Bibliography
Updated: October 2005

International News

United Kingdom

http://news.bbc.co.uk/1/hi/health/4034963.stm

Pushing forward reforms to mental health laws will be a priority in the coming year, the Queen promised in her annual speech on Tuesday.

The Mental Capacity Bill will provide rules on caring for people who lack capacity through mental illness or disability.

Proposals to allow patients to make advance decisions to refuse treatment have been criticised by some.

Opponents are concerned the creation of 'living wills' may lead the way to legalised euthanasia.

The Bill would set out a clear test for assessing whether a person lacks capacity to take a particular decision at a particular time.

Under the Bill, which would apply in England and Wales, patients would be able to nominate a person as their designated career to make decisions about their treatment and welfare.

Everything that was done for a person who lacked capacity would have to be in that person's best interests.

It would also be a criminal offence, with a maximum sentence of five years, for anyone who wilfully neglected or ill-treated a person who lacked capacity.

The Queen also said progress would also continue on the draft Mental Health Bill, which includes measures to allow the enforced treatment of potentially dangerous mental health patients.

It is being reviewed by a pre-legislative committee which should report in March.

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Ontario

http://www.health.gov.on.ca/english/public/program/mentalhealth/mental_reform/mentalreform_mn.html

Reforming Ontario's Mental Health System

Mental health reform is an investment in a healthy society. Each year the Ministry of Health and Long-Term Care spends more than $2.5 billion on mental health. This includes approximately $375 million, since 1995, in reinvestments for mental health care programs, infrastructure and community-based services.

In 1998, the Ontario government set in motion a plan to reform Ontario's mental health system. The government listened to key

stakeholders - including consumers, their families and service providers - about changing the way mental health services are delivered.

Following through on these consultations, the Ministry of Health and Long-Term Care produced a strategy called "Making it Happen" - an implementation plan that is the framework for reform - and established nine regional Mental Health Implementation Task Forces to recommend how best to implement reforms to the mental health system.

Through mental health reform, the Ministry of Health and Long-Term Care is shifting to a flexible, coordinated and accountable system of community-based services to deliver needed services and support to those with serious mental illness as close to home as possible. Mental Health Legislative Reform, known as Brian's Law, is part of the government's plan to create this comprehensive, balanced and effective system of mental health services and is in keeping with its commitment to ensure that people with serious mental illness get the treatment they need.

http://www.ctoproject.ca/id12.html [Ontario Community Treatment Order]

The [Ontario Community Treatment Order] legislation requires that the first review must be undertaken during the third year after the date on which the provision for issuing CTOs came into force. Subsequent reviews must be completed every five years after the first review is completed. Also, the Minister is required to make the written report of the person conducting each review available to the public for inspection.

A copy of **the** *Mental Health Act* can be found at:
http://192.75.156.68/DBLaws/Statutes/English/90m07_e.htm

Section 33.9 of the Act requires the Minister of Health and Long-Term Care to establish a process to review:

1. The reasons that CTOs were or were not used during the review period.

2. The effectiveness of CTOs during the review period.

3. Methods used to evaluate the outcome of any treatment used under CTOs.

Brian's Law (Mental Health Legislative Reform), 2000 amended the *Mental Health Act* to allow persons needing psychiatric treatment to live outside of a psychiatric facility under a community treatment order (CTO). The amended *Mental Health Act* describes the purpose of CTOs as follows:

"33.1(3) The purpose of a community treatment order is to provide a person who suffers from a serious mental disorder with a comprehnsive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility. Without limiting the generality of the foregoing, a purpose is to provide such a plan for a person who, as a result of his or her serious mental disorder, experiences this pattern: The person is admitted to a psychiatric facility where his or her condition is usually stabilized; after being released from the facility, the person often stops the treatment or care and supervision; the person's condition changes and, as a result, the person must be re-admitted to a psychiatric facility."

- The criteria for a psychiatric assessment and involuntary admission were changed to permit intervention by health professionals and families at an earlier stage of a person's current epicode of ongoing psychiatric illness to prevent substantial deterioration
- Changes were enacted to allow for CTOs for persons with a history of hospitalization for mental health reasons
- Changes were enacted to allow for wider use of leave of absence provisions so that patients of psychiatric facilities can be monitored and cared for in the community subject to the terms of the leave of absence.

The Act (supplemented by the Regulations) sets out the many conditions that must be met with respect to the issuing and management of CTOs.

2005

Frank, Richard G and McGuire, Thomas G. "Integrating People with Mental Illness into Health Insurance and Social Services," in Pollicy Challenges in Modern Mental Health Care. 2005: Rutgers University Press, New Brunswick, NJ. Pp. 223-237.

". . . in 1997 government played a significant role in financing mental health care, accounting for about 50 percent of spending, but most of that spending occurred through public insurance programs such as Medicare and Medicaid. Less than 15 percent of total spending went directly from government to state and local public mental hospitals. Now a diverse set of private providers and professionals deliver mental health care, including general hospitals, nursing homes, primary care physicians, psychologists, and social workers, among others. Private insurance now accounts for over a quarter of all spending." (223-224).

"The advent of insurance as the central form of financing for mental health care has decentralized decision making and given markets a prominent role. (224)

". . . integrating mentally ill individuals into health insurance and other social programs continues to be a central challenge with a number of dimensions."

". . . One set of integration issues thus involves how to manage mental disorder in the context of general medical care."

"A second aspect of integration concerns the organization and financing of mental health care. As Medicare, Medicaid, and private insurance have come to dominate financing, coverage and payment have become matters of public policy." . . .

"As treatment of people with severe mental disorders have moved from the public mental hospital to community-based settings, care has intersected with social programs aimed at poor and disabled people—a third dimension of integration." (224)

Kessler, Ronald C et al. "Prevalence and Treatment Of Mental Disorders, 1990 to 2003," The New England Journal of Medicine, 352:24 (Jun 16, 2005), 2515-2532.

"The estimated prevalence of a 12-month mental disorder that met the criteria of the DSM-IV did not differ significantly between the surveys (29.4 percent between 1990 and 1992 and 30.5 percent between 2001 and 2003, P = 0.52. There was no significant change in the prevalence of serious disorder (5.3 percent vs. 6.3 percent, P= 0.27), moderate disorders (12.3 percent vs. 13.5 percent, P= 0.30), or mild disorders (11.8 percent vs. 10.8 percent, P=0.37), and not statistically significant interactions between time and sociodemographic characteristics in the prediction of prevalence." (2518)

"Although there are limitations to our study, there were five important results. First, no notable change occurred in the prevalence or severity of mental disorder in the United States between 1990 and 1992 or between 2001 and 2003. . . .

Second, a substantial increase in the rate of treatment occurred between 1990 to 1992 and 2001 to 2003 in the proportion of the populations treated for emotional disorders, even though the majority of those with such disorders still received no treatment. . . .

Third, the increase in the rate of treatment varied among the sectors of mental health services, leading to a shift in the type of treatment, most notable an increase of more than 150 percent in the rate of treatment in the sector of general medical services. . . .

Fourth, the increase in the rate of treatment was unrelated to sociodemographic variables. . . .

Fifth, although a small positive association was found in both surveys between the severity of the disorder and the receipt of treatment,

severity did not interact with time in predicting receipt of treatment." (2519-2522)

"Our data suggest two directions for future research and policy analysis. First, because most people with a mental disorder do not receive treatment, efforts are needed to increase access to and demand for treatment. . . . . Efforts are also needed to evaluate widely used treatment for which there are as yet no data on effectiveness and to increase the use of evidence-based treatments." (2522).

Koyanagi, Chirs et al. "Medicaid Policies to Contain Psychiatric Drug Costs," Health Affairs, 24:2 (March/April 2005, 536-544.

"Exhibit 1. Overview of State Medical Policies Affecting Access to Psychiatric Drugs, 2003. (538-539)

State Medicaid Policy	Number of States
Preferred drug list	20
Any psychiatric drug groups excluded from preferred drug list	13
Prior authorization	49
Exception to prior authorization for any psychiatric drugs	30
Exceptions to generic mandates for any psychiatric drugs	6
Fail-first policies apply to any psychiatric drugs	18
Limits on number of prescriptions apply to any psychiatric drugs	15

"Stressed Out and Traumatised," The Economist, March 5, 2005, 30-31.

Laurie Garduque of the Mac Arthur Foundation, a big funder of research in mental health, points to three key issues that plague the mentally ill in America: a gap between the latest research findings and actual treatment; a gap in access to treatment; and the ongoing stigma of mental illness, which she says is 'alive and well.'" (30)

"The trend away from psychotherapy and towards treatment with medicines worries many in the field, not least because of a debate over the potential side-effects of anti-depressants. (These are still available to teenagers in America, though banned in Britain because they seem to increase the risk of suicide.) The shift away from therapy has occurred not only because drugs have become more effective, but also because they are easier to administer along. Perhaps because of this trend, there

are not too many psychotherapists in large cities on the coast. But while the shrinks of LA and Manhattan may be finding more time for golf, psychologists and psychiatrists are desperately needed in smaller communities across the heartland where—contrary to the tranquil rural image—too many Americans are traumatized, worried or unhappy." (31)

Tannenbaum, Sandra J. "Evidence-Based Practice as Mental Healtlh Policy: Three Controversies and a Caveat," Health Affairs, 24:1(January-February 2005), 163-173.

"In psychology, perhaps the most influential evidence hierarch has been the one adopted by the APA's Division 12 (Clinical Psychology). In the early 1990s Division 12 charged the Task Force on the Promotion and Dissemination of Psychological Procedures with creating a list of Empirically Validated Treatments (EVTs) for dissemination to practitioners and educators. These were treatments (more recently called 'empirically supported' and then 'evidence based') for which there existed sufficiently rigorous evidence of efficacy—at least two RCTs [randomized clinical trials] or ten single-case experimental studies—with patients filling the specific diagnostic criteria of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition." (164)

"This controversy [about the APA list] is complex. . . .Should the public compilation of approved treatments be organized around techniques, or around the kinds of relationships found to be as or more effective in less methodologically controlled studies? Many mental health interventions, as 'socially complex services,' necessarily violate the assumptions—precise protocols, equivalent trial conditions, and more—of experimental research. Experimental methodology is especially ill suited to psychodynamic and humanistic psychotherapies." (165-167)

"A more policy-relevant question might be: Can EBP in mental health commit itself to an inclusive enough evidence hierarch not to privilege techniques unfairly over relationship? Can it do so without further stigmatizing psychology vis-à-vis medicine (including psychopharmacology), thus undermining mental health care's claim to effectiveness worthy of funding?" (166)

"The second controversy is, Can, and if so should, practice consist of the faithful application of research evidence?" . . . The difficulty of changing practitioners' behavior contributes to a larger controversy in mental health about whether practices is in fact applied science." (166-167).

"In the field of mental health, the meaning of *effectiveness* is especially contentious." (169)

Zuvekas, Samuel H. "Prescription Drugs and the Changing Patterns of Treatment for Mental Disorder, 1996-2001," *Health Affairs*, 24:1 (January-February 2005), 195-205.

NOTE: Data is from Medical Expenditures Panel Survey and Excludes homeless people, state psychiatric institutions, nursing homes, and residential treatment centers.

From Exhibit 1—Trends in Mental Health and Substance Abuse Treatment Use and Spending, 1996-2001 (197)

	1996	**2001**	**Compound Growth Rate (%)**
US Population	268.9 m	284.2 m	1.1%
Percent with treatment	9.3%	10.7%	2.9%
Percent with ambulatory use	6.9%	7.1%	0.5
Percent with psychotropic drug use	5.9%	8.1%	6.4%
Mean drug spending per user	$374	$639	6.4%
Total spending on Ambulatory care—constant dollars	$11.9B	$13.2 B	5.0%
Total spending on psychotropic drugs—constant dollars	$ 5.9B	$14.7 B	19.8
Total spending on inpatient stays—constant collars	$ 9.8B	$ 7.3 B	-5.6%
Per capital spending in constant dollars	$103	$124	3.8%

"About 80 percent of the growth in MH/SA drug spending during 1996-2001 is explained by just two categories of medications: selective

serotonin reuptake inhibitors (SSRIs) and other newer antidepressants (52 percent); and atypical antipsychotics (28 percent)." (197)

2004

Lehman, Anthony F. et al. "Evidence-Based Mental Health Treatments and Services: Examples to inform Public Policy." Milbank Memorial Fund, June 2004.

"The states have historically assumed substantial responsibility for the care of persons with severe and disabling mental illnesses across the life span. This responsibility manifests itself in the form of treatment programs directly operated by or contracted for by the states, as well as in the form of state Medicaid programs that support private-sector services. Many persons with severe mental illnesses rely upon these programs as a result of their disability, and the consequent poverty and unemployment to which they are vulnerable. Hence, the treatment of persons with severe mental illnesses represents a major investment of resources for states, as well as for other local government entities. It is essential that these resources be invested wisely so as to maximize value to patients, families, and society." (4)

"A significant approach to increasing the value gained from the expenditure of health care dollars is adoption of evidence-based practices: that is, the purchase of treatments and services that have been scientifically confirmed to improve outcomes. With respect to treatment for persons with severe mental illnesses, the news is both good and bad. The good news is that solid scientific evidence suggests that many potentially available treatments and services are *efficacious*; substantial gains in the form of improved symptoms and functioning are possible with the right treatment. The bad news is that there are substantial gaps between what science tells us to do and what we do in actual practice, despite the significant investment of public resources.[1] These gaps exist for several reasons:

- The knowledge and skills of practitioners, as well as of state mental health authorities, lag substantially behind the evidence. Hence, practitioners and service systems often continue to provide some interventions that either are unsupported by evidence or have been shown to be ineffective.
- Policies related to the expenditure of public mental health dollars often do not hold practitioners or public mental health authorities accountable to provide evidence-based practices and to eliminate practices that do not help people.

Monitoring program fidelity and outcomes is essential for ensuring this accountability.
- Public funding for mental health services in various instances is often inadequate, or is constrained in such ways as to make support for certain evidence-based practices difficult (for example, the awkward and multiple funding streams needed to support certain employment rehabilitation services), or is poorly invested for other reasons. “ (4)

“The policy challenge is not only how to ensure that there are adequate resources to enable the provision of evidence-based practices, but how to hold practitioners and state mental health authorities accountable to ensure that these practices are delivered in an effective manner and that resources are not wasted on ineffective treatments and services.” (5)

“There are two groups of mental health patients of particular concern as regards public-sector policy in the United States:

- Adults with severe and persistent mental disorders, including disorders of late life (e.g., schizophrenia, bipolar disorder, dementia)
- Children and adolescents with severe emotional disturbances (e.g., schizophrenia and other pervasive developmental disorders in addition to conduct disorder) “ (7)

“Patterns of governance, responsibility, accountability, and financing for mental health services have been changing:

- The public mental health system and public mental health authorities now serve most population groups.
- No one agency is accountable for all services and resources.
- The service system is fragmented, making it difficult to meet the multiple needs of each individual.
- Financing streams, especially federal funding sources, have changed significantly in the past decade with contraction and reduction of social service funding sources and expansion of Medicaid as a source of ever-widening treatment and support.
- Considerable devolution of responsibility has taken place at all levels of government, in accordance with the so-called new federalism and the trend toward increasing home rule. “(7)

“Although evidence-based practices are necessary for a quality mental health system, they are not sufficient. This is a critical point.

> A distinction must be made between treatments and services that have been shown to be ineffective (or substantially less effective than other evidence-based alternatives) and those about which there is little or no systematic evidence either way. Clearly, the former are to be discouraged in favor of proven evidence-based alternatives. For many services, however, there is often little systematic outcome evidence upon which to base informed decisions. Practitioners and policymakers are left to evaluate the merit of these services based upon prevailing professional standards of practice, community needs, and other pragmatic factors."(18)

Mark, Tami L. and Coffey, Rosanna M. "The Decline in Receipt of Substance Abuse Treatment by the Privately Insured, 1992-2001," *Health Affairs*, 23:6 - (November/December 2004), 157-162

> Study based on a MarketScan database of large employers, mostly Fortune 200 companies.
>
> "The percentage using any SA [substance abuse] services declined by 23 percent from 1992 to 2001. This decline was evident in all categories: inpatient, outpatient, and pharmaceutical usage." (158)
>
> "Overall, SA spending per covered life fell by 73.6 percent in nominal dollars. Expressed as a percentage of total health care spending, spending for substance abuse fell to an even greater degree, from making up 1.16 percent of total health care expenditures to only 0.2 percent in 2001." (159)

Mechanic, David and Bilder, Scott. "Treatment of People with Mental Illness: A Decade-Long Perspective, *Health Affairs*, 23:4 (July/August 2004), 84-95.

> Data source: Health care for Communities survey of the Community Tracking Survey.
>
> "Few major changes are apparent in the HCC [Health Care for Communities] data, both cross-sectional and longitudinal, comparing care over the three years when services were said to be deteriorating. However, there is evidence of increased access to care for people with SMI [serious mental illness] in the later period (2000-2001). The data also show decreased care for people with OMI [other mental illness] and those with not mental illness. The picture is less than encouraging because many people who reported needing care and who could benefit from evidence-based treatments were not receiving such care." (92)

> "Once people entered the mental health specialty sector, there was not apparent or statistically significant relationships between seriousness of illness and the number of visits, an observation made in earlier studies as well. It appears that there may be a 'democratization of care' in the specialty sector that gives insufficient attention to disparities in need once people have entered into care." (93)
>
> The good news—contrary to frequent assertions in the mental health community as noted at the outset—is that access to care for people with SMI has improved, and there is evidence of progress even in the more proximate period between 1997 and 2001. People with SMI were more likely to receive mental health specialty services in 2001 than in 1997, but those with OMI and no mental illness each showed declines. Since the latter two populations are much larger than the population with SMI, these decreases in the aggregate may contribute to the perception that services are less available." (93)

2003

Alegria, Margarita et al. "The Role of Public Policies in Reducing Mental Health Status Disparities for People of Color, *Health Affairs*, 22:5 (September/October 2003), 51-64.

Appelbaum, Paul S. "The 'Quite' Crisis in Mental Health Services," *Health Affairs*, 22:5 (September/October 2003), 110-116.

> "Over a little more than a decade, I have witnessed the progressive and systematic defunding of psychiatric services in Massachusetts and—despite some regional variation—in the United States as a whole. As a result, provision of mental health treatment in organized setting such as hospitals and clinicians has often become a money-losing proposition. With inpatient units and outpatient clinics driven by the inexorable economics of the situation to downsize or close, people in need of treatment are finding it more difficult, if not impossible, to get care. The situation is compounded by the flight of private practitioners from managed care networks, leaving insured patients struggling to find clinicians who will accept their coverage, and by the continuing retreat of the states from their historical roles as providers of last resort for psychiatric care." (110)
>
> Acute inpatient care in Massachusetts, except for the few state-run CMHCs [community mental health centers], is provided entirely in the private sector. State hospitals no longer have any acute inpatient units. As with outpatient care, Medicaid is the payer for most indigent patients who require hospital admission. Uninsured patients who are not on the Medicaid rolls, either because they do not quality for the program (a group

that has been increasing in number as the eligibility criteria have been tightened) or because they simply have never enrolled, must be admitted by any hospital unit that has a Medicaid contract as a condition of participation in the program. Essentially, the cost of hospitalizing the uninsured have been shifted to the hospitals; a fraction of the Medicaid day rate may be reimbursed to hospitals through a state-run free-care pool, but the bulk of the funds available in the pool come from contributions by those same hospitals." (111)

"Some number of patients who are unable to obtain timely outpatient care deteriorate to the point where urgent intervention is required. Emergency rooms are seeing a steady increase in the number of patient coming in for psychiatric evaluations. Clinicians in those settings have the impression that the increase in numbers is paralleled by a rise in the level of psychopathology and degree of acuity. As bad as the situation is for adults, it appears to be even worse for children. " (113)

Patients requiring admission back up in our emergency rooms as staff spend hours trying to find facilities that can and will accept them. Some unlucky patients are kept in holding beds in the emergency room for days while beds are sought." (114)

I have found that I was not bringing any news to people working in the mental health system. They were well aware of the situation I have described and of the forces that have brought it about. But I found little awareness of the severity of the problem on the part of political leaders, public administrators, insurers, business leaders, and others who could actually bring about some of the needed changes. In part, I think this is attributable to the slowly progressive nature of the problem. Instead of a sudden cataclysm, the mental health system has undergone steady attrition of available services and a corresponding diminution in access for people needing care." (115)

Brosseau, Ruth Tebbets et al. "Are Foundations Overlooking Mental Health, *Health Affairs*, 22:5 (September/October 2003), 222-229.

"The role of organized philanthropy in mental health can be traced to the early 1900s. The Rockefeller Foundation and the Milbank Memorial Fund were key funders in the establishment of the National Committee for Mental Hygiene in 1909. This organization, which later merged with two other groups to become the National Mental Health Association, brought together psychiatrists and citizens to focus on improving conditions and services for people with mental illness. Since its inception, it has been pivotal in shaping mental health policies and practices." (223).

"With the NIMH [National Institutes of Mental Health] in place, the responsibility for support of mental health research moved from the private to the public sector. Foundations continue to plan an important role in supporting mental health research, but public funds are now the primary source of mental health research dollars." (223)

"The last decade of the twentieth century witnessed an explosion in the growth of foundations, fueled in part by the longest-running bull market in U.S. history and by the early stages of an inter-generational transfer of wealth from those who made fortunes in the post-World War II era. According to FC [Foundation Center] data, in 1991 there were 33,000 foundations with combined assets of about $163 billion. By 2000 there were more than 56,000 foundations, and assets had more than tripled to reach $486 billion." (223-224)

"Foundation giving for mental health also increased funding the 1990s, but not at the same high rate as foundation giving generally or giving for health. The FC's annual data include grants for mental health and substance abuse (hereafter referred to as behavioral health). This category of giving increased from $108 million in 1991 to $218 million in 2000. Although the amount of grant funds going to behavioral health increased, this category became a smaller proportion of all foundation giving (dropping from 2.2 percent in 1991 to 1.5 percent in 2000)" (224)

"Data, recent trends, and discussion in GIH [Grantmakers in Health] meeting sessions on mental health over the past two years suggest several possible explanations for the relative decrease in mental health funding.

- First, mental health is not a major focus of either the largest foundations or the largest health foundations. . . .
- Second, the crisis of the uninsured has preoccupied health funders. …
- Third, the move to managed care contributed to marginalizing mental health. …
- Fourth, some foundation may avoid grant making in mental health because of a perception that their available resources are insufficient to address the current financing deficiencies for mental health services. In addition, the mental health system is sometimes perceived as being more fragmented and uncoordinated than the physical health system. As a result, foundation may believe that it is difficult to develop an effective strategy for promoting measurable change or to identify gaps that can be addressed through grant-making programs. Few foundations have staff with expertise in mental health.

- Fifth, new foundations are slow to move into mental health funding.[exceptions are the California Endowment and the California Wellness Foundation]. . . .” (226)

“The lists of top mental health funders and top grant recipients illustrate an important barrier to foundations impact. Rather than displaying a picture of a systematic approach to improving mental health services and policies, these lists demonstrate a patchwork quilt of funding, with each foundation having a different emphasis and geographic focus. Although foundations as a whole address a wide range of mental health issues and use a broad array of approaches, they infrequently communicate with each other, even when addressing the same issues. National foundations seldom work directly with state and local grantmakers to shape a collaborative foundation approach to a particular issue. Nor do most state, regional, or local foundations look to national foundations for leadership, because they respond primarily to needs in their target geographic areas. The tendency of most foundation to act as solo practitioners prevents a more collaborative or coordinated approach.” (227).

“Foundations have an important role to play in building knowledge about the need for mental health services and the capacity of mental health service systems at the local, state, and national levels. If foundations are to use their resources effectively, they must first understand what services people need, how they gain access to them, and the barriers they encounter.” (227)

Frank, Richard G. et al. “Medicaid and Mental Health: Be Careful What You Ask For,” *Health Affairs*, 22:1 (January/February 2003), 101-113.

“Medicaid has evolved into one of the most important components of the health care safety net for people with mental disorders.” (101)

Medicaid pays for a broad range of acute and long-term mental health care services. These range from acute hospital services, to psychosocial rehabilitation services, to a range of psychotropic medications. Medicaid spending on treatment of mental disorders accounts for about 20 percent of total mental health care spending in the United States in 1997.” (101)

Medicaid pays for mental health care primarily for two distinct populations: people enrolled in Temporary Assistance of Needy Families (TANF) and those enrolled in Supplemental Security income (SSI).It serves as a typical insurance program for TANF recipients, who have somewhat higher rates of treatment for mental disorders than the general population. For SSI, Medicaid provides financing for a key set of services for people

with severe and persistent mental disorders (including general medical care). (101-102)

Medicaid's role in the mental health safety net is a relatively new development. SSI's enrollment of people with mental disorders began its dramatic expansion in 1984, when new disability evaluation criteria were introduced by the Social Security Administration. Medicaid's changing role has helped to realign the division of labor between the historical government provider (and payer) of last resort, state mental health agencies, and the state-federal Medicaid programs, with its ties to insurance. One outcome of this realignment was a speeded-up deinstitutionalization process and a lesser-known phenomenon of moving psychiatric patients from one set of custodial institutions to others, referred to as trans-institutionalization. (102-103)

"State mental hospitals were viewed as custodial institutions and were the largest component of mental health spending during the 1960s. . . .the regulations governing Medicaid prohibited Medicaid payments to institutions of mental disease (IMDs) for people age 22-64. This means that a person eligible for Medicaid can have the costs of inpatient psychiatric care in a general hospital psychiatric unit reimbursed but not inpatient care provided in a state mental hospital." (105)

Glied, Sherry and Cuellar, Alison Evans. "Trends and Issues in Child and Adolescent Mental Health, *Health Affairs*, 22:5 (September/October 2003), 40-50.

"An estimated 11 percent of American children and adolescents have ad diagnosable mental health condition that causes significant functional impairment." (40)

Exhibit 1. Tends in Use of Child Mental Health Services (42)

Type of service/ Coverage source	Mid-1980s	Late 1990s
Child ambulatory care physician visits		
• Psychotropic drug prescribed	1.093 million (0.79% of all child visits)	4.49 million (3.31% of all child visits)
• Mental health diagnosis	1,901,310 (2.64% of all child visits)	5,950,106 (7.68% of all child visits)
All Children		
• Percent with treated disorder	4.95%	7.74%
• Percent with mental health ambulatory care visit	4.56	6.65

Children with a treated disorder • Medicaid • Privately insured	 9.19% 69.5%	 18.74% 59.21

"Despite these expansions in outpatient and pharmacological treatment, aggregate nominal spending on child mental health services remained virtually unchanged over this period, mainly because these expansions coincided with a sharp decline in costly inpatient service use." (43)

"In the late 1990s lengths-of-stay had fallen dramatically—to eight days in general hospital inpatient units. Rather than serving as treatment modalities, inpatients units are increasingly providing crisis care and discharging seriously ill children for community follow-up." (43)

"These new patterns of care—increased use of medication treatment through the medical system and more limited use of specialized inpatient facilities—have put greater demand on community-based modes of therapy and on services in the specialty medical sector. Many communities now report lack of availability of child psychiatrists and of inpatient hospital beds for crisis care in children." (43)

"After rising slowly through the 1980s, the ratio of child psychiatrists to children has remained flat since 1990." (44)

"Institutional alternatives to long-term hospitalization are also lacking in many communities. Reductions in inpatient service use have been accompanied by increase in the use of case management services, partial hospitalization, and other community-based services. However, the increase in the provision of these services—particularly evidence-based services—has not kept pace with reductions in inpatient use. Without viable community-based alternatives, families rely on crisis hospitalization in general hospital beds. The number of short (less than three days) stays in general hospital inpatient beds by child psychiatric patients increased by 41 percent from 1986 to 2000." (44)

"Expansions of Medicaid in the late 1980s and the introduction of SCHIP in the late 1990s altered the insurance distribution among children who used mental health services. The share of all children, and of children using services, who were uninsured fell." (44)

Goldman, Howard H. "How do you Pay your Rent? Social Policies and the President's Mental Health Commission, *Health Affairs*, 22:5 (September/October 2003), 65-72.

Huskamp, Maiden A. "Managing Psychotropic Drug Costs: Will Formularies Work?" *Health Affairs*, 22:5 (September/October 2003), 84-96.

Lave, Judith. "Developing A Medicare Prospective Payment System for Inpatient Psychiatric Care, "*Health Affairs*, 22:5 (September/October 2003), 97-109.

Mechanic, David. "Is the Prevalence of Mental Disorders A Good Measure of the Need for Services?" *Health Affairs*, 22:5 (September/October 2003), 8-20.

> "A major deficiency of measures to assess need is the lack of adequate longitudinal data on the persistence of symptoms, conditions, impairments and disabilities and how patterns change over time." (17)
>
> "Managed behavioral health care as currently administered is poorly regarded by many mental health professionals and patient advocates, but if we are to have a responsive mental health care system that is equitable and affordable, the benefit will require management. Such management should be build on individual assessment of need, guided by evidence of treatment efficacy and by a knowledge base informed by understanding of the benefits of treatment in terms of impairments, disabilities, and social role capabilities." (17)
>
> "The question remains: Should insurance cover mental health services of proven effectiveness if patients fail to meet the formal criteria of specified disorders? This is an increasingly important issue, as medical science and technologies bring new possibilities for improving performance, extending health life, and enhancing mood and quality of life. When only modest spending amounts are at stake, clinicians will find justifiable diagnoses. But as expenditure possibilities mount, the question of what should be covered or not and under what circumstances will become more pressing." (18)

Monahan, John et al. "Mandated Treatment in the Community for People with Mental Disorders," *Health Affairs*, 22:5 (September/October 2003),28-38.

New Freedom Commission Mental Health, "Background Paper: Subcommittee on Acute Care," *Achieving the Promise: Transforming Mental Health Care in America, Final Report*, DHHS Pub no. SMA-04-3876. U.S. Government Printing Office, 2004.

> "An important role for acute care is to provide a safe setting to address crises and to evaluate and assess the adult or child who is in crisis. It is generally thought that, in an ideal, fully developed mental health service system, inpatient settings are most appropriate for those situations in which personal safety is a significant consideration." (1)

"What seems clear from the national data is that the supply of most types of beds for short-term inpatient psychiatric care has declined with the most severe drop occurring in publicly operated services . . . . The decline in the supply of services has accompanied an increasing demand for admission into short-term inpatient care as shown by continued growth in additions [increase admissions] to some of these facility types. Increasing admission can co-exist with a shirking bed supply because of the continued drop in the length of stay nationally and an increase in average occupancy rates. In some communities, these conditions have led to the inability to admit people into short-term inpatient care." (6)

"The Subcommittee [on Acute Care of the New Freedom Commission on Mental Health] envisions a work group started and initially funded by the Federal Government with full participation by all stakeholder groups. The mission of the work group would be to:

- Synthesize existing knowledge,
- Review the many outstanding existing model programs,
- Develop new knowledge as necessary, and
- Attempt to develop a consensus on and policy options relevant to the following issues
    - The role of acute care in an array of community mental health services, including the proper connections among services.
    - The range and types of longer-term care and support services needed to effectively complement acute care in a comprehensive community system, with particular attention to evidence-based services and need for consumer involvement.
    - The forces that shape the role of acute care and the relationships in the service system.
    - Methods of assessing and quantifying the need for short-term 24-hour care. Such methods could include more widespread use of comprehensive, multi-disciplinary mental health assessment systems to indicate the appropriate level of acute care in the continuum of care. Also valuable would be the development and widespread use of psychiatric beds needs analysis. The methods should recognize that these assessments must be tailored to local conditions and regional variations.
    - Methods for paying for acute and crisis care that support a vision for a comprehensive system of care.
    - Standards for coordinating care between short-term 24 hour services and non 24-hour community services. These standards must consider the 'functional interface' between these setting that takes different forms in different communities on the basis of existing resources and policies

in other human services, such as in housing, homelessness services, and criminal justice for adult populations; and in child welfare, school, and juvenile justice for child populations.

- o Standards for determining the appropriate content of care and what constitutes effective short-term, 24-hour care and treatment." (9)

New Freedom Commission Mental Health, "Executive Summary," *Achieving the Promise: Transforming Mental Health Care in America, Final Report*, DHHS Pub no. SMA-03-3832. U.S. Government Printing Office, 2003.

"In any given year, about 5% of adults have a serious mental illness, according to several nationally representative studies. A similar percentage of children—about 5% to 9%--have a serious emotional disturbance." (2)

"Mental illnesses rank first among illness that cause disability in the United States, Canada, and Western Europe." (4)

"In the U.S., the annual economic, indirect costs of mental illness is estimated to be $79 billion. Most of that amount—approximately $63 billion—reflects the loss of productivity as a result of illness. But indirect costs also include almost $12 billion in mortality costs (lost productivity resulting from premature death) and almost $4 billion in productivity losses from incarcerated individuals and for the time of those who provide family care." (4)

"Successfully transforming the mental health service delivery system rests on two principles:

- First, services and treatments must be consumer and family centered, geared to give consumers real and meaningful choices about treatment options and providers—not oriented to the requirements of bureaucracies.
- Second, care must focus on increasing consumers' ability to successfully cope with life' challenges, on facilitating recovery, and on building resilience, not just on managing symptoms." (7)

"Goals: In a Transformed Mental Health System
Goal 1: American 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 to Services are Common Practices.
Goals 5: Excellent Mental Health Care is Delivered and Research is

Accelerated.
Goals 6: Technology is Used to Access Mental Health Care and Information." (8)

"The transformed mental health system will rely on multiple sources of financing with the flexibility to pay for effective mental health treatments and services. This is a basic principle for a recovery-oriented system of care." (11)

"In partnership with their health care providers, consumers and families will play a larger role in managing the funding for their services, treatments, and supports. Placing financial support increasingly under the management of consumers and families will enhance their choices. By allowing funding to follow consumers, incentives will shift toward a system of learning, self-monitoring, and accountability. This program design will give people a vested economic interest in using resources wisely to obtain and sustain recover." (12)

"The transformed system will ensure that needed resources are available to consumers and families. The burden of coordinating care will rest on the system, not on the families or consumers who are already struggling because of serious illness." (12)

New Freedom Commission Mental Health, "Policy Options, Subcommittee on Medicaid," February 5, 2003.

"The Subcommittee [on Medicaid of the New Freedom Commission on Mental Health] presents broad policy options within each policy goal area.

Improve Access

1. Delays and uncertainty related to Medicaid eligibility should be addressed.
2. Access to mental health related treatments and supports should be made equivalent to access to primary care.
3. Incentives and options for retaining health care coverage should be created and/or utilized.

Enhance Service Delivery

1. Public financing should support evidenced-based practices that are necessary and effective for successful community living.
2. Medicaid financial incentives and opportunities for the most appropriate community-based care should be increased.
3. Financial and regulatory barriers to the efficient and effective delivery of services should be eliminated.

Enhance Service Planning and Coordination

1. Federal leadership should guide and facilitate improved planning among State agencies that fund and implement services for persons with mental illness.

2. The federal government should assure proper data collection and reporting to facilitate and support mental health planning and quality management at all levels of the public mental health system.

Increase Consumer Responsiveness and Continually Improve Quality

1. The Medicaid program should facilitate the development and implementation of methods to promote consumer choice and control through recovery-oriented service models, including effective consumer-operated and peer services.
2. The Medicaid program should foster and facilitate early identification and treatment of youth with potential serious emotional disturbance.
3. Integration of primary health and mental health benefits and treatments should be enhanced through the Medicaid program.(4)

Regier, Darrel A. "Mental Disorder Diagnostic Theory and Practical Reality: An Evolutionary Perspective, *Health Affairs*, 22:5 (September/October 2003), 21-27.

Rowland, Diane et al. "Accomplishments and Challenges in Medicaid Mental Health, *Health Affairs*, 22:5 (September/October 2003), 73-83.

> "Mental health benefits available under Medicaid are generally more comprehensive than those offered by other payers." (75)
>
> "In many areas of mental health, Medicaid has been tapped repeatedly as an open source of funds to replace state-only dollars with federal matching dollars, most notably for care formerly provided in state mental facilities with state dollars. However, in one area—nursing and hospital services in an institution for mental disease (IMD)—states have not been able to shift the cost of care to their Medicaid programs. Under federal Medicaid rules, states can provide this benefit for people age sixty-five or older and can provide inpatient psychiatric hospital care to people under age twenty-one, but they may not use Medicaid to finance care for other people in these facilities." (76).
>
> "Although states have been making progress in providing community-based alternatives to institutional care, the demand still greatly exceeds the availability of these services." (77).
>
> "States facing budget shortfalls are likely to reexamine their coverage for people with mental illness who are among the costliest populations to serve. Such beneficiaries constitute only 11 percent of Medicaid beneficiaries, but they account for a third of high-cost beneficiaries." (81)
>
> "One reason for the high cost of care for this population is prescription drug use, which is one of the fastest-growing areas of Medicaid spending.

Most Medicaid beneficiaries with schizophrenia or affective disorders use psychotropic drugs covered by Medicaid, with the majority using more than one prescription for their mental health needs. Although the advent of new pharmaceutical technologies is help these people lead more productive lives, such advances come at a price. From 1992 to 1998 Medicaid payments for antipsychotic drugs grew by nearly 300 percent, and spending on antidepressants grew more than 240 percent." (81)

Scheffler, Richard M and Kirby, Paul B. "The Occupation Transformation of the Mental Health System, *Health Affairs*, 22:5 (September/October 2003), 177-189.

"Looking at workforce growth in recent years, we see dramatic changes. The most striking observation is the slowing of growth in the number of psychiatrists relative to the other professions, beginning in the mid-1990s. Psychiatrists have a unique role in the mental health marketplace, in part because of their training in psychopharmacology. Nonetheless, it is clear that psychologists and social workers are increasingly the largest component of the [mental health] workforce." (178)

"While the overall trend among psychiatrists has been one of very slow growth, this masks an important shift in psychiatric specialization. The number of child psychiatrists has increased much more rapidly than that of those treating only adults." (179).

"For each profession, the income gradients show a strong positive association between state per capita income and supply of mental health providers." (179)

"In 1982 they [psychiatrists] had the third-lowest mean net income among physicians; only general/family practitioners and pediatricians earned less. By 1996, psychiatric incomes had fallen to last place among physicians." (181)

"These income trends, in conjunction with changes in workforce composition, suggest that future growth in the mental health workforce will be weighted toward the lower-cost professions of psychology and clinical social work. The general consensus is that these trends are reinforced by the increased penetration of managed care. Our view is that this claim is persuasive." (182)

"The total enrollment in behavioral health programs (the term often used by provider organizations to refer to mental health care) rose from 70.4 million covered lives in 1993 to 169.1 million in 2000." (182)

. . . the percentage of psychiatrists who have any managed care contracts has roughly tripled, rising from 21 percent in 1985 to 61 percent in 1995,

an increase proportionate to that observed among all physicians (28 percent and 80 percent, respectively). . . the mean share of psychiatrists' revenue composed of managed care contracts rose from 4.5 percent in 1987 to 44.1 percent in 1998, compared with a jump from 13 percent to 52 percent for all physicians in the same period." (183)

"A common conception of psychiatrists' evolving role in the mental health system is that they increasingly serve as 'medication managers'." (185)

"If psychologists gain widespread prescribing privileges, we would expect less demand for psychiatrists, since the latter are higher-cost providers." (186).

Warshaw, Carole. "Fragmented Services, Unmet Needs: Building Collaboration Between the Mental Health and Domestic Violence Communities, *Health Affairs*, (September/October 2003), 241-249.

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Bailit, Michael H. and Burgess, Laurie L. "Competing Interests: Public-Sector Managed Behavioral Health Care, *Health Affairs*, 18:5 (September/October 1999), 112-115.

Burnam, M. Audrey and Escarce, Jose J. "Equity in Managed Care of Mental Disorders, *Health Affairs*, 18:5 (September/October 1999), 22-31.

Burns, Barbara J. et al. "Managed Behavioral Health Care: A Medicaid Carve-Out for Youth," *Health Affairs*, 18:5 (September/October 1999), 214-225.

"Managed care has resulted in a shift from use of demand-side cost containment strategies, which influence consumers' decisions through benefit-design features, to supply-side cost-control strategies. While it is clear that access to care continues to be restricted under managed care, the rules that define the restrictions are now much less obvious than were benefit restrictions. Utilization management protocols, definitions of *medical necessity*, formularies, and features of contracts with providers are not easily discerned and often are considered proprietary information. The ways in which managed care environments and processes influence the decisions of gatekeepers and treating clinicians are difficult to predict." (27)

"The appeal of managed care for containing costs is undeniable. Constraining costs through supply-side mechanisms rather than through benefit design can be a much more finely tuned rationing tool than demand-side benefit design, eliminating care where expected benefits are low and costs are high and substituting lower- for high-cost alternatives

when there is no or little marginal benefit to be had from paying more. Offering a more flexible benefit that is rationed on the basis of medical need by clinicians and case managers enables mental health care resources to be tailored to individual need.

At the same time, there are concerns that managed care strategies may encourage skimping or insufficient access to appropriate care, particularly if the providers themselves carry financial risk for services used by their patients." (27-28)

"The diagnostic methods used today, such as DSM-IV, use polythetic sets of criteria that organize self-reported symptoms and history of illness into specific disorders. The strength of this approach is reliability—that is, the ability of two trained observers to make the same diagnosis. What is far weaker for many of the diagnoses is validity. For some illnesses (schizophrenia, manic-depressive illness, major depression, panic disorder, and obsessive-compulsive disorder), for which much research data exist, this type of diagnostic system works about as well as most diagnostic approaches in medicine do. Thus, the procedure for making a clinical diagnosis of these illness is not much different from making a diagnosis of Alzheimer's or Parkinson's disease. The problem in mental disorders is the substantial number of categories in diagnostic schemata such as the DSM-IV for which there is little research evidence (for example, personality disorders). Persons who meet criteria for such diagnostic categories may represent a very wide spectrum of persons indeed, and these "diagnoses" may contain little useful information for prognosis or treatment response." (35)

"There are no current biological indicators for any specific mental illness, but intensive efforts are under way to find such markers based on abnormalities found in brain structure or functioning for many mental disorders and on abnormalities in cognitive testing." (36)

Feldman, Saul. "Strangers in the Night: Research and Managed Mental Health Care, *Health Affairs*, 18:5 (September/October 1999), 48-51.

". . . , the dominant changes in the way mental health services are provided and paid for that developed in the latter half of the twentieth century (community mental health care and managed care) were not the products of or particularly influenced by research findings. Rather, they came about much more as the result of economic and social factors in the larger society of which mental health services are a part." (48)

". . . managed mental health care came into being with little, if any, research based (with the exception, perhaps, of what had been done in managed medical care). It was an attempt to fix what appeared to be a major and rapidly growing problem: the escalating costs and questionable

quality of mental health services in the 1980s. The costs were in good measure the result of another change that had no empirical base: the rapid growth of private for-profit psychiatric hospitals. Because of what appeared to be the economic success that managed care was having in general medicine, the belief (or, perhaps more accurately, the hope) was that similar results could be attained in mental health." (48-49)

Findlay, Steven. "Managed Behavioral Health Care in 1999: An Industry at a Crossroads," *Health Affairs*, 18:5 (September/October 1999), 116-124.

Foote, Sandra M. and Jones, Stanley, B. "Consumer-Choice Markets: Lessons from FEHBP Health Coverage, *Health Affairs*, 18:5 (September/October 1999), 125-130.

Frank, Richard G. et al. "The Value of Mental Health Care at the System Level: The Case of Treating Depression, *Health Affairs*, 18:5 (September/October 1999), 71-88.

Goldman, William et al. "more Evidence for the Insurability of Managed Behavioral Health Care," *Health Affairs*, 18:5 (September/October 1999), 172-181.

Hogan, Michael F. "Public-Sector Mental Health Care: New Challenges," *Health Affairs*, 18:5 (September/October 1999), 106-111.

Kessler, Ronald C. et al. "Depression in the Workplace: Effect on Short-Term Disability," *Health Affairs*, 18:5 (September/October 1999), 163-171.

Lehman, Anthony F. "Quality of Care in Mental Health: The Case of Schizophrenia," *Health Affairs*, 18:5 (September/October 1999), 52-65.

"Schizophrenia is diagnosed in about 1 percent of the population worldwide, translating into about 2.5 million Americans. Because of its chronicity and associated disability, it accounts for 2.5 percent of all U.S. health care costs, 10 percent of all permanently and totally disabled citizens, and about 20-30 percent of the homeless." (54)

Mechanic, David and McAlpine, Donna. "Mission Unfulfilled: Potholes on the Road to Mental Health Parity, *Health Affairs*, 18:5 (September/October 1999), 7-21.

"Even in general hospitals, lengths-of-stay among persons with a primary psychiatric diagnosis in private, non-profit general hospitals—the primary place for acute inpatient care—fell from 12.6 days in 1988 to 8.6 days in 1995, despite a more severely ill patient population." (11)

Norquist, Grayson and Hyman, Steven E. "Advances in Understanding and Treating Mental Illness: Implications for Policy," *Health Affairs*, 18:5 (September/October 1999), 32-47.

Rosenheck, Robert A. "Effect of Declining Mental Health Service Use on Employees of a Large Corporation," *Health Affairs*, 18:5 (September/October 1999), 193-203.

Rosenthal, Meredith B. "Risk Sharing in Managed Behavioral Health Care, *Health Affairs*, 18:5 (September/October 1999), 204-213.

Rubenstein, Lisa V. et al. "Evidence-Based Care for Depression in Managed Primary Care Practices," *Health Affairs*, 18:5 (September/October 1999), 89-105.

Sharfstein, Steven S. et al. "Managed Care and Clinical Reality in Schizophrenia Treatment, *Health Affairs*, 18:5 (September/October 1999), 66-70.

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. 1999.

> "In the United States, mental disorders collectively account for more than 15 percent of the overall burden of disease from *all* causes and slightly more than the burden associated with all forms of cancer." (3)
>
> "Mental disorders and mental health problems are treated by a variety of caregivers who work in diverse, relatively independent, and loosely coordinated facilities and services—both public and private—that researchers refer to, collectively, as the *de facto mental health service system*. . . .
>
> - The *specialty mental health* sector consists of mental health professionals such as psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers who are trained specifically to treat people with mental disorders. The great bulk of specialty treatment is now provided in outpatient settings such as private office-based practices or in private or public clinics. Most acute hospital care is now provided in special psychiatric units of general hospitals or beds scattered throughout general hospitals. Private psychiatric hospitals and residential treatment centers for children and adolescents provide additional intensive care in the private sector. Public sector facilities include state/county mental hospitals and multiservices mental health facilities, which often coordinate a wide range of outpatient, intensive case management, partial hospitalization, and inpatient services. . . .
> - The *general medical/primary care* sector consists of health care professionals such as general internists, pediatricians, and nurse

practitioners in office-based practice, clinics, acute medical/surgical hospitals and nursing homes. . . .

- The *human services* sector consists of social services, school-based counseling services, residential rehabilitation services, vocational rehabilitation, criminal justice/prison-based services, and religious professional counselors. . . .
- The *voluntary support network* sector, which consists of self-help groups, such as 12-step programs and peer cou8nselors, is a rapidly growing component of the mental and addictive disorder treatment system." (405-406)

"Each sector of the de facto mental health service system has different patterns and types of care and different patterns of funding. Within the specialty mental health sector, state- and county-funded mental health services have long served as a safety net for people unable to obtain or retain access to privately funded mental health services. The general medical sector receives a relatively greater proportion of Federal Medicaid funds, while the voluntary support network sector, staffed principally by people with mental illness and their families, is largely funded by private donations of time and money to emotionally supportive and educational groups." (407)

A Vision for the Future [of Mental Health]

- Continue to Build the Science Base
- Overcome Stigma
- Improve Public Awareness of Effective Treatment
- Ensure the Supply of Mental Health Services and Providers
- Ensure Delivery of State-of-the-Art Treatments
- Tailor Treatment to Age, Gender, Race and Culture
- Facilitate Entry into Treatment
- Reduce Financial Barriers to Treatment (453-458)

Zarin, Deborah A. et al. "Characteristics of Health Plans that treat Psychiatric Patients," *Health Affairs*, 18:5 (September/October 1999), 226-236.