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'Fragmented' mental health systems target of reform

Focus is on cost-effective, evidence-based care

by Kate Tormey (ktormey@csg.org)

Roughly one in four American adults is struggling with a mental illness, according to the National Institute on Mental Health, and half of them are dealing with more than one disorder at the same time. About 20 percent of American children already have had a mental illness at some point in their lives.

While the severity of these disorders varies, the common thread is that mental illness can be life-altering for patients and their families. But for some affected by psychological disorders, help can seem worlds away. There is an average delay of eight to 10 years between when symptoms first show up and when someone seeks help.

Given the widespread nature of mental health issues in this country, why is there such a gap between those who are struggling and the care they need?

"We have a very fragmented system," says Bob Carolla of the National Alliance on Mental Illness. "It is very difficult, if not impossible, for a family to navigate, particularly because the onset of a mental illness often happens quickly."

Historically, Carolla says, the nation's physical and mental health care systems have been separated. Better integrating these two types of care, which are often interrelated, is a key recommendation in a NAMI report assessing state mental health care systems (see graphic on page 6).

Policy experts also point out another major weakness of the U.S. health system: many people simply don't have coverage for behavioral services. In addition to the uninsured, there are those who are "underinsured" — their health plan doesn't cover mental health services in the same way it covers physical conditions.

These structural issues, paired with the stigma associated with mental illness, keep many in need from receiving care.

This lack of care (or care that comes only when a crisis occurs) can be a tremendous strain on states' safety nets.

That's in part because people who live with, or have a child who suffers from, severe mental illness often exhaust their private health coverage, which typically doesn't include ongoing intensive services.

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>
> Bob Carolla, National Alliance on Mental Illness

Mental illness also puts people at higher risk of losing a job or becoming unable to work; others are forced to leave their jobs to care for a loved one. When people lose their private coverage, they turn to public services or Medicaid (if they are eligible).

"There is a cost shift onto public systems because public health care has become the default system for children and adults with the most severe mental health conditions," says Angela Kimball, NAMI's director of state policy.

And other parts of the safety net are impacted as well: emergency rooms, schools, housing and employment programs, and the criminal justice system, for example.

States have policy options

Since 2008, about 30 states — including Illinois, Indiana, Kansas, Nebraska and Ohio — have cut spending on mental health care, according to NAMI. In one-third of those states, including Illinois and Kansas, reductions accounted for more than 10 percent of total funding.

Some policymakers, citing the need for better care, especially for those who could be a danger to themselves or others, have proposed reversing this trend and investing more in mental health programs.

For example, Kansas Republican Gov. Sam Brownback recently announced a new $10 million program aimed at providing mental health care for the seriously ill. The program would put in place a regional system of services for the state's "most

▶ PLEASE TURN TO PAGE 6

Mental health in the Midwest: A look at prevalence of illnesses and state funding of mental health budgets

State	Adults reporting mental illness in past year	State mental health budget, FY 12	Percent change in budget, FY'09-'12	Per-capita state mental health spending, FY'09
Illinois	19.1%	$403.7 million	-31.7%	$85.30
Indiana	21.3%	$245.6 million	-1.7%	$87.65
Iowa	20.8%	$208.2 million	+3.2%	$136.27
Kansas	18.6%	$101.1 million	-12.4%	$130.24
Michigan	21.6%	$1.2 billion	+4.2%	$142.84
Minnesota	19.6%	$204.4 million	+6.8%	$159.13
Nebraska	19.9%	$108.2 million	-0.5%	$73.61
North Dakota	19.0%	$73.9 million	+48.1%	$86.15
Ohio	21.7%	$485.9 million	-5.1%	$74.26
South Dakota	18.8%	$45.5 million	+0.2%	$84.44
Wisconsin	20.1%	$438.4 million*	+4.7%	$121.45

** Total funds, including state, county, grants and other revenue*

Source: National Alliance on Mental Illness

INSIDE

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CONTINUED FROM PAGE 1

Policy options: Integrate care, improve access and implement evidence-based practices

challenging" cases, including intensive case management and care coordination, as well as parent- and peer-support and crisis-stabilization services. A newly created task force will evaluate the state's mental health system and recommend improvements.

Rep. Jim Davnie

But the spotlight on mental health care goes beyond dollars and cents. As a result of recent violence in this country, there has been a renewed focus on the need to improve care for the mentally ill.

The federal Substance Abuse and Mental Health Services Administration reports that people with mental illness account for a very small percentage of violent crime in the United States, and most people with a psychiatric condition are not violent. Still, concerns remain about whether people with serious illnesses, especially children, are falling through the cracks.

Minnesota Rep. Jim Davnie, for example, is working on a set of mental health reforms geared toward school children. Half of all cases of mental illness appear before age 14 — although those affected aren't likely to get care for many years later.

"Mental health practitioners treating adults are so supportive [of the legislation] because they recognize that many of their patients first started experiencing symptoms when they were children or adolescents," says Davnie, a Democrat. "These kids are going to be more successful as adults the sooner that we recognize the mental health issues and connect them with treatment."

Minnesota law already requires teachers to receive training on identifying possible mental illness in children upon re-licensure. A bill being considered this session would require mental health topics to be a part of the already-required high school health class.

"By adding mental health curricula into those classes, you are educating students, which is an opportunity for them to recognize problems in themselves or in their peers," he says. "And we're helping to work through the stigma that is a barrier for so many children and adults to get care."

In addition to identifying mental illness early, states can employ a number of other strategies to make sure those in need receive care.

"State lawmakers are in an incredible position to make a real difference," Kimball says.

Merging mental and physical health

One of the biggest barriers to getting psychiatric care in the United States is that mental and physical health care are treated in different systems. There tends to be little coordination between physical and mental health providers.

And the issue is well evidenced within the Medicaid program, where 11.5 percent of spending is on behavioral health (as opposed to 5 percent in private insurance plans, according to federal statistics).

Over half of disabled Medicaid enrollees also have a mental illness, according to the Integrated Care Resource Center, which helps states implement best practices for integrating physical and mental health for beneficiaries. For people with common chronic conditions and mental illness, health care costs are up to 75 percent higher than for people without a psychological condition. When a substance-abuse disorder is added to the mix, costs jump by two to three times.

Mental health policy experts recommend implementing strategies for "integrated care." One way to achieve this, Kimball says, is to better train doctors who traditionally treat physical ailments.

"[Mental health] isn't an integral part of primary-care training," Kimball says. "The end result is people are not getting routinely screened for mental health conditions."

And the disparity contributes to fears Americans have about mental illness, she adds.

"It is very stigmatizing because you are getting 'specialty care' and it promotes that you have something very wrong with you," she says. "When we don't have integrated care, it perpetuates that idea that mental illness is something unusual and bad."

Kimball suggests that states change their medical licensure laws to require primary-care providers to be better trained in identifying mental health issues. She also points out that some states have had success in requiring mental health screenings in schools.

In Minnesota, for example, children must receive a screening that includes a look at social-emotional and learning issues before they enroll in kindergarten.

Minnesota's Dakota County is also piloting a program aimed at integrating physical and behavioral health services for beneficiaries of public health programs. Under the program, launched in 2009, participants are assigned a "wellness navigator"

State efforts to improve mental health systems: Innovations in the Midwest

INNOVATIONS IN ILLINOIS

- Created Crisis Intervention Teams (CIT) for law enforcement and jail diversion programs
- Investment in peer-provided education and supports, including training for "peer recovery support specialists"
- Community education and awareness efforts seek to reduce stigma and discrimination

INNOVATIONS IN INDIANA

- Uses Assertive Community Treatment (ACT) programs, which provide intensive individualized care in community settings
- Publishes a consumer satisfaction report card for its community mental health programs
- Increasing use of CIT programs in prisons and for police officers

INNOVATIONS IN IOWA

- Legislature involved in ongoing mental health improvement initiatives
- First state to implement a Medicaid option providing more services for residents who meet specific income and other criteria
- Pilot projects to study crisis response services

INNOVATIONS IN KANSAS

- Hospital and Home Initiative identifies best practices and barriers to care
- Emphasizes safe and affordable housing options for people with serious mental health issues or co-occurring disorders
- Certified peer specialists assist discharge planning at state hospitals

INNOVATIONS IN MICHIGAN

- Evidence-based practices include education for families and treatment for people with co-occurring disorders
- Care is person-centered and recovery-focused
- Community mental health service programs include drop-in centers or "clubhouses," where people can voluntarily seek support from peers

INNOVATIONS IN MINNESOTA

- All state-funded insurance plans must cover a uniform package of mental health benefits
- State has invested in mental-health infrastructure through community-based resources and other reforms

INNOVATIONS IN NEBRASKA

- Support for recovery includes housing and employment programs
- Consumer and family teams monitor conditions at the two state hospitals, which are working to reduce use of restraints and seclusion
- Peer specialists to help develop Wellness Recovery Action Plans for patients

INNOVATIONS IN NORTH DAKOTA

- Evidence-based strategies being used include CIT training and a dual-diagnosis treatment initiative
- Consumer and Family Network enhances consumer involvement in policy development and education efforts

INNOVATIONS IN OHIO

- Evidence-based practices are promoted by state's Coordinating Centers of Excellence
- National leader in jail-diversion and community reentry services, such as transitional housing for inmates
- Toll-free phone system provides information and resources to consumers

INNOVATIONS IN SOUTH DAKOTA

- Pilot program promotes screening for depression in primary-care settings
- Community mental health system initiative seeks to better integrate care for people with co-occurring disorders

INNOVATIONS IN WISCONSIN

- State stresses importance of mental health's role in overall health and seeks to better integrate care
- Smoking-cessation programs available in state hospitals and community programs

Source: National Alliance on Mental Illness

who is his or her single point of contact for physical and mental health needs. The pilot program was authorized under a major 2007 reform of the state's mental health system.

Insurance coverage a key concern

Another key barrier for those in need of mental health services is access to coverage and/or affordable psychiatric care.

Iowa conducted a major overhaul of its mental health system last year amid concerns about equal access to care.

"Depending on where you lived, the services you received were different," says Renee Schulte, a former state representative who now works for the Department of Human Services to implement the legislation. The state's services will now be administered at the regional level (instead of by counties) but will be offered on a local level.

In Minnesota, uninsured and underinsured children with a psychiatric diagnosis are helped through a "school-linked mental health services program" that has been in place for four years. Under the program, the state provides grants to clinicians who collaborate with schools to care for children who are referred to the program. The program is aimed at treating young people's illnesses so they can be successful in school, and it often keeps them from needing special-education services.

Renee Schulte

In addition, the Minnesota program maintains privacy by hiring an outside mental health professional instead of a school social worker or guidance counselor. Parents don't have to take time off work, and children can stay in school for their treatment, says Sue Abderholden, executive director of NAMI Minnesota.

"It's a much smarter way to do it than just giving the money to schools," she says. "It is not the role of schools to treat mental illness."

Program successes include decreased suspensions and an increase in the proportion of children who follow treatment plans. The program is currently available in 17 percent of Minnesota schools, and Abderholden is hoping that the Legislature will increase funding this session. With a budget of $4.8 million for the last two years, the program has served about 4,000 children per year.

States have typically cared for their low-income uninsured populations through Medicaid, and expanding access to the program through the federal Affordable Care Act is one way for states to get more people the mental health care they need.

"If a state expands Medicaid, you have a way to pay providers to provide treatment," Kimball says, adding that the Medicaid programs tend to offer extensive coverage for mental health services.

The ACA will also better protect consumers in the private market. Plans sold in the small-group and individual markets through state health insurance exchanges will be required to cover mental health services and substance abuse treatment.

Rethinking treatment delivery

Ensuring coverage for more people, though, isn't helpful if there aren't enough mental health professionals to serve them. Kimball points out that the United States currently faces a shortage of mental health professionals.

The result can be long waits for appointments, a problem that discourages people from getting care and that leaves people in crisis without the help they need. NAMI recommends that states create incentives for people to become mental health professionals.

A key strategy for states to get people appropriate care while keeping costs down is to prevent mental health crises, which often result in expensive emergency care. One way to do this is by bringing services to people in their communities, not only in hospitals.

Kimball holds up Minnesota as a model of this strategy thanks to its Community Behavioral Health Services, a system of crisis and acute-care services, which has reduced the reliance on state hospitals to treat mental illnesses. Instead of simply placing people in inpatient care, the state uses techniques to prevent psychological crises.

For example, through Assertive Community Treatment (a technique used by many state and local governments), patients with serious and persistent mental illnesses are given around-the-clock, individualized treatment at home or in a community setting. These services have resulted in people spending 60 percent fewer days in hospitals, which has resulted in significant savings, a state report concludes.

And mobile crisis teams made up of mental health professionals are helping to ease the burden on the criminal-justice and hospital systems.

"You can call them instead of calling the police," Abderholden says. "They can actually go out to a home and provide stabilization services so people don't end up in hospital."

Thanks to the focus on community-based services, the state saw a 21 percent drop in the number of adults hospitalized in state institutions, and the average length of stay was halved between 2000 and 2010.

Kimball points out that similar programs would not only improve care in many other states, but they would be more cost-effective; states can receive Medicaid reimbursement for care offered in community-based facilities (state hospitals are generally not eligible).

Data and evidence-based services

When NAMI graded states on their mental health systems, Carolla says the organization had a hard time finding quality data about how they were performing.

Without accurate data, he says, "you may have programs running where no one really knows what the effective outcomes are … and what is most cost-effective based on evidence-based practices."

Kimball agrees, recommending that state policymakers consider investing in data collection.

"It's hard to improve without feedback," she says. "However, despite the key role that good data and analytics play in improving both quality and cost efficiency of mental health care, few states have made this a target for investment and focus."

Iowa's recent mental health reforms put in place a "core" set of services everyone should be able to access — and that are backed up by the latest research.

Schulte, who is trained in psychology and has worked as a counselor and case manager, has advocated for her state to get rid of so-called "legacy services," or types of care that have been around for a long time and are no longer considered best practices. For example, placing all but the most seriously ill patients in institutions isn't considered the best option; community-based treatment is considered more effective for many patients.

So what are considered best practices?

Schulte points to programs such as mental health courts, which operate from the traditional criminal-justice system and help mentally ill offenders get treatment they need to stay well — and out of prison. Statistics show that a quarter of state prisoners have a recent history of mental illness. The number is even higher among juvenile offenders: 70 percent.

Over the five-year rollout period, Schulte hopes the state will put in place other evidence-based methods, such as conducting a pre-assessment before committing a patient, launching drug courts, offering crisis services that divert people from emergency rooms, and putting in place better "subacute care" for patients leaving the hospital, which can shorten expensive emergency stays.

"These practices are newer but have more promise," Schulte says. "We're not bouncing people back and forth to prison and the hospital."

Policymakers throughout the country are seeking to utilize these proven techniques. Ohio has been a leader in promoting evidence-based practices through its "Coordinating Centers of Excellence." The centers focus on six key areas of mental illness treatment, and each hold a partnership with an in-state university.

The center for Integrated Dual Disorder Treatment, for example, studies how to best integrate mental health services with substance-abuse treatment. Research shows that this method is three times more effective than providing separate treatment for each disorder. The center assists community-based facilities and state psychiatric hospitals in adopting this approach.

Other centers focus on supported employment, wellness management and recovery, innovative practices, mental illness and developmental disabilities, and criminal justice.

For eight years, Michigan, too, has been promoting best practices in the state's public mental health system. In 2004, the state assembled a group of university researchers, advocacy organizations, consumers and state Department of Community Health staff to develop the strategy for disseminating evidence-based practices.

Programs are focused on "assertive community treatment" (team-based treatment for serious mental illness), education for families affected by a mental illness, supported employment, co-occurring disorders and medication guidelines.

"States play a pivotal role in providing focus, training and support for underfunded community health programs to develop new expertise in best practices," Kimball says.

Improving mental health care: Ideas for policymakers

- ✓ Boost insurance coverage rates for mental health care by expanding Medicaid, promoting enrollment in state exchanges and/or requiring parity with benefits for physical conditions
- ✓ Invest in early intervention and encourage or require mental health screening
- ✓ Provide school-based care to remove barriers to children receiving treatment
- ✓ Improve access to mental health professionals by promoting collaboration between behavioral practitioners and other providers, offering incentives for choosing mental health professions, and requiring primary-care workers to be trained in the diagnosis of mental health conditions
- ✓ Provide "recovery supports" for people with serious mental illness, such as housing, peer support services and employment services
- ✓ Improve crisis response services by training first-responders to identify and respond to mental health emergencies
- ✓ Create support programs for families and friends to understand how to get help for someone with a possible mental health issue

Source: National Alliance on Mental Illness