

# HOW TO TRANSFORM THE U.S. MENTAL HEALTH SYSTEM

EVIDENCE-BASED RECOMMENDATIONS

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# Summary

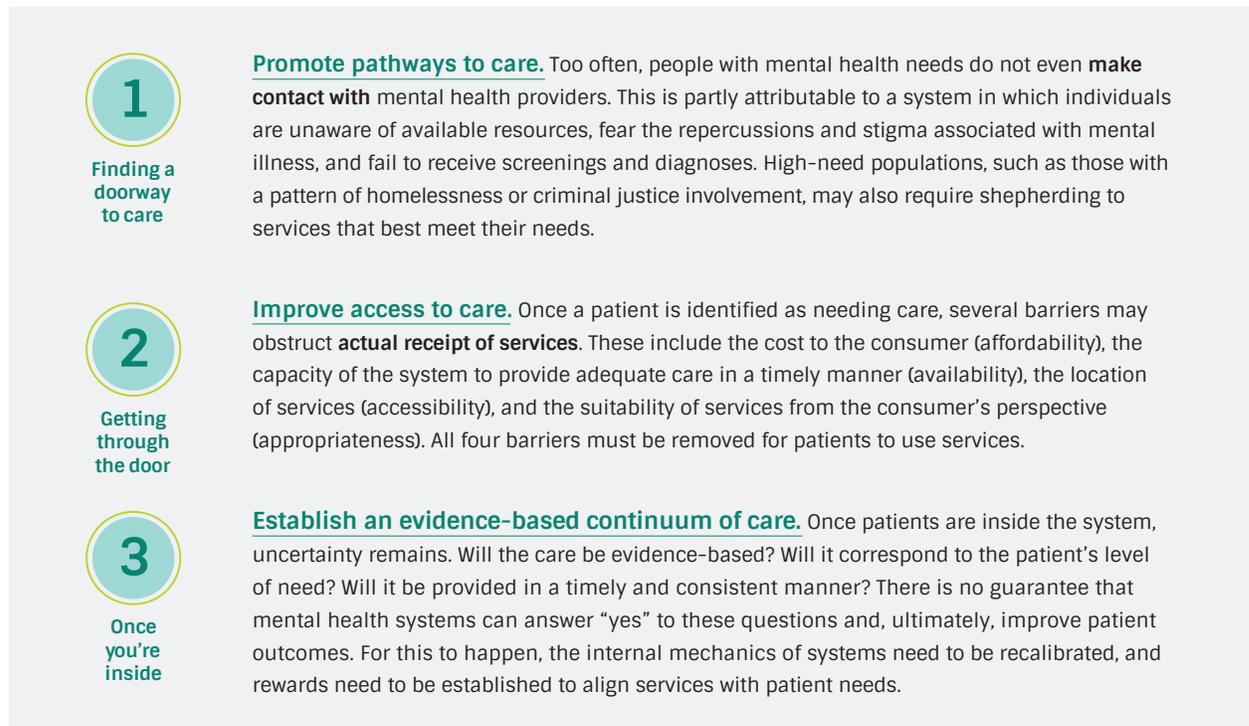
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The United States is at a time of promise for historic transformation in behavioral health care. For decades, systemic problems have persisted—including underdevelopment of community-based supports, high levels of unmet need, and inequities in access and quality of care. In 2019, only 45 percent of people with a mental illness received any mental health treatment.<sup>1</sup> This translates to more than 30 million Americans lacking care, ranging from those with mild to severe illnesses. Despite similar levels of need, racial/ethnic minorities in the United States are about half as likely to use mental health care as non-Hispanic Whites.<sup>2</sup> There are also striking geographic variations in availability of mental health specialty care, with rural areas particularly underserved.<sup>3</sup>

However, recent years have seen positive signs of change. Congress has passed key legislation—such as the 2008 Mental Health Parity and Addictions Equity Act—with overwhelmingly bipartisan support, states have endorsed an expanded role of Medicaid in providing coverage for individuals with serious mental illness who are often lower income and struggling with employment, and researchers have identified new evidence-based treatment models that health systems can implement.

This report provides recommendations to promote transformational change to improve the lives of the millions of Americans living with mental illness. To identify these recommendations, the RAND Corporation conducted a broad review of policy ideas related to three goals for the behavioral health system, as shown in Figure S.1.

Figure S.1. A Health System That Follows the Patient Journey



## How We Identified Opportunities for Change

To identify opportunities for change in the behavioral health care system, we surveyed the policy research literature, both traditional academic publications and articles published in nonacademic outlets. This evaluation examined the health care system broadly, encompassing the organization of people, institutions, and resources that support delivery of mental health services—and inclusive of adjacent sectors, such as housing and education. Readers can inspect key articles from this literature review by utilizing our interactive web tool, available at [www.rand.org/t/TLA889-1](http://www.rand.org/t/TLA889-1).<sup>4</sup>

We obtained stakeholder input from an advisory panel that consisted of mental health consumers, mental health advocates, researchers, clinicians, health system representatives, policymakers, and payers. At advisory panel meetings, held twice over the course of the project, panel members discussed the conceptual model and policy options for achieving goals of health system transformation. This included feedback on potential policy recommendations based on current levels of evidence, actionability, transformative potential, political feasibility, and novelty. The RAND team also conducted one-on-one key-informant interviews with more than 20 additional mental health policy experts.

## Recommendations

We used the literature review, interviews, and advisory panel input to develop 15 key recommendations that map onto our three overarching goals for improving the mental health landscape in the United States.

### Goal 1: Promote Pathways to Care

**1. Promote systematic mental health education.** Mental health education should be considered a key part of a comprehensive health education curriculum. Schools have the potential to provide a more sustainable mechanism for destigmatizing mental health and improving attitudes, enhancing mental health knowledge and skills necessary for prevention, and promoting increased help-seeking.

**2. Integrate behavioral health expertise into general health care settings.** Behavioral health conditions are often unrecognized in general health care settings. Integrated, whole-person care approaches are effective in connecting people to care but are underutilized. We recommend expanding integration of behavioral health care into general health care settings.

**3. Link homeless individuals with mental illness to supportive housing.** Without a roof over one's head, the path to recovery from mental illness may be unimaginable. Shelter not only improves one's quality of life but can also generate health

care savings. Administrators at all levels of government should expand supportive housing programs for individuals with serious mental illness.

**4. Develop a mental health diversion strategy centered on community behavioral health.** Correctional facilities are one of the largest providers of mental health care in the United States. We recommend pursuing evidence-based diversion strategies that prevent new and recurring justice system involvement and instead divert individuals to the community behavioral health system.

## Goal 2: Improve Access to Care

**5. Strengthen mental health parity regulation and enforcement.** Mental health parity is the law of the land, but parity has not been fully achieved in practice. States can take legislative and administrative actions that set clear standards for assessing parity compliance, require mental health coverage from a broader range of insurance plans, and strengthen enforcement of existing state and federal laws.

**6. Reimburse evidence-based behavioral health treatments at their true cost.** Establishing Medicaid reimbursement rates that are commensurate with the costs of providing care should encourage providers to offer evidence-based treatments that are currently unavailable to many beneficiaries. Improving access within Medicaid would particularly benefit Americans with low incomes and those with serious mental illnesses, as Medicaid is the primary insurer for these populations—for example, covering over a quarter of individuals with serious mental illnesses.

**7. Establish an evidence-based mental health crisis response system.** Many communities lack basic elements of an appropriate mental health crisis response system. Poor crisis care results in missed opportunities for engagement in treatment and sometimes ends tragically. Building an evidence-based response system that swiftly identifies individuals' mental health needs and efficiently triages individuals into appropriate care should reduce unnecessary suffering.

**8. Establish a national strategy to finance and disseminate evidence-based early interventions for serious mental illness.** There is strong and accumulating evidence for the effectiveness and cost-effectiveness of programs that deliver coordinated clinical and supportive services during the early phase of schizophrenia and related disorders. These programs, as well as other emerging early interventions for other serious mental illnesses, fall outside the Medicaid-based public mental health system and require a national strategy to broaden access to these services.

**9. Expand scholarships and loan repayment programs to stimulate workforce growth.** An essential part of the solution to mental health specialty workforce shortages in underserved areas is continuation and expansion of scholarship, fellowship, and loan forgiveness programs that attract a greater number of, as well as more diverse, students to undertake specialty training and commit to practicing in high-need settings.

**10. Improve the availability and quality of peer-support services.** Peer-support specialists—individuals with the lived experience of a mental illness who serve as paid members of a behavioral health treatment team—have a proven track record of being integral contributors to recovery-oriented care. Expanded access to training and credentialing, as well as the ability to reimburse for peer support, has the potential to improve access to high-quality mental health care.

**11. Expand access to digital and telehealth services for mental health.** Digital and telehealth services hold the promise of expanding access to mental health care throughout the United States, particularly in rural communities where there are shortages of providers. States and federal agencies should codify expansion of these services—stimulated by the COVID-19 pandemic—by ensuring that insurers cover these services, clinicians are adequately reimbursed, and consumers are familiar with these technologies.

**12. Include patient-important outcomes in treatment planning and assessments of care quality.** Mental health care is organized, incentivized, and delivered around health system goals. The result for many is an inefficient mismatch between provider- and patient-based care goals. Including patient-important outcomes like social functioning and occupational goals in care planning can enhance the patient-centeredness of mental health care.

## Goal 3: Establish an Evidence-Based Continuum of Care

**13. Define and institutionalize a continuum of care in states and communities.** Individuals with mental health needs often fall through the cracks because of a lack of clarity regarding who should provide care, at what level of intensity, and in what settings over time. Available tools provide an explicit framework for resolving these questions about level of care and can help optimize mental health spending within communities. State Medicaid systems should mandate their use.

**14. Launch a national care-coordination initiative.** Care coordination works, but few practices are doing it. A national, Centers for Medicare and Medicaid Services–led initiative modeled after the Transforming Clinical Practices

Initiative—delivering technical assistance, implementation tools, and a learning collaborative for implementers—would help transition practices to evidence-based models, such as the Collaborative Care Model.

**15. Form a learning collaborative for Medicaid behavioral health financing.** Medicaid is the largest payer in the United States for individuals with mental illness. Collaborations between Medicaid officials, advocates, and other policymakers within and between states can help ensure that emerging evidence on innovative financing and service delivery models drives improvement in behavioral health care systems for Americans with low incomes or serious mental illness.

## Limitations

This report has several limitations. First, because the goal of the report is to outline recommendations at a top level, we do not provide in-depth analysis on all of the issues raised throughout. For a more comprehensive study of the literature, we recommend the reader engage with our interactive web tool. Second, an important stakeholder group with whom we were unable to engage were those who have yet to come into contact with mental

health care despite needing services. This report aspires to reach millions of Americans who fall into this category but whom we were unable to identify because these individuals represent a hidden population. Lastly, we would like to acknowledge that there are numerous recommendations that RAND considered and believes to be important but that ultimately did not make it into this report. What is necessary, first and foremost, is that individuals across the political aisle, in public and private sectors, and in rural and urban communities come together and start a candid conversation about the goals articulated in this report and which strategies can be reasonably negotiated.

## Conclusion

RAND identified evidence-based strategies and mechanisms for promoting pathways to mental health care, improving access to care, and establishing a continuum of care. Our recommendations provide a path to mental health system transformation in the United States by guiding decisionmakers to feasible and effective strategies that support consumers in finding, accessing, and receiving high-quality, appropriate, and timely care.







# Introduction

1

## A Time for Transformation

The United States is at a time of promise for historic transformation in mental health care. Major challenges to the U.S. health system have persisted for several decades. These include lack of community-based support for adults with serious mental illness, poor access to care for people with treatable mild and moderate mental disorders, fragmentation of responsibility for care across systems,<sup>5</sup> and delivery of care that is inconsistent with evidence-based recommendations.

Inaction on these policy fundamentals has resulted in prisons and jails becoming the largest institutional providers of housing for people with serious mental illness and in high levels of unmet treatment need in the community.<sup>6</sup> Inequity in care also remains largely unaddressed, with larger gaps in treatment across racial/ethnic groups in behavioral health than in general health care.<sup>7</sup>

However, recent years have seen a resurgence of innovation and bipartisan advocacy for people experiencing mental illness. There have been significant changes in how mental health care is financed, and we have witnessed the emergence of a stronger evidence base for treatment and policy. This report aims to lay out how policy changes at all levels of government—federal, state, and local—can build on recent developments and effect broad transformational change to improve the lives of millions of Americans living with mental illness.

## Developments in U.S. Mental Health Care

The promise for transformational change is based on four inter-related developments related to the U.S. mental health care system. By *system*, we are referring the organization of people, institutions, and resources that support delivery of mental health services throughout the United States—inclusive of adjacent sectors, such as housing and education:

**1. The role of Medicaid.** Medicaid, continuing a trend extending over several decades, has emerged as the largest payer of mental health services in the United States, covering more than a quarter of adults with serious mental illness.<sup>8</sup> Medicaid also influences mental health systems as a driver of innovation, a role considerably strengthened by the payment reform initiatives of the Patient Protection and Affordable Care Act (ACA) of 2010.<sup>9</sup> Likewise, state Medicaid expansion has broadened behavioral health benefits to millions of Americans.<sup>10</sup>

**2. Mental health parity.** Mental health parity is now the law of the land,<sup>11</sup> requiring equitable insurance coverage for mental health treatment in most sectors of the health insurance market. Although true parity has yet to be achieved in practice, the legal, administrative, and scientific frameworks for achieving equity have been coming together, driving increased access to mental health.

**3. New treatments and models of care.** Research on new treatments and models of care provide a strong foundation for evidence-based policy. Historically, mental health care has lagged other types of medical care with respect to evidence. Evidence on what *should* be done is now emerging—for example, coordinated specialty care for first-episode psychosis,<sup>12</sup> crisis intervention teams,<sup>13</sup> and collaborative care management for depression and anxiety.<sup>14</sup> In addition, new financing and service delivery models are being piloted, such as Certified Community Behav-

ioral Health Clinics (CCBHCs).<sup>15</sup> It is less clear what is actually done *in practice* regarding such models, although the literature suggests large gaps in use of evidence-based care.<sup>16</sup>

**4. Bipartisan consensus.** Reform of the U.S. mental health system is supported by strong bipartisan consensus. Politicians on both sides of the aisle agree on the importance of mental health and the diagnosis of systemic failure. The Mental Health Parity and Addictions Equity Act of 2008 passed Congress with endorsement from large majorities of both Republicans and Democrats.<sup>17</sup> Bipartisan support continued for the Protecting Access to Medicare Act of 2014 and continues in 2020 with support for mental health protections embedded in the Coronavirus Aid, Relief, and Economic Security (CARES) Act.<sup>18</sup>

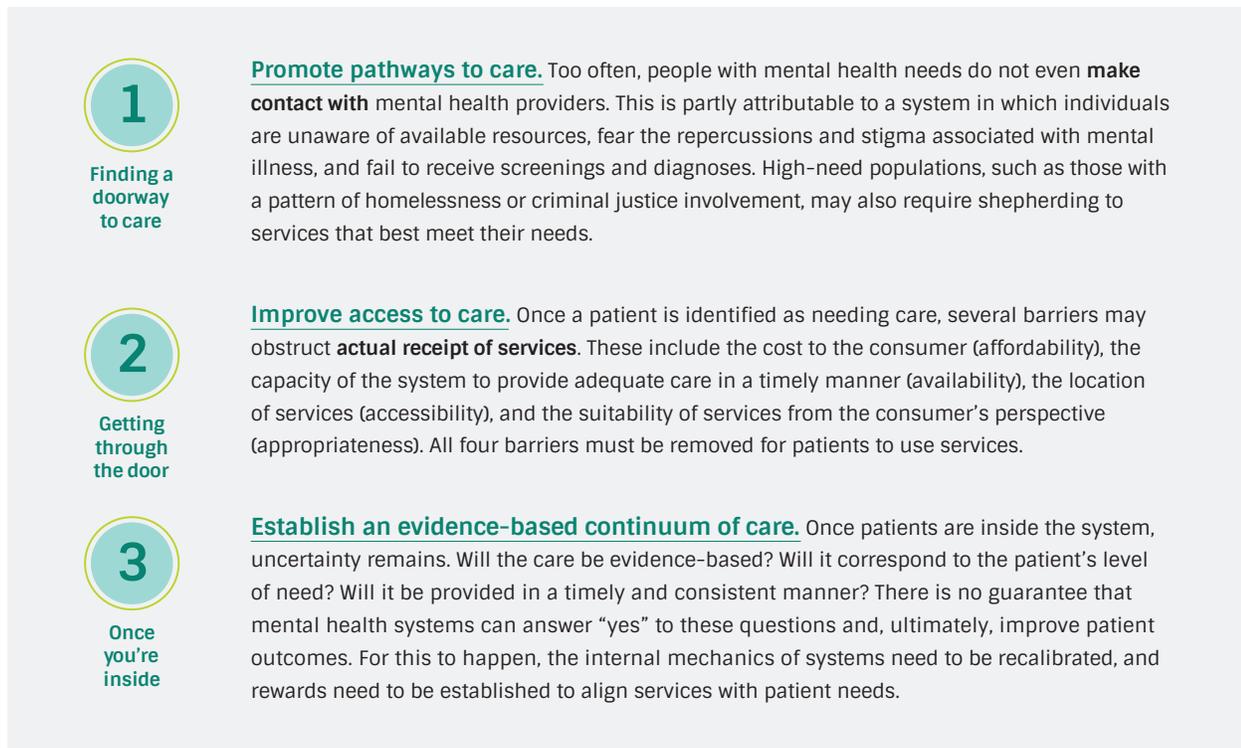
After surveying this landscape, we find it clear that decisive and transformative change is possible. However, for change to occur, politicians, public administrators, advocates, and policy experts need to coalesce around a focused set of objectives. Importantly, for these objectives to take root, they need to be broadly endorsed across the political spectrum, be grounded in evidence, and actually deliver on the structural reforms required to improve the lives of more than 60 million Americans affected by mental illness. This report articulates 15 recommendations to that end, based on inputs from more than 30 leading experts in the public and private sectors, as well as an extensive literature review undertaken by RAND.

## A Patient-Centered System

The 15 recommendations in this report correspond to three goals of mental health system transformation, as identified by RAND: to promote pathways to care, to improve access to care, and to establish an evidence-based continuum of care (see Figure 1.1).



Figure 1.1. A Health System That Follows the Patient Journey



## Development of Recommendations in This Report

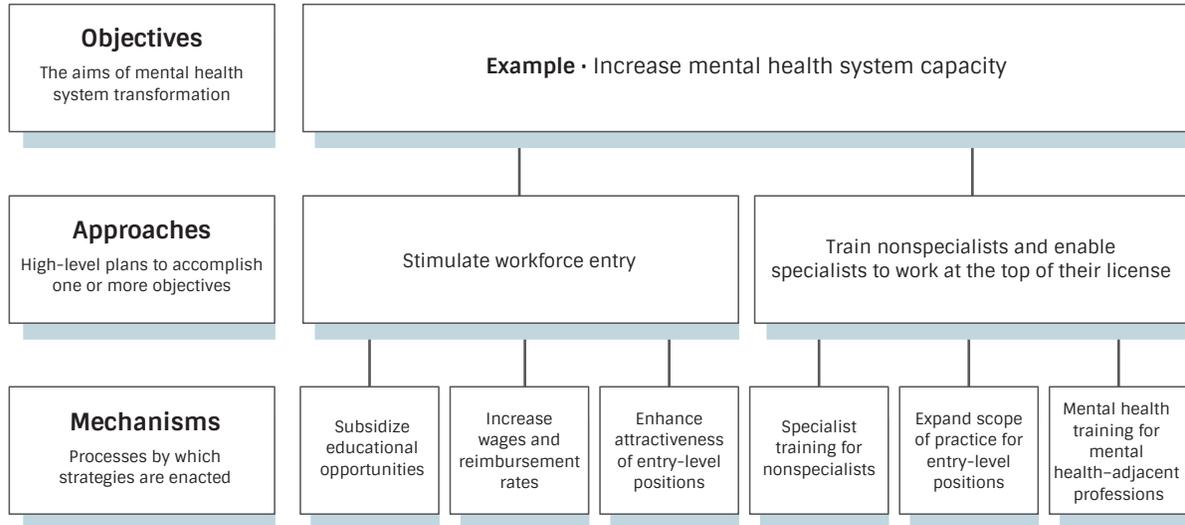
The recommendations in this report are the product of 12 months of speaking with mental health experts throughout the country. We spoke with government officials, public administrators, health system executives, and academics. For further information on key-informant interviews and a list of advisory panelists, see Appendix A and Appendix B.

In parallel with these conversations, we conducted a comprehensive review of the empirical literature to identify best practices and recent innovations in the mental health sector, which were presented to an advisory panel for further inputs. To explore these findings and to learn approaches for addressing concerns about your mental health system, visit the interactive web tool (see Figure 1.2).<sup>19</sup>



## Figure 1.2. Mental Health Systems Transformation Inventory

We developed a **web tool for readers** to learn about dozens of approaches and mechanisms to effect change at local, state, and federal levels. The web tool provides background resources and case studies of successful implementation in the United States and abroad. Visit [www.rand.org/t/TLA889-1](http://www.rand.org/t/TLA889-1)



SOURCE: Ryan K. McBain, Vishnupriya Kareddy, Nicole K. Eberhart, Joshua Breslau, Lori Frank, and M. Audrey Burnam, *Mental Health Systems Solutions Explorer*, Santa Monica, Calif.: RAND Corporation, TL-A889-1, 2021.



## Structure of This Report

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In the next three chapters, we provide short primers on each of the three goals of mental health system transformation, followed by a series of recommendations that would help realize these goals. Each recommendation can be read on its own and interpreted as a unique opportunity for improving mental health care. However, many of these recommendations are related to one another and would yield larger impacts if implemented in unison—for example, through a comprehensive piece of federal legislation akin to the 21st Century Cures Act or executive action at state and local levels along the lines of California’s simultaneous ratification of more than a dozen mental health–related bills in September 2020.<sup>20</sup>

We hope you come away from this report with a sense of enthusiasm about the possibility for mental health transformation and an understanding of specific actions that can be taken today to bring this about.



GOAL 1



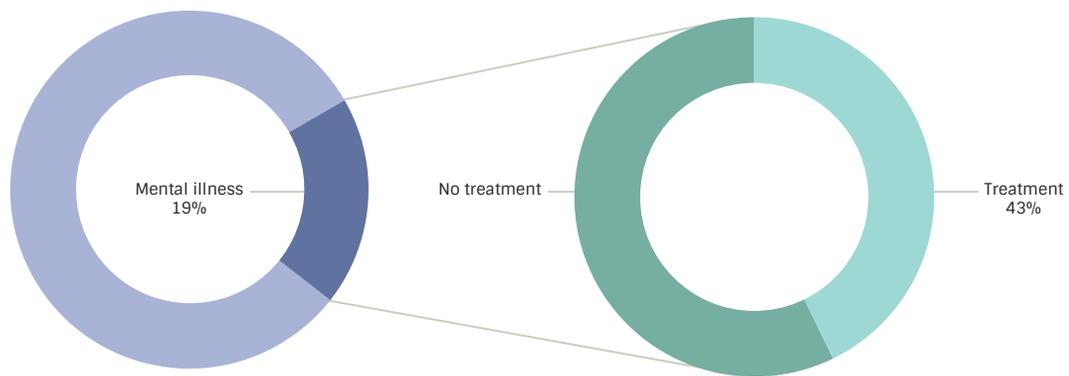


GOAL 1

# Promote Pathways to Care

Many Americans experience mental illness, but the majority of those in need of assistance go untreated. In 2017, 46.6 million adults (19 percent) experienced mental illness in the past year, but only 19.8 million (43 percent) of those Americans received mental health care (see Figure 2.1).<sup>21</sup> There are three major types of barriers that explain why people do not get treatment: (1) not recognizing that help is needed; (2) practical barriers, such as affordability, accessibility, and convenience of care; and (3) such attitudes as wanting to handle the problem on one's own.<sup>22</sup>

Figure 2.1. Percentage of Americans with Mental Illness Who Received Treatment



SOURCE: R. Mojtabai, M. Olfson, N. A. Sampson, R. Jin, B. Druss, P. S. Wang, K. B. Wells, H. A. Pincus, and R. C. Kessler, "Barriers to Mental Health Treatment: Results from the National Comorbidity Survey Replication," *Psychological Medicine*, Vol. 41, No. 8, 2011.

We have identified three solutions to increase mental health service utilization by those in need and tied these to three recommendations. First, education initiatives have the potential to effect broad change—they can improve attitudes toward mental illness, improve knowledge and skills to promote prevention, and help those with mild and moderate mental health issues recognize their need for care. Recommendation 1 provides relevant evidence and suggests specific actions.

Second, to help individuals get the mental health care they need, solutions need to “meet them where they already are.” Individuals with mild to moderate mental illness are unlikely to see a behavioral health specialist, but they often see other kinds of health care providers. For this reason, Recommendation 2 focuses on identification and treatment of mental health issues in general health settings, through expansion of behavioral health integration.

The “meet them where they already are” strategy is also applicable to those with serious mental illness. Many individuals

with mental illness experience homelessness, which serves to exacerbate their mental health issues. But there is a lack of appropriate housing for those with mental health needs. For these reasons, our third solution, which Recommendation 3 centers on, links homeless individuals with mental illness to supportive housing.

Those with mental illness are also overrepresented among those involved with the criminal justice system. Many individuals have encounters with law enforcement and are arrested when they would be more appropriately diverted to mental health services. As a result, correctional facilities are one of the largest providers of mental health services in the United States.<sup>23</sup> For these reasons, Recommendation 4 also recognizes the value of meeting people where they are by suggesting a multifaceted diversion strategy that is centered on community behavioral health.

“Early detection of depression and other mental health issues is crucial to better outcomes. Health systems can improve and even save lives by committing to universal treatment and screening for depression.”

—President & CEO of a mental health policy and research organization

## RECOMMENDATION 1

# Promote Systematic Mental Health Education

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### Summary

Mental health education should be considered a key part of a comprehensive health education curriculum. Schools have the potential to provide a more sustainable mechanism for destigmatizing mental health and improving attitudes, enhancing mental health knowledge and skills necessary for prevention, and promoting increased help-seeking.<sup>24</sup>

### Problem Statement

Americans lack mental health literacy, as there is no systematic mental health education in the United States. Without mental health knowledge, many people do not realize that they have a problem that would benefit from treatment. Indeed, individuals' lack of knowledge that they have mental health needs that could be addressed and their negative attitudes toward mental illness (e.g., stigma) are key barriers to seeking mental health treatment.

Education is needed to increase mental health awareness, destigmatize mental health, and guide individuals to needed treatment.<sup>25</sup> Many mental health problems first appear in childhood or adolescence, so any education effort needs to start in K–12 education, although broader educational efforts may also be helpful. Education is particularly important for those with mild or moderate mental health issues and those experiencing first onset of a mental health problem.

### Analysis

There is promising early evidence that school-based, universal mental health education is effective. A systematic review of 15 studies of U.S. school-based mental health awareness programs found that the programs were associated with improvements

in mental health knowledge, attitudes, and help-seeking.<sup>26</sup> One randomized controlled trial—the most rigorous study design—found that a school-based mental health educational intervention resulted in greater increases in mental health literacy and greater reductions in stigma than a personal development, health, and physical education class.<sup>27</sup> Recently, a study of a school-based stigma-reduction curriculum found that students assigned to this curriculum had greater mental health knowledge, more-positive attitudes, and reduced stigma and were more likely to seek treatment for their mental health symptoms than students in other kinds of programs or no program.<sup>28</sup>

Overall, school-based mental health education shows potential for improving the social climate related to mental illnesses in schools, improving mental health knowledge, and increasing treatment-seeking when needed. However, further research is needed to understand whether mental health education ultimately improves mental health outcomes of students and whether it has any unanticipated negative consequences (such as parents opting out or exacerbating mental health conditions). Nonetheless, the evidence so far regarding attitudes, knowledge, and help-seeking are encouraging, with more-supportive research than other approaches to effecting change in these areas. Further, incorporating mental health education into K–12 education is a strategic approach, as it has the potential to effect widespread change, allows for ongoing reinforcement of learning as part of regular schooling, and destigmatizes mental health by treating it the same as physical health. In addition, standard mental health education has the potential to reduce disparities; Black and Brown individuals tend to have less access to mental health care,<sup>29</sup> and this population-based approach provides a level playing field in which all individuals have access to mental health education.

Mental health social marketing campaigns and “gatekeeper” training may also be effective educational strategies, but evidence

that they positively affect treatment seeking and mental health outcomes is weaker. Broad mental health social marketing campaigns, such as California's Each Mind Matters initiative, can reduce stigma, increase perceived need for treatment, and increase treatment-seeking.<sup>30</sup> However, reviews of the literature on these programs find that the effects tend to be short in duration.

A third approach is to provide targeted educational initiatives to nonclinicians who come into contact with people who have mental illnesses in the course of their professional work, such as teachers. For instance, Mental Health First Aid programs, which aim to provide people with skills to assist individuals with mental health needs, have been linked, among training recipients, with increased mental health knowledge, improved attitudes, and increased confidence to intervene with those who have mental health problems.<sup>31</sup> However, there is a lack of evidence that this in turn results in help-seeking for individuals with mental health needs, so the programs should be considered as supplementary to, not a replacement for, more-comprehensive mental health education.<sup>32</sup>

### Example of Policy in Action: State Mandatory Mental Health Education Laws

Recently, more U.S. states have been requiring mental health education as part of a comprehensive approach to health education.<sup>33</sup> At least ten states require mental health curriculum by law, and at least 20 states and Washington, D.C., include mental health in their health or education standards.<sup>34</sup> Implementation varies across states, with some states defining content and standards for all grade levels and others requiring a single unit of study for a single grade only (see Table 2.1).

For instance, New York now has a mandatory K–12 mental health education law, although it provides counties with latitude to design curricula that meet local needs.<sup>35</sup> In 2018, the New York State Education Department, alongside mental health advisory committees, outlined the key principles of this new curricula in public schools.<sup>36</sup> This includes

- instituting efforts to reduce stigma regarding mental health
- supporting children and youth in the development of stress management skills, positive routines and practices, and regular sleep habits
- promoting a positive school climate and culture

- providing support to students with concerns about the mental health of themselves, friends, and family members
- developing support for school staff regarding their own mental health and wellness.

### How It Would Work

There are various options for how to make systematic mental health education a reality in the United States. States could pass legislation mandating mental health education as part of comprehensive health education. Alternatively, the federal government could consider providing guidance for minimal standards for such education and incentivize states to provide mental health education through grants or other means. The U.S. Department of Education and state departments of education could also consider developing curricula for dissemination. Finally, local school districts and communities could pursue incorporating mental health education into health curricula, following the lead of other districts that have already implemented this approach. School districts could consider partnering with county and state departments of mental health to develop and administer these curricula.

This recommendation envisions the integration of mental health education into health education, so that mental health is not considered different or separate from physical health. This approach minimizes the stigma around mental illness. However, we recognize that broad implementation might not be feasible in the short term. Therefore, we provide suggestions of where to start. Although some states have integrated mental health into all grade levels, available evidence comes from grades 5–12,<sup>37</sup> with higher-quality evidence from interventions focused on grade 6 and grades 9–10.<sup>38</sup>

Given that the typical age of onset of mental illness is in adolescence, a reasonable approach would be to start with middle school students. Research suggests that even a brief one-week curriculum can be effective,<sup>39</sup> but more commonly the evidence supports six-week, six-session curricula.<sup>40</sup> Key topics to cover are reducing mental health stigma and improving attitudes toward mental illness, increasing knowledge of mental illness, coping skills to promote mental health, and seeking help for oneself and others when needed.

Table 2.1. Examples from NBC News of State Mental Health Legislation and Standards

STATES THAT REQUIRE MENTAL HEALTH CURRICULUM BY LAW	
Connecticut	Connecticut Public Act No. 17-42 incorporates mental and emotional health, including youth suicide prevention and substance misuse prevention as a prescribed course of study.
Kentucky	Kentucky Law 704 KAR 8:030 adopts into law the Kentucky Academic Standards for Health Education, which includes mental health.
Maine	Maine Legislative Document 1024 requires elementary, middle, junior high, and high school health education to include the relationship between physical and mental health and reducing the stigma of mental illness.
Nevada	Nevada Senate Bill 204 requires a course in health to include mental health instruction.
New Jersey	Effective in the 2020–2021 school year, New Jersey requires by law public school health education to include mental health. For example, the law calls for sixth graders to compare and contrast common mental illnesses and ways to detect and treat them.
New York	New York Bill A3887B, signed into law in 2016, requires mental health education to be a part of health education across all grade levels. One of its goals is to enhance understanding and promote human dignity.
South Carolina	South Carolina Bill H. 3257, signed into law September 2020, requires ninth graders to complete one unit of study in mental health and wellness.
Vermont	Vermont Law 16 V.S.A. § 131 requires family health and mental health education that includes family communication skills and an understanding of depression and the signs of suicide.
Virginia	Virginia Bill SB953, signed into law in 2018, requires mental health education to be taught to students in grades 9 and 10.
Wisconsin	Wisconsin Statute 118.01(2)(d)(8) requires education designed to help students develop positive psychological, emotional, and problem-solving responses to situations while avoiding negative and fearful reactions.
EXAMPLES OF INCLUSION OF MENTAL HEALTH IN EDUCATIONAL STANDARDS, NOT BY LAW	
District of Columbia	The District of Columbia’s health education standards include mental and emotional health components in each grade. For example, by grade 8, students should be able to define and identify symptoms of anxiety and depression.
Idaho	Mental, emotional, and social health are key parts of Idaho’s content standards at all grade levels, according to the state’s Department of Education. From kindergarten through grade 2, for example, instruction includes a positive sense of self-image.
Utah	Mental health is integrated into Utah’s core health standards. For example, the standards outline that third graders should identify strategies to cope with disappointment, grief, and sadness.
SOURCE: NBC News graphic in Bernie Lubell and Kate Snow, “TODAY Analysis: More States Requiring Mental Health Education by Law,” <i>Today</i> , September 18, 2019.	

## RECOMMENDATION 2

# Integrate Behavioral Health Expertise into General Health Care Settings

### Summary

Behavioral health conditions are often unrecognized in general health care settings. Integrated, whole-person care approaches are effective in connecting people to care but are underutilized. We recommend expanding the integration of behavioral health care into general health care settings.

### Problem Statement

Individuals with mild to moderate mental illness are unlikely to see a behavioral health specialist, but they often see other kinds of health care providers.<sup>41</sup> However, behavioral health conditions often go unrecognized and untreated in primary care and other general medical care settings. Moreover, people with behavioral health conditions tend to receive poorer-quality care for their physical health conditions than people without behavioral health conditions.<sup>42</sup> These challenges, which derive from multiple sources, are rooted in a long history of segregation of behavioral health care from the mainstream of general medical care in training and in practice. Fragmentation remains a challenge today,<sup>43</sup> as does stigma related to mental illness among health care practitioners.<sup>44</sup>

The result is inefficiencies associated with ignoring the whole person to the detriment of health care quality and with attendant unnecessary health care costs.<sup>45</sup> One major success in addressing this gap is the Collaborative Care Model (CoCM), first developed for treatment of depression in primary care. The CoCM demonstrates the potential for care integration to improve outcomes while expanding access to care, but it is resource-intensive, and its implementation remains limited. Innovative models are being developed and tested with some success to bring behavioral health expertise into a broader range of health system practices, reducing stigma and possibly improving care.

### Analysis

Our expert panel members pointed consistently to a cultural problem in health care that disadvantages the treatment of people with behavioral health conditions, affecting not only behavioral health care but general medical care as well. To address this cultural challenge, a range of strategies that incorporate behavioral health knowledge and expertise into practice guidelines and clinical skills for general health care are recommended. Although no single intervention or policy will accomplish the goal of integrating care, several promising developments reported in the literature provide momentum for change. We provide some examples here.

**CoCM** is supported by a large body of research demonstrating its clinical effectiveness and cost-effectiveness for managing behavioral health conditions in primary care.<sup>46</sup> CoCM has multiple components, including regular screening, a patient-centered team care with shared treatment plans, population-based care using patient registries, and measurement-based treatment. Although the evidence that CoCM can improve patient outcomes is strong, implementation of the model remains relatively rare.<sup>47</sup> Outside highly integrated health systems, pulling the pieces of the model together and maintaining them through existing reimbursement mechanisms remain a challenge.<sup>48</sup> Furthermore, CoCM is primarily reimbursed by Medicare and considerably less frequently by Medicaid at the state level or by commercial payers.<sup>49</sup> Similarly, **Screening, Brief Intervention, and Referral to Treatment (SBIRT)** is an evidence-based approach to identification and early intervention in substance use disorders designed for general medical settings.<sup>50</sup> Despite evidence of cost-effectiveness, reimbursement for SBIRT services is inconsistent across payers and differ from state to state. Concerted efforts to support CoCM and SBIRT by commercial and public payers could improve the model's dissemination.





**Zero Suicide** is a strategy of deploying a coordinated series of interventions across a health care system to increase identification of patients at risk for suicide and respond with evidence-based, targeted interventions.<sup>51</sup> The strategy is notable because it focuses on the health care system rather than on behavioral health care providers in particular. It is a continuous quality improvement framework, with tools for monitoring fidelity and adjusting practices to new information.<sup>52</sup> To be clear, the impact of the Zero Suicide strategy on suicide completion is not yet supported by rigorous evaluation. However, because it creates a platform for incorporating evidence-based behavioral health interventions into health care systems, it represents an important historical development for integrated care.

A large and growing proportion of emergency department (ED) visits involve a behavioral health condition.<sup>53</sup> Historically, EDs have been unequipped to manage behavioral health conditions, especially among people with serious mental illness, but new models of management are emerging. For instance, a brief safety planning intervention delivered in the ED was found to reduce suicidal behaviors in a randomized controlled trial.<sup>54</sup> Screening for mental health and substance use disorders in the ED are being investigated, although robust models of care have yet to emerge.<sup>55</sup>

## How It Would Work

Integrating behavioral health into general health care should be thought of as a long-term, multipronged strategy rather than as a problem to be solved by designing and implementing the right model of care. It should involve rethinking medical education to ensure that awareness of behavioral health conditions and their treatment is universal among clinical staff at all levels. Medical education should also include the expansion of financing for CoCM in primary care, along with models that have been successful in reducing the cost of care using digital and telehealth technologies.<sup>56</sup>

Enforcing parity requirements, discussed in Recommendation 5, could provide additional motivation to commercial payers to expand these services. Broader system change will likely require a longer process of creative problem-solving, assessment of evidence, dissemination of findings, and implementation of quality improvements at the level of individual health systems and providers. Financial reforms, advocacy, and measurement all have roles to play.

“

What would you say if a primary care practice said that they refuse to screen for or treat hypertension? But that’s the way it is for behavioral health, and it’s accepted! A majority of primary care practices don’t screen or treat alcohol misuse—at most they refer. It’s the same with depression.”

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—Former federal behavioral health policy official

## RECOMMENDATION 3

# Link Homeless Individuals with Mental Illness to Supportive Housing

### Summary

Without a roof over one's head, the path to recovery from mental illness may be unimaginable. Shelter not only improves one's quality of life but can also generate health care savings.<sup>57</sup> Administrators at all levels of government should expand supportive housing programs for individuals with serious mental illness.

### Problem Statement

Any given night, almost 600,000 people experience homelessness in the United States—an estimated 2 million people every year.<sup>58</sup> One-quarter of individuals experiencing homelessness are also coping with a serious mental illness (see Box 2.1).<sup>59</sup>

Homelessness exacerbates mental illness and is a risk factor for incarceration among those who are mentally ill.<sup>60</sup> Those with mental illness who are homeless are more likely to be justice-involved, experience emergency hospitalization, and have substance use disorders.<sup>61</sup> Intervening early and addressing social needs—including housing insecurity—together are a critical step in getting people back on their feet.

### Analysis

Supportive housing, including Housing First programs, combine stable housing with social and mental health services to help stabilize individuals who are dealing with homelessness and mental health issues—most often, serious mental illness (see Figure 2.2). Housing First is a subtype of supportive housing that does not require individuals to meet criteria, such as “being clean” from substance use as a contingency for receiving housing support. Delivered properly, these programs can be a cost-effective way of managing care and have been shown to decrease incidence of incarceration, justice involvement, hospitalization, and homelessness while improving individuals' quality of life.<sup>62</sup>





**BOX 2.1. INFLECTION POINTS**

**Mild-to-Moderate Mental Illness  
Versus Serious Mental Illness**

Mental health conditions include a broad range of diagnosable disorders with diverse symptom profiles. Within specific diagnostic conditions, people affected can vary widely in symptom severity, length and recurrence of episodes of illness, and impact of the illness on cognitive, emotional, physical, and social functioning. In considering policy related to mental health, this complexity of mental health experience is generally lumped into two broad categories that tend to be treated in different settings and affected by different types of policies: serious mental illnesses and mild-to-moderate illnesses.

The first category, **serious mental illnesses**, consists of conditions associated with long-lasting and severe functional impairments. People experiencing these serious illnesses often eventually become eligible for Medicaid insurance because of their disability. Those with serious mental illnesses tend to be

treated by specialty behavioral health services that are publicly supported, largely through state and federally funded Medicaid programs. The population receiving publicly supported mental health care includes many people with schizophrenia, bipolar disorders, and severe cases of major depressive disorder.

The second category includes everyone else with mental health conditions, most of whom are **people with mild or moderately severe symptoms** or with less severe or shorter-term impacts on functioning. Mild and moderately severe mental illnesses, which are much more common than serious mental illness, tend to be treated in general health care settings, such as primary care clinics, although many also receive some specialty behavioral health care. Mild and moderate conditions are also clinically diverse; the most common diagnoses in this category are depression, anxiety, and trauma and stress-related disorders.

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Our recommendations address all mental health conditions, but some recommendations address treatment of serious mental illness, some are targeted more to mild and moderate conditions, and some address both equally. We highlight several contrasting examples:



### Recommendation 1

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This recommendation focuses on mental health education, equally emphasizing destigmatization of serious and mild-to-moderate mental illnesses.



### Recommendation 5

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This recommendation is related to mental health parity and focuses on policy related to behavioral health coverage by commercial insurers. Since the population covered by commercial insurers is largely employed, parity regulations will routinely affect treatment of mild and moderate conditions. However, commercial insurance may also cover family members with serious mental illnesses who are unemployed.

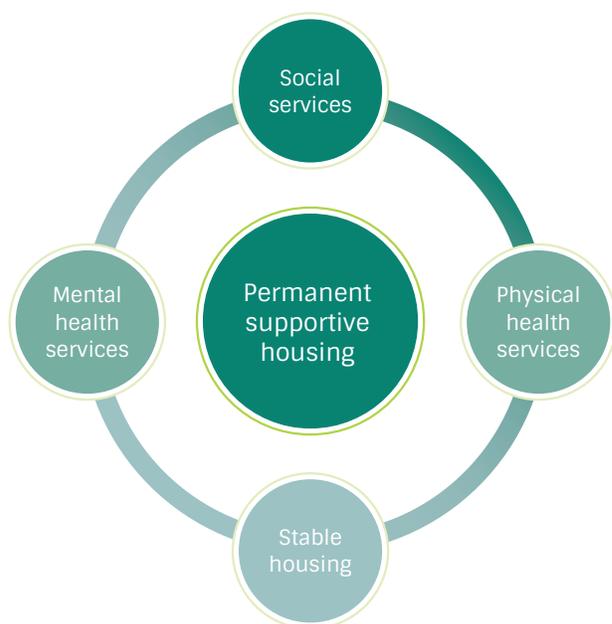


### Recommendation 6

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This recommendation is related to Medicaid reimbursement for behavioral health care and focuses on services used by people with serious mental illnesses. For this population, policy goals include provision of a much broader range of supportive social services in addition to high-quality evidence-based medical care.

Figure 2.2. The Components of Supportive Housing



Despite the promise of supportive housing programs, implementation in the United States has been relatively circumscribed. There are two major sources of funding for supportive housing in the United States: the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Projects for Assistance in Transition from Homelessness (PATH) program and the U.S. Department of Veterans Affairs (VA) and U.S. Department of Housing and Urban Development’s (HUD’s) joint Housing First program called HUD-VASH (standing for U.S. Department of Housing and Urban Development–Veterans Affairs Supportive Housing).<sup>63</sup> PATH served about 65,000 clients in 2019,<sup>64</sup> and HUD-VASH served approximately 90,000.<sup>65</sup> This means that these programs serve just 56 percent of individuals classified as chronically homeless in the United States. In 2020, the budget for these programs was flat relative to 2019, and the Trump administration’s President’s Budget for 2021 recommended cutting HUD-VASH vouchers completely.<sup>66</sup> Although state, local, and private foundations also fund supportive housing, they are much more limited in terms of their reach.

At a time when there are historic levels of unemployment and dramatically escalated rates of psychological distress because of the COVID-19 pandemic,<sup>67</sup> there needs to be greater investment in supportive housing. In the context of budget constraints, this may imply strategically targeting populations that benefit most from them, including those with serious mental illness.<sup>68</sup> Although many would benefit from stable housing during tough times, those with mental illness are uniquely at risk for

having their health condition exacerbated by homelessness, and housing these individuals yields significant cost savings in other domains.<sup>69</sup>

### Example of Policy in Action: Housing First in Los Angeles County

California has the largest homeless population of any state,<sup>70</sup> and Los Angeles has the second-largest population of homeless individuals of any city in the United States.<sup>71</sup> To tackle this issue, the Los Angeles County Department of Health formed the Housing for Health division, which began enrolling participants in 2007. This division runs a Housing First program that takes a client-centered approach, meaning that a case manager evaluates the needs of the enrollee and works hand in hand with the client to develop an individualized plan. Plans consist of housing assistance, eviction prevention, case management, linkage to mental health and substance use services, assistance with benefits (Supplemental Security Income, VA benefits, etc.), life skills training, employment assistance, and education assistance.<sup>72</sup>

As shown in Figure 2.3, research on this program shows that 96 percent of early participants were stably housed for at least one year, ED visits reduced by 80 percent, days of medical health inpatient stays reduced by 61 percent; medical outpatient visits reduced by 47 percent, and mental health outpatient visits reduced by 44 percent reduction. Furthermore, in the year prior to enrollment, participants' public service expenditures averaged about \$38,000 per individual. After enrollment, this cost was reduced to roughly \$15,000. Factoring in the cost of the program, which was also \$15,000, this equaled a 20 percent savings.<sup>73</sup> Other studies show more-modest savings or programmatic cost offsets.<sup>74</sup>

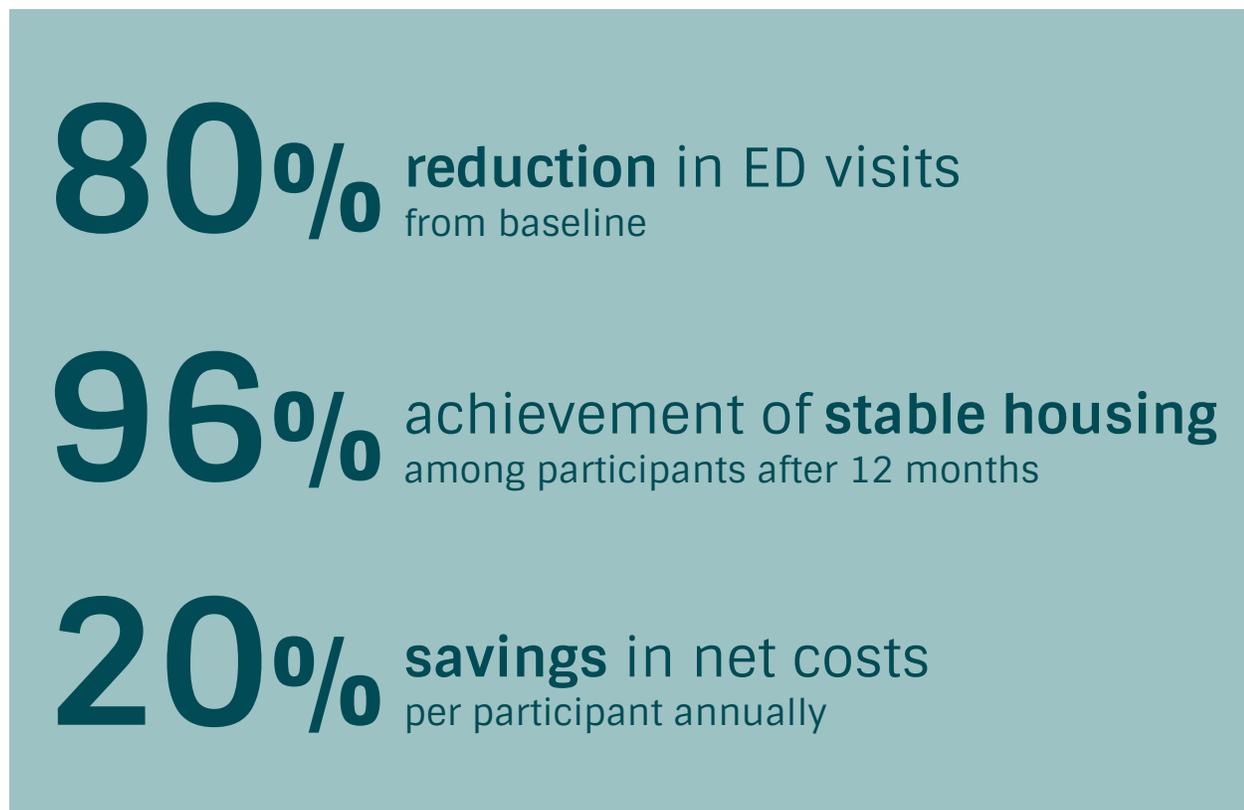
To increase the political feasibility, funding allocations to implementers could be tied to evaluations assessing program effectiveness and cost-effectiveness. This would help offset a substantial amount of the upfront investment in supportive housing. Those delivery models identified as being most successful in improving lives and cost-effective at local levels could then be replicated in other settings.

Research also demonstrates that these programs have the greatest impact among the severely mentally ill who are most in need of supportive services. To target this population specifically, funding mechanisms could incorporate bonuses for outreach to and enrollment of these individuals.<sup>75</sup>

### How It Would Work

The federal government should increase its annual investment in PATH and HUD-VASH programs. PATH is currently funded through HUD's McKinney-Vento Homeless Assistance Grants program, while HUD-VASH is funded under the Veteran's Appropriations Bill.

Figure 2.3. Results of Los Angeles County's Housing First Program



## RECOMMENDATION 4

# Develop a Mental Health Diversion Strategy Centered on Community Behavioral Health

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### Summary

Correctional facilities are one of the largest providers of mental health care in the United States. We recommend pursuing evidence-based diversion strategies that prevent new and recurring justice system involvement, diverting individuals to the community behavioral health system.

### Problem Statement

At least one in four individuals with serious mental illness has a history of involvement with the criminal justice system,<sup>76</sup> and individuals with mental illness are overrepresented in prisons.<sup>77</sup> Indeed, correctional facilities are one of the largest providers of mental health care in the United States.<sup>78</sup>

In addition, many individuals with mental illness have encounters with law enforcement when in crisis. These encounters with law enforcement result in the arrest of 2 million Americans with mental illness each year.<sup>79</sup> These arrests are disproportionately of Black Americans, who are also less likely to receive access to care once incarcerated (see Box 2.2).<sup>80</sup>

There is little coordination across criminal justice and mental health systems to divert individuals with mental illness to treatment instead of jail when appropriate. There is also a lack of consistent supports for previously incarcerated individuals reintegrating into the community—encompassing mental health and substance use systems of care, as well as social services.





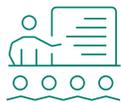
**BOX 2.2. INFLECTION POINTS**

**Ensuring Equity in Mental Health  
Care—Systematic Change So Everyone  
Gets Access to Mental Health Care**

# Systematic change so everyone gets access to mental health care

Access to mental health care is not equal. There are systematic disparities by race, sexual orientation, gender, and income. Black Americans and Latinx Americans are more likely to experience persistent symptoms of emotional distress than White Americans. Despite this, just one in three Black adults who need mental health care receives it. Among Latinx Americans, 33 percent receive mental health care, compared with 43 percent of White Americans. Among LGBTQ+ individuals, LGB adults are more than twice as likely as non-LGB individuals to

experience a mental health condition, and transgender individuals are almost four times as likely to experience a mental health condition than cisgender individuals. Income-based disparities are also commonplace: Those living in high-poverty neighborhoods have been shown to experience significantly greater symptoms of emotional distress. Throughout this report, we make several recommendations to address these disparities. Below we provide several examples.



**1**

## SCHOOL-BASED EDUCATION

School-based mental health curricula provide training and resources for mental health care to students of all backgrounds.



**3**

## SUPPORTIVE HOUSING

Supportive housing programs address economic disparities. They reduce incidence of incarceration, justice involvement, hospitalization, and homelessness.



**4**

## DIVERSION PROGRAMS

Programs that reduce justice involvement for those with mental illness benefit Black and Brown Americans, who are more likely to be justice-involved.



**6**

## ADEQUATE REIMBURSEMENT

Reimbursing behavioral health services at a level that covers the cost of evidence-based practices could make those services more available for people with low incomes.



**7**

## CRISIS RESPONSE

People of color are less likely to receive care before a mental health crisis occurs. A comprehensive crisis response system and 988 hotline provides an important alternative.



**9**

## WORKFORCE SUPPORT

Scholarships, fellowships, and loan forgiveness programs should be provided to populations who are underrepresented in the mental health workforce and to encourage workers to serve in rural areas.



**11**

## DIGITAL MENTAL HEALTH

Geographical disparities in access to mental health services—particularly in rural communities—can be addressed, in part, through telehealth.



**15**

## PAYMENT MODELS

Inadequate access to mental health care for those unable to pay out of pocket can be addressed, in part, through innovative payment and delivery models implemented through Medicaid.

## Analysis

There is evidence to support various approaches to diversion, and we will highlight some of them here. However, there is increasing recognition that individual diversion programs are not enough, and it is important to bring together all the components in a coordinated manner that recognizes individuals' multifaceted needs.

Indeed, an integrated community-based behavioral health system that collaborates with substance use treatment, criminal justice, and social service systems is needed to address the many factors that contribute to justice involvement among individuals with mental illness and address the complex needs of this population. The Sequential Intercept Model (depicted in Figure 2.4) proposes five points of contact for intervening with a person with mental illness at risk for criminal justice involvement,<sup>81</sup> with the recent addition of Intercept 0, which aims to prevent criminal justice involvement via crisis response and community supports.<sup>82</sup> This community-based intercept seeks to reduce interactions with law enforcement, which is particularly desirable given concerns about overpolicing in communities of color. The prevention approach should include ED diversion strategies, which are effective in connecting individuals to mental health care.<sup>83</sup>

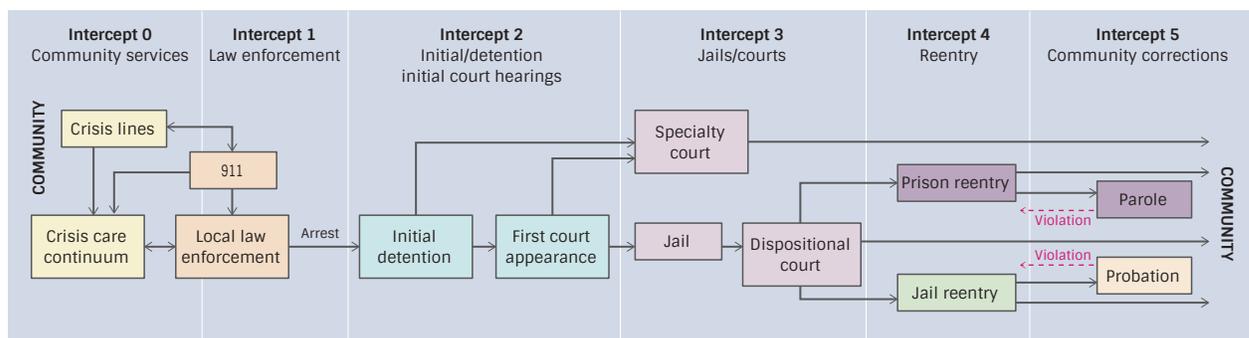
With respect to interactions with law enforcement and crisis response, there is strong evidence that first-responder training can be effective in decreasing arrests and increasing connection

to mental health care for those in crisis. For instance, the widely implemented crisis intervention team (CIT) model provides police officers with training on mental illness and is associated with increased referrals to mental health, decreased arrests, and reduced mental health stigma among officers received CIT training.<sup>84</sup> Alternative approaches involve co-response by mental health providers or response by mental health providers alone, recognizing that law enforcement might not be the most-appropriate responders to all mental health crises.

After an arrest has been made (i.e., postbooking), there is strong evidence that mental health courts are associated with lower rates of recidivism.<sup>85</sup> However, the evidence for mental health service utilization is more mixed: Although several studies have found that mental health courts are associated with increased connections to mental health services, some studies have not found this connection or have weak research designs that were inconclusive.<sup>86</sup>

With respect to reentry into the community, given that recently incarcerated individuals often lack health insurance, some reentry programs focus on expediting Medicaid enrollment. There is good evidence that these programs have been successful at increasing mental health service utilization<sup>87</sup> and should be extended to all states (note that 16 state prison systems still do not facilitate Medicaid enrollment at release).<sup>88</sup> However, there is little available evidence that reentry programs influence mental health outcomes; more research is needed to fully understand the effects.

Figure 2.4. The Sequential Intercept Model



SOURCE: Adapted from Dan Abreu, Travis W. Parker, Chanson D. Noether, Henry J. Steadman, and Brian Case, "Revising the Paradigm for Jail Diversion for People with Mental and Substance Use Disorders: Intercept 0," *Behavioral Sciences and the Law*, Vol. 35, No. 5-6, September-December 2017, p. 382. Used with permission.



### Example of Policy in Action: RecoveryOhio

RecoveryOhio is an initiative to provide a full continuum of mental health and substance use care to all in the state.<sup>89</sup> Directors of key state agencies work collaboratively on this issue, and those with criminal justice involvement have been identified as a special population served in this collaborative approach.

For this population, Ohio has a specialized court docket that offers a therapeutically oriented judicial approach and coordination of court supervision with treatment. Local communities are encouraged to develop collaborative relationships between behavioral health and criminal justice systems. Funding is provided for psychotropic medication, case management services, and treatment and recovery services. The program has seen the following results:

- 15,000 people seeking care on the crisis hotline
- 1 million queries on Ohio's prescription tracking system each day
- 75 recommendations from the RecoveryOhio council being implemented.

### How It Would Work

Behavioral health systems, rather than criminal justice systems, should generally take the lead in caring for those with mental illness and criminal justice involvement. Diversion efforts should be implemented at every stage of the Sequential Intercept Model: from crisis response, to specialized court processes for those with mental illness, to community reentry supports.

To achieve this, directors of county or state agencies should establish joint guidelines and tie together dollars for mental health, substance use, criminal justice, and social determinants of health. Specific steps to consider include the following:

**1. Establish agreements** between police and mental health departments to co-respond to behavioral health crisis calls and provide mental health training to first responders.

**2. Create data systems** for identifying, as a special population, those with mental illness and criminal justice involvement; then, target interventions at those with high need and coordinate across systems of care.

**3. Invest in specialized case management services** for this high-need population that address the full spectrum of needs—inclusive of mental health and substance use supports, as well as social services.

**4. Set up a specialized mental health court docket** in which members of the justice system, community behavioral health system, and other support systems coordinate to provide resources and support.

**5. Establish agreements** between corrections and community mental health in which community mental health providers work with incarcerated individuals to improve transition planning around community reentry, including warm handoffs from jails and prisons to mental health providers and assistance with Medicaid enrollment.

GOAL 2



## GOAL 2

# Improve Access to Care

Once people decide to seek care for a behavioral health problem, services that they value and want to access should be available to them in their community without undue financial burden. In this chapter, we focus on the front doors to care. How do we ensure that services are affordable, available, accessible, and acceptable?

**Affordability:** The landmark RAND Health Insurance Experiment showed that higher out-of-pocket costs diminish the use of behavioral health care.<sup>90</sup> In recent years, costs have become less of a barrier to care in the United States, with reductions in the size of the uninsured population and passage of a federal mental health parity law, which requires equal coverage for behavioral and general medical care.<sup>91</sup> However, having health insurance is not enough. Continued expansion of behavioral health coverage and enforcement of existing parity laws are needed to ensure that care is affordable.

**Availability:** People who seek care face long wait times before they can be seen by a behavioral health provider. In many parts of the country, there are few or no psychiatrists and limited behavioral health clinicians of any type. Policies to increase the size of the behavioral health workforce are important. However, we also need larger systemic efforts to make better use of existing clinical resources.

**Accessibility:** Behavioral health care must extend beyond its current footprint to engage people where they are when they need care. Technology, including smartphone apps, internet-based screening and treatment, and telehealth have untapped potential. Furthermore, integration of behavioral health care into general health settings can provide additional sources of entry to care.

**Acceptability:** Even when people have access to care, they may find that the care that is offered does not address their needs. Improvements in patient-centered care, culturally competent health systems, and self-directed care can ensure that services reach their target populations.

Our recommendations to enhance access to and availability of services revolve around a range of strategies, from addressing workforce and licensure challenges to expanding digital health and integrated care. Some of these recommendations build on promising initiatives but have limited availability for all Americans. Other recommendations present novel approaches to improving care access. Crosscutting themes of improving patient-centeredness and the cultural competency of care are referenced throughout but are also the focus of a specific recommendation.

## RECOMMENDATION 5

# Strengthen Mental Health Parity Regulation and Enforcement

### Summary

Mental health parity is the law of the land, but parity has not been fully achieved in practice. States can take legislative and administrative actions that set clear standards for assessing parity compliance, require mental health coverage from a broader range of insurance plans, and strengthen enforcement of existing state and federal laws.

### Problem Statement

The Mental Health Parity and Addiction Equity Act (MHPAEA),<sup>92</sup> which became law in 2008, required most insurance policies to provide equal coverage to behavioral and general health care.

However, the promise of the MHPAEA for improving coverage for mental health care has only been partially realized because of remaining gaps in the types of plans to which the law applies, fragmented enforcement, and lack of legally established criteria for assessing medical necessity for mental health care.<sup>93</sup> Extraordinarily low participation of specialty providers in behavioral health networks has also impeded consumers' ability to utilize their mental health insurance coverage.<sup>94</sup> As a result, despite having insurance that covers mental health conditions, many people may face larger barriers to accessing mental health care than they do for general health care.

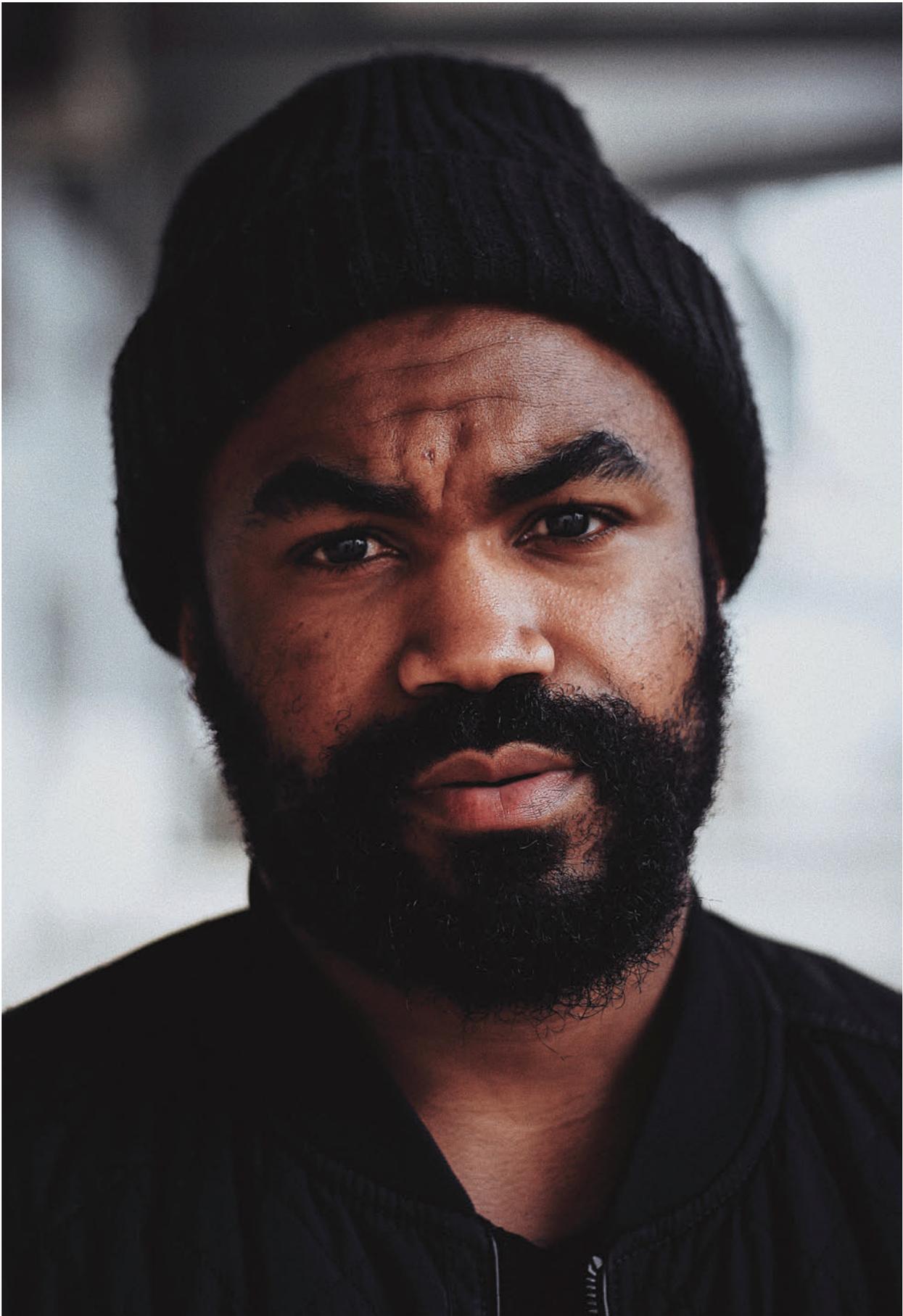
### Analysis

Historically, health insurers have placed disproportionately restrictive limits on coverage for mental health care, limiting payment for outpatient and inpatient mental health care

more strictly than services for general health conditions.<sup>95</sup> The MHPAEA has created a legal foundation for change that has already had positive effects. With some notable exceptions—e.g., Medicare and fee-for-service Medicaid—rules for parity developed by Centers for Medicare and Medicaid Services (CMS) now apply to the large majority of private and public health insurance plans, and evidence suggests that access to and utilization of mental health care have improved as a result.<sup>96</sup> Enforcement of existing law and supplemental state legislation can ensure that the goals of parity are more fully realized.

States have the power to improve mental health care coverage by making parity with general medical care coverage a reality through a variety of legislative and administrative actions. Chiefly, states can

- require coverage for mental health services that are frequently not covered, including rehabilitation, residential care, and inpatient stays in psychiatric hospitals
- increase the enforcement of existing state and federal parity legislation through the active monitoring of both quantitative and nonquantitative treatment limitations<sup>97</sup>
- establish standard mechanisms for reporting parity violations and standard processes for evaluating claims that cut across insurance types
- adopt standards for determining medical necessity for mental health care that are transparent and supported by clinical care guidelines
- establish and monitor requirements for behavioral health network adequacy
- require that reimbursement rates for mental health care be determined by the same methods as reimbursement rates for general medical care.



“We have a parity law, but we don’t have real parity.”

—Executive at a consumer advocacy organization

### Example of Policy in Action: *Wit v. United Behavioral Health*

Although litigation related to implementation of mental health parity is ongoing, a landmark decision was made in March 2019 by the U.S. District Court in Northern California in the case of *Wit v. United Healthcare*.<sup>98</sup> This class-action case, made on behalf of more than 50,000 affected individuals, was brought by 11 plaintiffs, including the family of Natasha Wit, for whom the case is named. Wit was repeatedly denied coverage for treatment of psychiatric disorders by the United Behavioral Health insurance company, resulting in out-of-pocket expenses by the family totaling over \$30,000.

The court found that the insurer’s coverage decisions did not reflect evidence-based guidelines developed by clinical specialty organizations. The court mentioned specific clinical guidelines developed by the American Academy of Community Psychiatrists and the American Society of Addiction Medicine as standards to which coverage decisions should be held. Although this case was not decided under the parity statute, its implications for parity enforcement are clear because of its identification of explicit standards of medical necessity for behavioral health care.<sup>99</sup> It is widely understood that, if this decision stands, it will provide an explicit standard for evaluating decisions regarding coverage of behavioral health care, comparable to decisions made regarding general health care.

### Example of Policy in Action: State Actions on Mental Health Parity

There is a long history of state actions on mental health parity. States began passing mental health parity laws in the 1990s, and many states had a parity law at the time that the federal parity law was passed in 2008.<sup>100</sup> Recently, as limitations of the federal parity law have become apparent, states have begun to act again to fill the gap.

For example, in September 2020, California passed Senate Bill (SB) 855 (Health Coverage: Mental Health or Substance Use

Disorders), which clarified and extended existing parity legislation, increasing the scope of behavioral health coverage. SB 855 expanded the scope of parity regulations to include a broader range of commercial health insurance plans, specified a uniform definition of *medical necessity* for behavioral health treatment, and prevented insurance plans from limiting behavioral health care coverage to acute treatments. Similar bills have been enacted or are under consideration in states across the country.<sup>101</sup>

### How It Would Work

There are a number of ways that states can strengthen parity regulation and enforcement. Among the most powerful is specification that standards for medical necessity are publicly available and reflect professionally recommended and evidence-based practice standards and guidelines. Other approaches include removal of restrictions on billing for behavioral health and general health care services on the same day, restrictions on use of prior authorization in cases of psychiatric emergency, ending *fail-first* policies (sometimes called *step therapy requirements*) that require patients to fail on lower-cost treatments before progressing to higher-cost treatments, and applying stricter criteria regarding network adequacy for behavioral health treatment or requiring full reimbursement for out-of-network treatment.<sup>102</sup>

States also have the ability to improve mental health parity by facilitating enforcement of existing law. Patients have limited ability to identify parity violations; they are unlikely to be aware of the regulations, and, if they are aware, are unlikely to be able to compare the behavioral health and general health care coverage they are provided by their insurer. States can facilitate complaints from providers, who have more in-depth experience with insurance coverage than patients. States can also establish an office to identify and coordinate reporting of parity violations and pursuit of corrections through administrative action or the courts. State regulators can also increase monitoring or reporting requirements so that insurers carry the burden of demonstrating equal treatment of behavioral health and general health care claims.

## RECOMMENDATION 6

# Reimburse Evidence-Based Behavioral Health Treatments at Their True Cost

### Summary

Setting Medicaid reimbursement rates commensurate with the costs of providing care should encourage providers to offer evidence-based treatments that are currently unavailable to many beneficiaries. Improving access within Medicaid would particularly benefit Americans with low incomes and those with serious mental illness.

### Problem Statement

Medicaid is now the largest single payer for behavioral health care in the United States, and Medicaid plays the major role in covering low-income Americans and adults with serious mental illness. Yet reimbursement rates for behavioral health care in Medicaid are low relative to other types of health services and relative to reimbursement by commercial insurance and Medicare.<sup>103</sup> Low reimbursement for behavioral health services, despite evidence of their effectiveness, is frequently cited as a major barrier to scaling up service availability.<sup>104</sup>

Low reimbursement also reduces access to care because it negatively affects the behavioral health care workforce. Many providers do not accept payment through Medicaid because of low reimbursement rates. Psychiatrists are less likely to accept Medicaid payment than other types of physicians, and the proportion of psychiatrists accepting Medicaid has declined in recent years.<sup>105</sup> Low reimbursement affects care across the continuum, from inpatient hospitalization to routine outpatient care, to treatment for substance use disorders.

### Analysis

A common theme that emerged from discussions with policy experts and our examination of the research literature is that we

have evidence-based treatments (see Box 3.1), but we are unable to provide them to the people who would benefit because of low capacity and low reimbursement. For people with low incomes and people with serious mental illness, Medicaid reimbursement plays a large role in the availability of these services. Medicaid reimbursement is partially a federal and partially a state decision. Decisions to reimburse behavioral health services at a level that covers their costs could make those services more available.<sup>106</sup> Any discussion of increasing reimbursement will need to consider overall impacts on the costs of care to payers as well. However, costs should not be the dominant concern when determining coverage for evidence-based treatments that can improve the lives of people with serious medical conditions.

Several types of care that are supported by research evidence could be made more available through improved Medicaid reimbursement. First, there are a range of rehabilitative and recovery-oriented services that are not reimbursed at all by many states and reimbursed at unsustainably low levels by states that do. For example, Individual Placement and Support (IPS), a vocational program, has demonstrated positive impacts on educational and labor market outcomes for adults with serious mental illness. Implementation studies of IPS services have found low reimbursement to be a major barrier to sustainability,<sup>107</sup> although some states have begun to provide reimbursement for the program through Medicaid.

Second, clinical services that involve diverse teams of providers in care for adults with serious mental illness are strongly supported by research evidence but limited by reimbursement. For instance, Assertive Community Treatment (ACT), in which multidisciplinary clinical teams provide intensive coordinated services, has been shown to decrease hospitalization and homelessness. However, financing of ACT teams varies widely across state Medicaid programs.<sup>108</sup> A challenge with team-based care is providing funding for each type of clinician, including peers.



**BOX 3.1. INFLECTION POINTS**

**The Role of Evidence in Providing Care:  
Ensuring That Care Is Effective  
and Appropriate**

# The Role of Evidence in Providing Care

Ensuring That Care Is Effective & Appropriate

## What evidence-based forms of care are discussed in this report?

- For decades, mental health experts have been demanding that health systems prioritize care that works—meaning care that is **effective** at improving patient outcomes and is **appropriate** for addressing patients' specific needs.
- Nevertheless, individuals with mental illness in the United States continue to receive care that lacks evidence or is inappropriate for individuals' needs.
- In this report, we discuss numerous evidence-based treatments that policymakers should consider:

**Supportive housing**  
for patients with serious mental illness (see Recommendation 2)



**Assertive Community Treatment (ACT)** for individuals with serious mental illness (see Recommendation 5)



**Diversion programs**  
for individuals with mental illness who are involved in the criminal justice system (see Recommendation 3)



**First-episode psychosis interventions,** such as RAISE (see Recommendation 6)



**Peer-support services**  
as part of treatment and recovery teams (see Recommendation 8)



**Zero Suicide strategy**  
to identify patients at risk of suicide (see Recommendation 10)



**Telemental health services**  
for those with common mental disorders (see Recommendation 9)



**Collaborative care management**  
for depression care (see Recommendation 13)



“It makes no sense that in-patient beds, the most intensive treatment setting for mental illnesses, are not adequately reimbursed.”

—Physician executive at a large health care system

These challenges are particularly acute for models of crisis intervention services, which may involve clinicians working alongside law enforcement, and school-based care.<sup>109</sup> Reimbursement for these services may be facilitated by payment systems that do not reimburse for specific procedures provided by specific clinicians, such as the CCBHC model.

Third, a broad range of routine treatments for psychiatric and substance use disorders are not reimbursed at cost. Low reimbursement limits growth and sophistication of outpatient behavioral health clinics. The CCBHC model, described in more detail below, aims to address this problem through a cost-based prospective payment system. However, community behavioral health care continues to be provided by relatively small community organizations that rely on nonreimbursement sources of funding to remain in operation.

Finally, services that are tailored to specific underserved populations, including racial and ethnic minorities, are not supported through reimbursement at a level that covers the costs of providing quality care to these communities. Disparities in use of behavioral health services are large among the Medicaid-covered population. Addressing historical sources of inequity that contribute to these disparities, through outreach efforts, investments in tailored clinical programs, and hiring of appropriate staff, involves costs that are generally beyond the budgets of most community providers.

### Example of Policy in Action: Certified Community Behavioral Health Clinics

In 2014, Congress mandated a demonstration of a new model of mental health center, known as a CCBHC.<sup>110</sup> Reimbursement at cost of care was one of the innovative features of the CCBHC model. Although the evaluation of the CCBHCs is ongoing, published evidence suggests that the clinics were able to increase staffing and improve access to a range of evidence-based treatments.<sup>111</sup> As results from the evaluation become clear, states can build on the demonstration experience to assess the potential for implementing similar cost-based financing models adopted to the needs of their community mental health systems.

### How It Would Work

Medicaid reimbursement schedules are joint federal and state responsibilities, but states have considerable flexibility in setting rates. State Medicaid administrators and legislators, policymakers at other governmental levels, and advocacy organizations can assess current reimbursement levels to identify services to target for change.

Given that state expenditures will be affected, strategic priorities should be set to balance concerns with costs and impact on care. In many cases, the true cost to providers of providing evidence-based services is unknown. Providers, researchers, and advocates have an important role to play in conducting objective analyses of the budget impacts of providing these services that can be used to set optimal rates.



## RECOMMENDATION 7

# Establish an Evidence-Based Mental Health Crisis Response System

### Summary

Many communities lack basic elements of an appropriate mental health crisis response system. Poor crisis care results in missed opportunities for engagement in treatment and sometimes ends tragically. Building an evidence-based response system that swiftly identifies individuals' mental health needs and efficiently triages individuals into appropriate care should reduce unnecessary suffering.

### Problem Statement

Mental health crises are common. Many mental illnesses are episodic and recurrent and can include episodes that require an urgent medical response and may even be life-threatening. Indeed, suicide is the tenth leading cause of death in the United States and the second leading cause for individuals under the age of 35.<sup>112</sup> When Americans experience mental health crises, they cannot count on an appropriate emergency response. If an individual calls 911 for mental health needs, first responders might not have mental health training. Often, police officers who serve as first responders lack information and training to appropriately manage the threat of an individual experiencing an acute episode of mental illness.

More than 5 million people each year in the United States visit an ED for a mental health crisis.<sup>113</sup> Many of these EDs are not

prepared to respond appropriately to mental health crises.<sup>114</sup> Crisis response systems are highly localized, varying according to community resources. The adoption and integration of key elements of an evidence-based mental health crisis response into local and regional crisis response systems can improve care for people experiencing mental illness or suicidality and can reduce suffering and social costs related to mental illness.<sup>115</sup>

### Analysis

Although mental health crisis response systems look different throughout the country, there is growing evidence about what works—including mobile mental health crisis units, law enforcement education programs (such as CIT), and step-down psychiatric facilities.

**Mobile mental health crisis teams** consist of mental health professionals, EMTs, police officers, or a mix of these personnel who are deployed when 911 is called (in the future, 988). These units can be dispatched to a person's house, the street, an office, or any other location where a person might be in crisis. Ideally, they stabilize the individual to avoid unnecessary hospitalization or incarceration.<sup>116</sup> Evidence to date shows that mobile crisis teams can save money and decrease hospitalization and ED use among youth and adults.<sup>117</sup>



Figure 3.1. Crisis Now

- Improved Crisis Clinical Fit to Need (CCFN) by **6x**
  - Reduced potential state inpatient spending by **\$260m**
- Saved the equivalent of **37 FTE** police officers
  - Saved hospital EDs **\$37m** in avoided costs/losses
- Reduced total psychiatric boarding by **45 years**

SOURCE: Crisis Now, "The Crisis Now Difference," fact sheet, 2020.

NOTE: FTE = full-time equivalent.

### Example of Policy in Action: 988 Hotline

A national mental health hotline (988) is set to launch in July 2022, after Congress passed legislation in May 2020 designating this number.<sup>118</sup> Passage of this legislation reflects concern over the rising suicide rate in the United States. The line would be similar to 911 but specifically for suicide prevention and will replace the current National Suicide Prevention Lifeline, a ten-digit number: 1-800-273-TALK. A modest amount of additional funding was also allocated to increase staff at crisis centers taking calls.<sup>119</sup>

The new 988 hotline offers an opportunity for states and communities to strengthen their capacity to appropriately respond to mental health crises. In the absence of planning and preparation, however, resources may be additionally burdened by an influx of phone calls that they are not equipped to handle. The introduction of 988 should be taken as a catalyst for communities to plan and implement an evidence-based response to assist individuals when they call the hotline.

Although trained hotline staff may be able to help many individuals without the need to deploy additional crisis interventions, some callers will need further support. In addition to training for individuals to manage the hotline, localities need to train response teams and facilities where appropriate care can be provided, which may include psychiatric facilities or EDs with specially equipped staff.<sup>120</sup>

Research shows that roughly one in ten individuals with whom the police come into contact have a mental illness.<sup>121</sup> One in five people shot by police in the United States has a mental illness.<sup>122</sup>

The most commonly used method for training police to interact effectively with individuals having a mental health crisis is **CIT** (see Recommendation 3), often in conjunction with mobile crisis teams. Studies have generally supported the conclusion that

CIT improves officer-related outcomes, such as self-perceived reduction in use of force and increased prebooking diversion from jails to psychiatric facilities.<sup>123</sup> There is less evidence indicating the effect of CIT on measures of arrest or officer or citizen injury. In addition, there have been calls for increased use of mental health providers in addition to or instead of officers in response to mental health crises. In a similar vein, training on clinical evaluation guidelines—such as the Emergency Care Psychiatric Clinical Framework<sup>124</sup>—has the potential to reduce the length of ED stays for psychiatric patients.

For individuals in crisis, “**step-down**” **psychiatric facilities** (also known as *crisis respite* care or *psychological emergency rooms*) can also ensure timely crisis care. These are facilities that provide short-term crisis care and observation (under 24 hours) outside the hospital setting, usually in a home-like environment.<sup>125</sup> Although some of these facilities are equipped to take patients actively in crisis from emergency medical services, others are smaller and may be less equipped to take certain types of patients, such as those who are actively violent.<sup>126</sup> Cities that have step-down facilities include Portland, Los Angeles, Providence, Louisville, and New York City. Evaluations of these facilities have concluded that they represent a viable alternative, cost-saving approach to managing individuals in crisis.<sup>127</sup>

### Example of Policy in Action: Crisis Now

The Crisis Now model includes a 24-hour mental health crisis hotline, mobile mental health teams, and step-down crisis facilities. Cities and counties across the United States have implemented this model, but only Arizona has implemented this statewide. In Phoenix, this has resulted in a \$260 million reduction in in-patient hospitalization costs and has reduced unnecessary time in the ED for individuals in psychiatric crisis (see Figure 3.1).



“Most people know what to do when I might be having a heart attack. And when that rescue squad responds to the 911 call, how they interface with me will be exactly the same whether I’m in Washington, D.C., or at a ranch in South Dakota. . . . But that isn’t true with mental health. How people respond to a mental health emergency is going to be completely different depending on where you are. . . . It’s very random, and it’s governed more by policy than by science.”

—Behavioral health policy and research director



## How It Would Work

An effort to implement a crisis-response system should start with state and local planning to prepare for launch of the 988 number in July 2022. Such planning should ensure that key elements of mental health crisis response are in place, including

- a hotline—staffed 24 hours a day, seven days a week—to manage calls from individuals in crisis
- a mobile crisis response team that includes first responders trained using a framework similar to CIT and integrated with community mental health professionals

- available regional step-down facilities or similar alternatives to boarding at EDs and a plan for continued care following acute crisis.<sup>128</sup>

A concerted effort by policymakers, health care providers and law enforcement is needed to accomplish the transformation needed to establish appropriate mental health crisis response systems throughout the United States. Funding at local, state, and federal levels should be prioritized to make this transformation successful and to evaluate quality improvement over time.

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## RECOMMENDATION 8

# Establish a National Strategy to Finance and Disseminate Early Interventions for Serious Mental Illness

### Summary

There is strong and accumulating evidence for the effectiveness and cost-effectiveness of programs that deliver coordinated clinical and supportive services during the early phase of schizophrenia and related disorders. These programs, as well as other emerging early interventions for other serious mental illnesses, fall outside the Medicaid-based public mental health system and require a national strategy to broaden access to these services.

### Problem Statement

In 2019, 5.2 percent of adults were estimated to have suffered from a serious mental illness—i.e., a mental illness associated with serious functional impairment—in the past year.<sup>129</sup> These illnesses typically begin in late adolescence or early adulthood, are often recurrent or persistent, and result in a high social burden of disability. Yet most Americans with serious mental illnesses are unable to access appropriate clinical and supportive services until years after onset. This is because programs that deliver coordinated services to those with serious mental illnesses are almost exclusively reimbursed through state Medicaid programs, most young adults do not qualify for Medicaid, and Medicaid was not designed to deliver early-intervention services. Although many young adults have private health insurance, commercial insurance is not designed to provide coordinated supportive services.

In light of this financing gap, the United States has lagged behind many developed nations in disseminating evidence-based early intervention programs. Community mental health block grant set-asides in 2014 and 2016, as well as the recent 21st Century Cures Act,<sup>130</sup> provided federal incentives that have resulted in the implementation of programs for first-episode psychosis

in most states, but there is still a large gap between need and program availability. To address this gap, federal policy should move beyond limited set-asides and start strategically planning for and fostering state-partnered programs that incorporate evidence-based early intervention programs into the continuum of publicly available mental health care services.

### Analysis

Specialized early intervention services for mental illnesses are not widely available, although there are compelling arguments for including effective early interventions into the continuum of essential public behavioral health services. Most serious mental illnesses begin in teen years and early adulthood; thus, they can have deleterious effects on developmental milestones, such as educational attainment, employment, and friend and family formation, resulting in lifelong disadvantages.

The social costs of experiencing a serious mental illness are startlingly high; in one study, costs of schizophrenia alone were estimated to be \$155 billion in 2013, and these costs do not take into account the personal suffering of affected individuals and their families.<sup>131</sup> Early diagnosis and intervention—if appropriate, comprehensive, and timely—can, in principle, minimize illness progression, impairment, and disability.<sup>132</sup>

The evidence is promising, but research is still very limited about the effectiveness of early intervention for several serious mental illnesses, including bipolar disorder, borderline personality disorder, and depression.<sup>133</sup> Evidence for the effectiveness of early intervention for first-episode psychosis, however, has rapidly accumulated, with studies in the United Kingdom, Denmark, and Norway first establishing the effectiveness of a comprehensive coordinated intervention for a wide range of patients.<sup>134</sup>



In the United States, the National Institute of Mental Health–funded Recovery After an Initial Schizophrenia Episode (RAISE) studies concluded that coordinated specialty care (CSC) should be the standard of care for new-onset psychosis after finding that a CSC intervention (including psychopharmacology, individual resilience therapy, family therapy or psychoeducation, and supportive employment or education), as compared with usual community care, resulted in improved quality of life, reduced symptoms, and improvement in work or school participation.<sup>135</sup> Questions remain about how long the CSC intervention should be sustained. Demonstration programs have been designed for two years of treatment, but for some individuals this might not be sufficient to retain gains without a transition to ongoing clinical and supportive services.

Implementation of such programs has been demonstrated feasible, and health care systems in the United Kingdom, Australia, and northern Europe have broadly integrated these kinds of programs into their mental health care systems.<sup>136</sup> In the United States, recent mental health block grant set-asides have provided an avenue for states to begin to implement CSC programs, but

in most states availability and accessibility are very limited, and states do not have public resources for broader dissemination. There are barriers to access through commercial health insurance plans because young adults are the most likely demographic to be uninsured and because the specialty-team expertise and infrastructure required to provide coordinated supportive services generally do not exist within commercial insurance networks.

Early interventions for serious mental illnesses that have onset during late teenage years and early adulthood are likely to provide a high social return on investment, saving money by increasing retention in school and in the labor force and reducing later-life caretaking, institutional, criminal justice, and medical costs. With the exception of recent research investment and block grant set-asides for early intervention for first-psychotic episodes, there has been little national attention to developing and evaluating early-intervention strategies for serious mental illness. With no obvious source of public or private financing of such services, the absence of attention is not surprising.<sup>137</sup>

## Example of Policy in Action: State Dissemination Initiatives

The Oregon state government has invested in disseminating evidence-based first-episode psychosis programs throughout the state. Oregon's Early Assessment and Support Alliance (EASA) was first established in 2001 and now includes 29 programs serving all counties. The EASA programs provide information and support to young adults experiencing early symptoms of psychosis and use multispecialty teams to deliver coordinated clinical, counseling, and supportive services for up to two years. The programs have access to training, technological assistance, and fidelity guidance from a center for excellence shared across Portland State University and Oregon Health and Science University. They ensure adherence to updated evidence-based guidelines by using written practice guidelines, training and supervision, and fidelity review processes.<sup>138</sup> Beginning in 2013, New York has also disseminated first-episode psychosis programs throughout the state under the banner "On Track NY."<sup>139</sup> New York's program is based on the RAISE study's CSC model and is a collaboration of the state with Columbia Psychiatry, New York State Psychiatric Institute, and the Research Foundation for Mental Hygiene.

Both states have created inviting and informational websites oriented toward teens and young adults to facilitate access to their programs.

## How It Would Work

A national strategy for early intervention with mental illness should initially focus on broadening dissemination of the most-current evidence-based CSC treatment for first-episode psychosis but also address the broader system gap in early intervention services for other serious mental illnesses that have high probability of onset in early adulthood.<sup>140</sup>

Block-grant funding has seeded implementation of programs in most states, but to make these programs accessible to most Americans, a national strategy should include the creation of financing mechanisms that will incentivize organizational providers to invest in their implementation and to deliver high-quality services. One well-considered proposal is a three-part payment method that would include a prospective case-based rate to incentivize engagement and retention, a fee-for-service component that compensates for costs of specific services delivered, and a third component that is based on attaining measurable and risk-adjusted outcomes.<sup>141</sup> Public-funding mechanisms could include a wraparound to other payment mechanisms or a stand-alone early intervention program and would ideally include partnership and commitments from both federal and state authorities.

“We’ve made real progress on understanding early interventions for psychosis and bipolar disorder, and yet our entire focus is on Medicaid. While that is fine, the real public health issue is getting people before they’re so sick they end up on Medicaid.”

—Mental health policy researcher

## RECOMMENDATION 9

# Expand Scholarships and Loan Repayment Programs to Stimulate Workforce Growth

### Summary

An essential part of the solution to mental health specialty-workforce shortages in underserved areas is the continuation and expansion of scholarship, fellowship, and loan forgiveness programs that attract a greater number of and a more diverse population of students to undertake specialty training and commit to practicing in high-need settings.

### Problem Statement

The United States is facing acute behavioral health provider shortages in rural areas. Nonmetropolitan counties have a lower supply per capita of behavioral health providers (psychiatrists, psychologists, and psychiatric nurse practitioners)

than metropolitan counties (see Figure 3.2).<sup>142</sup> What is more, although 27 percent of metropolitan counties lack a psychiatrist, 80 percent of noncore counties (the most rural) lack a psychiatrist (see Figure 3.3).

The availability of providers also varies wildly by region. Whereas only 3 percent of New England counties lack a behavioral health provider, 40 percent of counties in the west north central (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota) and the west south central regions (Arkansas, Louisiana, Texas, Oklahoma) do—a 13-fold difference. Overall, the New England area has the highest supply of behavioral health providers per capita, nearly 3.5 times that of the west south central region, which has the least supply per capita.<sup>143</sup>

Figure 3.2. Nonmetropolitan Counties Have a Lower Supply of Behavioral Health Providers

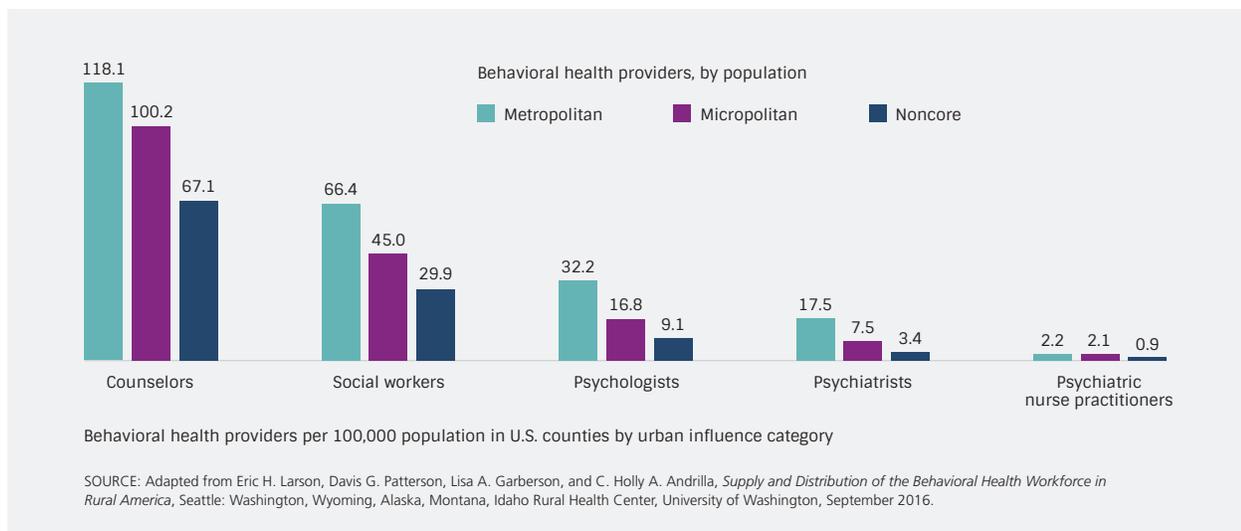
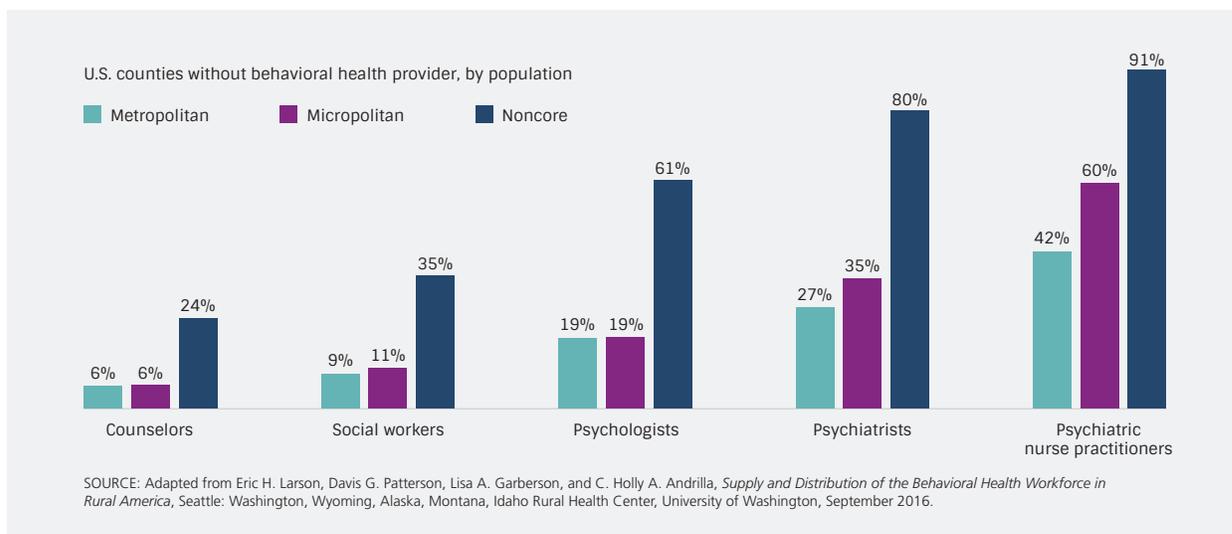


Figure 3.3. Eighty Percent of Noncore (Most Rural) Counties Lack a Psychiatrist



Furthermore, the U.S. behavioral health workforce does not reflect the growing racial/ethnic diversity of the population. In 2015, 88 percent of psychologists in the health services workforce were White (62 percent of the overall U.S. population is White), and 12 percent were from a racial/ethnic minority group (compared with 38 percent of the U.S. population). Older data reveal a similar story for psychiatrists, psychiatric nurse practitioners, and marriage and family therapists. Research shows that a diverse workforce is important for patient satisfaction and reaching underserved communities.<sup>144</sup> And a lack of cultural understanding can lead to under- or misdiagnosis of mental illnesses in minority populations, contributing to health disparities.

### Analysis

Increasing and redistributing the training pipeline is a key part of the solution to mental health workforce shortages in many communities and in public clinics throughout the nation. Scholarships, fellowships, grants supporting training at higher-education institutions, and loan-forgiveness programs are well-established policy mechanisms for incentivizing health care workforce expansion in underserved areas. The major national program to address shortages of health care providers in many parts of the United States is the National Health Service Corps, which provides scholarships and loan payback awards to primary health care providers who work for two years in designated high-need areas called Health Provider Shortage Areas.<sup>145</sup>

Mental health clinicians and substance use disorder treatment providers have recently been included in the types of primary care

providers eligible for the program, and during the past decade there has been a large growth in the participation of behavioral health providers in the program—currently more than 4,000 behavioral health providers are working in Health Provider Shortage Areas, including more than 1,400 in rural areas.<sup>146</sup> States also offer loan repayment and scholarship programs and direct incentives to attract health providers to high-need areas. A study of state programs in 2010 reported 727 mental health providers participating in 27 state programs.<sup>147</sup> Minority fellowship programs for psychiatrists, psychologists, and behavioral health clinicians aim to diversify the workforce, promote a treatment culture that is sensitive to and respectful of racial and cultural differences, and help eliminate minority health disparities.<sup>148</sup>

Although national programs do not strategically target particular kinds of providers to fill specific local workforce needs, state programs bring a local perspective on workforce needs and have adopted a variety of approaches to address shortages. Many states have programs that coordinate with or supplement national loan repayment and scholarship programs, which are considered by state officials to be one of their most effective tools to recruit providers to underserved areas.<sup>149</sup>

Some states are addressing extreme shortages of psychiatrists with programs to recruit and train psychiatric nurse practitioners to work in underserved areas,<sup>150</sup> others allowed clinical psychologists to prescribe psychotropic medications.<sup>151</sup> Another strategy used by some states are pipeline or pathway programs that aim to educate and recruit youth and college students residing in rural areas to undertake careers in behavioral health, based on the premise that they will be “place-committed” and return to a rural area to practice.<sup>152</sup> Although evidence for the effective-

ness of pathway strategies is weak, studies show that health care providers (medical doctors, nurse practitioners, and physician assistants) with rural backgrounds are more likely to practice in rural areas.<sup>153</sup> Some states also provide direct financial incentives to providers who choose to work in underserved areas, such as tax credits.<sup>154</sup>

Expansion of scholarship and loan forgiveness programs that are tied to commitments to work in underserved areas is a well-established policy strategy that can increase the numbers of providers working in those areas. But these programs alone are unlikely to address the long-standing maldistribution of the workforce. Retention of behavioral health specialists in high-need areas and in public-sector clinics is an ongoing challenge that loan repayment and scholarship programs do not address. Experts and stakeholders we interviewed emphasized that once training repayment commitments are satisfied, most providers leave for more-lucrative practices in urban areas. And available evidence shows that rural training experience among health care providers is a weak predictor of choosing to work in a rural area.<sup>155</sup>

Basic information needed to develop a more comprehensive, strategic approach to address workforce shortages at the community level is generally lacking. Most states lack information about their existing mental health specialty workforce and workforce needs and how those needs vary across communities. And little information is available about the effectiveness of various kinds of state initiatives, such as pathway programs or direct incentive programs.

Because so little is known about the effectiveness of pipeline programs that aim to attract and retain specialists in high-need areas, and because these programs take a long time to have an impact, states should consider complementary policy strategies to address workforce shortages, including regulatory flexibility that supports more-efficient deployment of mental

health specialists and allows providers to work at the top of their licenses. Improving availability and quality of peer-support services (see Recommendation 10) and expanding access to digital and telehealth services (see Recommendation 11) could be important components of a broader plan to address mental health workforce issues.

## How It Would Work

State and national programs should continue to incentivize the expansion and diversity of practicing mental health specialists and in particular incentivize an increase in the number of specialists who practice in geographic areas and settings with highest need through scholarship, fellowship, and loan-payback programs. Because of extreme workforce shortages in much of the nation, these programs should be expanded but ideally be coordinated and guided under a broader strategic planning process. Because states face very different mental health workforce challenges and needs, strategic planning at state and local levels is important.

A broader strategic planning process should include defining and establishing goals for the continuum of care (see Recommendation 13), so that workforce goals, policies, and programs are consistent with and support the broader plan.

Workforce data are essential for informing strategic planning; some experts have proposed a minimum behavioral health workforce data set.<sup>156</sup> Adoption and standardization of a minimum data set across states would inform both state and national behavioral workforce goals and programs. Strategic planning efforts would also benefit from greater investment in collecting follow-up information to learn about the impact of workforce programs and policies, such as pipeline, scholarship, and direct incentive programs. States could partner with academic institutions to develop and analyze workforce and program data.

“It’s our job to take education to people in underserved areas so they can be the providers those communities need. Provide quality education and train people where they are rather than have them come to places they can’t be.”

—Executive at a regional higher-education commission and rural health policy expert

## RECOMMENDATION 10

# Improve the Availability and Quality of Peer-Support Services

### Summary

Peer-support specialists—individuals with the lived experience of a mental illness who serve as paid members of a behavioral health treatment team—have a proven track record of being integral contributors to recovery-oriented care. Expanded access to training and credentialing and the ability to reimburse for peer support have the potential to improve access to high-quality mental health care.

### Problem Statement

There is increasing recognition of a recovery orientation in mental health treatment.<sup>157</sup> Recovery implies more than improved symptoms. It encompasses improved daily functioning and quality of life. Peer-support specialists can be integral members of treatment teams because they are role models for recovery and have a unique set of skills, training, and experiences (see Figure 3.4).<sup>158</sup>

One of the biggest problems facing the U.S. mental health care system is a shortage of providers, and this problem is likely to worsen as the current workforce—particularly psychologists and psychiatrists—ages. One hundred twenty-three million Americans live in designated Mental Health Professional Shortage Areas, and it would take nearly 6,000 providers to fill this gap.<sup>159</sup> Peer-support specialists have the potential to help solve this issue. However, there needs to be regulatory support to integrate peer-support specialists into the mental health workforce, as many states do not reimburse for these services.<sup>160</sup> There is also a shortage of opportunities for peer-support specialists to receive adequate training.<sup>161</sup>

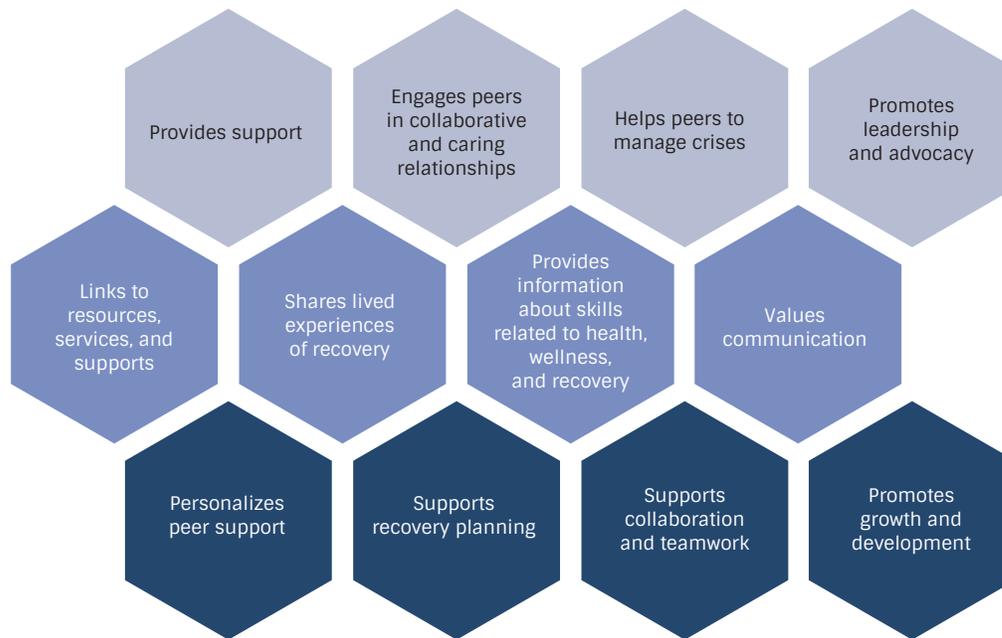
### Analysis

A peer-support specialist is someone who has a lived experience of recovering from a mental health condition. These specialists provide nonclinical, strengths-based support, such as self-help training, links to education and resources, and recovery-plan development with patients.<sup>162</sup> Care involving peer-support specialists has been associated with increased health-related quality of life,<sup>163</sup> confidence,<sup>164</sup> feelings of self-control,<sup>165</sup> hope,<sup>166</sup> empathy,<sup>167</sup> self-care,<sup>168</sup> and social support among patients.<sup>169</sup> Peer support has also been shown to raise scores on empowerment scales,<sup>170</sup> as well as decrease hospitalizations and episodes of substance use and psychosis.<sup>171</sup>

Peer-support specialists are also cost-effective. Research shows that care for patients enrolled in a peer-supported Medicaid-funded crisis support program costs, on average, \$2,138 less than Medicaid patients not receiving peer support. Similarly, Colorado found that, for every \$1 invested in a peer-support program, the health care system experienced a \$2.28 return on investment. Georgia reported that those who use peer services as part of behavioral health care generate an average savings of \$5,494 per patient per year.<sup>172</sup>

Despite the promise of peer support, this workforce has not been leveraged effectively in the mental health care system. Medicaid reimbursement for peer-support services has increased the number of peer-support programs that exist;<sup>173</sup> however, there remain 15 states where Medicaid does not reimburse for peer-support services.<sup>174</sup> Across all states, a shift to value-based payment (VBP) models, such as capitation, could incentivize providers to integrate peer-support services as a way of reducing emergent and inpatient care that can be much costlier than intervening earlier in community-based settings with peer-support services.<sup>175</sup>

Figure 3.4. SAMHSA Core Components of Peer Support



In states where Medicaid does reimburse for peer-support services, programs have cited difficulties with digital literacy and billing terminology as barriers.<sup>176</sup> Moreover, peer-support specialists require institutional support to function effectively as members of a team.<sup>177</sup> Readiness assessments for peer-support workforce integration can help prepare organizations for this process.<sup>178</sup>

**Example of Policy in Action:  
Peer Support in the VA**

Peers have the potential to improve access to mental health care services, especially when they are integrated into a health care system. The VA vet-to-vet peer support program provides an example of this. This program includes a training tool kit, classes, and a certification for veterans to provide care to other veterans.<sup>179</sup> Peers must be selected to participate in the program and are paid for their services as a peer. Once trained, peers provide care in a structured program in which peer facilitators are independent from the VA mental health system, but mental health professionals provide administrative and clinical supervision.<sup>180</sup> Research shows that veterans undergoing mental health treatment at the VA and in the vet-to-vet program are more empowered, more confident, better functioning, and less likely to use alcohol than veterans enrolled in the same mental health program without the peer component.<sup>181</sup>

**How It Would Work**

To improve availability and quality of peer-support services, all states should approve Medicaid reimbursement for peer support at a level commensurate with the value the programs contribute and prioritize training for integrating peer-support specialists. To achieve this, CMS could withhold funding from states that do not integrate peer-support specialists or offer incentives to states for incorporating these services into their reimbursement schedules.

Federal agencies, such as SAMHSA, could similarly offer grants to states to enhance standards for integration of peers into behavioral health services. These enhanced standards may include such metrics as readiness assessments.<sup>182</sup> Improvements to scores could be met with bonus payments to states. States should also include additions to their current training options to increase the rate at which peers are trained and certified. These trainings should meet the standards established by the U.S. Government Accountability Office in its report *Leading Practices for State Programs to Certify Peer Support Specialists*.<sup>183</sup> These standards consist of screening of applicants, conducting core training in person, incorporating physical health and well-being into training, training organizations to effectively use peers, continuing education, and engaging peers in leadership and development of peer-certification programs. Through these efforts, peer-support specialists should be ready to uphold the core competencies outlined for peer specialists by SAMHSA.

## RECOMMENDATION 11

# Expand Access to Digital and Telehealth Services for Mental Health

### Summary

Digital and telehealth services hold the promise of expanding access to mental health care throughout the United States, particularly in rural communities, where there are shortages of providers. States and federal agencies should codify the expansion of these services—stimulated by the COVID-19 pandemic—by ensuring that insurers cover these services, clinicians are adequately reimbursed, and consumers are familiar with these technologies.

### Problem Statement

Digital and telehealth services are care provided remotely, including video and audio consultations with providers, internet-based care provided through online platforms, and direct-to-consumer mobile apps.<sup>184</sup> This care also includes wearable technologies, such as smartwatches and biosensors for self- or provider-monitoring.

Prior to the COVID-19 pandemic, there were limited incentives for providers to offer telehealth and other remote forms of mental health care because of inadequate reimbursement. In fact, a survey of behavioral health provider organizations in 2018 found that fewer than half offered telehealth as an option.<sup>185</sup> CMS changed this landscape in response to the pandemic by expanding reimbursement for telehealth services,<sup>186</sup> alongside modifications to Health Insurance Portability and Accountability Act (HIPAA) regulations.<sup>187</sup> In parallel, governors mandated telehealth coverage by private insurers and established reimbursement parity for remote care.<sup>188</sup> However, most of these reim-

bursement policies are temporary,<sup>189</sup> and variation in provider regulations across states has continued to obstruct provision of clinical care across state lines.

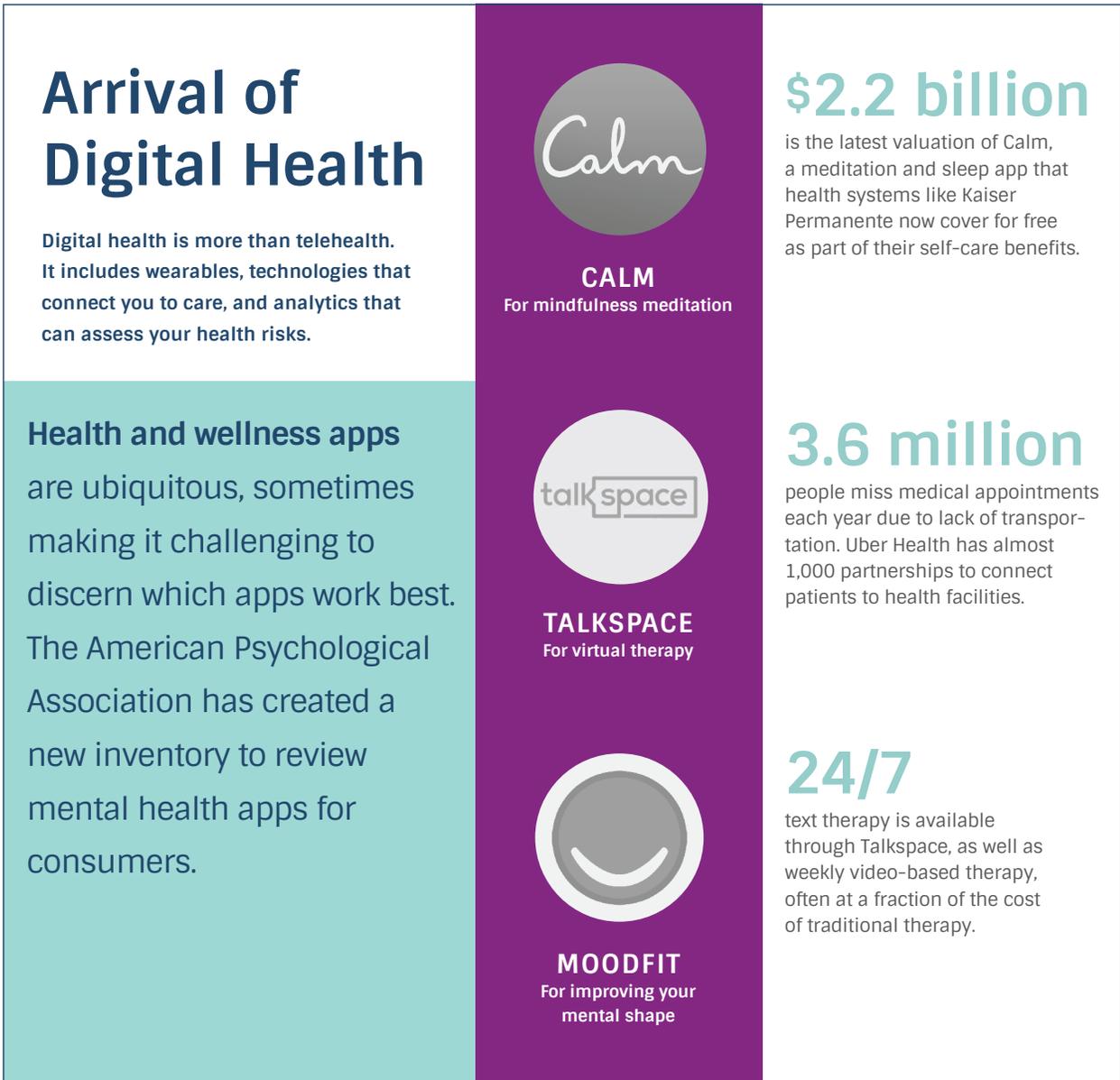
Another concern is that internet and cellular services, as well as smartphones and computers that depend on them, are not available to many individuals who need mental health care. For example, broadband coverage is weakest in rural communities that would gain the most from remote care.<sup>190</sup>

### Analysis

Digital technologies and telehealth in particular can expand access to mental health care and facilitate effective treatment of mental health conditions.<sup>191</sup> However, prior to the pandemic, telemental health services were generally reimbursed at a lower rate than in-person services or else not reimbursed at all. Even with emergency orders in place to allow remote care, reimbursement parity between in-person and remote care is still not universal across states.<sup>192</sup>

Although low digital literacy may be a barrier for some patients to use telehealth, remote care typically expands, rather than constricts, access.<sup>193</sup> Today, more than a third of working-age adults are digital natives who can readily use new digital platforms. Given the proliferation in digital health technologies over the past decade, digital literacy and familiarity with these technologies are essential for promoting mental health. Figure 3.5 highlights several innovations in digital mental health over the past decade.

Figure 3.5. Growth in the Digital Mental Health Industry



Experts interviewed for this work—including clinicians and health system administrators—reported a wide array of benefits generated by the transition to telemental health. Clinicians reported that fewer consumers have missed telehealth appointments, compared with in-person care, and clinicians can practice across state lines. For health system administrators, remote care potentially reduces overhead costs for physical space, while for patients it may mean reduced wait times and broad access to a national provider network. Existing state reciprocity policies provide a blueprint for wider expansion.<sup>194</sup>

### How It Would Work

To fully realize the advantages of digital mental health care, specific steps should be considered. First, audio-only and video-enabled telehealth visits should be treated as equivalent to in-person care with respect to reimbursement levels. This will incentivize providers to make this highly accessible form of care delivery mainstream over the long term. Likewise, permanently removing reimbursement requirements that telehealth services are video-based should ensure access for patients without smartphones or high-speed internet. In both instances, these transformational changes would require that states extend provisions currently in place during the COVID-19 pandemic.

Second, Congress has repeatedly called for greater investments in infrastructure, and any investments along these lines should account for digital infrastructure, which is sorely lacking in many rural communities throughout the United States. These investments should be accompanied with online training for patients and providers to help problem-solve barriers to uptake of telemental health services, ranging from limited in-home privacy to poor familiarity with interfaces, such as Zoom.

Third, differences in licensing standards across state lines must also be reconciled through reciprocity guidelines for telemental health. Although licensing boards may be resistant to national-level standards, realizing the opportunity of telehealth requires licensing that allows for providers to practice across state lines.

Lastly, with the proliferation of digital health options, consumers need a guide to those options—vetted by credible organizations, such as professional societies—so that consumers are aware of the technologies that are evidence-based and appropriate for meeting their needs.<sup>195</sup> Some professional organizations already have existing evaluation initiatives from which a centralized consumer guide that is authoritative and usable could be developed.

### Example of Policy in Action: VA Video Connect

The VA Video Connect program of the Veteran's Health Administration offers care across multiple modalities—including real-time videoconferencing at home and through mobile monitoring:

- The Virtual HelpDesk is available 24 hours a day, seven days a week. It is supported on Windows and Mac laptops and on Android and Apple smartphones and tablets.
- The program provided 2,700 group therapy sessions on VA Video Connect in March 2020, up by 200 percent from the month prior—before the COVID-19 pandemic entered the United States.
- The program provided 154,000 mental health care consultations by phone in March 2020, up from 40,000 appointments in February.<sup>196</sup>

Care is available for a range of therapeutic areas, including addiction services and general mental health.<sup>197</sup> One strategy that supports the success of the digital offerings has been identification of telehealth “champions,” providers experienced with telehealth options and familiar with the range of technology challenges, who serve as internal leaders for their colleagues, providing a specific go-to source for help and who provide formal and informal training for other providers to expand telehealth capabilities within the health system.<sup>198</sup>



## RECOMMENDATION 12

# Include Patient-Important Outcomes in Treatment Planning and Assessments of Care Quality

### Summary

Mental health care is organized, incentivized, and delivered around health system goals. The result for many is an inefficient mismatch between provider- and patient-based care goals. Including patient-important outcomes, such as social functioning and occupational goals, in care planning can enhance the patient-centeredness of mental health care.

### Problem Statement

Patient-centered care in mental health systems remains more an ideal than reality. Health care for people with serious mental illness is shaped by a history of mental illness stigma, discrimination, and coercive treatment. Providers may share common public stereotypes that people with serious mental illness are dangerous and lack decisionmaking skills, undermining patient self-efficacy and recovery efforts.<sup>199</sup> Because serious mental illnesses usually have onset in teen years or early adulthood and affect functioning, quality-of-life outcomes can be central to patient experience of mental illness, including social connections, educational progression, housing, safety, and employment.<sup>200</sup>

Mental health care systems are often not designed to address these important patient outcomes. Reimbursement incentives that favor clinical outcomes, such as reduction in symptoms, over patient-based goals, such as improved social functioning, contribute to the system-centered rather than patient-centered orientation in treatment planning. Ultimately, reimbursement policies and quality performance metrics need to be redesigned and aligned with outcomes of value to patients, as well as health care systems. Mental health providers do not routinely elicit patient preferences about treatment goals. Incentives are lacking for providers to learn and use tools for identifying patient goals.

### Analysis

The Institute of Medicine identified patient-centered care as one of six domains of health care quality, defining *patient-centered care* as “respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.”<sup>201</sup> Since then, patient-centered care has received more attention, although incorporating patient goals of care in treatment planning remains the exception rather than the rule. One reason is that existing quality measures focus on narrow clinical outcomes to the exclusion of functional outcomes, such as employment or academic performance.<sup>202</sup> A growing evidence base supports the link between relevance of treatment goals to patients and positive impacts on process and outcomes of care.<sup>203</sup>

Within public mental health systems, many elements of ACT are often incorporated into treatment of individuals with serious mental illness. The ACT model, developed in the 1970s, was paradigm-shifting, setting out a holistic and team-based approach toward community-based treatment that included help with problems of living. There is strong evidence of the advantages of this model over conventional clinically focused care. Recent adaptations of the ACT model have incorporated principles of patient-centered care, including a focus on recovery and shared decisionmaking.<sup>204</sup> Evidence-based rehabilitative and supportive interventions and tool kits have also been developed in recent years to address aspects of quality of life for individuals with serious mental illness, including supported education, supportive housing, family psychoeducation, illness management and recovery, and supported employment. But mental health provider organizations and broader community resources are seldom organized to deliver patient-centered care and provide access to the full range of rehabilitative and community supportive services that are needed.<sup>205</sup>



“I think it is time to walk the talk on patient-oriented care and orient the care towards the patient.”

—Former senior government official



Patient advocates, health providers, and health system administrators all point to patient-centeredness and cultural competence as critical orientations for improving behavioral health.<sup>206</sup> Many of the stakeholders interviewed for this work define a *patient-centered* orientation to care as one that includes identification of outcomes important to patients as part of the treatment planning process.

To incorporate patient-important outcomes in quality reporting, patient-experience measures require further development. Recent initiatives, such as those from the National Quality Forum, are building a basis for incorporating patient-centered outcomes in quality measurement.<sup>207</sup>

### How It Would Work

Patient-centered mental health care requires system transformation that incorporates three complementary strategies: (1) identify patient-centered outcomes as part of treatment planning, (2) incentivize patient-centered care through care-quality metrics, and (3) ensure access to community services and programs that address patient-important goals. Engaged patients and the advocacy community are important partners in initiatives to improve patient-important outcomes—both as target consumers and coparticipants in these efforts.

A national effort to develop definitions, assessments, treatment planning tools, and quality metrics for patient-centered behavioral health care is a key step. States, and their respective behavioral health and Medicaid authorities, must provide leadership to effect patient-centered transformation of public behavioral health systems. Some states have engaged in efforts to shift their public behavioral health systems in this direction. North Dakota, for example, undertook a comprehensive system assessment and strategic planning process for behavioral health. One strategic goal area is “person-centered, trauma informed, and culturally/linguistically competent approaches.”<sup>208</sup>

Federal policies that facilitate the alignment of Medicaid financing with patient-centered care are also essential, providing states with the flexibility and financing mechanisms to support system transformation. A federal initiative that attempts to align financing and quality behavioral health care may help pave the way. Federal statute (Section 223 of the Protecting Access to Medicare Act) established a demonstration program for CCBHCs.<sup>209</sup> Certified clinics were expected to meet specific criteria representing high-quality care, one of which is the requirement of ensuring that services are “person and family-centered, recovery-oriented care, being respectful of the individual consumer’s needs, preferences, and values, and ensuring both consumer involvement and self-direction of services received.”<sup>210</sup> Evaluation of this demonstration is still under way.

“

We continue to focus on narrowly oriented treatment and services towards symptom relief and do too little on functional improvement, which is reflected in school functioning, employment, et cetera. So the outcomes that patients care about get put in the second tier, instead of the first tier.”

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—Former senior government official

GOAL 3



## GOAL 3

# Establish an Evidence-Based Continuum of Care

63

Communities should be equipped to provide a well-coordinated and evidence-based continuum of mental health services to meet the needs of people with mental illnesses. Mental health services range from low-intensity services, such as community-based outpatient care, to high-intensity services, such as inpatient facilities, with intermediate levels in between—including partial hospitalization, residential facilities, and intensive outpatient services.

Individuals vary widely in their needs, with generally smaller numbers using more-intensive services. Moreover, individuals' needs vary over time. Although individuals with mild to moderate illness may require only intermittent community-based services, such as psychotherapy, individuals with serious mental illness may need crisis intervention services at some points and medically monitored facility-based services at other points. From a system perspective, the ability of patients to access the level of care they need, when they need it, depends on the existence of an evidence-based care continuum and the well-managed allocation of services.

Although different communities may provide access to a unique mix of specific services, the array of services should be adequate to cover anticipated needs. In the best-case scenario, these services should represent a broad-based continuum in which patients are provided with services that meet their needs in a timely manner.<sup>211</sup> Patient needs in this context should be defined holistically to encompass services that extend beyond crisis stabilization (see Figure 4.1).<sup>212</sup>



Figure 4.1. Level of Care in the Mental Health System



Establishing a broad-based continuum of care is a challenging feat. In some states, federal courts have stepped in to require that options other than high-intensity, hospital-based care be provided to individuals with serious mental illnesses.<sup>213</sup> In other settings, such as low-income communities, specialty care is altogether lacking.<sup>214</sup>

States have also struggled to ensure that the services provided at each level of care are high quality and evidence-based.<sup>215</sup> A focus on evidence-based care at each level of the continuum is essential because it helps communities with limited budgets strategically invest in services that maximize value for patients. In settings outside the United States, governments have undertaken considerable efforts to ensure that services are evidence-based. For

example, in the United Kingdom, the National Health Service has provided training on evidenced-based therapies to more than 10,000 providers, leading to a remarkable transformation in service delivery and patient outcomes.<sup>216</sup>

This chapter offers three recommendations for achieving a well-functioning, evidence-based care continuum. For the continuum to succeed, it is necessary to (1) guide individuals to a level of care that corresponds to their level of need, (2) promote effective channels of communication and coordination within the continuum, and (3) establish a payment structure that rewards evidence-based practices with the care continuum. Our recommendations tackle each of these in turn.

# Define and Institutionalize a Continuum of Care in States and Communities

## Summary

Individuals with mental health needs often fall through the cracks because of a lack of clarity regarding who should provide care, at what level of intensity, and in what settings over time. Standardized guidelines, such as the Level of Care Utilization System (LOCUS), provide a structure for resolving these questions and can help optimize mental health spending within communities. State Medicaid systems should consider mandating use of such guidelines.

## Problem Statement

Too often, individuals in need of mental health services end up in the ED or in problematic settings, such as homeless shelters or prisons, because the health system failed to provide care before a crisis. Other individuals, when they are discharged from a hospital or high-intensity care, fail to receive the level of support they need and wind up back where they started.

Frequently, this is because individuals do not have a treatment plan that adequately responds and adapts to their level of need.<sup>217</sup> In many states and health systems, there are high-intensity services, such as inpatient care, and low-intensity services, such as outpatient services, but medium-intensity services—including partial hospitalization programs, intensive outpatient care, and residential programs—are absent, underfunded, or poorly defined in terms of who qualifies.

In a growing number of states, standardized guidelines, such as the LOCUS<sup>218</sup> and American Society of Addiction Medicine (ASAM),<sup>219</sup> are being deployed to define services within a care continuum (see Figure 4.2). These guidelines provide a vali-

dated rubric for health systems to assess the level of care that matches patients' needs over time.<sup>220</sup> At the community level, these guidelines can help identify gaps and priorities for building out this continuum and inform decisions about how limited mental health dollars are allocated. However, many states have yet to apply these frameworks. In states that have, there have been variable levels of oversight.

## Analysis

The LOCUS, ASAM, and other guidelines offer an algorithm for health systems to assess appropriate settings and levels of care for individuals with behavioral health needs—evaluating risk of harm, functional status, comorbidities, environmental supports, treatment history, and engagement status.<sup>221</sup> These guidelines also provide an entry point for communities to identify sore spots where levels of care are lacking and require greater investment. Training on these tools is broadly available.<sup>222</sup>

Only about half of states have adopted such tools as the LOCUS or ASAM since their development in the 1990s. However, in the past several years, there has been renewed interest as a result of legislation, such as the MHPAEA and enforcement by court systems. For example, Mississippi—which historically has failed to apply the LOCUS or similar standards to guide care decisions—was recently ordered by a federal court to provide more-expansive community-based care.<sup>223</sup> A 2020 House Bill (HB 1184) put forth by Representative John Hines would compel Medicaid managed-care programs in Mississippi to implement utilization management practices that include the LOCUS and ASAM.<sup>224</sup>

Figure 4.2. Instruments for Defining Levels of Care



Recently, new technologies have offered promise to streamline utilization management processes associated with these tools. For instance, Change Healthcare has designed InterQual Auto Review™, which provides automated guidance on InterQual criteria.<sup>225</sup> Ultimately, the LOCUS and ASAM establish standards of care that correspond to individuals' level of need and help ensure there are no gaps in the care continuum. They also provide benchmarks for determining whether communities have the necessary components of a care continuum and help providers understand their responsibilities in terms of service delivery.

### How It Would Work

In states that have yet to outline a continuum of care using instruments such as the LOCUS or ASAM, state legislatures or governors should consider mandating their usage, following the pathway taken by other states.<sup>226</sup> In most instances, this would entail endowing authority to state Medicaid agencies to write contracts with Medicaid vendors that require the application of these tools as an assurance that an appropriate continuum of care is offered. This exercise may reveal a need for additional resources to bolster mental health systems—for example, in the event that medium-intensity services are absent in communities. In such situations, these standardized guidelines may be seen as a touchstone for identifying community needs and bringing stakeholders together to determine strategies for filling gaps in the care continuum.

As a second step, for all states that have already implemented such instruments, effective monitoring and incentives are necessary to ensure proper usage. Without these mechanisms, mental health systems risk backsliding. In Oregon, for example, use of the LOCUS received heightened scrutiny after a contractor received a special dispensation not to use the instrument.<sup>227</sup> Medicaid vendors may be incentivized, in part, by the prospect of rebidding on contracts—for example, if a vendor fails to perform adequately.

A third consideration extends to commercial insurers, who might not be obligated to implement such tools. Here, states could require that services within the care continuum be covered by commercial insurers. Autism insurance mandates, for instance, have been passed by all 50 state legislatures to compel coverage for applied behavioral analysis and similar services. Aetna has proactively designed its own Level of Care Assessment Tool (LOCAT<sup>SM</sup>) to establish levels and types of care deemed medically necessary.<sup>228</sup> Recent court cases, such as *Wit v. United Behavioral Health*, have also established precedent for court systems to compel commercial insurers to offer a continuum of care, as guided by the court ruling specifically drawing attention to the importance of the LOCUS and other tools (such as ASAM), as well as other criteria for determining appropriate care.<sup>229</sup>

“We need systems attuned to what people need. People are unique in their needs. Even if they are in congregate settings, it needs to be person-centered to do the assessments, with close coordination of care.”

—Former federal health policy official

## RECOMMENDATION 14

# Launch a National Care-Coordination Initiative

### Summary

Care coordination works, but few practices are doing it. A national, CMS-led initiative modeled after the Transforming Clinical Practices Initiative (TCPI)—delivering technical assistance, implementation tools, and a learning collaborative for implementers—would help transition practices to evidence-based models, such as CoCM and SBIRT.

### Problem Statement

Several models of care coordination improve patient outcomes while reducing health expenditures. As noted in Recommendation 2, this includes CoCM, in which primary care providers are paired with case managers and specialty mental health providers to deliver care for such conditions as depression. More than 80 randomized controlled trials<sup>230</sup> have shown that CoCM is effective<sup>231</sup> and yields a 13:1 return on investment.<sup>232</sup> CMS has even introduced billing codes for CoCM and SBIRT among Medicare beneficiaries.<sup>233</sup>

Yet implementation of models like CoCM has have been underwhelming and largely confined to academic medical centers. The new Medicare billing codes for CoCM have been underutilized,<sup>234</sup> and providers have expressed consternation about the level of practice transformation required to execute CoCM—including hurdles related to regulation, licensing, reimbursement, and logistics of workflow.<sup>235</sup> These shortcomings are not unique to CoCM. They apply to other care coordination models, ranging from SBIRT,<sup>236</sup> to Primary and Behavioral Health Care Integration,<sup>237</sup> to Improving Mood-Promoting Access to Collaborative Treatment (IMPACT).<sup>238</sup> In short, there remains a wide gap between evidence showing the impact of care coordination

on improved mental health and what is being done in primary care settings throughout the country.

### Analysis

When practices and providers are interviewed about challenges with implementing care coordination models, such as CoCM or SBIRT, several are mentioned, including the need to introduce new clinical and billing workflows,<sup>239</sup> generate practice leadership and buy-in, and overcome financial barriers,<sup>240</sup> such as capital investments and insufficient reimbursement. Some of these financial concerns are also borne out in modeling studies.<sup>241</sup>

None of these obstacles is insurmountable. The Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington has developed a standardized approach to support practices in implementing CoCM, which includes team-building and technical activities that garner buy-in and help address workflow challenges.<sup>242</sup> SAMHSA has also supported a Center of Excellence for Integrated Health Solutions, led by the National Council for Behavioral Health, which provides training, resources, and technical assistance.<sup>243</sup> Monitoring tools to support implementation, such as the Stages of Implementation Completion, have also shown early promise.<sup>244</sup>

What is missing is a national initiative that brings to scale the learnings and technical resources of the AIMS Center, Center of Excellence for Integrated Health Solutions, and others. The TCPI is an instructive model: TCPI channeled \$685 million toward remodeling health care delivery in the United States, working with more than 140,000 providers to implement VBP models.<sup>245</sup>

By comparison, the Center of Excellence for Integrated Health Solutions has an annual budget of only \$2 million to support clinics.<sup>246</sup> This level of funding and support is a start, but it is not sufficient. Widescale adoption of care coordination models, such as CoCM and SBIRT, will require broadly available, hands-on technical assistance equivalent to that provided by consulting firms in the private sector.<sup>247</sup> This should be coupled with higher reimbursement rates by state Medicaid agencies and CMS that reflect the value of services to patients (see Recommendation 6). Without adequate reimbursement rates,<sup>248</sup> incentive for uptake will remain low.

### Example of Policy In Action: Transforming Clinical Practice Initiative

CMS's TCPI,<sup>249</sup> from 2015 to 2019, provided technical assistance to more than 140,000 clinicians and 22,000 clinics through 39 practice transformation networks and support and alignment networks to

- transition at least 75 percent of practices to alternative payment models
- provide education on the Quality Payment Program
- develop and report a standard set of performance measures.

Although CMS has yet to release a formal evaluation of the costs and benefits of TCPI at the practice level, a recent special report in *Annals of Family Medicine* outlines the impact that TCPI has had on health care delivery throughout the country—in particular, transitioning thousands of practices to VBP arrangements

to increase value of care.<sup>250</sup> In the wake of TCPI, clinicians have asked what new practice transformation efforts will emerge in subsequent years,<sup>251</sup> and a national care coordination initiative could fit that bill.

### How It Would Work

CMS should model the National Care Coordination Initiative after TCPI, establishing regional peer-based learning networks to provide technical assistance and mentorship for practices implementing care coordination and care integration models—particularly CoCM and SBIRT that are already endorsed by CMS. Participating practices should be provided with adequate compensation for their participation to defray capital costs and be rewarded with higher reimbursement rates to ensure that care coordination continues after conclusion of the initiative.

As an initial step, CMS should convene such institutions as the AIMS Center and the Center of Excellence for Integrated Health Systems that have supported early implementation of CoCM, SBIRT, and other evidence-based models—to learn what tools, resources, and forms of technical assistance are necessary to make the initiative a success. CMS should also ensure that the initiative extends over a period of five or more years, similar to TCPI, to ensure an appropriate ramp-up and transition period. Monitoring and evaluation of health improvements among patients, as well as return on investment among implementing practices, should provide fodder to compel private insurers to reimburse for these services.<sup>252</sup>



## RECOMMENDATION 15

# Form a Learning Collaborative for Medicaid Behavioral Health Financing

### Summary

Collaborations between Medicaid officials, advocates, and other policymakers within and between states can help ensure that emerging evidence on innovative financing and service delivery models drives improvement in behavioral health care systems for Americans with low-income or serious mental illness.

### Problem Statement

This is a period of unprecedented experimentation in Medicaid behavioral health care financing and service delivery. New models of financing, such as prospective and VBP systems, and restructuring of existing financing streams, such as carve-ins that integrate payment for behavioral and general health care, are being implemented in many states.

However, although state Medicaid systems are similar in some respects and face similar problems, each is an independent agency with its own priorities, populations, and resources. There are unlikely to be uniform solutions to the diverse policy challenges across U.S. states. Yet leaving states on their own to develop local solutions would miss an opportunity to learn from the wide range of innovative models being tested around the country. Support is needed to build infrastructure within and between states to guide evaluations, learn from policy experiments, and improve system design over time.

### Analysis

As noted elsewhere in this report, Medicaid's role in paying for behavioral health care is large and growing, giving the program influence over significant portions of the behavioral health care

system, particularly with respect to treatment for people with serious mental illness. More than 9 million adults on Medicaid had a mental illness in 2015, and nearly 2 million of these had both a mental illness and a substance use disorder.<sup>253</sup>

The growth of Medicaid as a payer for behavioral health puts Medicaid policymakers at the state and federal levels in strong positions to unify a historically fragmented health system.<sup>254</sup> In addition, the ACA helped create a regulatory environment that encourages innovation and experimentation with respect to financing structures for health care.<sup>255</sup> CMS promotes state-level experimentation with financing structures that aim to improve care quality by moving away from *paying for volume* through fee-for-service systems to *paying for value* through a variety of alternative payment models. These financial reforms seem ideal mechanisms for addressing long-standing structural problems in behavioral health care, including overreliance on psychopharmacology and inpatient care, by enabling delivery of comprehensive evidence-based models that coordinate clinical, rehabilitative, and social services.

There is a lot to learn about how Medicaid payment policies can contribute to construction and sustainability of high-quality systems of behavioral health care. One issue is whether Medicaid contracting for behavioral health services should be conducted separately from contracting for general health care, known as a carve-out. Since the 1990s, Medicaid, along with other insurers, has often used carve-outs, believing that patients with behavioral health conditions would not be well served without a separate system of specialty care.<sup>256</sup> In recent years, there has been a trend in the opposite direction, with states electing to *carve in* behavioral health services that had previously been carved out.<sup>257</sup> This new direction in Medicaid policy is motivated by an interest in simplifying the administrative structures of care



“Providers are trapped because of the way we are funded. If we are to pivot, we have to have a bridge to make that transformation.”

—Executive at a mental health policy advocacy foundation

to facilitate care integration, particularly for patients who need both behavioral and general medical care. Evidence of the impact of carve-ins in the Medicaid context will begin to emerge only in the coming years.

An equally important area of innovation where empirical data are needed to guide Medicaid policy is in the design of VBP models that cover behavioral health care. VBP models aim to promote quality care and cost reduction by aligning financial incentives.<sup>258</sup> Rather than reward volume of services as under a fee-for-service system, VBP models aim to reward quality of care or care outcomes across a covered population. Although there is broad consensus on the ultimate goals, there are countless empirical questions related to the design of these new systems, which will need to be based on behavioral health-specific metrics.

Many mental health clinics providing care to the Medicaid population are “mom and pop” organizations that lack technology and infrastructure needed to participate in VBP financing models. To date, introduction of VBP in behavioral health has lagged other areas of medicine, and VBP systems that aim to be comprehensive, such as accountable care organizations, have been slow to include behavioral health in their scope of practice, with mixed evidence on impacts.<sup>259</sup>

Although these are broad issues that are shared by systems across the country, local issues also vary state to state. Because of this, it is important to engage state policymakers, who are familiar with

their own states’ systems, in the process at all levels—designing and implementing demonstrations and disseminating information among stakeholders.

## How It Would Work

As noted, Medicaid policies are made by administrators and legislators at the state and federal levels. Within states, Medicaid offices are often internally divided between behavioral health and general health administrators, whose collaboration is required for advancing behavioral health policy. At the federal level, policies are made within CMS and other agencies in the U.S. Department of Health and Human Services. The goal of a learning community would be to forge links among behavioral health policymakers in these different settings who would otherwise work in the relative isolation of their own state government or federal government office.

A collaborative could be privately or publicly supported, but it is important that it operate at a national level with all state Medicaid offices able to participate. The network would compile information on state strategies that are being implemented and provide a nationwide community of experts to inform demonstrations and their evaluation and to help states improve data infrastructure to support new financing and service delivery models.

“  
States need to come together  
to understand what’s going on  
in other states to learn from  
each other.”

—Former federal health policy official



CONCLUSION





# Conclusion

We stand at a crossroads on the path to reforming mental health care in the United States. If we proceed down the current path, the United States will continue to observe incremental progress: piloting new care delivery models and pressing forward with payment reform, promoting evidence-based treatments and pairing these with quality-assurance mechanisms, and supporting initiatives to expand the behavioral health workforce.

Alternatively, leaders in government and the private sector could chart a new course: one that that would catalyze rapid transformation that improves the lives of tens of millions of Americans and reflects goals endorsed across the political spectrum. The 15 recommendations in this report offer concrete steps on this path to transformation. These recommendations are rooted in evidence, and they are patient-centered—mapping directly to the patient journey traversed by those affected by mental illness (see Figure 5.1).

Figure 5.1. How to Transform Mental Health in the United States

# Transforming mental health means structural reforms that speak to patients' challenges in terms of finding, accessing, and receiving high-quality, appropriate, and timely care.

CONCLUSION

## Promote pathways to care

We need to ensure that people come into contact with care, and their needs are identified through screening and diagnosis by appropriately trained professionals.

-  Promote systematic mental health education
-  Integrate behavioral health expertise into general health care settings
-  Link homeless individuals with mental illness to supportive housing
-  Develop a mental health diversion strategy centered on community behavioral health

## Improve access to care

Making sure that people have access to care means more than overcoming geographic barriers. It means ensuring that care is affordable, available, accessible, and appropriate.

-  Strengthen mental health parity regulation and enforcement
-  Expand scholarships and behavioral health stimulate workforce growth
-  Reimburse evidence-based behavioral health treatments at their true cost
-  Improve the availability and quality of peer-support services
-  Establish an evidence-based mental health crisis response system
-  Expand access to digital and telehealth services for mental health
-  Establish a national strategy to disseminate early interventions for serious mental illness
-  Include patient-important outcomes in treatment planning and assessments of care quality

-  Define and institutionalize a continuum of care in states and communities
-  Launch a national care-coordination initiative
-  Form a learning collaborative for Medicaid behavioral health financing

## Establish an evidence-based continuum of care

Once patients are in care, it is the responsibility of the health system to make sure that patients are receiving care that meets their level of need and that all providers are on the same page.



For people to get the mental health care they need, communities should be sensitized to the importance of mental health, ideally beginning in school systems where children and adolescents can be provided with consistent information about the importance of mental health (see Recommendation 1). To identify population-level mental health needs, screening and treatment models linked to primary care should be broadly implemented in public and private sectors (see Recommendation 2). For those with serious mental illness, needs pertaining to social determinants of health should be addressed—including connections to housing for the homeless (see Recommendation 3) and diversion strategies for those who are incarcerated or end up in EDs with no other recourse for medical care (see Recommendation 4).

Once patients seek care, the process of accessing services should be straightforward. This implies that the right services are available when patients come through the door, which is not a guarantee. Enforcement of mental health parity and provision of financial incentives should guide health systems to make mental health services available (see Recommendations 5–6), while evidence-based models of care should help inform what the right services are (see Recommendations 7–8). However, both strategies are dependent on health systems having access to a robust and well-educated mental health workforce (see Recommendations 9–10). Bringing services closer to patients

through telehealth should ensure that care is accessible (see Recommendation 11), while prioritizing those outcomes that are important to patients can help guarantee that care is appropriate (see Recommendation 12).

The care journey itself can be unnecessarily convoluted and bureaucratic for patients. To streamline this process, communities should consider using established guidelines to define a continuum of care that is appropriate for meeting individuals' level of need, which may change over time (see Recommendation 13). For patients with both physical and mental health conditions, or who have diverse mental health needs, coordinated care among different providers is essential. There is strong evidence demonstrating what works, but a national effort is necessary to push out care coordination models at scale (see Recommendation 14). Lastly, providers are primarily incentivized to provide quantity rather than quality of mental health services. However, a growing movement—led by CMS—has sought to rectify this (see Recommendation 15).

Our web tool offers additional strategies to meet the needs of specific communities and provides a sortable and interactive way to learn more.<sup>260</sup> However, the 15 recommendations outlined in this report encompass the fundamental building blocks that policymakers should consider to bring about transformative change in the U.S. mental health system.



# Appendix A: Methods

## Environmental Scan

To find and review relevant peer-reviewed and nonacademic literature, RAND began with a top-down approach based on a concept map representing a model for thinking about how to improve mental health care in the United States. Specifically, the top-down approach involved the following steps:

- **Development of a concept map.** RAND experts used their preexisting knowledge to develop the initial model. An independent advisory panel provided input later on. In the model, RAND included mechanisms for improving health care and associated programs and policies. RAND then queried the literature (see below) related to each mechanism of improvement to review relevant evidence. The literature was inspected from three vantage points: scope and scale of implementation to date, strength of empirical evidence, and relevant case studies that might serve as models for adoption. RAND also revised the concept map based on its review of the literature.
- **Academic literature.** In a focused effort to examine the peer-reviewed evidence base, we applied Boolean search criteria to PubMed, a comprehensive inventory of the academic health literature. We prioritized systematic reviews and highly cited publications within the previous ten years.
- **Non-academic literature.** Advanced Google Search and Google Scholar were queried using a prespecified set of Boolean search criteria—based on the programs, policies, and mechanisms delineated in the concept mapping exercise. We then cataloged salient reports published in the past ten years, as well as earlier, seminal reports that have laid a foundation for continued work today.

RAND supplemented the environmental scan with a bottom-up approach, soliciting inputs from sources, including the following:

- **An advisory panel.** A panel of experts within the mental health landscape—including policymakers, health system administrators, patient advocates, researchers, and clinicians—provided feedback on the concept map, including additional mechanisms for investigation in the literature and specific policies and programs that could be included as stand-out illustrations (see further discussion below).

- **Academic literature.** Using the inputs from key informants, we further queried the academic research literature to examine the body of evidence corresponding to programs, policies, and mechanisms that key informants identified.
- **Nonacademic literature.** Members of the project team at RAND reviewed policy reports, perspective pieces, white papers, and court rulings as listed on key government, policy, and advocacy websites to identify recent trends in mental health care delivery, as well as novel programs and policies. These searches were informed by the topical areas, programs, policies, and mechanisms noted by the advisory panel.

## Stakeholder Interviews

To supplement the findings from the environmental scan, RAND also collected information from knowledgeable stakeholders to help guide the conceptualization of the challenges with improving mental health care in the United States and to help identify promising policy recommendations.

Between June and September 2020, RAND conducted 15 interviews with a total of 16 individuals (two staff members working within the same congressional office joined a single interview). Interviewees were recruited from a list generated by the project team, identifying individuals who could represent mental health care consumers and payers, care providers, researchers, and policymakers at the federal level and at the state level, with some policymakers reflecting executive branch experience and some reflecting legislative branch experience. Stakeholders representing both Republicans and Democrats were included.

Two RAND team members conducted each interview, with one primary interviewer and one primary notetaker. A semi-structured interview guide addressed the following five main topic areas: a global view of structural problems with mental health care in the United States, access to care, workforce, whole-person and person-centered care, and financing. For each topic area, interviewees were asked to identify challenges, areas for improvement, potential solutions, examples of programs, and the pandemic's impact. All interviews were conducted remotely via audio and video conference. Interviews were recorded to aid with summarizing results. The RAND team created summary

notes from each interview as an initial step toward identifying key themes and findings, and notes were then entered into a single spreadsheet for comparison of themes across stakeholder types. Input from interviews was referenced in drafting of the final set of recommendations.

## Project Advisory Panel

RAND created an advisory panel with members selected from the following communities: mental health consumers, family members, mental health advocates, researchers, clinicians, health system representatives, policymakers, and payers. A list of potential invitees was initially generated by the project team, and recruitment proceeded with attention to the balance of stakeholder types participating. We sought input from knowledgeable researchers and policymakers with specific mental health expertise, and we sought to include input from leadership of such clinician groups as the American Psychiatric Association and the National Association of Social Workers, as well as from leadership of consumer advocacy organizations and major health systems. Target size of the group was set at ten or fewer to obtain diverse perspectives while permitting active group engagement. A total of 11 panelists participated. A list of members is provided in Appendix B.

RAND convened advisory panel members at two time points: once in spring 2020, prior to interview data collection, and again in late summer, following completion of the concept map and at the conclusion of interview data collection. The meetings were conducted remotely using phone and videoconferencing. Panelists consented to recording of the meetings for use by project staff in summarizing input. At both time points, the panelists met in two separate groups of four to six members, for two hours, enabling every panelist to provide substantial input during the meeting.

The first meeting addressed the following: project goals and methods, project deliverables and methods for generating environmental scan and concept map, content of concept map and review of mechanisms within it, and plans for data collection through interviews with other external stakeholders. The concept map was shared during the first meeting, with specific mechanisms of change identified within three main domains: (1) pathways to care, (2) care access and availability, and (3) continuum of care. Panelists were asked to review the exemplar programs identified by RAND for each element within the concept map, particularly those useful for informing policy recommendations that are the ultimate goal for this work; discuss the strength of

evidence; and offer additional examples. They were also asked to consider and discuss potential policies and programs that would be innovative and transformative.

Input from the set of panel meetings was used to refine the concept map and to expand the environmental scan on cross-cutting themes of equity and patient-centered care. In general, panelists endorsed use of the concept map as a helpful way to organize the major issues with the mental health care system in the United States.

Prior to the second meeting, panelists were asked to review a rating sheet with 24 discrete mechanisms of change proposed for the mental health care system in the United States, organized across the three main concept map areas of pathways to care, care access and availability, and continuum of care. Panelists were invited to identify the top eight of the 24 mechanisms and to rate those mechanisms as low, moderate, or high across five dimensions:

- 1. Evidence-based.** There is strong evidence, such as randomized controlled trials and quasi-experimental evidence, to support the effectiveness and cost-effectiveness of implementation.
- 2. Actionable.** Policymakers could implement the mechanism quickly and relatively easily, with few practical obstacles.
- 3. Transformative.** Once effectively implemented, the mechanism would lead to transformative change in mental health care. There is potential to make a big difference.
- 4. Politically feasible.** Policymakers on both sides of the aisle could agree to this, or else there is a window of opportunity to push this forward right now.
- 5. Novel.** This is something that is new and exciting or has not been widely known and implemented.

The discussion at the second panel meeting centered on the concept model mechanisms and the panelist ratings. Panelists were asked to identify any additional programs that provided good examples of mechanisms within the concept map. As part of the discussion, panelists were also encouraged to identify potential policies and programs that would be innovative and transformative for the mental health care system in the United States. Panelist input through the ratings, along with discussions at the panel meetings, were considered as the final set of recommendations were developed.

## Appendix B: Advisory Panel Members

Kirsten Beronio, J.D., Director of Policy and Regulatory Affairs, National Association for Behavioral Healthcare

Teri Brister, Ph.D., L.P.C., National Director, Research and Quality Assurance, National Alliance on Mental Illness

Diana Clarke, Ph.D., Deputy Director of Research, American Psychiatric Association

Tim Ferris, M.D., Chief Executive Officer of Mass General Physicians Organization; Professor of Medicine, Harvard Medical School

Susan Foonsness, M.S.W., M.P.P., Senior Business Operations Advisor, Behavioral Health, BlueCross BlueShield of North Carolina

Mary Giliberti, J.D., Executive Vice President of Policy, Mental Health America

Howard Goldman, M.D., Ph.D., Professor of Psychiatry, University of Maryland School of Medicine

Jennifer F. Kelly, Ph.D., A.B.P.P., President-Elect, American Psychological Association

Anna Mangum, M.S.W., M.P.H., Deputy Director, Programs, National Association of Social Workers

Joe Parks, M.D., Medical Director, National Council for Behavioral Health; Distinguished Research Professor of Science, University of Missouri, St. Louis

Steven Sharfstein, M.D., M.P.A., Former President and CEO, Sheppard Pratt Health System



## About This Report

This project aims to describe the landscape of mental health in the United States and identify opportunities for system transformation. It identifies key problems, provides analysis of the available research evidence, and recommends solutions that many different kinds of decisionmakers can implement.

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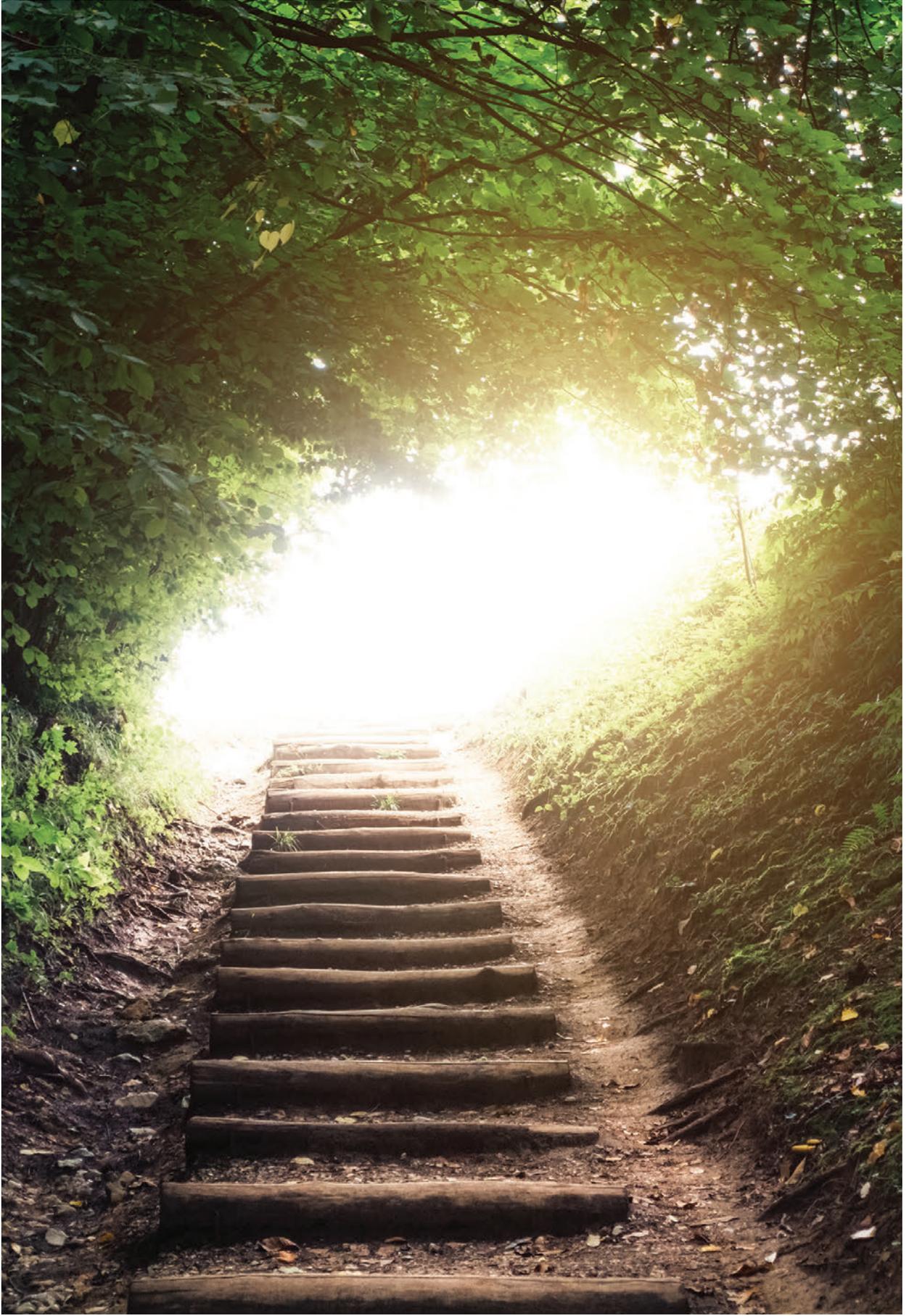
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