



The Costs and Consequences of Disparities in Behavioral Health Care

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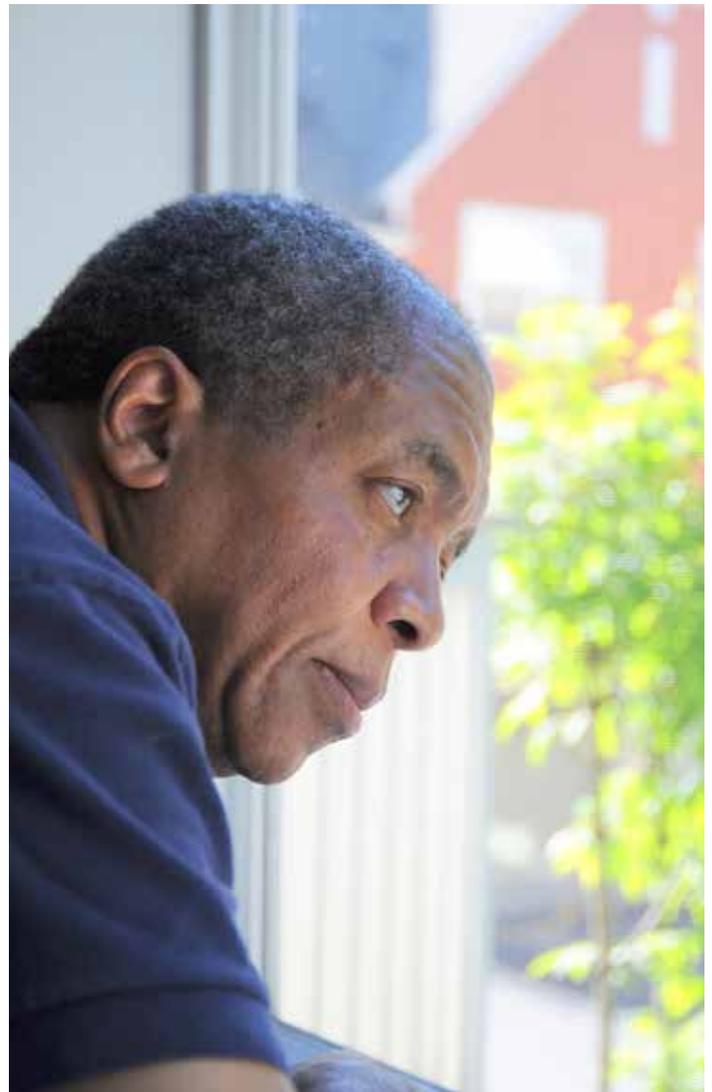


Introduction

Each year, people belonging to racial and ethnic minority groups experience worse behavioral health status and treatment outcomes, along with more difficulty accessing services, than their peers in other groups. These disparities in behavioral health care—which addresses people’s mental and emotional well-being—lead to significant human and financial costs. According to the National Institute of Mental Health, “members of racial and ethnic minority groups in the U.S. are less likely to have access to mental health services, less likely to use community mental health services, more likely to use inpatient hospitalization and emergency rooms, and more likely to receive lower quality care.”¹ The cost to states is significant. Eliminating health disparities would have reduced direct medical care costs by \$229 billion nationwide between 2003 and 2006,² according to the Joint Center for Political and Economic Studies.

State legislatures have adopted various policies to reduce barriers to behavioral health services and improve mental and emotional health across population groups. These approaches vary across states and can focus on developing the behavioral health workforce, as well as improving coverage, service availability, affordability and quality. To understand how legislators address behavioral health challenges and disparities in their states, NCSL conducted an analysis of all legislation related to behavioral health disparities that was introduced in 2017. This brief:

- summarizes behavioral health issues and challenges;
- highlights state actions from the 2017 legislative sessions; and
- identifies common legislative approaches, as well as emerging strategies, to improve access to behavioral health providers and services.



Defining Behavioral Health and Disparities

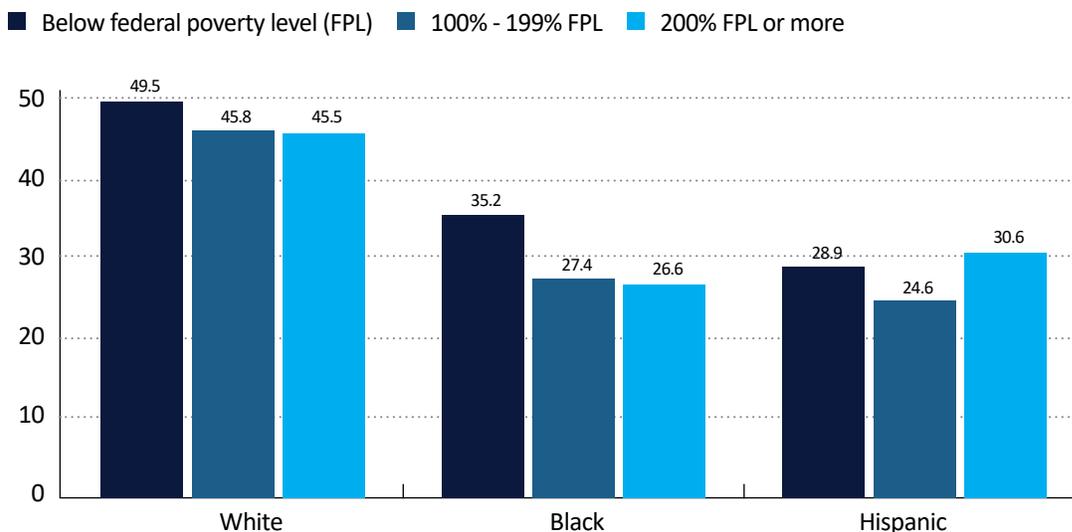
Behavioral health refers to mental and emotional well-being and the actions that affect wellness, according to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Behavioral health problems include substance use disorders, alcohol and drug addiction, and serious psychological distress, suicide and mental disorders. While the illnesses and disorders may be chronic, people can and do recover with appropriate clinical and support services, which may include individual and group counseling, psychotherapy, medication and case management. SAMHSA’s definition of behavioral health also describes the service systems that encompass emotional health promotion, prevention and recovery support.

Behavioral health disparities refer to treatment differences in access to services and outcomes related to mental health and substance misuse experienced by groups based on their social, ethnic and economic status. Behavioral health disparities can be found in the U.S. based on age, gender, income, disability status, sexual orientation, language, geographic location and other factors.

Health disparities refer to differences in health status or treatment outcomes among population groups in areas such as mental or physical health, disease or illness, injury and disability, and life expectancy. Racial and ethnic minorities experience health disparities across a variety of health indicators, including birth outcomes, chronic diseases, oral health, health behaviors and access to health care services. State approaches for reducing health disparities are highlighted in the 2017 NCSL brief, “State Approaches to Reducing Health Disparities.”

Figure 1. Among low-income adults with a mental illness, whites use mental health services more than those who are black or Hispanic.

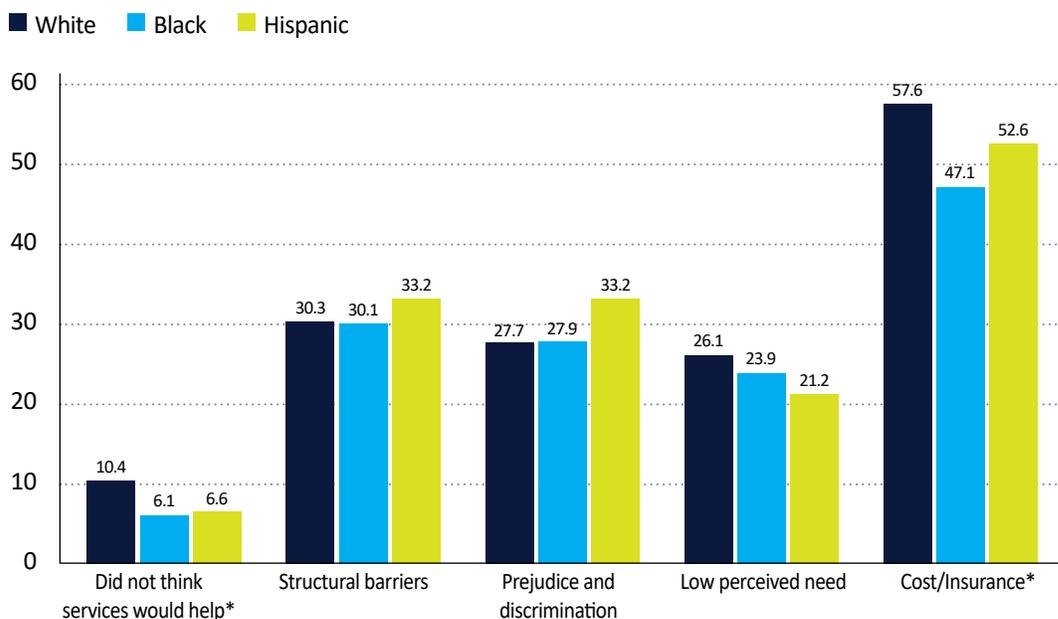
Annual average percent of adults with any mental illness who used mental health services, by race/ethnicity and poverty status, 2008-2012



Source: Substance Abuse and Mental Health Services Administration, 2015

Figure 2. Cost is the most commonly reported barrier to using mental health services.

Annual average percent of adults with any mental illness who had an unmet need for services, by reason for unmet need and race/ethnicity, 2008-2012

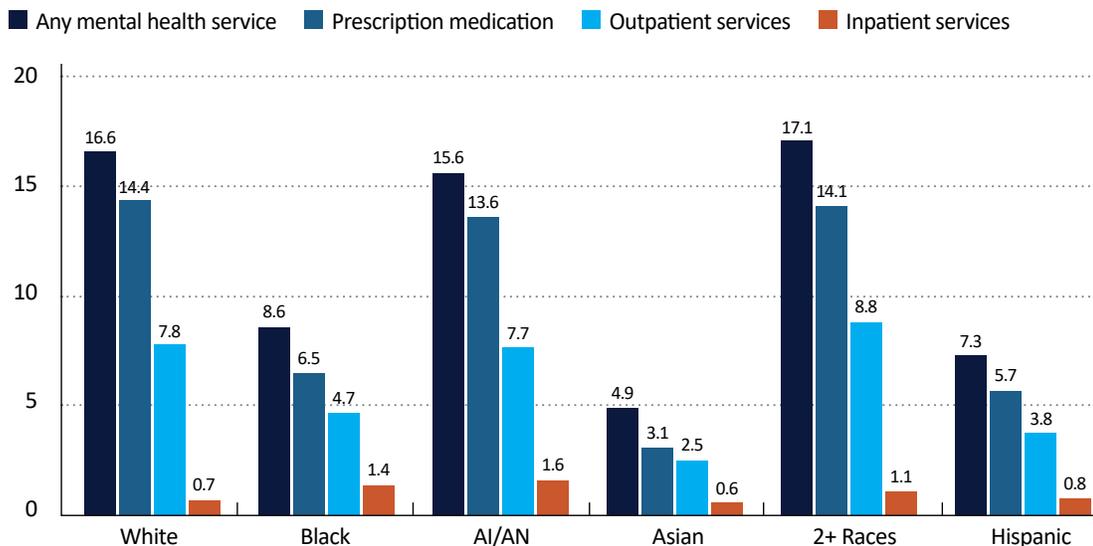


* Indicates significant difference by race/ethnicity

Source: Substance Abuse and Mental Health Services Administration, 2015.

Figure 3. Use of mental health services is relatively low among blacks, Asians and Hispanics.

Annual average percent use by adults of mental health services, by race/ethnicity and service type, 2008-2012



Note: AI/AN = American Indian/Alaska Native

Source: Substance Abuse and Mental Health Services Administration, 2015.

Prevalence, Costs and Barriers

Mental health and substance use disorders are the “leading cause of disease burden in the United States, and the U.S. has the highest mortality rate for these disorders among similarly wealthy countries,”³ according to a 2017 report published by the Kaiser Family Foundation. Access to mental health and substance use disorder services is lacking for many Americans, especially for members of racial and ethnic minority populations.

- Each year, approximately 9.8 million American adults experience a serious mental illness that causes substantial functional impairment.⁴ Adults who are uninsured or low-income are more likely to experience serious mental illness than individuals with insurance or higher incomes. And white adults with serious mental illness are more likely to use prescription medication than black or Hispanic adults (64 percent versus 47 percent and 25 percent, respectively), according to a 2017 report published by the Kaiser Family Foundation.⁵
- For each year between 2008 and 2012, black, Hispanic and Asian adults were significantly less likely to report using any mental health services than individuals who were white or American Indian and Alaska Native. (Figure 1.)
- On the same survey, respondents reported similar barriers to care regardless of race or ethnicity. As shown in Figure 2, adults with an unmet need for mental health services most frequently cited cost or inadequate insurance coverage as the main barrier to receiving care. Among poor adults with a mental illness, white adults were more likely to use mental health services than those who were black or Hispanic. (Figure 3.)

Barriers to Care for Racial and Ethnic Minority Groups

According to the National Alliance on Mental Illness, the following barriers prevent racial and ethnic minorities from receiving appropriate care:

- Lack of availability
- Transportation, child care, difficulty taking time off work
- The belief that mental health treatment “doesn’t work”
- The high level of mental health stigma in minority populations
- A mental health system weighted heavily towards non-minority values and norms
- Racism, bias and discrimination in treatment settings
- Language barriers and an insufficient number of providers who speak languages other than English
- Lack of adequate health insurance coverage (and even for people with insurance, cost sharing makes it difficult to afford)

Figure 4. Annual Behavioral Health Economic Impacts



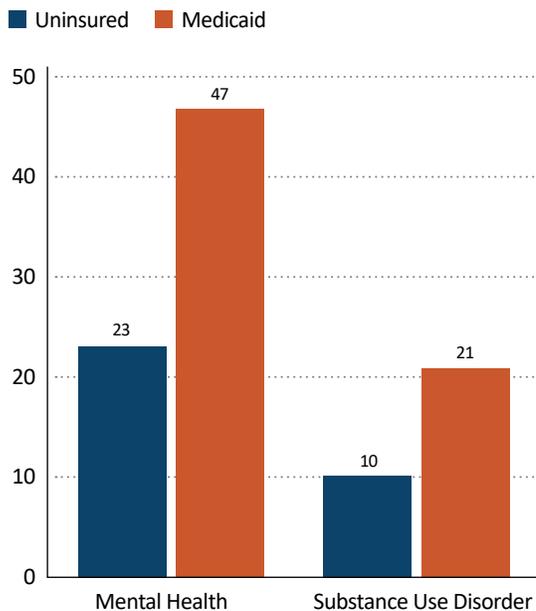
Source: Substance Abuse and Mental Health Services Administration, 2011.

COSTS

In addition to the human toll related to mental, emotional and behavioral disorders, and substance use disorders, the costs to individuals, employers and governments are staggering. As shown in Figure 4, the estimated total societal costs of substance abuse exceed \$510 billion annually, according to the Substance Abuse and Mental Health Services Administration (SAMHSA).

Mental health and substance use treatment services accounted for about 7 percent of overall health spending in 2014.⁶ Public programs—including Medicaid, Medicare and other state and local funding—paid for about 60 percent of all mental health spending and about 70 percent of all substance use disorder spending in 2014, totaling \$110 billion and \$22 billion, respectively.⁷

Figure 5. Proportion of Adults with Behavioral Health Conditions Who Received Treatment, 2015



Source: Kaiser Family Foundation, 2017.

Factors Contributing to Behavioral Health Disparities

Several factors contribute to behavioral health disparities, including lack of access to affordable and culturally and linguistically competent health care services and providers. Other factors include cultural barriers, stigma surrounding treatment, and fears about psychotropic medications.⁸ Some of the key barriers to care are listed on page 3 and discussed in greater detail below.

PUBLIC AND PRIVATE COVERAGE AND COST

Medicaid plays a substantial role in covering and paying for behavioral health care. Medicaid is the single largest payer for mental health and substance use services in the United States, accounting for 26 percent of all behavioral health spending in 2009, according to a 2015 report from the Medicaid and CHIP Payment Access Commission (MACPAC). While one in five individuals enrolled in Medicaid has a behavioral health diagnosis, they account for almost half of all Medicaid expenditures, totaling more than \$131 billion (spent on medical, behavioral health and other covered services).

Compared with uninsured individuals, Medicaid enrollees are significantly more likely to receive mental health and substance use disorder treatment, as shown in Figure 5. However, a 2017 Kaiser Family Foundation report found that gaps persist for 2.5 million Medicaid enrollees who reported having an unmet need for mental health treatment. Several access and payment barriers prevent some people from receiving needed care, including a shortage of behavioral health providers who accept Medicaid, different eligibility requirements for Medicaid across states, inadequate coverage of behavioral health services, and transportation and language barriers.

The high cost of behavioral health services is an impediment for many people, especially those who lack health insurance.⁹ Individuals diagnosed with mental illness are less likely than those without mental illness to have health insurance. Moreover, compared with whites, non-elderly minorities were more likely to lack insurance as of 2015.¹⁰ Even among those with insurance, the cost of deductibles and copayments may be a barrier to getting mental health care. “Cost sharing may disproportionately affect people with mental illness, who have lower family incomes and are more likely to be living in poverty than those without mental illness,” found a 2013 Health Affairs study.

ACCESS TO PRIMARY CARE

Higher uninsured rates among racial and ethnic minorities means that those individuals are less likely to have a usual source of care. People with a usual source of care or stable primary care provider are more likely to receive health services, including preventive care. “Primary care that includes mental health screenings and treatments that take into account a patient’s language and cultural background can help address mental health care disparities among ethnic minorities,” notes the American Psychological Association.¹¹

WORKFORCE AVAILABILITY AND CULTURAL COMPETENCY

Access to behavioral health services depends on an adequate workforce to meet the population’s needs; however, serious workforce shortages persist. Shortages among professionals and paraprofessionals across the country, including child and adolescent psychiatrists, clinical social workers and the addiction services workforce, remain a problem, according to SAMHSA.

In addition to overall shortages, racial and ethnic minorities are underrepresented in the behavioral health workforce. “There is a scarcity of providers who can render culturally competent services for minority populations,” according to SAMHSA. Cultural competency is defined by the Office of Minority Health (OMH) as, “services that are respectful and responsive to the health beliefs, practices and needs of diverse patients.” The definition also states that, “by tailoring services to an individual’s cultural and language preferences, health professionals can help bring about positive health outcomes for diverse populations.” The lack of culturally competent providers and services is an issue that contributes to current disparities in mental health and substance use treatment and services. According to a 2016 Psychiatric Services study, “cultural and linguistic competency in the delivery of mental health services for racial and ethnic minority populations has a profound effect on access to and quality of care.” The authors went on to note that a diverse workforce that represents the population is “key to the delivery of such services.”

USE OF SERVICES

Barriers to the treatment of mental illness for racial and ethnic minority populations included low medication use, poor provider-patient communication and “persistent stigma,” according to a 2016 study published by the American Psychiatric Association. The study’s authors found that racial and ethnic minority groups initiate antidepressant medication treatment at a lower rate than whites and were more likely to stop depression treatment without consulting their provider, even though they were just as likely as whites to have received a prescription. The authors noted a “general mistrust of medical providers,” resulting from perceived mistreatment due to race or ethnic background and other factors. The authors also cited higher depression relapse rates for Hispanic adults, caused by a range of factors such as socioeconomic stress, deteriorating medical health and discomfort about antidepressant treatment.

A 2013 Health Affairs study concluded that about half of all black and Hispanic adults who entered publicly funded alcohol treatment programs completed those programs, compared with 62 percent of white patients. Researchers found similar completion rate disparities in drug treatment programs. Given those disparate outcomes, researchers pointed to culturally competent treatment that incorporates family support concepts as a promising approach. “Equipping providers with the skills to communicate with patients of all backgrounds is an important priority in the evolving treatment system,” researchers concluded.

State Actions

During the 2017 legislative sessions, legislators in at least 19 states considered 74 bills related to behavioral health disparities. The state actions described below highlight legislative trends gleaned from a review of filed and enacted legislation. The vast majority of bills focused on raising awareness of behavioral health disparities or promoting cultural competency among providers or services. Other state legislation included behavioral health disparities as part of broader efforts or legislation. For example, the Massachusetts General Court considered HB 495, which focused on quality improvements and also tied hospital reimbursement rates to their ability to reduce racial and ethnic disparities in health care. For more details and links to legislation, see NCSL's behavioral health disparities legislation webpage at nctl.org.

RAISING AWARENESS

At least seven states introduced resolutions in 2017 that included language acknowledging behavioral health disparities. Although resolutions do not have the same effects as laws, they express legislative support and can raise awareness about important issues. Resolutions considered in 2017 either recognized behavioral health disparities experienced by a certain population, or addressed disparities as part of a broader behavioral health strategy. For example, the California and Pennsylvania legislatures introduced resolutions to recognize May 2017 as National Mental Health Awareness Month in their states.

The Pennsylvania legislature adopted HR 141, which focuses on mental health issues in the black community. It designates May 2017 as "Mental Health Awareness in the Black Community Month" in conjunction with the 2017 Black Brain Campaign, a mental health and well-being campaign led by Philadelphia's Department of Behavioral Health and Intellectual Disability Services. The resolution states that "racial inequity and race-based exclusion in the United States has translated into continuing mental health disparities among African-Americans and a continuing mental health care gap." The resolution asserts that health care policy change is needed to reduce behavioral health disparities.

California adopted ACR 96, which recognizes National Mental Health Awareness Month in May 2017 to "enhance awareness of mental illness." In contrast to Pennsylvania's resolution that speaks to a particular population, California's resolution raises awareness for mental health disparities on the whole. The resolution states, "Although mental illness impacts all people, many of those in lower-income communities receive less care, poorer quality of care, and often lack access to culturally competent care, thereby resulting in mental health disparities."

SEAT AT THE TABLE

State leaders are also looking to address behavioral health disparities by making sure that those who are affected by such disparities have a seat at the table. This category of legislation typically addresses the creation, membership and/or duties of a task force, committee or other type of working group. For example, in California, the Legislature enacted AB 1688 to rename the Mental Health Planning Council as the Behavioral Health Planning Council. The legislation stipulates that council members must include people who have experience with behavioral health issues and be a balance of demography, geography, gender and ethnicity.

At least six states introduced legislation requiring work group representation by people affected by health disparities. These strategies seek to engage key stakeholders and partners, including members of population groups affected by disparities, to serve as resources and advise on matters related to behavioral health policy development and quality improvement.

Minnesota, which considered the most bills related to behavioral health disparities in the 2017 legislative analysis, enacted HF 945. The legislation, part of the health and human services budget bill, created an Alzheimer's Disease Working Group. It requires the working group to reflect the diversity in Minnesota and include representatives from rural and metropolitan areas, along with those of different ethnicities, races, genders, ages, cultural groups and abilities.

Montana passed similar legislation related to a new task force to combat opioid, heroin and methamphetamine abuse. The act, D 784, establishes requirements for task force membership and stipulates

Legislative Case Study of Behavioral Health Disparities

With support from the U.S. Department of Health and Human Services Office of Minority Health (OMH), NCSL conducted a legislative case study to identify and analyze policies that address disparities in behavioral health, particularly related to access and quality.

NCSL staff members developed search terms in collaboration with OMH and SAMHSA, and used them to identify behavioral health disparities legislation introduced in the 2017 legislative session. The search terms were crafted to focus on disparities among racial and ethnic minorities and medically underserved communities in four areas: behavioral health, mental health, substance use and cultural competence in behavioral health. As shown in the table below, the search initially identified hundreds of bills related to behavioral health disparities. Some of the bills crossed multiple categories, but the majority focused on mental health disparities (419) and substance use disparities (209).

Project staff refined the search terms and reviewed the legislation to identify only relevant legislative examples that directly related to behavioral health disparities—which totaled 74 bills. As of December 2017, 26 of these bills were enacted or adopted.

NCSL Behavioral Health Tracking Results

Search Term/Focus Area	Number of Identified Bills
Behavioral Health Disparities	113
Mental Health Disparities	419
Substance Use Disparities	209
Cultural Competence in Behavioral Health	75

that of the four members appointed by the governor, one must be a member of an Indian tribe located in the state.

While Minnesota’s legislation requires the task force to be representative of the state’s population and Montana’s requires representation from a specific group, both acts seek inclusion of communities that are underserved in the decision-making process.

CULTURALLY COMPETENT WORKFORCE AND SERVICES

States considered legislation to improve care for racial and ethnic minorities and reduce behavioral health disparities by requiring clinicians working with diverse populations to be representative of those populations or trained to be culturally competent. One state, Minnesota, required linguistic competency.

Some states considered requirements that clinicians be representative of the population they are serving, as was the case in Minnesota, Montana and Washington. One of Minnesota’s bills would define a culturally competent worker as “a provider who understands and can utilize to a client’s benefit the client’s culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.” It also would require that a mental health practitioner is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner’s clients belong.

At least six states—including California, Illinois, Minnesota, New York, Texas and Washington—considered legislation to require behavioral health treatment services to be culturally competent, meaning the programming is available in the language of the patient and in a format that responds to the cultural norms of the population. California enacted legislation and Massachusetts introduced legislation (pending as of December 2017) that would require a portion of the revenue collected from marijuana sales to be spent on child and youth substance use treatment programs that are both culturally and gender competent.

USING DATA TO TARGET POLICIES

In addition to culturally competent programs, lawmakers considered other programmatic strategies. At least two bills were enacted in 2017 to require health and human services programs to collect and track relevant data to reduce behavioral health disparities.

Washington enacted HB 1661, which requires the Department of Children, Youth and Families to establish goals and metrics to reduce disparities, including those experienced by income, race and ethnicity. The act acknowledges that children and youth of color experience disparities at a higher rate. It requires the department to report the outcomes of its goals and metrics to reduce disparities and increase equity. This act also requires treatment coordination for mental health, developmental disabilities, alcoholism and drug abuse services among the Department of Social Health Services, the Department of Children, Youth and Families, and the Health Care Authority.

California enacted AB 470 requiring the Department of Health Care Services to create a performance outcome dashboard for mental health services provided to eligible Medi-Cal (Medicaid) recipients. It requires information and data on eliminating or reducing mental health disparities to be available on a public website.

Questions for Consideration

Legislators who are interested in addressing behavioral health disparities in their states may wish to ask the following questions or consider the following ideas.

- Which populations or groups experience the greatest disparities in behavioral health? What are some of the drivers of those disparities, such as coverage, access to services and quality of services? Where are the greatest needs?
- What data related to behavioral health disparities are available? If data are not available, what data could be collected and what would constitute measures of success?
- Which stakeholders can or should be involved in discussions about programs or policies? Are there representatives of the populations who experience disparities who should be at the table?
- What efforts are already underway in the state to address behavioral health disparities? For example, what strategies are the state office of minority health or health equity pursuing? Are there other efforts in the private sector?

Conclusion

Behavioral health disparities affect different populations, including racial and ethnic minorities, who face greater challenges in accessing care and receiving services that are culturally appropriate. A number of policy strategies exist for state lawmakers interested in reducing these disparities. In 2017, state legislators relied on a variety of policy levers to improve access to behavioral health services and reduce disparities in care and health status. NCSL identified several common themes and legislative approaches for reducing behavioral health disparities in 2017:

- **Improving awareness about differences in behavioral health status and access to services.** Several states adopted strategies, such as resolutions, to improve awareness of the impact of behavioral health disparities.
- **Addressing behavioral health disparities directly and indirectly.** These efforts are part of targeted legislation aiming to reduce specific disparities, as well as improve health systems more generally.
- **Engaging diverse perspectives and populations.** States rely on participation of key constituencies and members of racial and ethnic minority populations on work groups, commissions and task forces.
- **Promoting cultural and linguistic competence.** Recognizing the effect of cultural and linguistic competence on access to and quality of care, states considered strategies to develop the workforce generally, and to strengthen the workforce through culturally competent programs and services.

Notes

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- 3 Rabah Kamal, “What Are the Current Costs and Outcomes Related to Mental Health and Substance Abuse Disorders?” (Washington, D.C.: Kaiser Family Foundation, July 31, 2017), <http://www.kff.org/slideshow/what-are-the-current-costs-and-outcomes-related-to-mental-health-and-substance-abuse-disorders/>.
- 4 National Alliance on Mental Health, “Mental Health by the Numbers” (Alexandria, Va.: NAMI, n.d.), www.nami.org/Learn-More/Mental-Health-By-the-Numbers.
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- 6 Substance Abuse and Mental Health Services Administration, “State and Local Government Partnerships” (Rockville, Md.: SAMHSA, 2014), www.samhsa.gov/state-local-government-partnerships.
- 7 Ibid.
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- 10 S. Artiga, P. Ubbri, and J. Foutz, “Health Coverage by Race and Ethnicity: Examining Changes under the ACA and the Remaining Uninsured” (Washington, D.C.: KFF, Nov. 4, 2016), <http://www.kff.org/disparities-policy/issue-brief/health-coverage-by-race-and-ethnicity-examining-changes-under-the-aca-and-the-remaining-uninsured/>.
- 11 American Psychological Association, “Ethnic Minorities Still Receiving Inferior Mental Health Treatment, Says APA Journal” (Washington, D.C.: APA, December 2014), <http://www.apa.org/news/press/releases/2014/12/inferior-treatment.aspx>.

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