Improving Mental Health Care in the States:
Opportunities for Governors

DEMOCRATIC GOVERNORS ASSOCIATION

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Preface

States face a large and growing burden relating to medical and economic costs associated with mental illness. This paper explores the human and economic burden associated with mental illness, barriers to treatment, and evidence-based policy options Democratic governors are using to enhance mental health and well-being.

Democratic governors have a strong record of supporting access to affordable, quality healthcare including mental health treatments and services. With states facing uncertainty about federal healthcare reform and budgetary challenges, identifying and sharing reforms that work to lower the burden of mental illness is increasingly important. The recommendations that follow can apply to potential savings for state-covered populations, including state employees, Medicaid, and the state prison population, as well as promoting mental health and well-being for all state residents.

Executive Summary

Depression, anxiety, and other mental illnesses affect millions of Americans each year. People living with mental illness face many barriers to improving their health, including overcoming stigma, finding an available healthcare provider, having coverage to access medically necessary care, and many more. Those affected also face issues relating to employment, poverty, housing, and maintaining personal relationships, which can mean higher costs to the state. State costs can include costs associated with homelessness, unemployment and underemployment, incarceration and extended jail time, and lost productivity.

This paper describes the burden of mental illness on individuals and states, barriers to improving health, and suggested policy solutions. For each of the suggested policy ideas, the paper highlights programs Democratic governors have adopted that can serve as models for other states. Potential policy solutions include:

- ***Raising awareness to address stigma;***
- ***Early identification of mental health conditions and intervention;***
- ***Integrating physical care and mental health care services;***
- ***Innovating to address provider shortages;***
- ***Improving treatment adherence; and***
- ***Enhancing coverage for mental health care treatments and services.***

Introduction

Mental health conditions are far more prevalent than American society commonly acknowledges. In fact, only about 17 percent of U.S. adults are considered to be of optimal mental health.[1] Many Americans have mental health concerns over the span of their lifetime. However, these concerns become mental illnesses when ongoing symptoms affect one's ability to function.[2]

Although mental health and mental illness are related and the terms used interchangeably, they represent very different psychological states. Mental health is **"**a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[3] Mental illness on the other hand, detracts from one's state of mental health and is characterized by conditions or disorders that affect mood, behavior, and thinking. Examples of mental illness include depression, schizophrenia, anxiety, addiction, and eating disorders, among many other conditions.

Another term that is sometimes conflated with mental health is "behavioral health". Behavioral health includes substance use disorder (SUD) services and mental health treatment in order to provide more comprehensive and coordinated care.[4]

A key element of any analysis of mental health care policy is the acknowledgement that mental health and physical health though distinct, are closely related. As noted by Dr. Brock Chisholm, renowned psychiatrist and the first Director-General of the World Health Organization (WHO), mental health and physical health are intrinsically linked, and that "without mental health there can be no true physical health".[5]

Researchers suggest that there are three categorical indicators of mental health.[6] They are:

- **Emotional well-being** – perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being** – self-acceptance, personal growth – including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being** – social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

People living with mental illness face many challenges, including barriers relating to access and adherence to treatment, insurance coverage, and a shortage of mental health care providers. Those affected by mental illness also face issues relating to employment, poverty, housing, and personal relationships. In addition, many face societal stigma. People needing help often do not ask for or pursue the treatment or care they need. No one questions a patient with diabetes needing insulin, or a cancer patient receiving chemotherapy or radiation treatments, but we live in a time where there still is stigma associated with the need to address and improve one's mental health.

In this paper, we will discuss how governors and state governments can improve the treatment of individuals with mental illness in their states.

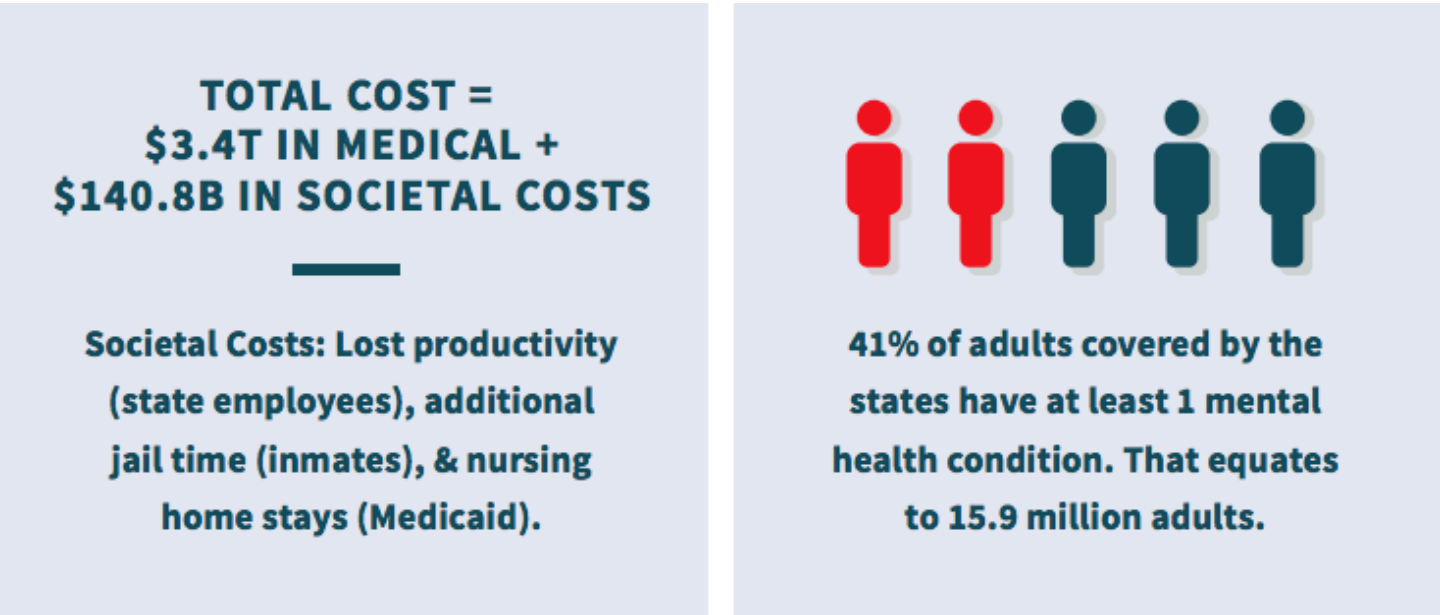
Mental health in the United States

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2015, 17.9 percent of adults – or 43.4 million Americans – were living with diagnosed mental illness.[7] However, more than half (56.5 percent) of adults with mental illness received no treatment in the past year. And, for those who do seek treatment, 20.3 percent report unmet treatment needs. [8]

Because of under-diagnosis and under-treatment of mental illnesses, estimates on prevalence of different types of conditions may vary:

- Major depression is one of the most common mental illnesses, with an estimated 6.7 percent of adults in the U.S. having at least one major depressive episode in the past year;[9]
- Severe anxiety affects 4.1 percent of the U.S. population;[10]
- Bipolar disorder affects nearly 3 percent of the U.S. population;[11] and
- Schizophrenia affects 1.1 percent of the U.S. population.[12]

A recent economic model developed for the Partnership to Fight Chronic Disease by IHS Markit estimates that among three populations covered by state funds – Medicaid recipients, state employees, and state inmates – mental illness costs states $3.4 trillion in medical treatment and nearly $141 billion in societal costs (e.g., lost productivity, additional jail time for inmates, and Medicaid-supported nursing home stays). On average, mental illness accounts for $69.7 billion in medical treatment and $2.7 billion in societal costs for these state-funded populations.[13] These figures don't include the broader societal costs that accrue from those with private or no health insurance.



Source: Partnership to Fight Chronic Disease

When it comes to serious mental illness (SMI), there is even greater concern about states' ability to promote quality, affordable care. Federal regulations define SMI as a condition that affects someone age 18 or older with a mental, behavioral, or emotional disorder that substantially interferes with or limits one or more major life activities. Individuals with SMI may have difficulty maintaining interpersonal relationships, conducting basic daily living activities, self-care, or had their condition impact their job. The definition of SMI specifically excludes developmental and substance use disorders, dementias, and mental disorders caused by a general medical condition.[14] Mental illnesses typically considered SMI include schizophrenia and schizoaffective disorder, psychotic disorders, major depressive disorders, bipolar disorders, and borderline personality disorder. Anxiety disorders (such as obsessive-compulsive disorder and panic disorder) or eating disorders can meet criteria for SMI.[15]

The National Institutes of Health reports that in 2015, there were an estimated 9.8 million adults in the U.S. aged 18 or older with SMI within the past year – or 4 percent of all U.S. adults.[16] The National Institute of Mental Health conservatively estimates the total (indirect and direct) costs related to SMI are more than $300 billion per year.[17]

The legal definition of SMI carries more flexibility as it varies by state, includes childhood diagnoses, and does not include functional impairment.

The intersection of physical and mental health

There is very strong evidence showing the connection between mental health and physical health. For example, in patients who are depressed, the risk of having a heart attack is more than twice as high as in the general population.[18] Depression and diabetes are common comorbidities, though it is unrecognized and untreated in approximately two in three people with both conditions.[19] Having depression increases the risk of death in patients with cardiac disease.[20] Moreover, treating the symptoms of depression after a heart attack has been shown to lower both mortality and re-hospitalization rates.[21]

SAMHSA reports 34 million American adults, or 17 percent of the adult population, had comorbid mental and physical conditions within a 12-month period.[22] Historical treatment of mental and physical health conditions as separate issues however, has led to challenges to integrating treatment in a coordinated fashion that focuses on the whole individual, rather than a narrow focus on specific conditions.

The high prevalence of comorbidity, coupled with fragmentation in physical and mental health care delivery have and will continue to adversely impact the quality and cost of care in ways that are more complicated and expensive than treating the individual conditions separately. Integrated physical and mental health models of care have been shown to benefit this population, but they are not widely available in routine diagnostic, treatment, and care settings.

SAMHSA also reports "people with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder."[23] Substance use disorder is a common co-morbidity as people may self-medicate with alcohol or drugs against an underlying mental illness.

Mental illness affects every corner of society

Mental illness affects families and loved ones, communities, workplaces, schools, the military and our veterans, as well as the criminal justice and social services systems.

About half of adults in the U.S. will meet the criteria for a mental illness in their lifetime.[24] Most mental illness begins between 12–24 years of age, though it is often not diagnosed until later in life. Poor mental health is strongly related to poor overall health and development in young people, including lower education achievements, substance use disorder, violence, and a higher incidence of sexually transmitted diseases.[25]

In Schools

One in five children living in the U.S. shows signs or symptoms of mental illness.[26] In other words, in a typical classroom of 20 kids, 4 of them may be struggling with depression, anxiety, other mental illness or substance use disorder. Parents and schools are struggling to find ways to address the mental health needs of young Americans, including challenges with diagnosis, social stigma, and access to care.[27] Mental illness among children can lead to chronic absenteeism, poor behavior, sub-standard achievement and, in some cases, dropping out of school altogether. As Americans age out of school and transition into the workforce, these challenges can be magnified.

At Work

Depression is the most common and most studied indicator of the commercial impact that mental illness has on businesses. The Integrated Benefits Institute (IBI) reports that the cost of depression to employers is approximately $62,000 annually per 100 employees in lost work time and medical treatment.[28] The IBI also conducted research that showed depression extends the duration of short-term disability (STD) claims when it is co-morbid with another disability diagnosis.[29]

In the IBI study, reduced productivity from time lost at work was found to be the largest cost component of such depression disability claims. Coupled with wage-loss payments, these depression-related costs are 2.5 times the costs of physical health care and pharmacy expenditures. Evidence also showed that early identification of and treatment for employees with depression may be cost effective in reducing disability lost time. Self-reported data from the same study showed that depression prevalence in the workplace is at or near 30 percent, with 70 percent of those individuals not currently receiving treatment.

Mental illness can also be a barrier to employment for many Americans who are looking for work. The National Alliance on Mental Illness (NAMI) reports that nearly 60 percent of the 7 million Americans receiving publicly funded mental health services want to work, but less than 2 percent of them receive state-supported employment opportunities.[30]

The societal effects of mental illness represent significant costs to states. An economic model developed for the Partnership to Fight Chronic Disease by IHS Markit estimated productivity losses associated with mental illness within state employee populations. The model also

estimates potential savings associated with reducing extended jail time often associated with inmates with mental illnesses. The federal 21st Century Cures Act passed last year included the Comprehensive Justice and Mental Health Act which reauthorized millions of dollars for state and local governments to develop innovative approaches to reduce the number of people with mental illness in jail.[31]

	Lost productivity for state EE's (annual) *in millions	Prison years avoidable – cost savings *in millions
National Cumulative	$3,630.42 million	$397.74
National Average	$71.18	$7.80
Alabama	$58.95	$9.23
Alaska	$19.88	$0.86
Arizona	$55.25	$11.91
Arkansas	$44.39	$4.58
California	$286.53	$63.57
Colorado	$54.72	$7.30
Connecticut	$55.26	$5.91
Delaware	$22.98	$1.45
DC	$10.3	$0.81
Florida	$176.71	$24.36
Georgia	$100.86	$12.24
Hawaii	$26.33	$1.73
Idaho	$23.02	$1.7
Illinois	$79.55	$12.04
Indiana	$46.14	$9.63
Iowa	$33.61	$1.98
Kansas	$45.68	$1.77
Kentucky	$56.6	$3.35
Louisiana	$57.69	$6.77
Maine	$21.38	$1.20
Maryland	$88.58	$7.9
Massachusetts	$105.17	$4.57
Michigan	$104.55	$11.83
Minnesota	$60.99	$4.44
Mississippi	$58.37	$3.54

	Lost productivity for state EE's (annual) *in millions	Prison years avoidable – cost savings *in millions
Missouri	$89.32	$6.71
Montana	$18.4	$1.2
Nebraska	$32.7	$2.1
Nevada	$30.4	$2.7
New Hampshire	$19.2	$1.4
New Jersey	$150.9	$6.7
New Mexico	$41.8	$2.8
New York	$278.8	$20.7
North Carolina	$150.5	$9.6
North Dakota	$16.7	$1.2
Ohio	$84.7	$12.8
Oklahoma	$63.4	$5.1
Oregon	$68.0	$6.3
Pennsylvania	$174.8	$21.4
Rhode Island	$19.9	$0.9
South Carolina	$64.1	$4.1
South Dakota	$9.8	$0.8
Tennessee	$62.2	$7.7
Texas	$248.8	$38.3
Utah	$39.0	$2.3
Vermont	$11.1	$0.6
Virginia	$88.5	$10.6
Washington	$87.6	$9.2
West Virginia	$32.7	$2.7
Wisconsin	$42.3	$3.7
Wyoming	$11.4	$1.2

Source: Partnership to Fight Chronic Disease

Poverty

Poverty and mental health are inextricably linked. The lower someone's socioeconomic status, the higher his or her risk for mental illness.[32] With poverty on the rise in the United States, especially among women and minorities, we need to focus greater attention on these underserved communities and find ways to address mental illness that keeps people and families trapped in poverty.[33] For example, a study based on data from the National Center for Education Statistics showed that the odds of a household experiencing food insecurity increased by up to 80 percent if a mother had moderate to severe depression.[34]

Veterans' Health

Military veterans are greatly impacted by mental illness. The American Psychological Association reports that of the 1.7 million veterans who served in Iraq and Afghanistan, 20 percent suffer from post-traumatic distress disorder (PTSD) or major depression.[35] And data from the U.S. Veterans Administration show that approximately 20 veterans a day commit suicide. In 2014, more than 7,400 veterans committed suicide – accounting for 18 percent of all suicides in America, though veterans make up less than 9 percent of the U.S. population.[36]

Homelessness and Criminal Justice

Approximately one-third of the homeless population includes men and women with untreated SMI.[37] Having a safe and secure place to live is integral to mental health and well-being, but having a mental illness can make it difficult to find and keep a home.[38]

Not only are state, county, and city social service systems overburdened with the challenges of mental illness, criminal justice systems are working to find better ways to address the intersection of mental health and crime. Based on data from the U.S. Department of Justice, NAMI reports that 64 percent of inmates have a mental illness, and that 83 percent of those inmates did not have access to adequate treatment.[39] These inmates tend to have extended terms or no chance for parole because of rule compliance, or violence while incarcerated.[40] They are also at higher risk for recidivism once they are released.[41]

Challenges to improving mental health in the states

There are myriad challenges for state governments when it comes to improving mental health. A major concern is the under-diagnosis and under-treatment of mental illness. Doctors identify less than half of those who meet diagnostic criteria for psychological disorders.[42]

Even when mental illness is diagnosed and treatment options are both available and accessible, the issue of stigma remains a significant barrier to overcome. Promoting parity in perception of mental illness as a medical condition, cost, access, and coverage can help make strides toward dismantling stigma.

The ongoing debate over the potential repeal of the Affordable Care Act (ACA) has contributed a significant degree of uncertainty to the mental health care space. In particular, current congressional proposals to repeal the ACA include potential Medicaid cuts of up to $834 billion,

in spite of the strides that several states have made in utilizing Medicaid to implement and improve mental health and substance use disorder programs.[43] The ACA and other reforms (Mental Health Parity and Addiction Equity Act, 21st Century Cures Act) have expanded access to mental health services, increased health insurance coverage and care, and increased patient protections for people living with mental illness.

Access to care is critical in promoting mental health parity

Source: Mental Health America

Access to care continues to be a challenge in promoting parity for mental health services. Access to care covers variety of leverage points – access to insurance, treatment, quality and cost of insurance, as well as special education and employment opportunities.

According to Mental Health America, one out of five (20.3 percent) adults with a mental illness report they are not able to get the treatment they need.[44] State and local level policies have the biggest impact on access to mental health care.[45] In states that embraced various ACA reforms, including Medicaid expansion, residents have greater access to mental health services.

When it comes to access, the shortage of mental health care professionals presents a serious barrier. Nationally, existing providers are able to meet only 44.2 percent of need for care.[46] The shortage among specialized mental health professionals – such as child psychiatrists or forensic specialists – is even higher.[47] The U.S. Department of Health and Human Services projects the U.S. will need to add 10,000 mental health providers by 2025 to meet the expected growth in demand.[48]

According to the federal government more than 4,000 areas across the U.S. are considered mental health professional shortage areas.[49] Residents in these areas must often travel in-state for hours or across state lines to access services. Low reimbursement rates combined with the limited number of providers and high demand for treatment means that many providers do not accept insurance and are “out-of-network”, forcing families and individuals to pay high out-of-pocket fees or go without care.

Source: Mental Health America

An NIH-funded study on mental health care access and costs, showed barriers to treatment and care across public and private insurers, as well as the uninsured. 64 percent of uninsured adults with mental illness reported cost as a primary challenge to accessing care. This compares to 18.2 percent of adults with public insurance, and more than 30 percent of those with private insurance.[50]

People with mental illness are also 2.5 to 7 times more likely to face challenges accessing regular medical care. Barriers include lack of access to a primary care physician, lack of access to needed medication, and costs.[51] In fact, half of adults who have an untreated mental health need lack treatment due to cost.

Another barrier to access is the delineation between traditional physical health care and mental health care. Mental and physical illnesses seldom occur in isolation.[52] So when mental health and physical health care are disconnected, identifying the need for care, finding available providers, navigating coverage, and coordinating care among providers is left to the patient and/or family members – a project that can be difficult to manage in the midst of a mental illness.

Opportunities to improve mental health care while containing costs

The Partnership to Fight Chronic Disease reports that there are opportunities to save money in the states. Policy solutions to address mental health parity and integration, access, and adherence, could reduce the $3.6 billion lost annually in productivity among state employees with at least one mental illness.[53]

Governors can support state and federal policies that include protections for people living with mental illness and their ability to obtain coverage and access to mental health treatment. By identifying opportunities to engage with stakeholders at the state and local level to promote affordable access and care coordination, governors can help their states realize improved health and wellness outcomes while reigning in costs.

Source: Partnership to Fight Chronic Disease

Raising awareness to address stigma

The state of California commissioned a RAND analysis on what states can do to address stigma surrounding mental illness.[54] As a result of the study, the California Mental Health Services Authority created the Stigma & Discrimination Reduction initiative.[55] This initiative covers a variety of prevention and early intervention strategies including mini-grants to community organizations, social marketing and outreach campaigns, resource development and dissemination, education and training, integrated health promotions, best practices and benchmark programs for providers, and policy solutions to address discrimination.

Early identification of mental health conditions and intervention

Minnesota is one of eight states chosen by the U.S. Department of Health and Human Services to pilot a new model of mental health care. This new one-stop model, Certified Community Behavioral Health Clinics (CCBHC), is designed to bring together physical and behavioral health care for children and adults having trouble getting diagnoses and treatment. Support for the CCBHC program is one component of Governor Mark Dayton's $47 million commitment to the state's mental health care system. The Governor's Task Force on Mental Health also identified CCBHCs to promote solutions that can increase integration and offer person-centered care.[56]

Integrating physical care and mental health care services

Colorado Governor John Hickenlooper has long been a mental health advocate. Under his leadership, seven of Colorado's health insurers are coordinating with the Colorado State Innovation Model (SIM) office to transform the way primary care and behavioral health care are delivered and financially supported. Under the signed Memorandum of Understanding, all agreed to:

- "Provide value-based payments to primary care practices within their networks. The SIM-chosen practices will be paid based on their progress in reaching specific transformation goals.

- Share necessary and reasonable data with the primary care practices regarding the total cost of care and utilization services by their beneficiaries and members.

- Report progress with a core set of well-established quality measures related to population health that fit into each health plan's value-based payment and clinical models/efforts with practices included in the SIM Initiative.

- Measure progress with a set of agreed-upon milestones. The health plans will provide appropriate and reasonable data that show how patients benefit by each health plan's value-based payment model.

- Communicate and meet regularly to ensure that the payment and clinical efforts are supporting the primary care transformation as intended by the SIM Initiative."

Colorado's SIM will not only provide better-integrated care, it also will lower costs. Changing the payment model from fee-for-service to one that promotes a more integrated care delivery approach will enhance sustainability for providers, health plans, and patients.[57]

Innovating to address provider shortages

Washington Governor Jay Inslee announced in 2016 that the state's Workforce Training and Education Coordinating Board partnered with the state's Health Workforce Council to evaluate and project workforce shortages in behavioral health so that the state can prepare and address this issue proactively. The workforce board will release its final analysis and report in December 2017. "This evaluation will establish a baseline for behavioral health workforce shortages and provide a plan for improving how we coordinate the right services for patients," said Governor Inslee.[58] This follows Governor Inslee's "whole person" health care legislation enacting integrated health care delivery.[59]

Improving treatment adherence

Montana Governor Steve Bullock announced a collaborative project in 2016 to increase access to mental health services for Montanans in rural areas. This will provide opportunities to improve and increase treatment adherence in these traditionally hard-to-reach communities. Using telemedicine and other outreach tools, rural communities will see increased access to mental health care and services. Governor Bullock's administration has made unprecedented investments in mental health services, including crisis intervention, youth mental health and short-term care, as well as emergency detention. This announcement follows previous efforts by the governor, including creating the Governor's Council on Healthcare Innovation in 2015 to bring together the health care industry to work towards improving outcomes and reducing costs.[60]

Enhancing coverage for mental health care treatments and services

Earlier this year, Oregon opened its first psychiatric-specific emergency room – the Unity Center for Behavioral Health, designed to improve care for people experiencing a mental health crisis. This innovative program is a $40 million collaborative effort among Adventist Health, Kaiser Permanente, Legacy Health, and Oregon Health & Science University. This approach is designed to allow for better outcomes and reduced risk of hospitalization. Oregon Governor Kate Brown is a proponent of this collaborative model and believes it will give people in her state the tools and resources to safely return to communities.[61]

Connecticut's Department of Mental Health and Addiction Services also runs a program available through a Medicaid waiver called ***Recovery Assistants,*** which provides specialized home care for people with mental illness. Through psychiatric rehabilitation and independent living training, they assist people with mental illness on the path to recovery. According to department data, 78 percent of individuals enrolled maintained or achieved a level of functioning in the community thanks to the use of Recovery Assistants.[62]

Conclusion

Mental illnesses and other chronic conditions are the leading drivers of healthcare costs, disability, and premature death in the U.S.[63] For all chronic conditions, but particularly for mental illness, associated medical costs represent only one part of the burden of poor health. Reducing barriers to prevention, diagnosis and treatment of mental illness present opportunities to address both healthcare spending and societal costs associated with productivity losses, unemployment, homelessness, poverty, and incarceration.

Building on successful programs showing results across the country, Democratic governors can reform how their states integrate and deliver services to people with mental illness and provide models for the nation as a whole. Adopting policies that reduce stigma, promote access to care, and address societal impact of mental illness can have a meaningful impact on state budgets beyond healthcare spending and create healthier communities in the states.

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