Responding to the Newtown Tragedy

A White Paper
on Behavioral Health as a
Partner in the Solution

From the

NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS

representing the nation's treatment providers

The National
DIALOGUE
on Mental Health

+ AK/HI

Spring 2013

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INTRODUCTION

In response to the devastating tragedy in Newtown, CT[1], in 2012 as well as earlier incidents, President Obama has committed to a year-long national dialogue.[2] There is a two-pronged focus of attention: gun control and mental health.

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) will focus in this white paper on the issues that we understand best—those affecting Americans of all ages who face serious and life-threatening mental and addictive disorders. Founded in 1933, the National Association of Psychiatric Health Systems (NAPHS) advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations that collectively own or manage more than 700 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral healthcare divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks.

We offer the following analysis and recommendations to provide a lens on the dialogue from our own perspective as healthcare system leaders. Our members and our association are committed to working with Congress, the Administration, consumers, families, providers, and other stakeholders to take actions that will make a meaningful and long-term difference both in the lives of Americans of all ages facing mental and substance use disorders and in the lives of American communities.

NAPHS BOARD OF TRUSTEES
Spring 2013

DEFINING the PROBLEM/FRAMING the ISSUE

Many questions related to the national dialogue are beyond the scope of what we will address in this white paper. We leave it to others to contribute more directly to questions related to gun control and gun registration.

But the broad questions being raised about the role of mental health are ones that we welcome the opportunity to comment on.

To help frame the discussion for this white paper and for ongoing discussions in communities around the country, we outline below some specific questions that need to be addressed about prevention, identification, and treatment of mental and addictive disorders:

- What can we do to identify and intervene earlier to reduce the burden of mental and addictive disorders on individuals, families, and communities?

- How can we expand coverage and access to ensure that appropriate resources are available at the right time and in the right setting?

- What needs to be done differently to sustain recovery and live a healthy life over time?

- How can we help diverse systems that touch the behavioral health population (e.g., mental health and addiction treatment, legal/justice, foster care, education) better coordinate existing resources?

- Which actions can be taken now that will have the greatest impact on the most people? And what issues will require longer-term discussion and investment?

These are the questions around which we focus our discussion and recommendations.

*Brain disorders are medical problems.*

They affect people of all ages.

WHAT WE KNOW ABOUT BEHAVIORAL HEALTH

Science has taught us much about behavioral health.

Brain disorders are medical problems.

Composite MRI scan data showing areas of gray matter loss over five years, comparing 12 normal teens (left) and 12 teens with childhood-onset schizophrenia. Red and yellow denote areas of greater loss. Front of brain is at left.
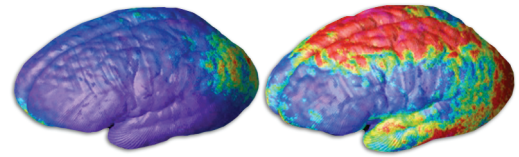
SOURCE: National Institute of Mental Health

Brain disorders affect people of all ages.

They occur with varying levels of intensity and frequency.

Behavioral disorders can be life-threatening. For example, suicide was the 10th-leading cause of death for Americans of all ages in 2010, according to the Centers for Disease Control and Prevention (CDC). That statistic translates into an average of 105 deaths each day.[3] Suicide is an even more significant problem within many age groups. For example, it was the third-leading cause of death for those 15–24 years old, the second-leading cause of death for those 25–34, the fourth-leading cause of death among those 35–54, and the eighth-leading cause of death for those 55–64.

Severe forms of mental illnesses and substance use are often chronic conditions.

Half of those who will ever be diagnosed with a mental disorder show signs of the disease by age 14, and three-quarters by age 24.[4]

According to the National Institute of Mental Health[5] (NIMH), an estimated 26.2% of Americans ages 18 and older—about one in four adults—suffer from a diagnosable mental disorder in a given year. Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion—about 6%, or 1 in 17—who suffer from a serious mental illness.[6]

Many people suffer from more than one mental disorder at a given time. Nearly half (45%) of those with any mental disorder meet criteria for two or more disorders, with severity strongly related to comorbidity.[7]

National Institute of Mental Health (NIMH) Director Thomas Insel, M.D., highlighted several surprising statistics in an essay on "Turning the Corner, Not the Key, in Treatment of Serious Mental Illness."[9] For example, each year there are nearly twice as many suicides (33,000) as homicides (18,000).[10] The life-expectancy for people with major mental illness is 56 years, while the average life-expectancy in the U.S. general population is 77.7 years.[11] Mental and substance use disorders are the leading cause of disability in the United States and Canada.[12]

We know mind and body are linked in fundamental ways. Behavioral health challenges are often associated with concurrent medical conditions, such as diabetes or heart disease. Many other factors also affect overall health, including a wide range of developmental disorders such as learning disorders, mental retardation, and pervasive developmental disorders. More than 68% of adults with a mental disorder who were studied had at least one medical condition, according to a Robert Wood Johnson Foundation[13] report. Heavy and binge drinking are also associated with numerous health problems, including damage to liver cells, inflammation of the pancreas, various cancers, high blood pressure, and psychological disorders, according to SAMHSA.[14] Smoking[15] lowers the life-expectancy for people with behavioral health disorders.[16]

Interventions have long-term effects, often across generations. Adverse childhood experiences (ACEs)—such as verbal, physical, or sexual abuse as well as family dysfunction (an incarcerated, mentally ill, or substance-abusing family member, domestic violence, and absence of a parent due to divorce or separation)—have been linked to a wide range of negative health outcomes in adulthood, including substance abuse, depression, cardiovascular disease, diabetes, cancer, and premature mortality.[17] Victims of abuse can become abusers themselves without appropriate intervention. According to the American Academy of Pediatrics,[18] "a child who is severely mistreated may become depressed or develop suicidal, withdrawn, or violent behavior. As he gets older, he may use drugs or alcohol, try to run away, refuse discipline, or abuse others. As an adult, he may develop marital and sexual difficulties, depression, or suicidal behavior. Identifying a child victim is the first step. Recognizing the importance of early trauma to future development is crucial to assisting the victim."

People with mental illnesses are more often the victims of violence than the perpetrators.[19]

The economic impact of mental and substance use disorders is substantial. Costs to society are both direct (that is, paying for treatment, medications, etc.) and indirect (lost productivity, mortality, homelessness, school failure, and other unwanted consequences). One study found serious mental illness is associated with an annual national loss of earnings totaling $193.2 billion.[20, 21]

The U.S. Department of Justice's (DOJ) National Drug Intelligence Center (NDIC) estimated[22] that illegal drug use had an economic impact of $193 billion in 2007. The researchers examined the economic impact of illegal drug use on crime, health, and productivity and attributed the primary cost of illegal drug use to lost productivity equal to $120.3 billion.

The public supports coverage for behavioral health disorders on par with other medical conditions. Overwhelmingly, Americans believe that health services that address mental health illnesses and treatments and addiction services "should be covered and part of any basic private healthcare plan," according to a national online survey conducted in 2012 by Public Opinion Strategies[23] for the National Association of Psychiatric Health Systems. A total of 93% agreed (with 57% strongly agreeing).

The public supports coverage for behavioral health disorders on par with other medical conditions.

WHAT WE KNOW ABOUT IDENTIFYING and DIAGNOSING MENTAL and ADDICTIVE DISORDERS

Despite the widespread prevalence of mental and addictive disorders, many people never receive needed treatment. Only about 4 in 10 people (39.2%) experiencing any mental illness in the past year—and only 60.8% of those experiencing serious mental illness—received any mental health services during that period. Some 23.1 million Americans aged 12 or older (9.1%) needed specialized treatment for a substance abuse problem, but only 2.6 million (or 11.2%) received it.

Stigma[26] plays a role in the avoidance of discussing and seeking help for behavioral health problems. For example, emergency departments may avoid asking about addiction for fear that an affirmative response might affect the individual's insurance coverage. Parents and teachers may be reluctant to "label" a child with a mental or substance use diagnosis. Others may fear workplace reaction to their seeking help or the negative reaction of society at large.

We need timely and better information about the whole person to help make appropriate diagnoses. Information technology, such as interoperable electronic medical records that can be used by each clinician involved in a patient's care, holds promise to do this.

WHAT WE KNOW ABOUT TREATMENT of MENTAL and ADDICTIVE DISORDERS

We know that treatment works.[27, 28, 29]

We know that—just like treatment for all other medical conditions—treatment for behavioral disorders is most effective when it is individualized to meet the unique needs of the patient.

To be able to not only suggest, but to follow through with a customized treatment plan,[30] people need to be able to access services available across a continuum of care (to match the varying needs of individuals at varying stages of illness and recovery). If a child is in a car accident, it's understood that physical rehabilitation may be needed after leaving the hospital, and outpatient follow-up may also be required as part of the recovery process. Intermediate levels of care (such as skilled nursing facilities, rehabilitation hospitals, and long-term care facilities) are all covered services in health plans for a reason. Providing all levels of care means that people can receive care in the right setting, at the right time, with the right level of supports. Similarly, if a child faces a life-threatening mental or addictive disorder, intermediate and outpatient care may be needed. In behavioral health, these levels of care include such services as residential treatment, partial hospitalization, and outpatient follow-up.

Insurance coverage for mental and addictive disorders plays an important role in making treatment accessible and affordable. Without coverage, there is no access. Even with coverage, limitations on the

benefits and/or micromanagement of the benefit often prevent people from getting the services they need. For example, adolescents who lack health insurance are less likely to use mental health services than those who have coverage. [31, 32]

We know that interdisciplinary teams (including—for example—physicians, nurses, social workers, addiction specialists, special education teachers, and occupational therapists) are particularly effective at identifying and developing effective treatment plans for the complex bio-psycho-social issues that contribute to behavioral health.[33]

We know that family involvement is critical[34] in every setting in which treatment occurs, from hospitalization to home-based services.

We know that behavioral health treatment modalities evolve over time—just as they do in general medicine—with new medications, improved protocols, and better diagnostic techniques continually being tested and introduced into clinical practice.

Stigma plays a role in the avoidance of discussing and seeking help for behavioral health problems.

THE SCOPE OF THE PROBLEM

There is a disconnect between what we know and what we do. We know that we need to treat the mind as part of the body. Because behavioral health is an integral part of overall health, whatever we do to identify and treat general medical disorders, we need to do for mental and addictive disorders.

But this is not how the system works today.

The systems that have evolved to treat disorders of the mind and of the body have historically been carved out and treated very differently from each other.

There are distinct public and private systems for treating behavioral health.[35]

Public funding sources play a larger role in financing behavioral health care (61% of expenditures) than they do in overall health services (46% of expenditures), according to a Kaiser Family Foundation report.[36] "While Medicaid and Medicare account for roughly equal shares of general healthcare financing (17% and 18%, respectively)," the authors note, "Medicaid's role in financing behavioral health services is more than three times larger than Medicare's (26% and 7%, respectively)." In addition, "state and local dollars play a larger role in behavioral health care than overall medical care, reflecting their historical role in financing these services."

Medicaid is the largest payer for behavioral health today.[37] In 2005, 10% of total Medicaid spending was for mental health. Medicaid's share of mental health spending has been increasing, while the share of spending by state and local governments has declined.

Share of Mental Health Spending by Selected Payers, 1986–2005

(as a % of mental health expenditures)

|	1986	2002	2005
Medicaid mental health spending	17%	27%	28%
Non-Medicaid state and local funding		20%	18%

SOURCE: Mark TL, et al. Health Affairs. February 2011.

Share of Substance Abuse Spending by Selected Payers, 1986–2005

(as a % of all substance abuse expenditures)

	2005
Medicaid substance abuse spending	21%

SOURCE: Mark TL, et al. Health Affairs. February 2011.

Over time, mental health and substance abuse expenditures as a percentage of all healthcare expenditures has dropped significantly (from 9.3% in 1986 to 7.3% in 2005).[38]

Mental Health and Substance Use Spending

(as a % of all U.S. health expenditures)
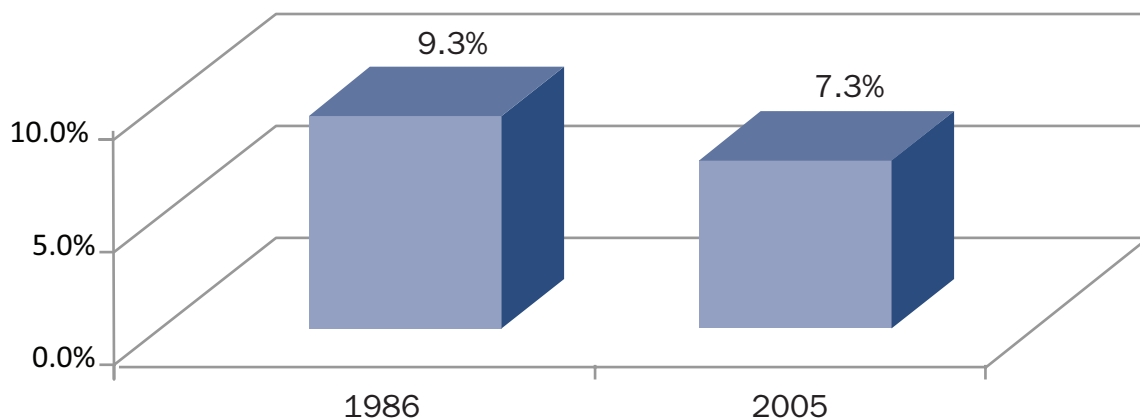
SOURCE: Mark TL, et al. Health Affairs. February 2011.

Those with severe mental and addictive disorders have been significantly impacted.

Distribution of Selected Mental Health Expenditures, 1986–2005
(as a % of all health expenditures)

	1986	2005
Inpatient	42%	19%
Residential Treatment	22%	14%
Drugs	7%	27%
Outpatient	24%	33%

SOURCE: SAMHSA Spending Estimate Project. 2010. (Also see Kaiser Commission on Medicaid and the
Uninsured. "Mental Health Financing in the United States: A Primer." April 2011.)

Inpatient beds per capita declined significantly from 1990 to 2000. During this time, state and county beds per capita were down 44%, private psychiatric hospital beds were down 43%, and beds in psychiatric units in general hospitals were down 32%.[39]

Inpatient Beds per Capita Have Declined
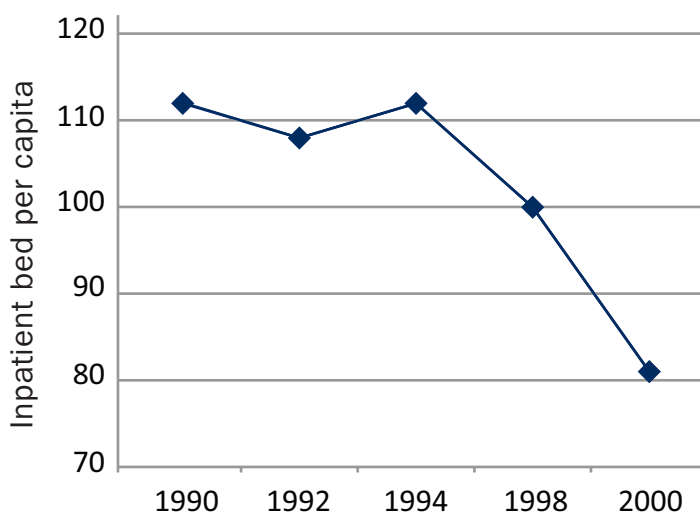
SOURCE: Center for Mental Health Services/SAMHSA, 2003. In *Acute Care Subcommittee Report*.
NOTE: 2000 data are provisional.

Economic pressures have intensified, and overall expenditures[40] for treating mental and addictive disorders have declined significantly.

The state-hospital system—which had long been a safety net—has been dramatically cut back. According to the National Alliance on Mental Illness (NAMI), about 30 states have reduced mental health spending since 2008 (when revenues were declining steeply). Cuts were greater than 10% in a third of those states. During that time, nine state psychiatric hospitals were closed, eliminating some 3,200 psychiatric beds. "These cuts came as unemployment was rising, causing more people to lose private insurance and forcing them to shift to public assistance," according to an *Associated Press* report.[41]

As the state system has contracted, **responsibility has moved to community providers (including hospitals and community-based programs).**

There continue to be barriers to access and coverage for needed treatment.

Public policies have created gaps, particularly in the availability of intermediate-level services such as partial hospitalization, residential treatment, and intensive outpatient.

Traditionally, behavioral health coverage has faced discrimination. This disparity, however, ultimately led to passage of the federal parity law in 2008 (the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*),[42] which eliminated arbitrary financial and treatment limits in private health insurance plans. In 2008, Congress also approved legislation to equalize the Medicare outpatient copayments for mental and physical health.

But we need to continue to build upon this parity foundation. Care for the sickest patients continues to have complexity and barriers that don't exist for other complex or chronic illnesses.

Caring for the mind is part of caring for overall health. We welcome the opportunity to be part of the solution.

Historic, arbitrary limits impose barriers to treatment for behavioral disorders at a time when it is most needed. For example, Medicare beneficiaries continue to be limited to 190 days of inpatient psychiatric hospital care during their lifetime (known as the "190-day lifetime limit"). This lifetime limit does not apply to psychiatric units in general hospitals, and there is no such lifetime limit for any other Medicare specialty inpatient hospital service. The 190-day lifetime limit is problematic for patients being treated in psychiatric hospitals, as they may easily exceed the 190 days if they have a chronic mental illness.

Different payment systems (for example, for individuals dually eligible for Medicare and Medicaid coverage) have different—and sometimes conflicting—requirements.

Deinstitutionalization and the creation of a community mental health system in the 1960s came without concurrent support for community-based alternatives.[43] This has led to a situation today with emergency department backlogs in many communities.[44]

Behavioral health providers are actively excluded from receiving health information technology (IT) incentives that are available to other medical services. (The original health IT funding approved by Congress was distributed to facilities paid under the inpatient prospective payment system; facilities paid under the separate inpatient psychiatric facility prospective payment system were not eligible.)

The ultimate goal of widespread adoption of health information technology—to save American lives through improved coordination of care—is particularly relevant to persons with mental and addictive disorders. Studies[45] have shown that higher mortality among those with serious mental illnesses is tied to the high incidence of untreated, co-occurring, chronic medical conditions in this patient population including cancer, hypertension, diabetes, asthma, heart disease, and cardio-pulmonary conditions. It has been reported that hospitalized patients with bipolar disorder have mortality rates that ranged from 35% to 200% higher than any other patients; again, the cause of death was co-occurring chronic diseases. Health information technology is the essential cornerstone of efforts to address this emerging public health crisis. Health information technology will enable behavioral health and substance abuse providers to effectively coordinate care across mental health and substance abuse service systems, primary care entities, and specialty medicine.

The inability to be tied in electronically to the overall care system medical record undercuts all of the efforts to extend services for prevention and assessment.

Public policies have created gaps, particularly in the availability of intermediate-level services such as partial hospitalization, residential treatment, and intensive outpatient.

BEHAVIORAL HEALTH IS PART OF THE SOLUTION

Caring for the mind is part of caring for overall health. We welcome the opportunity to be part of the solution.

PRINCIPLES BEHIND OUR RECOMMENDATIONS

As a nation, we need to get the most value for what we are spending by making scarce dollars work as hard as they possibly can. Changes should make a meaningful difference in the lives of individuals and families.

We need to choose actions that make a meaningful difference for the most people…and for the most severely impacted individuals.

We need to offer hope to those with mental and substance use disorders

We need to remove longstanding barriers to coverage, access, and adequate resources for behavioral health.

PRIORITY AREAS

Using these principles, we urge Congress and the Administration to focus on the following priority areas:

1. **Make sure that every American has coverage for mental and addictive disorders at parity with coverage for other medical conditions.**

2. **Ensure that every American has access to all levels of behavioral health care (inpatient—intermediate—outpatient) so that they can get the right help, at the right time, in the right setting.**

   Coverage—without access to services—prevents people from receiving needed care. Access means that services must be available (with a sufficient and qualified workforce to provide the services), must be affordable, must be appropriate for the individual's needs, and must have adequate funding (so that providers are adequately reimbursed so they can continue to provide services).

3. **Provide adequate resources to fund gaps in community services.**

4. **Ensure predictability and consistency of funding for the treatment continuum...with accountability for quality.**

   Without reliable funding, there is no incentive to commit to building treatment resources (either inpatient, intermediate, or outpatient).

   We also need to know what we are buying and hold providers accountable for delivering quality services.

DO SOMETHING THAT MATTERS

To strive for these policy priorities, NAPHS offers the following specific action steps.

The following recommendations are concrete actions that Congress, the Administration, and others can take now to improve behavioral health. These actions need to have broad impact, be feasible to accomplish, and be cost-effective.

NAPHS RECOMMENDATIONS

The National Association of Psychiatric Health Systems specifically recommends the following:

FAIR and EQUAL COVERAGE

Continue to enforce the federal parity law, which is the groundbreaking legislation that has helped to set the bar for ending longstanding discrimination against mental and addictive disorders.
- Give the Departments of Labor, Treasury, and Health and Human Services full authority to take action against anyone who is not living up to the letter and spirit of the law.

Issue a final parity rule to clarify that the intent of the law is to ensure that the full continuum of inpatient, intermediate, and outpatient services remains available for mental and addictive disorders.
- To accomplish this, modify the classification system outlined in the parity Interim Final Rule (IFR) to include the intermediate level of care.

Ensure that the essential health benefits in the *Affordable Care Act*—which include mental health/addiction treatment as one of 10 categories of essential benefits—are carefully and fully implemented.
- Have the federal government closely monitor state implementation of mental health/substance use benefits in health plans that are subject to the essential health benefits requirements of the *Affordable Care Act*.

Pass legislation to eliminate the discriminatory Medicare 190-day lifetime limit.
- In 2008 Congress approved legislation to equalize the Medicare outpatient copayments for mental and physical health. However, stigma and discrimination against mental illnesses still exist in the Medicare program as Medicare beneficiaries continue to be limited to 190 days of inpatient psychiatric hospital care during their lifetime. This lifetime limit does not apply to psychiatric units in general hospitals.
- There is no such lifetime limit for any other Medicare specialty inpatient hospital service.
- The 190-day lifetime limit is problematic for patients being treated in psychiatric hospitals, as they may easily exceed the 190 days if they have a chronic mental illness.

Monitor the progress and carefully evaluate the Medicaid Emergency Psychiatric Care Demonstration Project.
- The Medicaid Emergency Psychiatric Demonstration was established under Section 2707 of the *Affordable Care Act* (ACA) to test whether Medicaid programs can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain services for which Medicaid reimbursement has historically been unavailable. The demonstration is providing up to $75 million over three years in federal Medicaid matching funds to enable private psychiatric hospitals (also known as "institutions for mental diseases" or IMDs) to receive Medicaid reimbursement for treatment of psychiatric emergencies provided to Medicaid enrollees aged 21 to 64 who have an acute need for treatment. Participating states are Alabama, California, Connecticut, the District of Columbia, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, and West Virginia.
- An initial report from the Centers for Medicare & Medicaid Services (CMS) to Congress on the status of the demonstration is due by December 31, 2013.

PREDICTABLE and CONSISTENT FUNDING

Provide adequate resources to fund gaps in community services.
- Broader availability of community-based services will help alleviate emergency department backlogs and more quickly help individuals access the right care, in the right setting, at the right time.

Provide consistency and predictability of funding for treatment of mental and addictive disorders.
- Review, for example, Medicare partial hospitalization rates and regulatory burdens. Extreme rate fluctuations in recent years have led to the loss of many partial hospitalization treatment programs. Additional complex and burdensome regulatory requirements have been barriers to opening partial hospital programs. These programs offer both a transition from hospitalization and an alternative to hospitalization.

SUPPORT of INNOVATION and QUALITY

Extend health information technology incentives to behavioral health providers by passing the *Behavioral Health Information Technology Act.* Versions were introduced in 2012 as H.R.6043 and in 2011 as S.539. The bills are in the process of being reintroduced in 2013.
- This technology will help medical professionals better collaborate and coordinate mind and body treatment plans.

EARLY IDENTIFICATION and PREVENTION

Support prevention, early identification, and intervention for mental and substance use disorders.
- Because the first signs of behavioral disorders often occur at an early age, the earliest interventions possible hold the greatest potential for long-term positive outcomes.
- Disorders left untreated—at any age—can become more difficult to treat, make positive outcomes more challenging, and increase the use of resources in both mental health and general medical health care.

Support education and training for school personnel, law enforcement, families, primary care physicians, and members of the community to teach them how to recognize the signs and symptoms of mental and addictive disorders and how to identify and respond compassionately to youth and adults experiencing a crisis.

CONCLUSION

The commitment to a year-long national dialogue on mental health that has resulted from the tragedy in Newtown, Connecticut, is an important step toward healing and toward positive change. As an association representing treatment provider organizations and professionals, the National Association of Psychiatric Health Systems is proud to work with its members to contribute to this critical conversation.

We believe that implementing the recommendations outlined in this white paper—to improve coverage and access as well as to definitively end discrimination against those facing mental and addictive disorders—will have a lasting impact on the lives of individuals, families, and communities.

We look forward to the opportunity to work with the Administration, Congress, consumers and families, healthcare leaders, employers, insurers, and all other stakeholders to take action.

The demand

for the most

intensive

services is high

...yet the supply

of intensive

services

is down.

ENDNOTES

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