NATIONAL HEALTH POLICY FORUM

Forum Session
Meeting Announcement

Wednesday, June 14, 2006
11:45am–12:15pm — Lunch
12:15–2:00pm — Discussion

"Mental Health: Progress and Pitfalls," the *Health Affairs* Special Issue—A Discussion of Trends in Mental Health Services

A Discussion Featuring:

Sherry Glied, PhD
Chair
Department of Health Policy and Management
Columbia University

Benjamin G. Druss, MD, MPH
Rosalynn Carter Chair in Mental Health
Associate Professor of Health Policy and Management
Rollins School of Public Health
Emory University

Peter Cunningham, PhD
Senior Health Researcher
Center for Studying Health System Change

Location

Hyatt Regency on Capitol Hill
400 New Jersey Avenue, NW
Columbia A Room

Registration Required

Space is limited. Please respond as soon as possible.

Send your contact information by e-mail to: **nhpfmeet@gwu.edu**

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON DC

"Mental Health: Progress and Pitfalls," the *Health Affairs* Special Issue—A Discussion of Trends in Mental Health Services

OVERVIEW

This Forum session will highlight the work of three researchers who recently published reports in a Health Affairs special issue, "Mental Health: Progress and Pitfalls." The meeting will review historical trends in the financing of mental health services and explore the implications of these trends for the organization and delivery of mental health care. Speakers will also discuss what improvements are needed to provide quality and accessible behavioral health care today in the context of increasing pressures to control costs and improve standards of care.

For additional information – *See the* Health Affairs *May/June 2006 special issue, "Mental Health: Progress and Pitfalls," available at www.healthaffairs.org.*■

SESSION

For several decades, expert panels have repeatedly condemned the disorganization of our nation's mental health system. From The Carter Commission on Mental Health in 1978[1] to more recent reports of the Surgeon General in 1999[2] and the President's New Freedom Commission on Mental Health in 2003,[3] policymakers have long called for a fundamental transformation of our health care system to better serve the mental and behavioral health care needs of Americans. Yet, one can reasonably argue that transformation has been occurring over the past three decades, with significant shifts in who receives, provides, and pays for mental health services. The results of this gradual transformation have been mixed, however, and clearly have yet to yield a well-integrated, widely accessible system of care.

Access to mental health services has increased, but it is unclear whether these expansions have reached those most in need of services. The proportion of Americans receiving mental health treatment has nearly doubled since 1991 (rising from 12 percent to 20 percent) while disease prevalence rates have remained fairly constant. However, the resulting decline in untreated mental illness appears less impressive when two

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facts are considered: (i) approximately half of all mental health services are provided to individuals who do not meet diagnostic criteria for a mental health disorder, and (ii) less than one-third of adults and fewer than half of all children with diagnosable mental disorders actually receive treatment.[4]

As the population receiving mental health services has grown, the nature of services provided has also changed dramatically. Hundreds of thousands have moved out of permanent residence within psychiatric hospitals as a result of "deinstitutionalization," which began in the 1960s and accelerated during the 1970s and 1980s. During this time, outpatient visits for mental health services more than tripled due to expanded access through primary care, ambulatory, and other community-based services that are strongly favored by consumer advocates. Advances in psychosocial interventions, psychiatric medicines, and federal funding for supportive housing and employment have enabled many to recover and live more independently within their communities.

The shift toward community-based care along with an expansion in psychotropic drug use, though beneficial in many respects, has not been an entirely smooth transition. While more Americans obtain mental health services in community-based settings than ever before, experts argue that they do so in a complex system that is stressed to capacity, disorganized, and overly reliant on psychotropic medications. In addition, many argue that inadequate access to an effective continuum of mental health services to support medication compliance and holistic recovery has resulted in "transinstitutionalization": the cycling of individuals with mental disorders in and out hospital emergency rooms, prisons, and homelessness.[5]

In many ways this evolution of service delivery has been driven by deliberate changes in mental health financing policies. Funding has moved away from dedicated state mental health programs and personal out-of-pocket spending toward reliance on health insurance mechanisms, particularly public programs such as Medicaid and Medicare. States have reduced the budgets of mental health agencies and have increasingly relied on Medicaid to fund mental health services for the indigent and disabled. Concurrent with this trend, employer-initiated coverage expansions and state mandates have expanded basic mental health benefits through private health insurance plans. However, many plans use care management strategies, such as utilization review, that consumer advocates argue are counterproductive, are overly constrained by criteria for determining medical necessity, and deny access to psychosocial and supportive services that fall outside the traditional medical model.

These changes occurred in the context of relatively slow mental health spending increases that are modest in comparison to overall health care spending[6] and are almost entirely attributable to increased expenditures

for prescription drugs.[7] In 2001, three-quarters of individuals in mental health treatment received pharmacotherapy either alone (34 percent of those treated) or in combination with psychological treatment in ambulatory care settings (41 percent).[8] Antidepressants account for more than half of all prescription drug spending for mental health disorders, and their use is likely concurrent with the large increase in the number of individuals with mild to moderate disorders receiving treatment. In addition, it appears that psychotropic drugs are being misused: over-prescribed in some cases, under-prescribed in others, and inappropriately prescribed in still others.

This Forum session will feature a panel of speakers who will evaluate the progress achieved and the challenges remaining in the ongoing transformation of our nation's mental health system. Speakers will examine how the financing and organization of mental health care have changed, acknowledging positive advances and highlighting significant weaknesses in the continuum of mental health care.

KEY QUESTIONS

- How have mental health care spending patterns changed over the past three decades in terms of the types of services purchased and the sources of funding? How do these changes compare to overall health care spending?
- To what extent have explicit choices in financing policies influenced the nature of available services and the mix of payers?
- To what extent are spending changes driven by the expanding evidence base in mental health treatment and other clinically motivated changes in the structure of mental health services? Have these changes led to improved patient outcomes?
- Do access and quality vary across income and among racial and ethnic groups? Does severity of illness affect the accessibility and quality of mental health care?
- Should financial incentives such as coverage policies and reimbursement rates be re-aligned at the federal, state, and local levels to further shift the mix of mental health services available and to optimize treatment effectiveness?

SPEAKERS

Sherry Glied, PhD, will discuss how aggregate spending for mental health services has changed over the past several decades, will describe the shifts in treatment settings and financing sources underlying these spending dynamics, and will consider these changes within the context of trends in overall health spending. Dr. Glied is chair of the Department of Health

Policy and Management at Columbia University in New York City, where her principal areas of research are in health policy reform and mental health care policy. Her work in mental health policy has largely focused on the problems of women and children; much of her recent research focuses on the uninsured and health insurance expansion efforts. Dr. Glied served as a senior economist for health care and labor market policy to the President's Council of Economic Advisers, under former Presidents Bush and Clinton. In the latter part of her term, she was a participant in President Clinton's Health Care Task Force.

Benjamin G. Druss, MD, MPH, will discuss the extent to which changes in the funding, organization, and nature of mental health services have resulted in improvements in quality of and access to care. Dr. Druss is the Rosalynn Carter Chair in Mental Health and Associate Professor of Health Policy and Management at the Rollins School of Public Health at Emory University, where he is working to build linkages between the mental health community and the broader public health and health policy communities. Prior to this position, he was on faculty in the Departments of Psychiatry and Public Health at Yale University. Dr. Druss's work focuses on the interface of policy and systems issues between primary care and mental health.

Peter Cunningham, PhD, will review qualitative data from 12 U.S. communities that describe how services for low-income people with serious mental illnesses have been constrained in recent years—especially for uninsured people—as a result of state budget pressures and Medicaid cost-containment policies. Dr. Cunningham is a senior health researcher at the Center for Studying Health System Change, where he specializes in access, the uninsured, and safety net issues. Prior to this position, he was a researcher at the Agency for Healthcare Research and Quality, where he worked on the 1987 National Medical Expenditure Survey.

ENDNOTES

1. Gerald N. Grob, "Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health," *Millbank Quarterly*, 83, no. 3 (2005): 425–456.

2. U.S. Public Health Service, *Mental Health: A Report of the Surgeon General*, Executive Summary, (Rockville, MD: U.S. Department of Health and Human Services, 1999); available at www.surgeongeneral.gov/library/mentalhealth/home.html.

3. New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*, DHHS Pub. No. SMA-03-3832, (Rockville, MD: U.S. Department of Health and Human Services, 2003); available at www.mentalhealthcommission.gov/reports/reports.htm.

4. Ronald C. Kessler *et al.*, "Prevalence and Treatment of Mental Disorders, 1990 to 2003," *New England Journal of Medicine*, 352, no. 24 (June 15, 2005): 2515–2523.

5. Peter Cunningham, Kelly McKenzie, and Erin Fries Taylor, "The Struggle To Provide Community-Based Care To Low-Income People With Serious Mental Illnesses," *Health Affairs*, 25, no. 3 (May/June 2006): 694–705.

Endnotes / continued ➤

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6. Richard Frank and Sherry Glied, "Changes In Mental Health Financing Since 1971: Implications For Policymakers And Patients," *Health Affairs*, 25, no. 3 (May/June 2006): 601–613.

7. Julie Donohue, "Mental Health In The Medicare Part D Drug Benefit: A New Regulatory Model?" *Health Affairs*, 25, no. 3 (May/June 2006): 707–719.

8. Samuel H. Zuvekas, "Prescription Drugs And The Changing Patterns Of Treatment For Mental Disorders, 1996–2001," *Health Affairs*, 24, no. 1 (January/February 2005): 195–205.

*The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at **www.nhpf.org.***