs/fastats/lcod.htm. Accessed January 28, 2013.

Ages	6–17	18–29	30–41	42–53	54–65	66–77	78+
Any MI diagnosis	27%	27%	38%	56%	51%	44%	45%

Table 1. Proportion of inpatients reporting one or more mental illness in 2010.

Source: TThe Nationwide Inpatient Sample, which tracks roughly 8 million hospital stays each year.

What Role Do Disparities in Access to Care Play in Detecting and Treating SMIs?

State Medicaid access policies contribute to overall underutilization of mental health care. What is less understood are the community-level factors that affect access to care. While disparities in mental health service utilization based on race/ethnicity and insurance status have been described nationally, we know less about the impact geographic disparities have on the ability to access mental health services. As the Washington State study demonstrated, geographic-based inequities reveal differences in patients' ability to access services, as well as regional population differences associated with utilization (e.g., racial and economic demographics).[5] Areas in Washington State with a higher proportion of Hispanic residents had lower utilization rates for mental health care. Although stigma surrounding mental illness and use of mental health care services in certain ethnic groups has been documented, more research is needed to identify best practices for effective outreach to individuals from diverse racial/ethnic backgrounds. This will help ensure culturally competent care is available to every community.[17] Such research can be a key component in improving the nation's mental health care delivery system by identifying disparities in access as well as communities with disproportionate burdens of mental illness. This evidence would help inform how scarce resources and funding can best be directed to have the greatest impact on reducing the burden of mental illness.

What Does Systems Innovation Research Offer?

SAMHSA has been at the forefront of integrating primary care and mental health and substance abuse services. Evaluation of patient-centered medical homes (PCMH) demonstration projects aimed at improving mental health outcomes through coordinated care would inform best practices as we redesign the nation's mental health delivery system under ACA. The PCMH model offers promise for earlier detection of mental illness and coordinated care through a team approach with clinicians and community-level providers as well as family members. This chronic care model has been associated with improved patient outcomes in diabetic, AIDS/HIV, and pediatric populations. But more research is needed to gauge its effectiveness in mental health care.

What Changes in the Mental Health Care Workforce Might Help?

A recent Institute of Medicine report indicates individuals will likely find it harder to get proper diagnoses and treatment for mental health conditions without a major effort to significantly increase the number of mental health professionals and service providers for baby boomers as well as children.[18] The SAMHSA proposal to train more than 5,000 mental health professionals to serve students and young adults could help fill the access-to-care gap for America's young people. This $50 million program would train social workers, counselors, psychologists, and other mental health professionals and place this workforce in highly accessible locations, such as schools. As was found in the Washington State study, school-based clinics facilitate early detection and treatment for children's emerging mental health needs.[5] The nearly 2,000 U.S. school-based health centers are an evidence-based, front-line strategy to identify and provide cost-effective mental health services to students.[19] Funding and expanding this program is essential in increasing children's access to mental health care. In addition to the SAMHSA training program, the President's Project AWARE, if funded, promises to provide mental health training for teachers to better detect the mental health needs of their students. Future research will need to evaluate the impact of these programs as well as identify factors associated with best practices and a framework for replication.

How Will Parity Affect Access to Mental Health Services?

ACA will be one of the largest expansions of mental health and substance abuse coverage ever, extending health coverage to more than 30 million Americans. Up to 10 million of these newly insured are estimated to have some form of mental illness. ACA expansions include coverage for preventive services, such as screening for depression and alcohol abuse. ACA will ensure that plans on the health insurance exchange cover mental health and substance abuse at parity with other benefits. The Obama Administration is expected to issue the Final Rule on defining essential benefits and implementing requirements for new small group and individual plans to cover mental health benefits at parity with medical and surgical benefits offered on the exchange.

The President's directive to ensure parity in health care coverage should help widen the range of mental health diagnoses treatable under Medicaid plans. As the Washington state case study showed, narrow insurance policies that restrict access to mental health care to only those individuals with the most advanced mental illness result in underutilization of care in many state Medicaid systems. These advanced diagnoses include schizophrenia, bipolar disorder, and manic depression but exclude emerging disorders such as attention deficit disorder, eating disorders, and episodic depression. Future research will need to measure the impact of Medicaid expansion—specifically, how access to and quality of care are affected, and what return on investment our nation receives for its health care dollars.

[17] Carpenter-Song, E. et al. Ethno-cultural variations in the experience and meaning of mental illness and treatment: Implications for access and utilization. 2010. Transcult Psychiatry 47:224–239.

[18] The mental health and substance abuse workforce for older adults. Washington, DC: Institute of Medicine of the National Academies. 2012. http://www.iom.edu/Reports/2012/The-Mental-Health-and-Substance-Use-Workforce-for-Older-Adults.aspx. Accessed February 1, 2013.

[19] Atkins, M.S. Toward a new model for promoting urban children's mental health: Accessible, effective, and sustainable school-based mental health services. Sch Psychol Rev 2003; 32(4):503–514.

2107 Wilson Boulevard, Suite 1000
Arlington, VA 22201
703-312-5220
www.csrincorporated.com
wellis@csrincorporated.com