Mental Health Liaison Group

Washington, DC

August 2006

Dear Candidate:

On behalf of the Mental Health Liaison Group (MHLG), a coalition representing the diverse mental health community that serves adults and children with mental disorders and their families, we are pleased to provide this ***briefing paper*** as a guide for your support of mental health issues in your campaign.

In recent years, mental health leaders have come together to support the need to transform mental health care throughout the nation. Several major advisory groups have helped to champion this message. The President's New Freedom Commission on Mental Health, the first such commission in almost 30 years, found in 2003 that ***our nation's failure to make mental health a priority is a national tragedy.*** For too many Americans with mental illnesses, mental health services and supports are disconnected and often inadequate, reported Commission Chair Dr. Michael F. Hogan. The Commission called for a fundamental transformation of the nation's approach to mental health service delivery. At the end of 2005, two more landmark policy reports were issued to advance the nation's transformation agenda. One was authored by the Institute of Medicine (IOM), entitled *"Improving the Quality of Health Care for Mental and Substance-Use Conditions,"* and the other by the National Business Group on Health (NBGH), entitled *"An Employer's Guide to Behavioral Health Services."* All of these reports provide a thorough overview of many of the current issues in the mental health system and offer suggestions on how to advance its transformation.

Major challenges facing this country add urgency to **your supporting our organizations** in pressing to make transformation of mental health service delivery a national priority. The demobilization of tens of thousands of National Guard and Reserve personnel, returning to the U.S. from Iraq and elsewhere, is adding pressure to our mental health system, which is fragmented, strained past its capacity, and in need of immediate improvement. Emerging evidence shows that 19 percent or more of returning service-members will require treatment for post-traumatic stress disorder (PTSD), depression, or anxiety. Alarming numbers of suicides among military personnel and returning veterans have already been recorded. Guard and Reserve component personnel -- citizen-soldiers who constitute most of the deployed forces -- rely on community-based health care to a far greater extent than on the Department of Veterans Affairs (VA). These returning service-members and their families face a harsh dilemma in seeking to access needed mental health care: widely prevalent and strict limitations on mental health service coverage under employer-provided insurance; an overstretched VA health care system; and a public mental health system that lacks enough community-based mental health services for all those in need. The aftermath of Hurricane Katrina has also underscored the limitations of our public mental health system, people's vulnerabilities to mental health trauma, and our lack of public mental health service preparedness for national or regional emergencies.

Mental disorders can be severe and are the **leading** cause of disability in the United States. Five to seven percent of adults has a severe and persistent disorder, such as schizophrenia, bipolar disorder or major depression. A similar percentage of children has emotional problems severe enough to disrupt social and academic functioning. While mental and emotional disorders are widely prevalent, studies reveal that fewer than one of every three people who need mental health treatment actually receive it.

We hope that this primer will provide you with insight into the mental health issues that are integral to the nation's overall health. This guide is organized by issue area and seeks to strengthen your resolve to champion these issues. For further information, please visit our Web site, www.mhlg.org.

Sincerely,

Mental Health Liaison Group Executive Committee Endorsing Organizations:

American Academy of Child and Adolescent Psychiatry
American Association for Marriage and Family Therapy
American Counseling Association
American Managed Behavioral Healthcare Association
American Mental Health Counselors Association
American Psychiatric Association
American Psychological Association
Bazelon Center for Mental Health Law
National Association of Social Workers
National Association of State Mental Health Program Directors
National Mental Health Association

Note: Endorsing organizations typically have national policy views in addition to those expressed here.

Briefing Paper on Mental Health Issues

Prepared by the Steering Committee of the Mental Health Liaison Group

Costs of Mental Disorders to the Nation

Mental, emotional and addictive disorders have a major impact on the lives of millions of Americans and their families. These disorders also cost the American economy and American businesses tens of billions of dollars each and every year. Worse yet, there is a tremendous toll associated with ***not*** providing meaningful resources for mental health programs: people with mental disorders cannot get the care they need to help them achieve recovery.

- The costs of mental disorders are exceedingly high. Four of the ten leading causes of disability in the United States are mental disorders. In 1996, the direct costs of mental health services in the United States totaled $69.0 billion, 7.3 percent of total health spending. Indirect costs of mental disorders resulting from lost productivity were estimated to exceed $78 billion. By 2000, the economic burden of depression alone was estimated to exceed $83 billion. More than 50 percent of all mental health expenditures were borne by the public sector through Medicaid, Medicare, and state and local governments. Furthermore, individuals with serious mental disorders represent the single largest diagnostic group receiving SSI.
- According to the Institute of Medicine (*Reducing Suicide: A National Imperative* (2002)), 90 percent of the 30,000 people who commit suicide in America every year has a mental disorder. Deaths from suicide are nearly twice the number of deaths from homicide (18,000). An estimated 650,000 people attempt suicide each year.
- A recent study employing a computerized diagnostic screening instrument found that nearly two-thirds of male and nearly three-quarters of female youth entering the juvenile justice system met diagnostic criteria for mental disorders.
- More than three million individuals (more than 35 percent of people with disabilities receiving SSI) are receiving disability benefits due to mental disorders.
- People with mental, emotional or addictive disorders are also disproportionately represented in our nation's homeless population.

Mental Health Treatment

Treatment Effectiveness

According to the 1999 *Mental Health: A Report of the Surgeon General*, "An armamentarium of efficacious treatments is available to ameliorate symptoms [of mental disorders]." For most mental disorders, there is a range of effective treatments. These generally include various forms of psychotherapy (e.g., behavior therapy and psychodynamic therapy) and pharmacological interventions. Research has demonstrated that a combination of the two approaches can be more effective than either one alone for the treatment of certain mental disorders.

Treatment outcomes for some serious mental disorders have been found to have higher success rates than for some physical health conditions. For example, as compared to the success rate of 41 percent for heart disease, treated with well-established medical or surgical procedures such as

angioplasty, the following treatment success rates have been documented for specific mental disorders:

- Bipolar Disorder: 80 percent
- Major Depression: 80 percent
- Panic Disorder: 80 percent
- Obsessive-Compulsive Disorder: 60 percent.
- Schizophrenia: 60 percent

Treatment Gap

- **Sadly, despite the proven effectiveness of mental health treatment,** more than 67 percent of adults and nearly 80 percent of children who need mental health services do not receive treatment.
- The reasons for this treatment gap include: (1) financial barriers, including discriminatory provisions in both private and public health insurance plans that limit access to mental health treatment, (2) the stigma surrounding mental disorders and treatment, and (3) shortages of mental health care providers in many parts of the country.
- On average, it takes an astounding 15 to 20 years for a scientific discovery to make its way into mental health service delivery.

Mental Health System Transformation

At the end of 2005, two landmark policy reports were issued to help guide the transformation of the mental health system. The first report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, was a follow-up to the Institute of Medicine's (IOM) 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. The IOM expert panel concluded that there are serious problems in the United States' service delivery system for the treatment of mental and substance use conditions in both the public and private sectors. The IOM report provides a set of recommendations and a blueprint for improvement in the behavioral health specialty sector, as well as strategies for better coordination and integration with general health care. The second report, *An Employer's Guide to Behavioral Health Services*, was developed by the National Business Group on Health (NBGH). Employers are recognizing the importance and value of behavioral health benefits, and this guide is a blueprint of actionable strategies and recommendations that will allow employers to create and implement a system of affordable, effective, and high quality behavioral health services. Both of these reports provide a thorough overview of many of the current problems in the mental health system and offer suggestions on how to advance its transformation.

As part of President Bush's policy agenda, the New Freedom Commission on Mental Health was established in April 2002 to ensure that Americans with mental disorders do not fall through the cracks; that lives not be lost; and that recovery be a realistic goal of treatment. The Commission conducted a comprehensive study of the U.S. mental health service delivery system, including public and private sector providers, and found the mental health system to be "in shambles" and in need of major repair. The Commission's final report, released in July 2003, included six key

goals for transforming the mental health system: President's New Freedom Commission on Mental Health.

- Goal 1: Americans understand that mental health is essential to overall health
- Goal 2: Mental health care is consumer and family driven
- Goal 3: Disparities in mental health services are eliminated
- Goal 4: Early mental health screening, assessment and referral are common practice
- Goal 5: Excellent mental health care is delivered and research is accelerated
- Goal 6: Technology is used to access mental health care and information

Public Mental Health: The Fragile Social Safety Net

The President's New Freedom Commission on Mental Health was influenced by the Supreme Court's decision in *Olmstead v. L.C. and E.W.* (1999), which found that individuals with mental disorders are protected under the Americans with Disabilities Act and entitled to community-based services rather than institutionalized care. Yet despite *Olmstead,* a severe shortage of community-based services remains.

Medicaid and Medicare

Combined, Medicare and Medicaid funds account for roughly one in three dollars spent on mental health services in the United States.

Medicaid

Although it was not designed as a mental health program, Medicaid, over time, has evolved to become an important financing vehicle for a range of services for adults with mental illness and children with emotional disturbance. Medicaid covers approximately 40 million individuals, including children, older persons, people who have disabilities, and individuals who are eligible to receive federally assisted income maintenance payments.

- Every state has implemented Medicaid payment for many of the community mental health services necessary for successful recovery in the community - rehabilitation and clinic services. These services are extremely vulnerable in times of tight budgets.

- Although federal Medicaid rules do not require states to cover many services and supports necessary for people with mental disorders to live successfully in their communities, most states have adopted Medicaid options that permit payment for a broad range of these services. However, states should be given greater flexibility with respect to community mental health services, so that they can more easily fund comprehensive programs that combine different Medicaid service options and pay for them as one package.

- Twenty-five percent of American children are enrolled in Medicaid and entitled to all necessary treatment services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. A 2001 Government Accountability Office (GAO) study

found that comprehensive screening rates are as low as 6 percent, severely restricting access to necessary services.

- The Deficit Reduction Act of 2005, designed to save $5 billion in Medicaid expenses over 5 years, made significant changes to the program. It does the following: (1) allows states to increase cost-sharing for Medicaid services, even for beneficiaries with incomes below the poverty level, and to charge premiums, (2) permits states to remodel their Medicaid benefits in a way that would dramatically reduce access to services that are currently available, including services for children, (3) requires higher cost sharing for non-preferred (i.e. non-formulary) medications; (4) denies federal matching funds for certain Medicaid Targeted Case Management (TCM) activities, particularly services related to foster care and child welfare services; and (5) requires that after July 1, 2006, all persons applying for Medicaid for the first time, as well as persons being recertified for Medicaid, provide proof of U.S. citizenship. It is critical that Congress ensure that these changes do not adversely affect Medicaid-eligible children and adults with mental disorders.

Medicaid and Custody Relinquishment

Thousands of families across the country too often are forced to choose between retaining custody of their child or obtaining access to the health care and services the child desperately needs. Intensive services to treat mental health problems are very costly and often not covered by private insurance. In many instances, these families are not eligible for Medicaid because of income, leaving parents unable to afford specialized care for their children. As a result, one in four families of severely emotionally disturbed children is counseled to consider relinquishing custody, and one in five finds it necessary to give up custody of their child to state agencies in order to secure treatment. Relinquishment of child custody solely to access necessary mental health services and supports is a horrific national problem that is directly related to the lack of access to appropriate mental health services for children in both the private and public sectors.

- In order to help families obtain the care that their child needs without giving up custody, the Deficit Reduction Act of 2005 (DRA) gives states the option to offer parents with incomes up to 300 percent of the federal poverty level the opportunity to buy into Medicaid on a sliding-scale basis, if their child is under age 18 and has a severe mental illness or other severe disability meeting the SSI standard of disability.

- The DRA also creates a demonstration program to test the cost-effectiveness of providing home- and community-based alternatives to psychiatric residential treatment centers. However, in order to eliminate the practice of custody relinquishment by families of children with emotional disturbance, Congress should enact legislation with funding for states for planning and expanding community-based services for children.

Medicare

Medicare provides health care coverage to over 39 million Americans. Medicare provides health insurance to people age 65 and over, as well as to certain people with disabilities. Regarding mental health, Medicare requires beneficiaries to pay 50 percent of the costs of outpatient

treatment – a blatantly discriminatory practice given that Medicare requires beneficiaries to pay only 20 percent of non-mental health related outpatient services. Medicare provides no coverage for certain services critical to many people with serious mental disorders – services such as case management or psychiatric rehabilitation – and Medicare also limits inpatient psychiatric hospital care to 190 days.

- Congress must correct discriminatory Medicare coverage policies that limit mental health services, particularly those concerning limits on the types of covered outpatient services and the types of providers eligible for reimbursement.

- Given the high prevalence of depression among the elderly and the alarming rate of suicide in this population (19 percent of all suicide deaths in 1999 were among those 65 years of age and older), it is critical that arbitrary barriers to mental health care be eradicated. This issue cannot be put off since retiring baby boomers will shortly begin to swell the Medicare rolls.

- On December 8, 2003, President Bush signed into law the Medicare Modernization Act, (MMA), which expanded the Medicare program to offer coverage for outpatient prescription drugs. Prescription drug coverage under the MMA (known as Part D) is voluntary for most beneficiaries, except for extremely low-income beneficiaries who are concurrently eligible for Medicare and their state Medicaid program (known as "dual eligibles"). These vulnerable beneficiaries (approximately one-third of whom have a severe mental illness) recently were automatically assigned from free and extensive Medicaid coverage to Part D drug plans, which may require that they make copayments and may provide more limited coverage.

- Many dual eligibles have been unable to access the drug therapies they need through Part D because of dosage limits and other utilization management techniques being inappropriately applied to individuals who had been stabilized on certain mental health medications prior to being enrolled in this new program. It is imperative that persons with mental illness be able to continue the treatment that enables them to function in daily life and function in the community.

Veterans' Mental Health

Emerging evidence increasingly suggests that the burden of combat-related mental health problems will be high for returning service-members and their families. (Combat deployments have historically been found to put returning service-members at increased risk of both physical and mental health problems.) Reporting in 2005, Army researchers found that among soldiers who were surveyed after returning from combat duty in Iraq, 19 to 21 percent showed evidence of post-traumatic stress disorder (PTSD), depression or anxiety. A 2006 study of health care utilization during the first year after return from Iraq showed that 19 percent of these veterans reported a mental health problem. VA data show that of veterans who served in Iraq or Afghanistan, 32 percent of those who sought VA health care were seen for a possible mental disorder.

The Departments of Defense and Veterans Affairs (VA) have taken unprecedented steps to screen returning service-members for possible mental health problems with an eye to early

intervention. With 250,000 service members projected to return from overseas deployments during 2006, many challenges still face those who have readjustment or mental health problems. As starkly described in the "*2005 Report of the Under Secretary for Health's Special Committee on Post-traumatic Stress Disorder, Fifth Annual Report (February 2006), " "[*V]irtually all returning veterans and their families face readjustment problems…[But even] specialized PTSD services are lacking in many VA medical centers (VAMCs) and are severely limited at Community Based Outpatient Clinics (CBOCs) …[VA is] not ready to meet the ongoing needs of veterans of past deployments while also reaching out to new veterans of service in Iraq and Afghanistan."

To ensure that returning service-members do successfully readjust and that those with mental health needs receive timely, effective services, Congress should:

- increase substantially funding for VA mental health care and readjustment services, to include funds for family-therapy and for training on PTSD for primary care providers and other clinicians;
- direct VA to offer education and support to all returning veterans and their families to foster veterans' readjustment;
- extend the time-limited (two-year) window of VA health-care eligibility for veterans who served in a theater of combat operations to five years; and
- clarify that VA may provide education, counseling, and/or therapy at any facility to family members of returning veterans to foster veterans' readjustment or recovery from disorders.

Parity in Group Health Insurance

Even though mental disorders can be reliably diagnosed and treated, people too often do not get needed mental health care, even when they have "good" insurance. Arbitrary, discriminatory insurance barriers to needed mental health treatment frequently stand in the way. Such barriers, which take the form of stricter limits on treatment duration and much higher out-of-pocket costs for mental health care than for other medical care, are commonplace. Lack of access to needed mental health treatment takes a severe toll – in unemployment, broken homes, other health problems, poor school performance, and even suicide.

Congress can end these discriminatory practices: the "**mental health parity**" legislation now before it says that if an employer elects to provide mental health benefits, such benefits would be on par with medical and surgical coverage. Mental health parity is both fair and affordable. Our organizations call on Congress to make enactment of a comprehensive mental health parity bill a high priority. The Congressional Budget Office has projected that enactment of the pending parity legislation would on average increase insurance premiums by less than one percent. That projection does not take into account the offsetting savings that would be achieved through increased worker productivity and reduced absenteeism.

President Bush in 2002 called on Congress to pass parity legislation. Currently, 226 members of the House of Representatives have cosponsored "The Paul Wellstone Mental Health Equitable Treatment Act," H.R. 1402, and 70 Senators in the previous Congress cosponsored S. 486, the Senate companion bill. This broad, bipartisan support for legislation, now backed by 351

organizations nationally, underscores the message that there is a moral imperative for ending discrimination against people with, or at risk of, mental illness.

Parity is affordable. Beginning January 1, 2001, the Federal Employees Health Benefit Program (FEHBP) implemented full parity benefits for its 8.5 million beneficiaries. A comprehensive study of FEHBP parity sponsored by the U.S. Department of Health and Human Services in 2004 showed that the cost increase associated with parity was only 0.94 percent, for both mental health and substance abuse benefit parity.

In a landmark report providing recommendations for design and delivery of behavioral healthcare services, **the National Business Group on Health recommended that employers equalize their medical and behavioral benefit structures** (*An Employer's Guide to Behavioral Health Services*, November 2005). This employer-group expressed strong support for equalizing benefits given evidence that parity yields clinical benefit without increasing overall healthcare costs.

Federal Discretionary Funding for Mental Health Services and Research

Substance Abuse and Mental Health Services Administration (SAMHSA)

The roles of the Substance Abuse and Mental Health Services Administration (SAMHSA) and its three centers, the Centers for Mental Health Services (CMHS), Substance Abuse Treatment (CSAT) and Substance Abuse Prevention (CSAP), are:

- to provide national leadership in improving mental health and substance abuse services by designing performance measures,
- to advance service-related knowledge development, and
- to facilitate the exchange of technical assistance.

SAMHSA fosters the development of standards of care for service providers in collaboration with states, communities, managed care organizations and consumer groups, and it assists in the development of information and data systems for services evaluation. SAMHSA also provides crucial resources to provide safety net mental health services to the under- or uninsured in every state. SAMHSA promotes the adoption of science- and research-based programs and emerging best practices to states and communities that in turn improve services for consumers.

The authorizing legislation for SAMHSA expired at the end of Fiscal Year 2004. The Senate has begun the process of reauthorizing this critical federal agency.

- In reauthorizing the agency, Congress should encourage programs and demonstration initiatives that support systems transformation as advocated in recent recommendations by the President's Commission, the Institute of Medicine and business leaders. These would include: (1) addressing the fragmentation across federal agencies; (2) supporting states in the development of systems of care for adults and children and in ensuring cross-agency planning of all services and supports that individuals with mental disorders need; (3) expanding the use of evidence-based programs and emerging best practices; (4) developing

strategies for addressing the critical shortages in the mental health workforce; (5) implementing the National Strategy for Suicide Prevention; (6) improving integration between physical health and mental health care; (7) promoting screening and early identification for children; and (8) expanding programs and services to divert individuals from juvenile and criminal justice, as well as other initiatives.

Disaster Preparedness/Response and Mental Health

The response to Hurricane Katrina highlights dramatically the limitations of our public mental-health system to meet population-wide mental health needs – especially in natural and other disasters – and the frequent failure to plan adequately for the often profound mental-health impact of such occurrences. Certainly there was an emergency mental-health response to this disaster, but insidious longer-term needs go unmet. Central to that emergency effort, the Substance Abuse and Mental Health Services Administration awarded over $97 million to affected states to support crisis counseling for hurricane victims. (It is estimated, however, that as many as 500,000 evacuees displaced by Katrina who did not get such support may have unmet mental health needs.) The Deficit Reduction Act also provided temporary Medicaid coverage for Katrina survivors, but it is becoming increasingly clear that many face longer-term mental health problems.

Katrina's devastation not only crippled an already frail system designed only for those with the most severe disorders, but it caused profound psychological trauma, particularly among children. A study conducted by the Mailman School of Public Health at Columbia University and the Children's Health Fund and released in April 2006 found that children displaced by the storm were twice as likely to develop depression, anxiety and behavioral and emotional problems as other children. The experience of this disaster underscores that, just as acts of terrorism have profound long-term psychological effects, we must plan for – and have the means to address effectively – the mental health impact of any disaster. That planning, and necessary resource commitments, must take many factors into account: from the limited mission and capacity of the public mental health system to the need to quickly initiate measures – beyond simply short-term emergency counseling – for population-based outreach, early intervention; and ongoing services and supports.

Department of Justice

Alarming numbers of people with mental disorders fall through the cracks of the mental health system and land in jail, prison, and juvenile detention. Overwhelmingly, people with mental disorders are incarcerated -- not because of commission of a serious, violent crime -- but because, lacking access to services, their behavior has led to contact with law enforcement. Congress recognized that the nation's jails, prisons and juvenile detention facilities have become de-facto psychiatric facilities that are ill-equipped to help people with serious mental health needs, and that communities need new tools to reverse the repeated**,** costly incarceration within this population. In 2004, Congress enacted the Mentally Ill Offender Treatment and Crime Reduction Act (P.L.108-414), which authorized $50 million in federal grants to help states and local communities develop collaborative cross-system efforts to end the criminalization of people with mental disorders.

Deploying $5 million in initial funding appropriated in the FY 2006 Science, State, Justice Appropriations Act, the Department of Justice plans to award 26 planning and implementation grants. These grants will enable communities to launch proven programs such as jail diversion; treatment programs; community re-entry services; and cross-training of criminal justice, juvenile justice, and mental health personnel. This is an important start. But given the severity of these problems and the cost of the status quo for corrections, law enforcement, and those with mental disorders, the Mental Health Liaison Group urges that Congress increase funding for the Act to enable more states and communities to establish model collaborative programs.

National Institutes of Health (NIH)

The National Institutes of Health (NIH) is the world's premier medical and behavioral research institution. The three institutes that focus their research on mental and addictive disorders are the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). An overwhelming body of science demonstrates that: (1) mental disorders have clear biological and social components; (2) treatment is effective; and (3) the nation has realized immense dividends from five decades of investment in research focused on mental disorders and mental health.

- The Mental Health Liaison Group advocates for continued robust federal funding for biomedical and behavioral research conducted at NIMH, NIDA, and NIAAA that aims to: (1) improve delivery of evidence-based treatment; (2) develop new treatments; and (3) ensure rapid and effective dissemination and use of research to policymakers, health care providers, and the public.

A Final Word to Candidates

Members of the Mental Health Liaison Group are eager to develop and work with candidates for Congress that wish to transform the nation's mental health system. The mental health needs of our nation are great. Through candidate education, we hope to improve candidates' understanding of the needs of the mental health system and win their support for many crucial issues they would face as members of Congress. We thank you for your attention to these issues and look forward to a long and productive collaboration to better address the nation's mental health needs.