



Mental Health Care Services in Primary Care

Tackling the Issues in the Context of Health Care Reform

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Executive summary

The responsibility for providing mental health care is falling increasingly to primary care providers. This may reflect both the treatment preferences of many Americans and the availability and affordability of health care services. Well over half of treated patients now receive some form of primary care for their mental disorder, mostly from a primary care doctor, and primary care is now the sole form of health care used by over one-third of patients with a mental disorder accessing the health care system.

As health care reform focuses on a central role for primary care in the delivery and coordination of health care services, especially for the chronically ill, it is timely to consider how mental health services could be better integrated into primary care, and how the implementation of health care reforms could optimally deliver this.

This paper considers the various issues in mental health care and suggests options for reform, highlighting those that are facilitated by the provisions of the Patient Protection and Affordable Care Act, or ACA. The principal focus is on the role of primary care in the delivery of mental health care services and how this can be improved.

The key issues considered are:

- Mental health workforce shortages and maldistribution problems
- The ability of the primary care workforce to diagnose and treat mental health disorders
- Lack of financial incentives for primary care providers to deliver quality mental health care
- Insurance and financial barriers for patients seeking treatment for mental health disorders
- Patients' perceptions and fears that are barriers to accessing effective and appropriate treatments for mental health disorders
- The quality of mental health services
- Comorbidities of mental health disorders with physical illness and substance abuse
- The need for early diagnosis and intervention
- Racial and ethnic disparities in mental health services
- The structure of the health care system as an impediment to the integration of mental health services

Alignment of the suggestions for reforms made in this paper with health care reforms enacted in the ACA and other recent legislation such as the American Reinvestment and Recovery Act highlights that several crucial elements are missing.

The most important of these can be categorized in three broad areas:

- Protection against discrimination for people with mental illness
- Better integration of the systems for addressing mental and physical health and substance abuse
- More youth-specific services

Achieving these goals, together with robust efforts to ensure that mental health is always considered in the implementation of the ACA, would make a substantial contribution toward expanding access to mental health services, improving the physical health of people with mental illness and the mental health of people with chronic physical illnesses, and addressing current health care inequalities for people with mental health problems, especially for those who are from racial and ethnic minorities.

Introduction

Mental health disorders are common in the United States, affecting some 44 million adults and 13.7 million children each year. Suicide is the eighth leading cause of death in the United States and 80 percent to 90 percent of people who die by suicide are suffering from a mental illness. Yet despite the facts that mental health disorders are as disabling as heart disease or cancer in terms of premature death and lost productivity, and most mental health disorders are treatable using medication and other therapies, fewer than half of adults and only one-third of children with a diagnosable mental disorder receive treatment.

Mental health remains a hidden health issue. It rarely receives public attention, is underfunded in both the public and private sectors, and was barely mentioned during the recent debate on health care reform.

The barriers to early diagnosis, treatment, and care are many: a shortage of mental health services and providers; a failure to link physical and mental health care and lack of parity in the way these services are provided; lack of public awareness of effective treatments; lack of health insurance coverage and financial costs; and stigma. The unmet need for treatment is greatest in traditionally underserved groups, including elderly persons, racial and ethnic minorities, those with low incomes, those without insurance, and residents of rural areas.

An Institute of Medicine report in 2005 concluded that the only way to achieve true quality (and equality) in the health care system is to integrate primary care with mental health care and substance abuse services.¹ This is particularly important as the majority of people with poor mental health who do get treatment see only a primary care physician.

As health care reform focuses on a central role for primary care in the delivery and coordination of health care services, especially for the chronically ill, it is timely to consider how mental health services could be better integrated into primary care, and how the implementation of health care reforms could optimally deliver this.

Achieving this goal would make a substantial contribution toward expanding access to mental health services, improving the physical health of people with mental illness and the mental health of people with chronic physical illnesses, and addressing current health care inequalities for people with mental health problems, especially for those who are from racial and ethnic minorities.

The growing burden and costs of mental illness

Mental illness imposes a substantial burden on individuals and society. Mental disorders are not only highly prevalent medical conditions but they are also highly disabling.

An estimated 26 percent of Americans aged 18 and older—about one in four adults—suffer from a diagnosable mental disorder in a given year. This translates to about 60 million people. While mental disorders are widespread in the population, the main burden of illness is concentrated in the 6 percent of the population who suffer from a serious and chronic mental illness.²

The massive Global Burden of Disease study conducted by the World Health Organization, the World Bank, and Harvard University reveals that mental illness, including suicide, accounts for more than 15 percent of the burden of disease in first world countries such as the United States. This is more than the disease burden caused by all cancers.

The Global Burden of Disease study uses a measure called disability adjusted life years, or DALYs, to compare the burden of disease across many different disease conditions. DALYs measure lost years of healthy life regardless of whether the years were lost to premature death or disability, and the disability component is weighted for severity of the disability. For example, disability caused by major depression is equivalent to blindness or paraplegia whereas the active psychosis seen in schizophrenia produces disability equivalent to quadriplegia.

Using the DALYs measure, major depression ranked first, ahead of ischemic heart disease, as the major disease burden in first world countries in 2004 and this burden is predicted to grow over the next two decades.³ The excess disability due to mental disorders is a result of their early age of onset and the growing impact with age.

Mental illness may result in an increased risk of living in poverty, having a lower socioeconomic status, and having lower educational attainment. Major depres-

sion, as well as other psychiatric disorders, has been shown to impair family function, increase the risk of teenage childbearing, and increase the risk of domestic violence.

The health expenditures for mental disorders rose from \$35.2 billion in 1996 (in 2006 dollars) to \$57.5 billion in 2006. The number of people accounting for expenditures for mental disorders increased from 19.3 million to 36.2 million over this decade.⁴

In 2008 the total economic costs of mental illness were estimated at \$317 billion.⁵ This excludes costs associated with comorbid conditions, incarceration, homelessness, and early mortality, yet this sum is equivalent to more than \$1,000/year for every American. The negative economic consequences of mental illness far exceed the direct costs of treatment, thus making it important to treat mental illness.

Rates of mental health problems are significantly higher for patients with certain chronic conditions such as diabetes, asthma, and heart conditions. Failure to treat both physical and mental health conditions results in poorer health outcomes and higher health care costs.⁶

The causes of most mental disorders lie in some combination of genetic and environmental factors, which may be biological or psychosocial. Certain demographic and economic groups are more likely than others to experience mental health problems and some mental disorders, and it is now recognized that socioeconomic factors affect individuals' vulnerability to mental illness and mental health problems.

Childhood mental health is expressed in the context of their development within their particular social environment. We do not yet know what factors place some at risk for mental illness and what protects some children but not others despite exposure to the same risk factors. There is growing recognition that there is much that can be done to prevent or treat mental health conditions in children and adolescents.

A substantial minority of older people is disabled, often severely, by mental disorders including Alzheimer's disease, major depression, anxiety, and other conditions. In the United States today, the highest rate of suicide—an all-too-common consequence of unrecognized or inappropriately treated depression—is found in older males.

The magnitude of the mental illness disease burden also results from the fact that only a minority of individuals with these disorders ever receives treatment in the specialized mental health care system or in the general health care system and initial treatment is frequently delayed for many years.

If disability is to be reduced, a bridging of the “treatment gap” must occur. The treatment gap represents the absolute difference between the true prevalence of a disorder and the treated proportion of individuals affected by the disorder. Most people with mental disorders in the United States remain either untreated or poorly treated. Interventions are needed to enhance treatment initiation and quality.

This fact underscores the urgency of ensuring that health care provider training properly emphasizes the skills required to differentiate accurately the causes of cognitive, emotional, and behavioral symptoms that may, in some instances, rise to the level of mental disorders, and in other instances be expressions of unmet general medical needs.

The growing burden of mental illness and the huge unmet need presents an unprecedented challenge in organizing, financing, and delivering effective mental health services.

Tackling the issues

This section of the report outlines the various issues in mental health care and suggests options for reform, highlighting those that are facilitated by the provisions of the ACA. The principal focus is on the role of primary care in the delivery of mental health care services and how this can be improved.

Mental health workforce shortages

Outline of the issue and its impact

The current shortage of mental health professionals, particularly psychiatrists, makes it inevitable that a considerable amount of mental illness care is provided in the nonmental health care sector.

Recent county-level estimates across the nation have identified widespread shortages of psychiatrists, and maldistribution of other mental health professionals, especially in rural areas.⁷ The authors of this study included the caveat that these estimates of need were extrapolated from current provider treatment patterns rather than from a normative standard of how much care should be provided and by whom.

A 2007 study showed there were 353,398 clinically active providers in six mental health professions: advanced practice psychiatric nurses, licensed professional counselors, marriage and family therapists, psychiatrists, psychologists, and social workers.⁸ Provider-to-population ratios varied greatly across the nation, both within professions and overall. Social workers and licensed professional counselors were the largest groups; psychiatrists and advanced practice psychiatric nurses were the smallest. Professionals tended to be in urban, high-population, high-income counties. Marriage and family therapists were concentrated in California, and other mental health professionals were concentrated in the Northeast of the country.

Of these mental health professionals, only psychiatrists and advanced practice nurses can prescribe the medicines that are an important part of many patients' treatment regimes. Mental health prescribers are currently represented by an estimated 32,000 psychiatrists and 8,000 advanced practice nurses nationwide.⁹ Psychiatrists are older on average than other mental health providers. The proportion of psychiatrist providers will decline over the next decade, which will increase the demand for prescriptions from nurses and other medical professionals and reopen issues about prescribing by psychologists.

The importance of the number of mental health professionals is reflected in the fact that, on average, the higher the number of psychiatrists, psychologists, and social workers per capita in a state, the lower the suicide rate¹⁰.

The shortage of mental health professionals is highlighted not just by current unmet needs but by the fact that for those patients who do get treatment, current service use is not overly generous: Adult patients with a serious mental illness such as psychosis typically spend 10.5 hours per year with nonprescriber mental health professionals and 4.4 hours per year with prescriber mental health professionals or primary care physicians in mental health visits; adults with a less serious mental illness such as depression or anxiety spend about 7.8 minutes with nonprescriber mental health professionals and 12.6 minutes with prescriber mental health professionals or primary care physicians in mental health visits per year¹¹.

Suggested reforms

Better long-term planning for workforce needs

Future workforce planning must not ignore the needs of mental health services. It must acknowledge the current large level of unmet need, the importance of appropriately trained mental health professionals to deliver services to children, adolescents, and the elderly, and the need for cultural sensitivity.

The primary care workforce is already acknowledged as being in short supply, and if primary care doctors are to do more in mental health, then this must be factored into the number of education and training places needed.

Future analyses must recognize that the mental health workforce is characterized by a considerable overlap of roles and functions, with numerous types of professionals vying for patients, recognition, and financial resources. The ability for different types of mental health professionals to substitute for each other is

complicated because of variations in state scope of practice laws and insurance reimbursement rules.

National workforce planning efforts would benefit from the central collection of standardized practice information from clinically active providers in all mental health professions.

More incentives to encourage people to enter the mental health workforce

The provision of academic assistance and financial incentives will help encourage students, especially those from disadvantaged backgrounds, to enter the mental health field.

Expanded academic training capacity for critical professions such as psychiatry, psychology, psychiatric nursing, and social work will also be required, along with opportunities for retraining and continuing professional education.

Incentives to address the maldistribution of the mental health workforce

The health care reform legislation recognizes that primary care clinicians can be encouraged to practice in areas of workforce shortage by the provision of additional Medicare payment incentives. Such incentives should be explored for a range of mental health professionals, in particular for psychiatrists and clinical and child psychologists who practice in underserved areas.

Better use of telemedicine and IT

The use of telecommunications to provide mental health services has been in existence for more than 40 years. It has been used successfully as a tool for treatment and providing counseling services in rural areas, with high levels of patient and physician satisfaction.¹² A number of payers and health services offer telemedicine mental health services and benefits, including Medicare and Medicaid.

The American Telemedicine Association recently released evidence-based practice guidelines for the use of telemedicine and videoconferencing in the delivery of mental health services.¹³ These guidelines are designed to form the standard of care for such services and to be the basis for the development and practice of uniform, effective, safe, and sustainable telemedicine mental health practices.

Such services can also be used to increase access to training and educational programs for mental health professionals.

Recognition of the important role of pediatricians

Pediatricians play an important frontline role in assessing the mental health and behavioral problems of children. Pediatricians consistently report that pediatric residencies do not adequately prepare them to treat patients with learning disabilities, attention deficit disorders, mental retardation, substance abuse issues, or psychosocial and behavioral problems. This deficiency should be remedied through changes in training and requirements for continuing medical education.

Provisions in the ACA that will help deliver these reforms

While there are very few provisions in the ACA that specifically address shortage and maldistribution in the mental health workforce, there is a raft of provisions to tackle these issues generally and judicious implementation of these can increase the supply of the range of mental health professionals.

In particular, the establishment of a national commission tasked with reviewing health care workforce and projected workforce needs (Section 5101) will help with the alignment of federal health care workforce resources with national needs.

In Section 5602, the secretary of health and human services is directed to establish a comprehensive methodology and criteria for designating medically underserved populations and health professional shortage areas. This work must include a consideration of mental health needs.

It is important to ensure that current and new education and training programs and recruitment and retention programs have a mental health focus that reflects the current and projected needs. Progress toward the better integration of physical and mental health services means that all health professionals need to have adequate training in managing mental health issues.

Section 5306 of the new law authorizes funds for mental and behavioral health education and training grants across a broad range of professions, and ensures that some of these grants go to historically black colleges or universities or other minority-serving institutions. For the fiscal years 2010 through 2013, this provision authorizes \$8 million for training in social work; \$12 million for training in graduate psychology, of which not less than \$10 million is to be allocated for doctoral, postdoctoral, and internship-level

training; \$10 million for training in professional child and adolescent mental health; and \$5 million for training in paraprofessional child and adolescent work.

It will be critical that these funds are fully appropriated. Moreover, given the need, it would be disappointing if the only focus on mental health workforce was through the provisions of Section 5306.

The ability of the primary care workforce to manage mental health disorders

Outline of the issue and its impact

The responsibility for providing mental health care is falling increasingly to primary care providers. Well over half of treated patients now receive some form of primary care for their mental disorder, and primary care is now the sole form of health care used by more than one-third of patients with a mental disorder accessing the health care system.¹⁴ Estimates are that some 11 percent to 36 percent of primary care patients have a mental disorder.¹⁵

While use of the primary care sector for mental health care clearly has grown—and this may represent patient preference—the intensity and quality of treatment remains shallow and uneven. Many cases go unrecognized and untreated and it has been estimated that only one-third of cases seen in the primary care sector received minimally adequate care.¹⁶

Research has confirmed that the provision of frontline mental health services in primary care settings, when appropriate and optimal, has positive impacts, including the improvement of patient, practitioner, and provider satisfaction; overall health care cost efficiency, including primary and specialty costs for physical health care; improved clinical and functional patient outcomes; and adherence to regimens and treatment of mental health disorders. Receipt of mental health services in primary care settings also reduces stigma for some consumers.¹⁷

Suggested reforms

Better training and tools for primary care clinicians

Concentrated outreach efforts to promote the recognition of mental health disorders and timely initiation of treatments in primary care settings are neces-

sary, given that these settings are increasingly the portals of entry into the service delivery system for most people with mental health needs.

This approach will require expanded training for primary care health professionals, increased awareness programs for providers and patients, and more effective tools to screen for mental disorders in primary care practices.

Primary care clinicians need to be aware of the range of treatment options for mental health disorders. If they are not trained to provide psychological interventions or counseling, then they need to be aware of where patients can be referred for these services. Moreover, they need follow-up mechanisms to ensure that their patients do access these referred services.

Ideally there should be effective and ongoing communications between the primary care doctor and the patient's other providers. Written patient management plans can facilitate this type of communication, and also help involve the patient in their care and the decision making around this.

Credentialing and recognition of mental health training programs

Specific credentialing of primary care doctors who have undertaken additional and ongoing training in mental health should be encouraged, perhaps by the provision of supplemental reimbursements. Credentialing standards should reflect the realities of rural service delivery by recognizing the important contributions of nonphysician mental health professionals.

Use of team approach

The Department of Veterans' Affairs has evaluated the effects of establishing a multidisciplinary mental health primary care team in primary care clinics.¹⁸ The team works in collaboration with primary care providers to evaluate and treat their patients. This approach means patients can be rapidly evaluated and stabilized, with a reduction in the number of referrals to specialty mental health care (and subsequent delays in treatment), and improved collaborative care. The effectiveness of this approach, however, does depend on provider attitudes and practices.¹⁹

Community health centers, rural health clinics, and community mental health centers should make judicious use of nonprofessional and paraprofessional mental health workers, especially for outreach and prevention activities. Linked to this is the need to directly fund or reimburse for services provided by care managers and social workers in integrated health care practices.

Provisions in the ACA that will help deliver these reforms

The Primary Care Extension Program (Section 5405), which is created to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health, has the potential to be a major factor in assisting primary care providers to recognize and manage the mental health needs of their patients.

Lack of financial incentives for primary care providers

Outline of the issue and its impact

Primary care physicians are major providers of mental health care, but payment mechanisms create a disincentive for comprehensive mental health screening in a system where they are overworked and undervalued.²⁰

Primary care visits typically last an average of 13 minutes and require the management of multiple patient problems. The detection and management of mental health problems must compete with other priorities such as treating an acute physical illness, monitoring a chronic illness, or providing preventive health services. Moreover, the primary care doctor often has to identify mental health problems that are obscured by physical symptoms or the patient's reluctance to acknowledge them. Eighty percent of patients with depression initially present with physical symptoms.²¹

These facts indicate how important it is to ensure that busy primary care doctors are appropriately recompensed as an incentive for them to spend the additional time required with patients who have, or may have, a mental health problem.

Suggested reforms

Increased financial incentives

Reimbursement practices favor shorter office visits, thereby discouraging identification of issues beyond the primary presenting disorder. There are no incentives in the payment system for identifying cases that could benefit from integrated care and in almost all cases, the extra time and effort required to create integration are not reimbursed.

While financial considerations are just one aspect to achieving better mental health services, including shared care, in primary care, they do currently present a considerable barrier that must be addressed.

There is no single way in which this could or should be done. The evidence shows, however, that most models for financing care that use fee-for-service, capitated arrangements, or “carve out” the delivery of mental health services from other health services do little to encourage collaborative treatment planning and coordination of care or have created conditions that work against such integration.²²

A report prepared for the Substance Abuse and Mental Health Services Administration, or SAMHSA, in 2008 addressed possible solutions for reimbursement of mental health services provided in primary care settings.²³

Paying for quality and outcomes

Improved public-sector contracts and private-sector reimbursement systems that provide incentives for the adoption of quality standards for providers as well as quality improvement programs are needed.

Analyses suggest that comprehensive financial incentives offer the prospect of significantly enhancing quality beyond the modest impacts of prevailing pay-for-performance, or P4P, programs.²⁴ Financial incentives alone, however, will not be enough. Organizational innovations such as the primary care medical home and accountable health care organizations can also help catalyze more powerful quality incentive models.

Consistency in Medicare and Medicaid policies

Inconsistent, complex, and confusing reimbursement policies interfere with the ability and willingness of mental health providers to provide needed services. For those populations dependent on Medicare and Medicaid, health care agencies need to address widely varying interpretations of reimbursement policies with clarifications of policies, definitions, and allowable services and then widely disseminate and publicize those clarifications to payers, fiscal intermediaries, managed care organizations, and state and local associations. These recommendations, which were made by the 2008 SAMHSA report, should be addressed in order to reduce the reimbursement barriers currently confronting those with public health insurance who come to the primary care sector for mental health services.²⁵

Provisions in the ACA that will help deliver these reforms

There is a possibility that state grants provided under Section 5606 to health care providers who provide services to a high percentage of medically underserved populations or other special populations could direct funds to those providers who focus on mental health services.

There are many initiatives in the ACA that focus on improving the quality of Medicaid and Medicare services and that will link payment to quality outcomes for both clinicians and hospitals. This includes, in Section 10322, the establishment of a quality measure reporting program for inpatient psychiatric hospitals beginning in 2014.

The ability of federal and state policymakers to link quality and mental health outcomes to reimbursement rates for mental health services has the potential to improve both these factors in the primary care setting. Public reporting of performance against agreed quality measures, as required by the ACA, will provide needed information to consumer and patient advocates.

Insurance and financial barriers for patients

Outline of the issue and its impact

Financial considerations are the leading barrier to receiving mental health care, either through lack of insurance coverage (52 percent) or concerns over cost (42 percent).²⁶

Individuals with psychiatric conditions have out-of-pocket health care costs that are more than double the costs individuals without psychiatric conditions face, even after adjusting for socioeconomic factors, health status, and functional limitations.²⁷ Private insurance is the major source of payment for specialty mental health and hospital services for children and adults but the share paid by public insurance has increased over time.²⁸

As a result of legislation enacted in 2008, group health plans and employers who self insure will no longer be allowed to impose different limitations on mental health and substance abuse coverage than they do for medical treatment. In other words, deductibles, copayments, covered hospital days, and any limits on outpatient treatments must be identical. Under this law, insurers can still require

that services be medically necessary and can require preapproval or prior review. They can also require medical evidence that the treatments are effective. The Department of Health and Human Services has recently promulgated rules to implement these requirements;²⁹ these rules took effect on July 1, 2010.

Medicare recipients aren't affected by this law; however, a measure adopted in 2008 eliminated discriminatory copayments in that program, which had been capped at 50 percent for mental health treatment, compared with 20 percent for most doctors' services. The Medicare change is being phased in gradually and will not be fully in force until 2016.

As a cautionary note, a recent study suggests that implementing mental health parity nationally will reduce some but not all of the barriers to mental health care.³⁰

Suggested reforms

Ensure that all people with mental illness are able to get affordable health insurance coverage

Health care reform makes important contributions toward the goals of universal coverage, reforming private health insurance, and making access to quality care more affordable for all Americans. These initiatives will help address the gaps in the provision of mental health services, especially those delivered in the primary care sector.

Provisions in the ACA that will help deliver these reforms

Provisions in the ACA that will prevent private health insurers from denying coverage on the basis of pre-existing conditions or limiting coverage when people most need it will help people with mental illness get and keep health coverage.

The ability of nonelderly, nonpregnant adults with incomes up to 133 percent of the federal poverty level to enroll in Medicaid, and financial assistance to help individuals and families with incomes between 133 percent and 400 percent of the FPL to purchase coverage on state-based insurance exchanges, will particularly benefit people with a mental illness, many of whom live in poverty.³¹ Provisions which place limitations on out-of-pocket costs will also help.

There are two provisions in the ACA that will reduce the cost of prescription medicines for people with a mental health disorder. Medicare Part D enrollees will benefit considerably from the provision (Section 1100) that will close the prescription drug “doughnut hole” by 2010. Section 2502 removes smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid’s excludable drug list, effective January 1, 2014. This will make these prescription medicines, used to treat mental health disorders and smoking, available and affordable to all Medicaid beneficiaries.

Patients’ perceptions and fears

Outline of the issue and its impact

Among many Americans there is still a pervasive reluctance to seek care for mental health problems, and a failure to acknowledge the clinical basis of these problems. The reasons for not seeking mental health treatment in the context of a perceived need are complex. Research shows that attitudinal barriers to mental health service use are more common than structural barriers across countries with differing health care systems.³²

What it means to be mentally healthy is subject to many different interpretations and varies across cultures. This in turn means that stigmatization of people with mental disorders also varies across population subgroups. Stigma deters people from seeking and wanting to pay for care, reduces patients’ access to resources and opportunities such as housing and jobs, and leads to low self-esteem, isolation, and hopelessness.³³

Concern about stigma appears to be heightened in rural areas relative to larger towns or cities and stigma also disproportionately affects certain age groups, such as children and older people.³⁴

An additional factor that influences the willingness to access treatment is a lack of mental health literacy on the part of the public, specifically a lack of knowledge of how to recognize mental disorders and beliefs about treatment that are at variance with those of health professionals.

Beliefs about various types of professional help and treatment are also important. For example, if a person with a mental disorder believes that consulting a psychiatrist or psychologist is unlikely to be helpful, this will reduce their chance of getting

appropriate help.³⁵ Surveys in several countries have found predominantly negative attitudes towards psychotropic medication, both because of concern about side effects and the belief that medications only deal with the symptoms rather than the causes. By contrast, psychological therapies are seen more positively.³⁶

Suggested reforms

Public education and awareness

There is no simple or single panacea to eliminate the stigma associated with mental illness. Knowledge of mental illness and its causes appears by itself insufficient to dispel stigma.³⁷ Overall approaches to stigma reduction involve advocacy and public education programs, and contact with persons with mental illness through schools and other societal institutions.³⁸ There is also an important role for the business community to play here, given that many employees struggle to manage the consequences of mental illness in their families.

A focus on recovery

Treatment regimes and patient support programs need to emphasize each individual's potential for recovery. The 2003 President's New Freedom Commission on Mental Health proposed that the mental health care system should be transformed to be recovery-oriented in its care and services.³⁹

The commission defined recovery as “the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.”

Care that is focused on increasing patients' ability to successfully cope with life's challenges and on facilitating recovery will require services beyond health and the treatment of symptoms, such as housing, training, and employment.

Protection against discrimination

The Americans with Disabilities Act, or ADA, is a legal tool to fight discrimination⁴⁰. To be protected by the ADA, someone must have a physical or mental impairment that substantially limits one or more major life activities, or be perceived by others as having such an impairment.

Provisions in the ACA that will help deliver these reforms

There is nothing in the new health care reform law to address these issues. It's conceivable that, with the right focus, some of the efforts to improve health literacy could encourage patients with mental health problems to seek treatment more readily.

Quality of mental health services

Outline of the issue and its impact

Despite the availability of evidence-based treatment for mental disorders, many patients and families do not receive effective treatment.⁴¹ One study estimates that less than 10 percent of patients diagnosed with major depression receive demonstrably beneficial therapy.⁴² Ethnic minorities, older patients, and less-educated patients are more likely to be subject to treatment disparities and to receive lower-quality care than other patients.⁴³

While the majority of primary care doctors feel confident about their ability to manage mental health problems, they do not always provide evidence-based care. For example, although primary care physicians prescribe 41 percent of antidepressants, these are not always prescribed in appropriate dosages and the requisite follow-up visits are not always scheduled.⁴⁴ The evidence indicates that optimal treatment of depression includes psychotherapy and this is not always provided or even available.

Suggested reforms

It is not enough to simply improve the level of diagnosis; more must be done to ensure that patients receive beneficial therapy and to improve the quality of treatment.

Use of evidence-based practice guidelines

Guideline-based protocols can improve detection and treatment of depression in primary care, reduce suicide risk, prevent relapse of symptoms, and improve outcomes.⁴⁵ Despite this, simply introducing treatment guidelines has not proven to be successful; more complex interventions are needed to improve patient outcomes.

These include clinician education, nurse case management, and a greater degree of integration between primary care and mental health services. Telephone medication counseling delivered by practice nurses or trained counselors is also effective.⁴⁶

Developing infrastructure for evidence-based psychotherapy and psychosocial treatments

Psychotherapy is one of the primary treatment modalities for mental health conditions. But there is a substantial gap between the state of evidence for effectiveness of particular models of structured psychotherapy and what is known about the content or effectiveness of psychotherapy as delivered. Although evidence-based psychosocial treatments such as cognitive behavioral therapy, or CBT, and interpersonal psychotherapy exist, there are no training, licensure, or certification requirements obligating providers to have competence in such therapies and no easy way for consumers or providers to identify practitioners who deliver the treatments.⁴⁷

This issue can be addressed through professional leadership, training, evaluation, and assessment tools.

Improved patient compliance

Rates of compliance with mental health appointments and medication are challenging problems in the treatment of persons with mental illness.⁴⁸ To a large extent, patient compliance is a direct reflection of the quality of the doctor-patient relationship. When consumers are empowered and motivated to improve their health with the help of a doctor, compliance or adherence to treatment is higher. When there is distrust, disagreement, or misunderstanding involved, as when mental health status is uncertain or treatment side effects are unwelcome, compliance is lower.

Provisions in the ACA that will help deliver these reforms

The new law (Section 6301) establishes a Patient-Centered Outcomes Research Institute, or PCORI, as a nonprofit corporation that is not an agency or establishment of the U.S. government. The institute's purpose is "to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of medical treatments, services, and items."

The PCORI must ensure that subpopulations are appropriately accounted for in research designs, so this would cover the mentally ill, and they (and their families and caregivers) should also be represented in the patient and consumer representatives on the advisory panels.

Section 10410 directs the administrator of the SAMHSA to award grants to centers of excellence in the treatment of depressive disorders. The work from these centers of excellence could help with the development of evidence-based treatment guidelines.

As previously noted there are a number of provisions in the ACA aimed at improving the quality of health care services. Section 3011 mandates the development of a National Strategy to Improve Health Care Quality to improve the delivery of health care services, patient health outcomes, and population health. Other related provisions require the establishment of a federal health care quality Internet website and an Interagency Working Group on Health Care Quality comprised of federal agencies to collaborate on the development and dissemination of quality initiatives consistent with the national strategy. The bill authorizes \$75 million over five years for the development of quality measures at the Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services.

Patient compliance with treatment and medication regimes requires a multifaceted approach; provisions that address care management and coordination, improve health literacy, involve patients more in their treatment decisions, and provide medication therapy management programs will all contribute to improved compliance. This is also an issue that should be addressed by the Center for Innovation in Medicare and Medicaid.

Comorbidities with physical illness and substance abuse

Outline of the issue and its impact

Mental illness often occurs together with other health conditions, complicating treatment and raising overall medical costs. Patients with mental disorders use general medical services more often and have higher related medical costs compared with patients without mental disorders. For example, patients with diabetes and comorbid depression have health care costs that are 4.5 times higher than those without comorbid depression,⁴⁹ and children and adolescents with comorbid mental and medical illnesses have significantly higher medical costs than others of the same age.⁵⁰

The prevalence of depression in the medically ill ranges between 15 percent and 61 percent in published studies.⁵¹ People with chronic illnesses such as cancer, heart disease, and neurological disorders have a significantly higher prevalence of anxiety and depressive disorders than people without such chronic illnesses.

Conversely, research results on the physical health of people with mental illness indicate the morbidity and the mortality from certain physical conditions is high in people with long-term mental illnesses. Persons with serious mental illness die on average 25 years earlier than the general population.⁵² Eighty-seven percent of years of life lost to premature death by the mentally ill are due to chronic disease, especially infectious, pulmonary, and cardiovascular diseases, and diabetes. Cardiac events alone account for more deaths than suicide.

There are several reasons for this:

- Patients with psychoses, including schizophrenia, are more likely than the general population to have lifestyle risk factors for cardiovascular disease and cancer; they are more likely to smoke, less likely to exercise, and more likely to have diets higher in fat and lower in fiber than the general population.
- Psychiatrists and family physicians are poor at recognizing and treating physical conditions in their psychiatric patients.
- Many patients with severe mental illness are homeless and jobless.
- Medications used by these patients often have severe side effects.
- Many people with mental disorders report difficulty in obtaining insurance and therefore cost is a barrier to obtaining the right medical care when it is needed.⁵³

Substance abuse and mental health

More than one in five adults living with serious mental illness have a co-occurring substance use disorder and people with substance use disorders are roughly twice as likely to have a mood or anxiety disorder.⁵⁴ An estimated 4.0 million adults met the criteria in 2002 for both serious mental illness and substance dependence or abuse (often referred to as dual diagnosis) in the past year. It is now generally agreed that as much as 50 percent of the mentally ill population also has a

substance abuse problem. The drug most commonly used is alcohol, followed by marijuana and cocaine. Prescription drugs such as tranquilizers and sleeping medicines may also be abused.⁵⁵

In some cases, people suffering from serious mental disorders (often undiagnosed) take drugs to alleviate their symptoms—a practice known as self-medicating. In other cases mental disorders are triggered by drug abuse. Chronic drug abuse by adolescents during formative years is a particular concern because it can interfere with normal socialization and cognitive development and thus frequently contributes to the development of mental disorders.⁵⁶

Too often these patients struggle to receive simultaneous treatment for their mental disorder and their substance abuse.

Suggested reforms

There are strong arguments for better integration of the mental and physical health care systems. The issue of comorbidity is ignored by many payment mechanisms and indeed there are often financial disincentives for integrated physical and mental care.

Better screening of chronically ill patients for mental health problems

The risk of becoming depressed for those with chronic illnesses is between 25 percent and 33 percent. It is especially high for those who have had a heart attack (40 percent to 65 percent), Parkinson's disease (40 percent), cancer (25 percent), and diabetes (25 percent). Clinicians need to be alert to this and willing to offer appropriate treatment.

Early diagnosis and treatment can reduce distress, as well as the risk of complications and suicide for those with chronic illness and depression. Depression treatment can produce an improvement in many patients' overall medical condition, quality of life, and likelihood of sticking to a long-term treatment plan⁵⁷.

Provision of better physical care for the mentally ill

The adverse medical effects of psychiatric medications and the poor health habits (such as smoking and obesity) associated with mental illness may underlie these findings, although the effects of psychiatric illness on immune and endocrine systems may also contribute to them.

The mentally ill should not miss out on preventive health screenings and programs, and when physical illness strikes, they are entitled to the same type and quality of care as all Americans. That is why mental health services, especially those for the seriously ill, should have strong ties to physical health care services.

“No wrong door” approach to dual diagnosis programs

Effective dual diagnosis programs combine mental health and substance abuse (including alcohol abuse) interventions that are tailored for the complex needs of clients with comorbid disorders. There is general agreement that broad-spectrum diagnosis and concurrent therapy (pharmacological and behavioral) leads to better outcomes for these patients.⁵⁸

The health care systems that treat substance abuse and mental illness are typically disconnected. Physicians tend to treat patients with mental illnesses, and a mix of providers with various backgrounds and training deliver substance abuse treatments. Some mental health facilities will not accept patients with a substance abuse problem, and some substance abuse treatment centers are biased against using any medications, including those necessary to treat patients with severe mental disorders. This dichotomy must be addressed.

Provisions in the ACA that will help deliver these reforms

Section 5604 authorizes \$50 million in grants to colocate primary and specialty care in community-based mental health settings. This will help with the provision of coordinated and integrated services to the mentally ill.

The provision (Section 2703) that gives states the option of enrolling Medicaid beneficiaries with chronic conditions into a health home (i.e. a medical home) could potentially be used to address the needs of the mentally ill and/or those with comorbid conditions.

Initiatives that seek to prevent and reduce the incidence of chronic diseases also have the potential to improve the care and outcomes for people with mental health disorders. Section 4108 authorizes the secretary of health and human services to award grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs, which must be comprehensive and must have demonstrated success in helping

individuals in areas such as lowering or controlling cholesterol and blood pressure, losing weight, quitting smoking, and managing or preventing diabetes, may also address comorbidities, such as depression, associated with these conditions.

The secretary may also award community transformation grants under Section 4201 for programs to prevent and reduce the incidence of chronic diseases associated with overweight and obesity, tobacco use, or mental illness.

The need for early diagnosis and intervention

Outline of the issue and its impact

The incidences of depression, anxiety, psychotic, personality, eating, and substance use disorders are highest in adolescence and early adult life. Research shows that half of all lifetime cases of mental illness begin by age 14 and an estimated 14 percent to 20 percent of children and adolescents are affected by a mental health problem every year.⁵⁹ But only one in four children and adolescents get treatment. Serious mental disorders increase mortality and may produce decades of disability and unfulfilled lives, so there are potential benefits associated with early intervention in mental disorders.

For those at high risk of schizophrenia, early intervention can delay the onset of the first psychotic episode; psychosis may even be preventable if detected and treated in the pre-illness phase.⁶⁰ But on average three years elapse between the time when young people with schizophrenia first experience symptoms and the time when they first access help. The corresponding interval for young people with mood disorders is seven and a half years.

Suggested reforms

Increased awareness of the need for early diagnosis and intervention

The first step in establishing successful early intervention is to ensure that the medical profession and the community better understand the potential seriousness of unrecognized and poorly treated mental illness. In the case of children and adolescents, this means awareness of behavioral problems and anxieties that, if not addressed, can lead to mental health disorders.

Better mental health services for children and families

The Comprehensive Community Mental Health Services Program for Children and Their Families provides grants for the improvement and expansion of systems of care to meet the needs of the estimated 4.5 million to 6.3 million children with serious emotional disturbances and their families. States, communities, territories, Indian tribes, and tribal organizations are eligible for the grant program, which was first authorized in 1992. Since that year, the program has funded 92 grantees across the country, and there are currently 61 grant communities and 31 former grant programs.

Data indicate that the program successfully reaches disadvantaged youth and can bring substantial infrastructure to address youth mental health disparities.⁶¹ There is clearly room for expansion of such services.

Other programs can prevent and offer treatment for severe behavioral, emotional, and developmental problems in children before mental health disorders develop. Some of these programs have a very strong evidence base (see for example the Triple P–Positive Parenting Program⁶²). The use of cognitive and coping skills for children along with parenting skills have been shown to help prevent the use of antidepressants, which remains controversial in children.

Youth-specific services

Developing youth-friendly services for enhanced access to quality multidisciplinary care has been described as probably the single most cost-effective measure in mental health care reform.⁶³

This is a population group which is often alienated from mainstream health services. They need a set of comprehensive, multidisciplinary health services including: assessment; treatment for a range of mental health problems including psychoses, eating disorders, and substance and alcohol abuse; and physical and sexual health services. For young people most at risk, additional services such as housing, independent living, education, and training are also needed.⁶⁴

Screening for at-risk groups

The use of evidence-based screening questionnaires that identify people suffering from underlying mental disorders has been shown to be more effective than observation or nonstructured assessment alone. Screening has been well received in the clinical setting and is adaptable to a range of primary care settings.⁶⁵

Despite a growing consensus for mental health screening in primary care, studies have shown that less than one-third of primary care providers routinely screen their patients for mental illness. There is substantial federal support and funding for such voluntary mental health screening programs. In 2003, the President's New Freedom Commission on Mental Health specifically recommended increased screening for suicidality and mental illness.

Screening is not without controversy, however, especially when it is used for children and adolescents, and it needs to be handled sensitively.

Certain population groups are more vulnerable to mental illness and depression and should be screened (formally or informally) more often. These include adolescents, pregnant women and new mothers, people with several chronic health conditions, the elderly, and those who have recently experienced physical or emotional trauma.

Provisions in the ACA that will help deliver these reforms

Section 2952 of the ACA provides for support services to women suffering from postpartum depression and psychosis and also for programs to educate mothers and their families about these conditions. It also provides for research into the causes, diagnoses, and treatments for postpartum depression and psychosis. Funding for this work is authorized only for three years, through to 2012.

Section 4101 authorizes a grant program for the operation and development of school-based health clinics, which are charged with providing comprehensive and accessible preventive and primary health care services to medically underserved children and their families. Such clinics have the potential to help screen and treat teenagers at increased risk of mental health disorders in a nonthreatening environment. While the ACA appropriates \$50 million each year for fiscal years 2010 through 2013 for expenditures for facilities and equipment for these school clinics, funding is not provided for staffing and services. In the absence of such funds there is a risk that needed facilities will stand unused.

Racial and ethnic disparities

Outline of the issue and its impact

Disparities exist in both access to and the quality of mental health care for racial and ethnic minority groups in the United States. Examples of these disparities include: the underutilization of psychiatric services by persons from ethnic minority groups, problems in treatment engagement and retention of persons from minority groups, the overdiagnosis of schizophrenia among African Americans and depression among Latinos, the inappropriate use of antipsychotic medications among African Americans (and the use of these medications at higher dosages among African Americans and lower dosages among Latinos), and very high rates of substance use disorders and completed suicide among Native Americans⁶⁶.

In addition to access barriers, such as inadequate insurance coverage and health workforce shortages, other factors that affect minority patients' utilization of mental health services include: inadequate detection of psychiatric conditions by primary care physicians, underreferral of these patients to psychiatric care, early dropout rates from treatment, and high rates of missed appointments.⁶⁷

The consequences are dramatic:

- African Americans are 30 percent more likely to report having serious psychological distress than non-Hispanic whites.
- Older Asian-American women have the highest suicide rate of all women over age 65 in the United States.
- In 2005 suicide attempts for Hispanic girls in grades 9–12 were 60 percent higher than for white girls in the same age group.
- While the overall death rate from suicide for American Indian/Alaska Natives is comparable to the white population, adolescent American Indian/Alaska Natives have death rates two to five times the rate for whites in the same age groups.

Suggested reforms

Improving access to care

As in general health care, mental health care disparities associated with lack of access and lack of insurance are significant in minority communities. Health care reforms to expand coverage and make health care more affordable for all Americans are needed.

Addressing providers' bias and stereotyping

Discrimination by race/ethnicity is a complex behavior that can stem from a number of sources—some malevolent, some not. Physicians may be especially vulnerable to the use of stereotypes in forming impressions of patients since time pressure, brief encounters, and the need to manage very complex tasks are common characteristics of their work.⁶⁸ The effectiveness of communication between patient and doctor can be compromised when patient and doctor come from different ethnic, racial, or language groups.

Providing more diversity in the mental health workforce

More than one-fourth of all Americans are from minority groups, but these groups are greatly underrepresented in the health workforce. The percentage of racial and ethnic minorities in the mental/behavioral workforce was estimated in 2004 to be: 6.2 percent for psychology, 8.7 percent for social work, 24.2 percent for psychiatry, 17.5 percent for psychiatric nursing, 15.4 percent for counseling, 5.5 percent for marriage and family therapists, and 5.3 percent for school psychology.⁶⁹ These data reveal the need to increase the pipeline of racial and ethnic minorities in mental and behavioral health professions.

Currently the only federal programs for addressing the diversity of the mental and behavioral health workforce development are SAMHSA's Minority Fellowship Program funded at approximately \$4 million and the Health Resources and Service Administration's Graduate Psychology Education Program funded at \$2 million. There is a need to substantially increase the funding available for these programs.

Provisions in the ACA that will help deliver these reforms

A number of provisions in the ACA recognize that there is a need for an increased effort to tackle racial and ethnic health care disparities. The most important provisions to drive this effort are those that will raise the profile of minority health. Section 10334 codifies the Office of Minority Health at the Department of Health and Human Services and a network of minority health offices located within HHS. It also elevates the National Center on Minority Health and Health Disparities at the National Institutes of Health from a Center to an Institute. The Offices of Minority Health will monitor health, health care trends, and quality of care among minority patients and evaluate the success of minority health programs and initiatives. It will be crucial that mental health is a key focus in this work, as racial and ethnic minorities who are mentally ill are doubly disadvantaged.

Efforts to support greater racial diversity and cultural competency in the mental health workforce will also be important and should be prioritized. In many minority communities, community health workers can help provide needed assistance with interpretation and translation services and culturally appropriate health education and information. They can also offer informal counseling and guidance on health behaviors and be advocates for individual and community health needs. Section 5313 authorizes the secretary to award grants to states, public health departments, clinics, hospitals, federally qualified health centers, and other nonprofits to enable them to use community health workers.

The better collection and use of data is essential to drive an improved understanding of health care disparities. Section 4302 requires that any ongoing or new federal health program must collect and report data by race, ethnicity, primary language, and any other indicator of disparity—this could include mental health. The secretary has responsibility for the analysis of this data and the dissemination of the information derived from it.

Structure of the care system

Outline of the issue and its impact

The report of the 2003 Presidential Commission described the present mental health system as “a ‘patchwork relic’ of disjointed state and federal agencies that frequently stepped in the way of people who were seeking care instead of helping them.”

The report called for a more streamlined system strongly focused on early diagnosis and treatment in patients’ own communities, a high expectation of recovery, and methods for helping people with mental illnesses find work and housing. The report did not recommend increased spending on mental health, but called for a more coordinated and efficient use of the money available now.

The U.S. mental health services delivery system remains pluralistic and minimally coordinated, with a persistent division between public and private sector providers. These disparities make it difficult to translate methods for estimating workforce adequacy from health to mental health.

Suggested reforms

Bringing mental health care into mainstream health care

The primary care sector functions as the ‘de facto mental health service system’ in the United States,⁷⁰ and given that this is unlikely to change, it is imperative that the structure, functioning, policies, and financing of health care through both the public and private sectors reflect this.⁷¹

The Robert Wood Johnson Foundation’s “Depression in Primary Care: Linking Clinical and Systems Strategies,” recognizes this need and is funding a five-year, \$12 million program of demonstration projects on incentives, research projects on the value of improved care for depression in the primary care setting, and physician leadership development.⁷² The evaluation of this program should be available shortly.

For many people, their mental disorder is a chronic condition, and so mental illness needs to be included alongside other chronic conditions when initiatives are established to better address and manage these.

Patient-centered medical homes

Medical homes, if implemented appropriately, could be of great benefit to people with mental illness as a solution to reducing unnecessary emergency department usage and preventable hospitalizations and improving access to primary care.

These medical homes need to be capable of providing both mental and physical health services.⁷³ Such collaborative care could be provided through “virtual” medical homes which link community mental health organizations with outpatient clinics, community health centers, or other providers of physical health services.

An analysis conducted by the Lewin Group of a model proposed by the American Academy of Family Physicians for rewarding physicians who provided a medical home found that physicians who met the standards set forth in the model could see their earnings rise 26 percent or more, while overall health care expenditures for their patients would drop. Expected savings would come from aggressive chronic care management and efficiencies like electronic health records, email communications and consultations, online appointments, and practice-management innovations.⁷⁴

Electronic medical records

Electronic medical records have the ability to improve the quality of mental health care and its coordination across a range of providers. For example, using an electronic health record with a clinical reminder system, the Department of Veterans' Affairs, or DVA, screens 89 percent of primary care patients for depression and 81 percent for substance abuse. In the DVA, 80 percent of patients hospitalized for mental illnesses receive follow-up outpatient appointments within 30 days (the Medicaid average is only 55 percent).⁷⁵

Electronic medical records can also help patients with mental health disorders manage their complex medication regimes.

The public's lack of confidence in the privacy and security of the electronic health record and the lack of national standards for data and communications represent the biggest challenges to implementing such systems.

Comparative effectiveness data

There are so many areas in mental health care where better data and analyses would help with decisions about the best treatments for people with mental health disorders.

In particular, given the large economic impact of depression and the reluctance of patients to use antidepressants, policymakers have a need for well-designed and sufficiently-powered economic evaluations of treatments for depression. The available evidence seems to indicate that psychotherapy has more substantial clinical effects than counseling.⁷⁶ Meta-analyses showed that psychotherapy was significantly more expensive than usual care, but not significantly more expensive than antidepressant treatment. Therefore, the emphasis should be on economic evaluations of forms of psychotherapy that have proved to be clinically effective.

Use of antidepressant drugs in the United States doubled between 1996 and 2005. Not only are more people being treated with antidepressants, but also those who are being treated are receiving more antidepressant prescriptions. More than 164 million prescriptions were written in 2008 for antidepressants, totaling \$9.6 billion in U.S. sales.⁷⁷ In part this may be due to a marked increase in spending on direct-to-consumer advertising, up from \$32 million in 1999 to \$122 million in 2005. Out-of-pocket costs for psychotherapy and lower insurance coverage for such visits may have driven patients away from seeing therapists in favor of a prescription from their primary care doctor.

Yet a very recent study of data on four new-generation antidepressants, from the class of drugs known as SSRIs, showed that these do not produce clinically significant improvements in depression in patients who initially have moderate or even very severe depression. Significant effects, over and above those produced by a placebo, are seen only in the most severely depressed patients. Given these results, the researchers concluded that there is little reason to prescribe new-generation antidepressant medications to any but the most severely depressed patients unless alternative treatments have been ineffective.

Provisions in the ACA that will help deliver these reforms

A prime focus of the ACA is encouraging the development of new patient care models and new ways to fund these. These models include medical homes, accountable care organizations, and bundled payment programs that reward coordinated care and move the focus from isolated services to health outcomes. Many of these offer real potential to improve the care of people with mental health problems, especially those with major psychoses and chronic comorbid conditions that require long-term care provided across acute, transition, and community settings.

Other innovative approaches that could help people with mental health disorders include the Independence at Home demonstration program (Section 3024) and the Community-Based Care Transitions program (Section 3026). The latter program provides funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission, and the legislative language recognizes depression as a risk factor.

As previously highlighted, the comparative effectiveness research that will be undertaken and sponsored by the Patient-Centered Outcomes Research Institute established under Section 6301 will make a major contribution to the evidence base about the best screening, prevention, and treatment modalities for mental health disorders.

What else is needed?

The list of what is needed for an ideal mental health system is endless. Aligning the suggestions for reforms made in this paper with health care reforms enacted in the ACA and other recent legislation such as the American Reinvestment and Recovery Act, however, it is apparent that several crucial elements are missing.

The most important of these can be categorized in three broad areas:

Protection against discrimination for people with mental illness

While important strides have been made in the area of health care insurance coverage in this regard, too many people with mental health problems are reluctant to seek treatment because of fear of discrimination and stigma, and others don't get the appropriate treatment because of bias. In the community at large, problems with discrimination mean that the mentally ill struggle to obtain and keep employment and housing.

This is a daunting issue that must be tackled through a whole-of-government approach. As a first step, however, enacted within the confines of the healthcare system, there should be education, awareness, and training programs to help all health care providers recognize mental health needs and deliver or refer the appropriate services. There should be a series of measurable goals and targets to assess progress in this area, and to measure patient satisfaction regarding the services delivered.

Better integration of the systems for addressing mental and physical health and substance abuse

This will result in better health outcomes for all patients. Addressing depression as a comorbidity with many other chronic conditions is an important way to improve quality of life and reduce health care costs.

The strong links, including causation, between mental health disorders and substance abuse (including tobacco and alcohol) mean that it is inappropriate to treat these two issues as separate problems.

Tackling this issue of better integration will require, in the long term, changing the culture of medicine and affiliated health care professions and the way these services are delivered and reimbursed. In the short term, however, primary care providers and those who deliver treatment and management services to the chronically ill are well placed to take the lead in this regard.

More youth-specific services

Given the growing burden of mental illness in children and young people, and the evidence that shows that early identification and treatment of psychosis both reduces the disruption to the young person's functioning and psychosocial development⁷⁸ and is cost effective, this is an imperative.⁷⁹

There are many excellent models of youth-specific services currently operating in the United States and these can serve as examples of what should be developed more widely. The increased focus on patient-centered outcome research should help to reinforce the increased need for these types of services.

Conclusion

The inevitable conclusion of this report and many others that have gone before is that considerable mental illness care is provided in the primary care sector and this will continue to be the case. Indeed, arguably, this is desirable, especially if primary care services are well integrated with mental health services, and if specialized secondary services in psychiatry are also available and accessible for further referral.

The delivery of mental health care through integrated primary care services can:

- Help close the treatment gap for mental disorders, which is currently enormous
- Help ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders
- Enhance access to mental health services and facilitate community outreach
- Ensure the monitoring, management, and care coordination of affected individuals
- Help minimize stigma, discrimination, and disparities
- Provide care which is affordable and cost-effective
- Generate good health outcomes, particularly if linked to a network of services at the secondary level and in the community

A number of barriers prevent the development and widespread implementation of these integrated services. These include:

- Mental health is currently carved out from the health system, resulting in a lack of accountability and transparency about which entities are responsible for payment, care coordination, and quality.
- There are workforce shortages and maldistribution in both the primary care and mental health care sectors.
- Financial structures and payer mechanisms do not support the coordinated care systems that have been shown to be feasible and effective.

There is a lack of application of evidence-based screening, early intervention, and treatment guidelines to ensure higher levels of treatment to remission and more effective recognition and care of the comorbidities that accompany mental health disorders.

There is no single lever that will radically transform a mostly fragmented system into one that is integrated—all these issues, and more, will need to be addressed.

Over the years government and nongovernment bodies have invested significant time, efforts, and resources in producing reports that outline what needs to be done. There is no value in repeating this work. In 2006 the Institute of Medicine, prepared a report that looks at how the IOM's aims, rules, and strategies for redesigning general health care can be applied to mental health care. The report emphasizes the importance of a client-centered approach that includes a focus on recovery and self-management, of developing and applying explicit standards for safety and effectiveness and valid quality measures, of innovations in financing, and of development of the professional workforce.⁸⁰ This report alone can serve as a roadmap for action and there are many other reports to inform policymaking in this area.

There are three additional prerequisites for action:

- A national understanding—by consumers, policymakers, and politicians—that mental health is essential to overall health
- A willingness to increase funding for mental health care
- Strong leadership at the highest levels

Then, it might be possible for the treatment of mental health disorders to become a model for how a highly prevalent and expensive set of chronic conditions could be addressed by primary care and specialty sectors in an integrated fashion.

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