NATIONAL CONFERENCE *of* STATE LEGISLATURES
FORUM *for* STATE HEALTH POLICY LEADERSHIP

FREQUENTLY ASKED QUESTIONS

Mental Health

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What is the difference between mental health and mental illness?

A person with good mental health can use his or her cognitive and emotional capabilities develop and maintain good relationships with family, participate in community life, and retain a job that provides for everyday needs. A person's mental functioning changes throughout his or her life span, with different expectations for differing age groups.

In contrast, mental illnesses are biologically based brain disorders that disrupt a person's thinking, feeling, mood, ability to relate to others and capacity for fulfilling daily activities. Mental disorders alter a person's thinking, mood, and/or behavior for a specific period of time.

Mental illnesses are diagnosed according to criteria that are categorized in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Examples include:

Anorexia nervosa	Bulimia
Anxiety	Dementia
Attention Deficit/Hyperactivity Disorder	Depression
Bipolar Disorder	Schizophrenia
Borderline Personality Disorder	Substance Use

According to a 2004 report from the Centers for Disease Control and Prevention, 33.9 percent of Americans reported having poor mental health on at least one day within the last 30 days. Altogether, an estimated 54 million U.S. adults have symptoms of a mental illness during the course of a year.

The effect of mental illness on health and productivity is considerable. Seventy-two percent of individuals with mental illness work; when they do not receive necessary treatment, their work performance suffers. It is estimated that mental illness cost the United States about $85 billion in 2001, according to a Substance Abuse and Mental Health Services Administration (SAMHSA) report, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1991-2001*. The World Health Organization predicts that, by 2020, mental illness will have increased by 50 percent and major depression will have become the number one cause of disability worldwide.

The most common mental illnesses among adults are anxiety disorders (16.4 percent), mood disorders such as depression and bipolar disorder (7.1 percent), and schizophrenia (1.3 percent). Only about 6 percent of adults have a serious mental illness that greatly disrupts their ability to function. Schizophrenia is the most persistently disabling mental illness in adults.

As for children, an estimated 11 percent to 13 percent exhibit symptoms of a diagnosable mental, emotional or behavioral illness, according to the federal definition, during the course of a year. Roughly 5 percent to 9 percent of children have a mental, emotional or behavioral illness so severe that it results in substantial to extreme functional impairment. Some children grow out of their disorders. A few mental illnesses, such as schizophrenia, generally develop when children reach their late teens or 20s.

How is mental illness treated?

Of the 12 million to 13 million U.S. adults with a serious mental illness, 5.9 million—45.3 percent—received treatment during the course of the year, according to 2005 research from SAMHSA. Thirty-nine percent of those in treatment obtained prescription medication, 28.5 percent received outpatient treatment, and 4.6 percent were treated as inpatients. According to federal statistics, on average, it takes an individual with mental illness more than a decade to seek treatment after the onset of symptoms.

In the last 20 years, a host of new drugs have been developed to treat depression, anxiety and schizophrenia. Because individuals have unique responses to the same drug, it is important that physicians provide individual treatment plans.

Antidepressant medications are believed to be effective in about 70 percent of mild depression cases and in 50 percent of cases of major depression. Of the major types of medications available to treat depression, psychiatrists tend to favor the newer selective serotonin reuptake inhibitors (SSRIs) as the first treatment for depression and certain other mood disorders because they are easier to use and have less severe side effects. Although physicians prescribe SSRIs for both adults and children, only Prozac has been approved by the Food and Drug Administration for use in patients younger than age 18.

Several new medications for schizophrenia, often called atypical antipsychotics, reduce symptoms and have fewer side effects than older medications. Atypical antipsychotics such as clozapine (Clozaril®) and risperidone (Risperdal®) are effective in approximately 30 percent to 50 percent of patients who do not respond to other medications.

Although different generations of antipsychotics have been developed, research varies on the effectiveness of each medication. It is important for individuals to work with their doctors to determine which best reduces symptoms and provides the fewest side effects, and to tailor treatment to the individual.

In addition to medication, psychosocial treatment is commonly used to help people with mental illness cope, perform daily activities and move toward recovery. Although hospitalization is required in a minority of cases, consumers and mental health providers generally prefer that treatment be delivered in the community, in the most appropriate and least restrictive environment possible. Not only is such treatment less costly than inpatient care, but it helps the patient adapt to life in the community.

In 1955, the United States began to deinstitutionalize the 599,000 patients residing in psychiatric hospitals after the first generation of antipsychotic medications began to reduce symptoms in many individuals. However, as states deinstitutionalized patients, no adequate community-based system was available to meet the needs of these individuals. In 1963, the Community Mental Health System Act authorized construction of 1,500 community mental health centers around the country so each area of 75,000 people would have one center. Only 800 centers were built, however, leading to significant inadequacies in the community mental health system.

Medicaid and other payers helped to finance community-based care and the development of prescription drugs. A substantial number of discharged patients went without needed care, however. Homelessness increased because many communities lacked a sufficient supply of low-cost, supportive housing—a crucial support for those with mental illness. Often financed at least in part by the state, supportive housing offers varying levels of supervision and support, from 24-hour care to nearly independent living with assistance from a case worker.

Since that era, experts have designed and tested several approaches to help people with mental illness function fully in the community. Effective, evidence-based practices include:

- Assertive Community Treatment. Intensive case management services are customized to the individual needs of the consumer, delivered by a team of practitioners, and available 24 hours per day with the goal of keeping the consumer out of the hospital and functioning in the community.
- Supported Employment. An employment specialist collaborates with treatment providers to help the consumer obtain and keep employment.
- Integrated Dual Diagnosis Treatment for Co-occurring Mental Health and Substance Use Disorders. Both mental health and substance abuse services are provided at the same time and in one setting.
- Illness Management and Recovery Programs. Consumers receive help to set personal goals and then to implement strategies in their everyday lives to meet those goals.
- Family Psychoeducation. Consumers, families, supporters and practitioners work together to help the consumer lead a meaningful life in the community.

What role do Medicaid and other public sources play in funding mental health services?

Medicaid benefits are divided into two categories: mandatory benefits required by federal law and optional services that states may choose to provide. Mental health care is not explicitly listed as a mandatory service, but it is covered under several broad categories of benefits. Many states use these categories—such as prescription drugs, case management and home- and community-based services—to provide a broad range of mental health benefits through their Medicaid programs.

The services covered by Medicaid vary from state to state, depending upon the optional services provided in the state Medicaid plan, but may include:

- General hospital inpatient care, residential treatment centers, and crisis intervention and group homes;
- Physician services, including psychiatrists;
- Clinic services, ranging from psychotherapy to medication management; and
- Community-based services, such as intensive home-based services and family support programs.

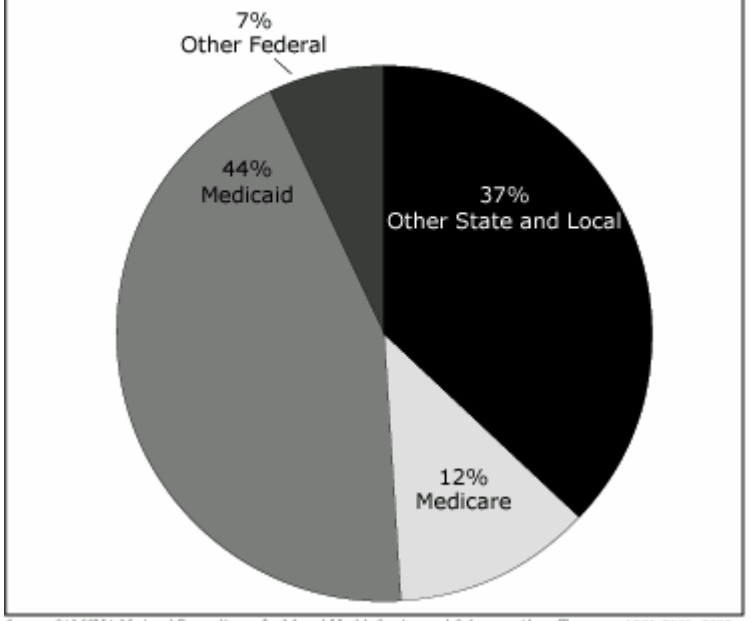
Children have a much broader entitlement to mental health services. Under Medicaid's Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) mandate, states must provide all "medically necessary" services to children to correct physical and mental illness and conditions discovered by the screening services.

Medicaid covers a more limited array of mental health services for adults. States cannot receive the federal Medicaid match for individuals between the ages of 21 and 64 in institutions of mental disease (IMDs), typically psychiatric hospitals with 16 or more patients. The IMD exclusion continues the historic responsibility that states have had for psychiatric hospitals (which existed before Medicaid). Many states circumvent the IMD exclusion by using Medicaid funds for residential treatment centers with 15 or fewer beds. For those over age 65, states can choose to cover IMDs.

As states began moving people with mental illness from state mental hospitals into communities, the state-only financing of mental health care was shifted to Medicaid. Although this enabled states to obtain federal matching funds to pay for community-based services, state spending on mental hospitals continued to grow until 2002, despite drastic reductions in patient numbers. The quality of care in hospitals improved greatly, but costs also continued to grow.

In 2001, Medicaid picked up 44 percent of the $54 billion in public expenditures for mental health care. Today, the federal/state partnership pays for more than half of the public mental health services that states administer.

Figure 1. Distribution of Public Mental Health Experenditures by Public Payer, 2001



Source: SAMSHA National Expenditures for Mental Health Services and Substance Abuse Treatment 1991-2001, 2005.

In addition to becoming an important funder of mental health care, state Medicaid agencies became important innovators in delivering care. These agencies encouraged expansion of community-based treatment—such as psychiatric rehabilitation and day treatment/partial hospitalization—for people with serious mental illness.

In 2001, states and local governments funded 23 percent of all mental health services and 37 percent of public mental health funding. Medicare accounted for 12 percent of mental health public expenditures; 7 percent of public mental health spending came from other federal government programs, such as Veterans Affairs and the Mental Health Block Grant. Figure 1 illustrates public funding for mental health services in 2001.

The Substance Abuse and Mental Health Services Administration is an important source of funding for states. SAMHSA administers the Mental Health Services Block Grant—flexible funding that enables states

to pilot test innovative community mental health services. In FY 2007, the federal government allocated $428 million to states, encouraging it to be used for "systems transformation" as outlined in the 2003 *Report of the President's New Freedom Commission on Mental Health*. Examples of transformation activities include linking mental health care to primary care, improving coordination of care among multiple systems, and promoting individualized plans of care for consumers.

What is mental health parity?

Commercial health insurance plans typically place lower limits on mental health benefits than on physical health and surgical treatments. The federal Mental Health Parity Act of 1996 stipulated that insurers who offer mental health benefits must adopt the same annual and lifetime spending limits for mental health care as they do for medical and surgical care. The law allows employers whose premiums increase by more than 1 percent because of parity to apply for an exemption. None have done so.

(NCSL deems a law or bill as "parity" if it requires an insurer to provide benefits for mental illnesses and/or substance abuse that are equal to those provided for other physical disorders and diseases. According to NCSL's definition, the federal parity law is a mandated benefit that does not achieve parity because it does not require insurers to cover mental health benefits.)

During the 110th Congress, additional comprehensive mental health parity bills were introduced in both the House and the Senate. Recent studies that indicate parity is cost-effective have abated some concerns of business owners and lawmakers that requiring parity would increase health care costs.

Parity laws vary from state to state. Some statutes require parity only for the treatment of a limited set of mental illnesses (usually the most severe), while others cover all mental disorders. Many parity statutes have exceptions for small businesses or allow exemptions if parity increases health care costs above a certain percentage. According to the NCSL definition of mental health parity, 33 states have passed mental health parity bills.

Eight states have laws similar to the federal law; they require insurers that offer mental health benefits to provide them with the same annual and lifetime limits as they do for medical and surgical benefits. Eight states and the District of Columbia require that health insurers offer some level of mental health benefit, but those benefits need not be equal to the plan's medical and surgical benefits. Wyoming is the only state that has no mental health insurance statute.

What are the issues surrounding involuntary treatment?

An individual receives inpatient care as a result of being committed to a hospital. This may happen in any of three ways.

- An individual may be deemed a danger to himself or others by family, police or another individual and can be involuntarily civilly committed, which is how approximately 80 percent of people enter inpatient treatment.
- An individual may be involuntarily criminally committed after he or she has committed a crime but is not deemed responsible or capable of standing trial due to mental illness. This accounts for approximately 20 percent of individuals receiving inpatient treatment.
- Finally, an individual may voluntarily commit himself to inpatient treatment, although this occurs only rarely.

In the most common form of commitment, when an individual is deemed to be a danger to himself or others, a judge may civilly commit him, forcing him to receive inpatient treatment at a hospital. A psychiatrist must assess the individual initially, then regularly perform reassessments to determine whether the individual remains a danger to himself or others. The involuntary commitment order is reviewed periodically by a judge.

When many individuals are released from the hospital after their condition has improved, judges will continue to commit them to continued treatment in the community. A condition of release from inpatient care is participation in outpatient treatment. Involuntary outpatient treatment forces an individual to participate in treatment in the community. Forty-two states have involuntary outpatient commitment laws. These policies were developed partly in response to the highly publicized acts of violence that have been committed by a small number of individuals with serious mental illness. However, studies have found that individuals with serious mental illness are not at higher risk for violence than the general population.

The question of whether inpatient and outpatient involuntary commitment laws infringe on an individual's constitutional and human rights has generated a good deal of controversy. Groups such as the Bazelon Center for Mental Health Law oppose *inpatient* commitment unless the individual is an immediate threat to himself or others. Committing an individual to a hospital in less than extreme cases violates the *Olmstead* Supreme Court decision, which found that all individuals must receive treatment in the least restrictive environment possible.

Bazelon and other disability rights groups oppose all forms of involuntary *outpatient* commitment. Those committed to outpatient treatment do not need 24-hour care, so advocates view outpatient commitment as a way to coerce individuals into receiving treatment, when they have chosen no treatment or an alternative way of coping with their illness.

Advocates for victims of people harmed by individuals with mental illness, however, view civil commitment as a way to protect the public and those suffering from mental illness. Studies vary on whether involuntary outpatient commitment is effective in treating those who participate.

What is the consumer movement and how does it address issues of recovery, stigma and adequate service delivery?

The consumer movement began in 1909 when Clifford Beers, a young Connecticut businessman who had suffered in the state's psychiatric asylums, organized a group of people to bring attention to the problem of maltreatment of people with mental illness. The organization he formed has evolved through the years into the advocacy group Mental Health America (formerly known as the National Mental Health Association), with local affiliates in every state.

In addition to Mental Health America, the National Alliance on Mental Illness (NAMI), its local affiliates and many other groups have worked to educate the public about mental health, reduce stigma and discrimination, promote effective alternatives to inpatient treatment, create better conditions in hospitals, reduce the use of seclusion and restraint techniques, and improve services and access to services for people with mental illness.

The consumer movement has been at the forefront in promoting the concept of recovery and in defining that concept. In 2005, 110 expert panelists convened under the aegis of SAMHSA produced the following National Consensus Statement on Mental Health Recovery:

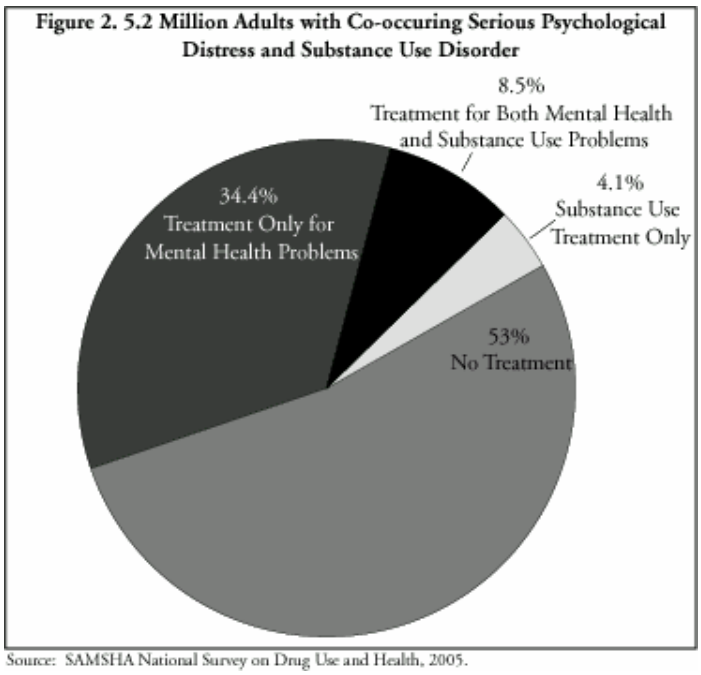
Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

What is the relationship between mental illness and other conditions?

Approximately 23 percent of people with a serious mental illness also have had a co-occurring substance use disorder within the past year, compared with 8 percent of individuals without a serious mental illness. Eighty-nine percent of people with a co-occurring disorder developed a mental illness before they had a substance use disorder. On average, mental illness precedes a substance use disorder by six years. If people with mental illness are diagnosed and treated shortly after their symptoms begin, they are much less likely to self-medicate with alcohol and illicit drugs. Thus, integrated substance abuse and mental health treatment is much more effective than treating the two disorders separately. This integrated approach to treatment can greatly increase the chances of recovery and also reduce long-term costs.

According to the 2005 *National Survey on Drug Use and Health: National Findings* report, however, of the 5.2 million adults with co-occurring serious psychological distress and substance use disorders, 53 percent receive no treatment. Figure 2 illustrates treatment types for people with co-occurring disorders.

Figure 2. 5.2 Million Adults with Co-occuring Serious Psychological Distress and Substance Use Disorder



Source: SAMSHA National Survey on Drug Use and Health, 2005.

Many modifiable behaviors—such as poor nutrition, smoking and little exercise—that cause chronic conditions are prevalent among people with mental illness. As a result, chronic physical diseases (such as cardiovascular disease, diabetes and respiratory disease) are much more prevalent in people with mental illness than they are in people without mental illness. In addition, the psychotropic medications used to treat mental illness may contribute to risk factors for chronic diseases, especially by increasing the likelihood of obesity.

According to a report by the National Association of State Mental Health Program Directors, consumers in the public mental health system die on average 25 years earlier than the general public, mostly from natural causes (not suicide, accidents or homicide) such as cardiovascular disease, diabetes, and respiratory and infectious diseases. When receiving care for their mental illness, individuals also must be monitored and treated for physical problems such as weight gain, body mass index, diabetes and blood pressure risk.

Conversely, mental health problems often are undetected in people with chronic illness. If doctors screen patients for mental health conditions during routine exams, people with co-occurring mental and chronic physical illnesses will be more likely to receive the treatment they need, greatly improving their prognosis.

How do other state services relate to the mental health system?

Adults and children with mental health needs rarely contact their state's mental health department for initial help. Instead, they are more likely to first come into contact with state services when they become involved with child welfare, criminal justice or educational agencies. Organizationally and financially, states have not developed integrated systems of care to serve those whose needs span social services, housing, mental health, physical health, substance use and other state systems. Consider these government programs.

- **The child welfare system**. Up to 90 percent of children in the foster care system have some type of mental health disorder, but between 75 percent and 80 percent of these children do not receive treatment. In addition, the vast majority of parents of children in the child welfare system have a mental health and/or substance use disorder. One challenge for child welfare systems is to obtain treatment for those who currently are on the agencies' roles. Another challenge is to connect children and their parents with mental health services after a child no longer is in the system, either due to regaining family stability or aging out of the system.

- **The criminal and juvenile justice systems**. According to the Bureau of Justice Statistics, 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of local jail inmates have some sort of mental illness. However, only one-third of the state prisoners who are ill, one-fourth of the federal prisoners, and one-sixth of the local jail inmates received mental health treatment while incarcerated.

  The problem of mental illness in the juvenile justice system also is severe. Approximately two-thirds of males and three-quarters of females in the juvenile justice system have mental health needs. Jail diversion programs are being implemented nationwide to provide alternatives to incarceration and ensure that individuals receive mental health services in the community, thus reducing the likelihood that they will re-offend.

  Not only do the criminal justice and juvenile justice systems have the challenge of providing services for individuals while incarcerated, they also must provide links to community mental health services for those who are re-entering the community. Coordination is key if ex-offenders are to be helped and rates of recidivism reduced.

- **Educational systems**. Since children spend so much time at school, educational systems are in a good position to identify and help children who have mental illnesses or are at risk for developing them. Such disorders can damage self-esteem and lead to poor academic performance, compromised relationships, bullying, school violence and/or suicide. Educating teachers and students about the signs and symptoms of mental health disorders and having mental health professionals available for treatment and referrals can help at-risk students obtain the help they need.

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