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Treating Behavioral Health Illness in a Patchwork System

Policy Snapshot



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More than 20 percent of Americans aged 18 and over live with a diagnosable mental illness.¹ Complicating treatment for these individuals is the fact that up to 50 percent of the mentally ill population also has a substance abuse problem.² Given the intertwined nature of mental health problems and substance abuse issues, the healthcare community frequently uses the term “behavioral health” when referring to the combination of the mental health and substance abuse fields.

How Care is Delivered: Then and Now

Mental illnesses are no different than physical illnesses in that appropriate treatments and supports are necessary to help people cope with the symptoms of their illness and to help them lead fulfilling lives. One differentiating factor, however, is that mental illnesses generally have a longer recover time than physical illnesses. Over the years, the way in which care has been delivered to those diagnosed with a mental illness has changed. In the past, many people suffering from mental illnesses lived in mental hospitals for long periods of time. The advent of deinstitutionalization, which began in the 1960s³ and accelerated in the 1980s, was touted as a more humane way to treat those with mental illnesses by shifting care to community-based settings, rather than institutional settings.

Today, mental health care is provided by either private entities or the public mental health system. The private side consists of inpatient psychiatric units, hospital emergency departments and private psychiatry and counseling offices. On the public side, Ohio’s mental health system is administered by the Ohio Department of Mental Health (ODMH) and includes state mental health hospitals, 50 county and multi-county boards, and nearly 500 community mental health agencies. The boards, which in many cases oversee both mental health and addiction services, do not directly provide services but do contract with agencies to provide services. In addition, ODMH licenses all private psychiatric hospital inpatient units and community residential programs in the state.⁴

Individuals suffering from a psychological crisis almost always come to hospitals through the emergency department. From that entry point patients are evaluated and, if appropriate and if the hospital has a psychiatric unit, they are admitted for further evaluation and treatment. Hospitals that do not have psychiatric

units, as well as those whose psychiatric units are already at capacity, may transfer patients to another hospital’s psychiatric unit or to a state mental health hospital. However, patients must meet certain criteria to qualify for transfer to a state mental health hospital. In most cases, patients that have medical problems (including those with diabetes or those who are pregnant) as well as patients that have commercial health insurance, Medicare or Medicaid do not meet the necessary criteria for transfer to state mental health hospitals. Under those circumstances, it can be a lengthy endeavor to find an appropriate treatment facility for patients and they sometimes can end up being cared for by a facility outside of the county, which can be a burden for the patient’s family.

Insufficient Resources Hamper Care Delivery

The idealism which precipitated the shift towards deinstitutionalization of the mentally ill has resulted in a shift away from longer inpatient hospital stays to shorter outpatient care.⁵ Yet for some individuals, longer term inpatient care is often what is needed, but the system is no longer set up to handle people who are either treatment resistant or who have more intensive needs. As pressures from payers, particularly managed care, have led to declining reimbursement and reduced lengths of stays, both the public and private sectors are witnessing increased admissions and discharges.⁶

In contrast to the system of care that exists to treat physical ailments, the safety net that has evolved over the years to treat behavioral health issues is a patchwork system in which insufficient resources exist to treat the number of people suffering from problems. Put another way, there simply aren’t enough dollars or licensed beds to handle the volume of behavioral health patients.

State lawmakers set out to address this by passing mental health parity legislation in 2006. Prior to passage of this legislation, commercial health insurance plans were not required to provide sufficient coverage to adequately treat Ohioans with severe mental illnesses.⁷ According to the Ohio Department of Mental Health, while most commercial insurance plans provided some coverage for mental illness, only five percent of policies covered the costs of serious, crippling cases of schizophrenia, bipolar disorder, or depression.⁸

Congress is currently working on similar legislation. Versions of mental health parity legislation have passed both the House and Senate. The legislation would

50 percent of the mentally ill population also has a substance abuse problem.²



require group health insurance plans offering mental health coverage to provide mental health and substance use disorder benefits on a par with medical and surgical coverage. The House version, H.R. 1424, which passed this month, requires insurers to cover more conditions than the version passed in September by the Senate, S.558. The differences between the two versions will need to be worked out before the legislation can be passed by Congress and sent to the President for signature.

While mental health parity legislation is a helpful step, more work remains. Problems with behavioral healthcare delivery stem not just from insurance inadequacies, but also gaps in the system. For many with severe mental illnesses, the community resources and supports necessary to ensure a successful transition following an acute episode are often insufficient. This leads to many mentally ill individuals cycling between periods of psychological crisis, in which they often end up in hospital emergency departments and community-based settings, and back into their homes or onto the streets.

*It has been estimated that anywhere from 30 to 50 percent of the homeless population has a mental illness.*⁹

Collaboration Necessary to Leverage Existing Resources

The cost of failing to adequately treat behavioral health problems is enormous. Mental illness ranks first among illnesses causing disability in the U.S.¹⁰ Left untreated, addictions and mental illness are estimated to cost American taxpayers almost \$600 billion annually through indirect costs, stemming from reduced productivity and unemployment, and costs that are diverted to other areas, such as criminalization, homelessness and public welfare.¹¹

As hospitals care for ever-rising numbers of individuals who come to the emergency room suffering from behavioral health illnesses, and the economic forecast continues to look dismal, we can expect further strain on the system. A recent study confirmed what many working within the system already knew: that economic cycles stress the healthcare safety net.¹²

Yet despite limited resources being available, improvements can be made. In recognition of this, area hospitals have formed a workgroup to determine ways to more effectively leverage existing resources to help improve the care provided to patients with behavioral health problems. The workgroup is hoping to increase the number of county crisis stabilization beds to ensure that sufficient spaces exist to

keep patients safe until they have emerged from a crisis situation. Another goal of the workgroup is to increase the level of collaboration between those working to improve behavioral healthcare on the private side and on the public side.



By working together it is hoped that service delivery and supports for those with behavioral health illnesses will become less fragmented. Creating a more connected system of care will grant behavioral health care providers greater capacity to help consumers not only learn to manage their symptoms and build resilience, but also gain hope of recovery.

Sources

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