# 7 | The Mental Health Care and Substance Use Treatment System

## Where We Are, Where We Need To Be

## | Overview

**Like the broader health care system in the United States**, mental health services and funding are decentralized. Treatment plans usually entail a mix of medications, providers, therapy approaches, and social services. Factors such as provider type, care setting, payer, and government regulations can all influence a patient's experience in seeking, receiving, and affording care.

**The median delay** between the onset of mental health symptoms and a person's first contact with a health care provider for treatment is **11 YEARS**.

Despite similarities and interconnections with the U.S. physical health care system, the mental health care system and its substance use treatment system can seem more siloed, impenetrable, cost-prohibitive, or culturally taboo.

As a result, each year millions of Americans with mental illness do not get any treatment. Indeed, the median delay between the onset of mental health symptoms and a person's first contact with a health care provider for treatment is 11 years. Barriers to getting mental health care in the U.S. include unaffordable cost, even with insurance coverage; trouble understanding where to go for help; stigma; inconvenience; and logistical burdens like lack of time or transportation.

An enlightened and transformed U.S. mental health care system would offer people with a diversity of conditions and severities not only access to mental health care and substance use treatment, but also sustained opportunities to recover and thrive. Legislative initiatives, program development, financial investment, and treatment innovations all hold promise for improving mental health care, with many valid perspectives on specific changes.

This primer surveys the mental health care system as it exists today, including critical shortcomings, and introduces opportunities for policy change. The facts and concepts are paired with traits—or hallmarks—that characterize excellence for a future, transformed version of the system.

**The hallmarks, defined by a diverse set of leaders convened throughout 2022 by the Alliance for Health Policy, include:**

1. Magnitude and Parity—A magnitude of improvement that is far-reaching, on par with the expansive needs of Americans
2. Access—Accessibility for patients
3. Coordinating and Integrating Care—Coordination and integration among physical health care, human services, and other systems
4. Developing a Sustainable Mental Health Care Workforce
5. Building Equity, Inclusivity, and Cultural Relevance for All—especially for historically underserved groups
6. Innovative in Delivering and Paying for Care
7. Measured for Quality

**More about the Hallmarks** and the experts and process convened by the Alliance is available at Mental Health in America.

# Contents

# BACKGROUND: THE SYSTEM TODAY

## Consumers of Mental Health Services

In 2020, at least 57 million youth and adults in communities across the United States received mental health services or substance use treatment. Separate estimates show an additional 43,700 people sought mental health care in residential treatment settings, while more than 475,000 people with a history of mental illness who reside in jails and prisons report receiving some treatment while serving time. Another 59,000 active-duty military personnel report receiving monthly mental health care through the U.S. military health system. The total mental health care system spans specialty and general medical providers, inpatient and outpatient settings, virtual care, prescription medication, school counseling, juvenile justice programs, child welfare services, and more.

However, mental health conditions are more wide-spread than treatment. Among adults with any mental illness, nearly 31 percent—16.1 million people—judged they needed treatment or counseling at least once in the past year, but did not receive it. Seven million of those patients had serious mental illness (disorders that are more severe), and 2.6 million of them received no mental health care all year. Studies estimate that between 50 to 80 percent of children who need mental health services receive none. This "treatment gap" affects Americans of all ages, races, genders, sexual orientations, geographies, and disability sta-tuses, with some of the greatest disparities between need and access falling on people with low incomes, in rural areas, racial minorities, and LGBTQ people.

## Providers

Although some patients get mental health treatment from primary care providers like family physicians and internists, mental health is the focus for several other types of providers. Core services are diagnosis, counseling or talk therapy, and prescribing medica-tions, with various occupations trained and licensed to deliver some or all categories of care.

**Prescribers:**
• Psychiatrists
• Advanced-practice psychiatric nurses
• Psychiatric physician assistants
• Psychiatric pharmacists can prescribe in some states

Prescribers have the most-advanced degrees in the mental health care workforce. Psychiatrists have medical degrees, and psychiatric pharmacists hold doctoral degrees in pharmacy. Physician assistants and advanced-practice nurses have master's or doctoral degrees. All prescriber roles are state-licensed. Psychiatrists, advanced-practice nurses, and psychiatric physician assistants can diagnose and counsel in addition to prescribing.

**Non-prescribers practicing independently:**
• Clinical psychologists
• Clinical social workers
• Marriage and family therapists
• Professional mental health counselors
• Substance abuse counselors

These practitioners counsel clients independently and most can diagnose and treat mental illness. Substance abuse counselors can diagnose only in some states. All roles are state licensed, and education requirements vary. Clinical psychologists have doctoral degrees. Clinical social workers, marriage and family therapists, and professional mental health counselors usually have master's degrees.

**Professional roles that do not typically practice independently:**
• Psychiatric aides and technicians
• Peer support specialists
• Paraprofessionals like case managers, outreach specialists, community health workers, or parent aides
• Recovery coaches
• Psychiatric rehabilitation specialists

Training, certification, and licensure vary across states and roles in this category. These positions often serve crucial outreach, navigation, and coordination roles.

## Facilities

In addition to delivering mental health and substance use treatment services in primary care and specialist private practices, providers also work in and with dedicated mental health care facilities.

**Those include:**
• Public and private psychiatric hospitals
• General hospitals with separate psychiatric units
• U.S. Department of Veterans Affairs medical centers
• Residential treatment centers for children and adults
• Community mental health centers, including county clinics
• Outpatient, day treatment, or partial hospitalization mental health facilities
• Multi-setting (non-hospital) mental health facilities

## Funding Treatment and Services

In 2015, the most recent year with comprehensive data available, all spending on mental health care and substance use treatment in the United States totaled $212 billion.
• Mental health service spending—$156 billion
• Substance use treatment spending—$56 billion

PUBLIC FUNDING

Public spending—divided among federal, state, and local governments—was the largest source of funding for services and treatment.

Medicaid and Medicare are mandatory spending programs, required to fund benefits for every person who qualifies. Medicaid is jointly administered by states and the federal government; Medicare is a federal program.

Other state and local spending includes state psychiatric hospitals, county clinics, and other programs.

Other federal spending includes treatment provided by the Department of Veterans Affairs, Department of Defense, and the Indian Health Service, among others. This spending also includes block grants administered by the Substance Abuse and Mental Health Services Administration (SAMHSA)—a branch of the U.S. Department of Health and Human Services (HHS) tasked with advancing behavioral health.

The Community Mental Health Services Block Grants and Substance Abuse Prevention and Treatment Block Grants are non-competitive grants to states, with substantial flexibility in how states spend the dollars on prevention, treatment, recovery support, and other services. These sources are reauthorized at legislated intervals, with spending levels negotiated in the appropriation process.

PRIVATE FUNDING

Private spending—divided among private insurance, out-of-pocket spending, and other private sources—comprised somewhat under half of funding for services and treatment in 2015.

Private insurance includes employer-sponsored health coverage and individual health plans. Out-of-pocket spending includes deductibles, copayments, and payment for services not covered by insurance. Private philanthropy is one example of other private sources.

## Table 7.1 Public and Private Funding Breakdown

| PUBLIC FUNDING | Mental Health Services | Substance Use Treatment |
|---|---|---|
| Medicaid | $38 billion | $14 billion |
| Medicare | $25 billion | $1.7 billion |
| Other state and local spending | $18 billion | $10 billion |
| Other federal spending | $9 billion | $6.2 billion |
| **Total Public Spending** | **$90 billion** | **$31.9 billion** |
| **Percent of all Spending** | **58 percent** | **57 percent** |

| PRIVATE FUNDING | Mental Health Services | Substance Use Treatment |
|---|---|---|
| Private insurance | $43 billion | $16 billion |
| Out-of-pocket | $17 billion | $5.5 billion |
| Other private sources | $6 billion | $2.5 billion |
| **Total Private Spending** | **$66 billion** | **$24 billion** |
| **Percent of all Spending** | **42 percent** | **43 percent** |

# ANALYSIS: IDENTIFYING GAPS, ENVISIONING A FUTURE AROUND HALLMARKS OF EXCELLENCE

## Magnitude and Parity

Currently, mental health care and substance use treatment services are somewhat detached from physical health care. In addition, the complexity of the field and the social stigma of mental illness can make the search for care a daunting, isolating experience. These difficulties are ironic considering the tremendous natural overlap and interaction between mental wellbeing and physical health, personal relationships, educational attainment, work experiences, and more.

Mental health and substance use conditions were the top cause of disability in the United States in 2015. People with severe mental illness die 10 to 20 years earlier than the general population. Very common, unavoidable stressors such as financial problems, or the death of a loved one can aggravate a mental illness, and mental health or substance use conditions can cause problems with work, school, and relationships. One's quality of life is inextricably linked to good mental health.

Unaddressed mental health problems can have devastating consequences for individuals and society. This gap in care creates enormous social and economic costs. As such, efforts to improve the system need to reach deeply and widely across sectors.

These are just some of the concrete elements of the system that diverge from standards in the physical health care system and require improvement:

### ATTITUDES ABOUT MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

Prejudice and discrimination, or stigma, attached to mental health and substance use disorders are widespread and interfere with people's successful treatment for those conditions. A 2018 national survey showed 65 percent of people believe alcoholism is caused by "bad character," 49 percent would not want a person with schizophrenia as a neighbor, and 40 percent would not want a person with depression to marry into their family.

Social stigma can cause patients to avoid treatment; believe they will not recover; lose opportunities for work, education or housing; and, as health care providers themselves are not immune to discriminatory thinking, receive poor physical or mental health treatment, for mental illness.

### COVERAGE LIMITS

Despite robust parity laws that protect mental health and substance use treatment benefits in many types of coverage, there are exceptions. Medicaid generally will not pay for care in "institutions for mental disease" (IMDs), facilities that provide diagnosis, treatment, or care to people with mental illnesses, including substance use disorders. Medicare will pay for no more than 190 days of in-patient care in psychiatric hospitals over the lifetime of a beneficiary. Some states have formed Medicaid 1115 waivers to permit payment for care in IMDs and closer coordination with community-based services. Federal legislation has been introduced, but not yet passed as of fall 2022, that would remove the 190-day limit in Medicare.

### ROUTINE, PREVENTIVE CARE

Although physical preventive care is common for healthy people, and providers are generally reimbursed for the services, interventions to prevent mental health or substance use problems from becoming disorders are generally not reimbursed. If a patient's concerns are "subclinical"—not having a mental health or substance use diagnosis—the provider typically cannot be paid by the insurer.

## KEY MENTAL HEALTH CARE AND SUBSTANCE USE TREATMENT LAWS

### 1973 AND 1975

*Section 504 of the Rehabilitation Act of 1973* followed by the *Individuals with Disabilities Education Act* guarantee free access to an appropriate public education for children with disabilities including some mental health conditions

### 1990

*Americans with Disabilities Act* is civil rights legislation that prohibits discrimination against people with disabilities, including mental illnesses

### 1993

*Family and Medical Leave Act* allows employees to take unpaid leave without losing their jobs when they cannot work due to their own or a family member's serious health condition—including mental illness—or substance use treatment

### 1996

*Mental Health Parity Act* eliminates annual or lifetime dollar limits on mental health benefits that are less favorable than the same type of limits imposed on medical or surgical benefits among large group health plans

### 2008

*Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act (MHPAEA)* requires group health plans and self-insured plans with more than 50 workers to cover behavioral health services on par with medical and surgical services

### 2008

*Medicare Improvements for Patients and Providers Act* began applying parity in out-of-pocket costs to Medicare coverage of outpatient mental health services

### 2010

*Patient Protection and Affordable Care Act (ACA)* extended MHPAEA to individual-market plans and certain small-group market plans, as well as Medicaid alternative benefit plans

### 2016

*21st Century Cures Act* created federal leadership roles and initiatives that focus on mental health and substance use treatment. The law created or codified the Assistant Secretary for Mental Health and Substance Use role, the Center for Behavioral Health Statistics and Quality, the Interdepartmental Serious Mental Illness Coordinating Committee, and the National Mental Health and Substance Use Policy Laboratory

### 2018

*Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act* required state Children's Health Insurance Programs (CHIP) which provide mental health and substance abuse treatment benefits to comply with MHPAEA parity requirements, and it expanded telehealth services in Medicare for such treatment.

More details on many of these laws and others are available on the SAMHSA website.

## Access

Removing the obstacles to finding and affording mental health services or substance use treatment is about more than convenience; it is vital for access to care.

The median 11-year delay in first accessing treatment after experiencing mental health symptoms partly reflects that about 50 percent of people with a mental health condition first developed it in childhood, when conditions are difficult to communicate or identify. Fear and stigma about getting treatment, complexity in the health care system, lack of affordability, and scarcity of suitable providers also keep people from accessing mental health care. Building a truly accessible system of mental health care and substance use treatment will simplify processes for patients, include roles for education and public safety sectors, invest in the mental health care workforce, and diversify sources of assistance for patients.

### SPECIALIZED PATHWAYS TO CARE

Calling a provider's office for an appointment is just one of the ways people initiate care. For example, education and policing are two systems that regularly identify mental health care or substance use treatment needs.

Law enforcement experts estimate that as many as 7 to 10 percent of police interactions involve persons with mental disorders. Without thoughtful diversion programs, police often see arrest as the only option for resolving public disturbances or risks of physical harm around mental health crises. The result is that people with severe mental illness are jailed at a rate four to six times greater than the general population, with about 2 million people with serious mental illness put in local jails each year.

A "co-response" approach—teams of law enforcement and mental health professionals who work together to respond to crisis calls—is an alternative that operates on some scale in 46 states. The goal of the model is to refer people with mental illness to treatment rather than jail. Outcome data is mixed and difficult to collect due to the fragmentation across and within health and criminal justice systems, but feedback on programs implementing the model is promising.

Other alternatives include the Crisis Intervention Team model, a police-based response that relies on officers with specialized training in de-escalating mental health crises, and the Mobile Crisis Team model, in which medics, crisis counselors, and peer-support workers provide stabilization and referral resources, generally without participation from police.

Elementary and secondary schools are also major pathways to mental health care. At most, only half of children with mental health conditions get care, but when they do, they are just as likely to receive services through schools than from community-based providers. Among all students, 11 to 12 percent have accessed care via an education system, compared to 7 percent who have seen specialty providers and 4 percent who have seen general medical providers not connected to the school.

## People with severe mental illness are jailed at a rate four to six times greater than the general population.

Most schools—96 percent over the 2021–2022 school year—offer some form of mental health care, with individual services like counseling or therapy the most common (84 percent). However, 43 percent of school staff responding to a survey described themselves as "strongly or moderately not believing they could effectively provide services to all students in need." Some of those pressures may ease in the future, with the Bipartisan Safer Communities Act designating $1 billion over five years for mental health supports in schools. It includes funding to double the number of school counselors, social workers, and other mental health professionals.

### SECURING CARE

When people seek care directly from a provider, rather than through another system, they usually do not see a mental health specialist. More than 60 percent of mental health visits are with primary care providers. In these encounters, patients are somewhat rarely referred to psychiatrists. Two out of three primary care providers report having difficulty referring patients to mental health specialty providers, either because they do not know of any that are accepting new patients, or they do not know any who accept the patient's insurance. Those reasons reveal two necessities for a truly accessible system: a sufficient number of providers and adequate payment they will accept. (See more on this in the sustainable workforce section.)

When patients are not able to get a referral from their primary care provider, or they have no primary care provider, they must search for a source of mental health services on their own. For anyone in emotional distress, especially people with severe mental illness, this is a challenging task amid what one psychiatrist calls "the uncoordinated panoply of practitioners with disparate and confusing titles and qualifications." The assistance of an approachable, nonjudgmental, knowledgeable advocate can make this process more accessible.

Getting care is easier, especially for people with serious mental illness or with unstable access to food and housing, if patients have navigational assistance. This assistance is one role provided by peer support workers or community health workers.

## Coordinating and Integrating Care

Overall health care costs are higher for people with mental illness than for people without mental health conditions, and significantly, a large share of the cost difference is related to *physical* health conditions. Twenty-nine percent of adults with medical conditions have mental health disorders and 68 percent of adults with mental health disorders have physical medical conditions. Despite this overlap, mental health and substance-use treatment providers usually are located separately from each other as well as from physical health care providers, with little coordination among health records, payment sources, or care planning. Patients whose mental health or substance abuse conditions cannot be adequately treated in primary care must try to navigate going to a specialty provider, often via referral. Even with a referral, as many as 50 percent of patients may drop off, and never go to one appointment with the specialty provider.

Structuring care delivery to best treat and support the patient across physical, mental, and social service needs is the heart of coordinated, integrated care. There are three defined levels of collaboration:

- Coordination, at its most basic level, relies primarily on communication across providers who work largely independently.

- Co-location, i.e. having multiple providers that can support physical, mental, and wrap-around services in one building or area, facilitates closer communication. Some shared systems like scheduling and record-keeping, and warm hand-offs of patients between providers can also meet this goal.

- Truly integrated care takes a team approach with multiple provider types, care managers, and paraprofessionals working together with patients on their treatment plans.

Strengthening the relationship between a patient's physical and mental health care providers is just one aspect of collaboration that can yield better outcomes and better value.

More than 5,700 geographic areas are designated as having provider shortages, including a more than one third of the U.S. population.

In many cases non-clinical services are also essential for improved mental health. For example, income support and housing stability both help lower psychological distress.

Integrating care is a goal for state and federal health care agencies, provider associations, and advocacy groups, with multiple designs to guide implementation. Some examples include:

- The Certified Collaborative Behavioral Health Clinic model, which began under federal planning grants to 24 states in 2015. The clinics coordinate and integrate physical health care, mental and substance use treatment and prevention, human services, and other systems. Grant funds and special Medicaid reimbursement rates allow the clinics, although they cannot provide food or housing directly, to compensate outreach workers or peer-support specialists who help patients navigate those resources via community partners.

- The General Health Integration Framework, presented by the National Council for Mental Wellbeing. This organizing model brings physical health screening and prevention, care, and care management into behavioral health practices, with flexibility around the number and complexity of medical services included over time.

- The Bridge Model of Transitional Care, developed by the Health and Medicine Policy Research Group and multiple health agencies. The model uses intensive case management to guide people with opioid use disorder into treatment and recovery services.

A "provider champion" connects appropriate patients to buprenorphine treatment, and a team of mid-level practitioners and navigators lays out a system of individualized care that is immediately accessible following discharge from the emergency department.

### Developing a Sustainable Mental Health Care Workforce

As already mentioned in other sections, when a person seeks mental health care, they are likely to confront the shortage of mental health care providers, either in absolute terms, or among those covered by their insurance. The Health Resources and Services Administration (HRSA, an agency of the Department of Health & Human Services) has designated more than 5,700 geographic areas as having provider short-ages, covering a population of more than 119 million Americans, or more than one third of the population. Throughout these areas, mental health workforce capacity meets only about 27 percent of the estimated need. Shortages are more common in rural areas, with 60 percent of rural Americans living in shortage areas.

HRSA maintains a dashboard with estimates of future U.S. supply and demand of the mental health care professionals. The projections show that by 2023, the mental health workforce will have too few psychiatrists and addiction counselors to meet the public's needs, but the number of social workers, psychologists, mental health counselors, marriage and family thera-pists, and psychiatric nurse practitioners and physician assistants are forecast to be adequate.

Access to providers is narrowed by insurance networks. Among individual plans sold on Affordable Care Act exchanges, only 21 percent of mental health care providers participated in insurer networks, compared to 46 percent of primary care providers. Multiple stakeholders consulted by the Government Accountability Office, including consumers, health plans, providers, and state officials, pointed to low reimbursement rates as a reason some mental health care providers—including graduate-level social workers, psychologists, school and clinical counselors, psychiatric nurse practitioners, marriage and family therapists, and other behavioral health professionals—may choose not to participate in insurance networks.

Insurers reimburse psychiatrists less than other medical doctors for the same diagnoses and services. In one analysis of services billed for 3.8 million patients, payment by private insurers was 13 percent lower to psychiatrists for low-to-moderate severity cases, and 20 percent lower for moderate-to-high severity cases, compared to payment to non-psychiatrist physicians for the same types of cases. A separate study of 11 state Medicaid programs found that in 9 states, psychiatrists were compensated between $1 and $34 less for a low-severity office visit and between $5 and $40 less for moderate-severity visits compared to primary care physicians providing the same services.

The participation of mental health care providers in Medicaid, especially, has implications for racial and ethnic health equity. As of 2020, Medicaid covered about 30 percent of Black, American Indian and Alaska Native, and Native Hawaiian or Other Pacific Islander non-elderly adults and more than 20 percent of Hispanic non-elderly adults, compared to 17 percent of white people in the same age group. The impact on children is even greater. Medicaid and CHIP cover more than half of U.S. children who are Hispanic, Black, American Indian and Alaska native, compared to 27 percent of white children.

## Building Equity, Inclusivity, and Cultural Relevance for All

Meaningful, effective mental health and substance abuse disorder treatment requires not only that providers are within geographic and financial reach of patients, but also that those practitioners are

**Only 21 percent** of mental health care providers participated in insurer networks, compared to 46 percent of primary care providers.

diverse in racial and other identities, and that they are culturally competent.

Trust, comfort, and understanding are essential in the therapeutic relationship between a patient and a mental health professional. Non-white consumers of mental health services get higher-quality mental health care when they share a racial background with their provider, or their provider demonstrates knowledge of discrimination and prejudice. Still, 83 percent of U.S. psychologists in 2015 were white, and in 2019, nearly 70 percent of social workers and 88 percent of mental health counselors were white. SAMHSA operates the Minority Fellowship Program (MFP), which provides grants to master's- and doctoral-level graduate students training to be mental health practitioners. The goal is to increase the number of culturally competent professionals in the workforce. In a 2020 workshop, three professionals connected to the MFP program named additional steps for recruiting, educating, and retaining people of color and people from other minoritized backgrounds. They stressed bringing social determinants of health into graduate education for mental health careers, building a clear path to financial security for students and trainees, connecting career education to the community, and incorporating mentorship and support for new professionals.

Diversity in the mental health care workforce is important for improving inclusivity, and at the same time, all providers need to show cultural competence. Culturally-competent providers recognize the importance of culture, stay alert to ways cultural differences affect communication, and adapt services to culturally unique needs. Language access is essential for a field as communication heavy as mental health care and substance use treatment. Title VI of the Civil Rights Act of 1964 requires that public services receiving federal funding provide reasonable accommodations for language assistance. In many health care settings, medical interpreters serve in person, by telephone, or by video connection. Researchers in New York recommend that interpreters should not just convert the language between the patient and provider, but actively serve as clarifiers, cultural brokers, and advocates or mediators to deliver the most effective mental health care to people with low English proficiency.

Showing respect for a person's language, culture, and background is implicit in the patient-centered care model, an approach that is "respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions." Providers adhering to these principles can begin to overcome disparities in care not only for racial and ethnic minorities, but also for other historically underserved populations or those maltreated in the mental health care system: lesbian, gay, bisexual, and transgender individuals; immigrant populations, people experiencing housing instability and homelessness; people with severe mental illness, and people with substance use disorders. The patient-centered care model also has potential to make mental health care more relevant for any patient, as it prioritizes the patient's goals and comfort.

## Innovative in Delivering and Paying for Care

### PAYMENT INNOVATION

Some of the most promising practices for improving mental health care are constrained by the dominant payment design in the U.S., the fee-for-service system. Innovative models will be necessary for transforming mental health care.

Most health care is compensated, by public and private coverage alike, at a dollar amount assigned to each service or type of encounter, represented by hundreds of billing codes, paid by volume of services delivered. This system limits which type of provider can be paid for each service, and for which diagnoses. In a truly patient-centered system of care, where physical health, mental health, and social service needs are addressed to produce the best outcome for the patient, extensive care coordination is necessary, and a variety of providers may serve a patient's needs.

Under traditional fee-for-service payment arrangements, however, many of those services would be difficult to reimburse. Care coordination is often not compensated or paid at a rate too low to be sustainable, and reimbursement for peer-support, navigation, and services like transportation or housing assistance are not available at all in many cases. There are options for alternative payment structures to facilitate comprehensive physical and mental health for patients, including modified fee-for-service arrangements that pay extra for high-quality outcomes, bundled payments that allocate a flexible budget for treatment of a condition, and "global" payments that cover all health needs per person in a population.

There are benefits and drawbacks to each approach, but innovating on *any* of the models may yield an even better option for facilitating mental health care. However, the global or "capitated" payment model incorporates mental health on par with physical health within the payment, allowing "seamless and unfettered access" to "mental health care as a natural extension of the primary care team."

### PHARMACEUTICAL INNOVATION

Prozac® became a true blockbuster drug for treatment of depression when it was released in the late 1980s, but in the following years new compounds or pharmacological mechanisms developed for treating mental illness frequently failed in clinical trials. The pharmaceutical industry's research into new psychiatric medications has slowed over the past two decades, dropping by as much as 70 percent between 2009 and 2019. Financial losses, especially from costly late-stage trials after preclinical research indicated promise for a new drug, led the industry to scale back research

and development of truly novel mental health drugs, focusing instead on refining existing compounds and repurposing drugs for additional conditions.

Despite this slowdown in research, two new mental health drugs designated Breakthrough Therapies by the Food and Drug Administration were approved in 2019, Esketamine nasal spray for treatment-resistant depression and intravenous Brexanolone for post-partum depression. Although Esketamine is based on a longtime anesthetic, both new drugs rely on novel mechanisms to treat depression, potentially opening a "new frontier" in mental health drug development.

The National Institute of Mental Health (NIMH) funds research to design and develop novel drugs to treat mental illnesses, with its focus shifting from clinical research (testing new drugs in patients) to preclinical neurological research and early clinical research. The goal is to establish a potential drug's interactions with a cellular or molecular target in the brain, using biomarkers or imaging. NIMH clinical trial funding requires researchers to conduct a "proof-of-molecular-mechanism" test before moving on to clinical study in patients. This arrangement is intended to end research projects early if tests of the mechanism fail, and to contribute to the knowledge base of those mechanisms. However, some researchers and practitioners consider the requirement an unnecessary burden that slows or impedes development of badly-needed new drugs.

### TECHNOLOGICAL INNOVATION

New payment options helped unleash the potential in a technological innovation in mental health care: telehealth. In most states before the COVID-19 pandemic, people with Medicaid coverage, if they had the necessary connection, could use telehealth as a covered benefit. However, Medicare would only pay for telehealth appointments in limited circumstances. During the COVID-19 public health emergency, the federal government waived that restriction and use of the services increased tenfold in 2020, to 53 million uses. Medicare coverage of telehealth services for mental health, including audio-only services, was made permanent. Today, more than a dozen states allow telehealth for mental health services, and require the services be paid on par with in-person visits, even once the public health emergency ends.

## Measured for Quality

Assessing the value of mental health interventions requires measurement. However, there is very little standardization of quality measures across mental health and substance use treatment. Developing and tracking quality data is key for improving care, and for allowing mental health care and substance use treatment to be compensated appropriately in value-based payment models.

Quality data is abundant in the health care system in general, but quite limited around mental health. Among 39 active federal programs requiring data reporting in health care, more than 1,400 measures and metrics are collected. Only 35 measures are unique to mental health and substance use disorders.

Ideally, quality metrics can help inform patient decisions. However, existing mental health and substance use disorder care measures, according to the National Committee for Quality Assurance (NCQA), do not include care coordination, patient experience, or health outcomes.

NCQA has developed a framework of measurement that integrates physical and behavioral health along with social systems.

Developing and tracking quality data is key for improving care.

## NCQA'S BEHAVIORAL HEALTH QUALITY FRAMEWORK

When NCQA researchers interviewed stakeholders throughout the health care system, they found that behavioral health care (mental health and substance use prevention and treatment) integration is widely supported, but different quarters of the system are unclear on who is accountable for achieving integration and how to measure its quality. They developed a customizable framework to help diverse entities resolve those uncertainties.

**Key components of the framework:**

1. Organizes around population health management

2. Includes measures that hold purpose for many participants across the system and are aligned with the population health goals

3. Requires investment in infrastructure to drive accountability and improvement

Stakeholders from throughout the system will coordinate to identify the goal-related measures most relevant to each level among:

1. The macro level—state and federal government

2. The meso level—managed care plans or accountable care organizations

3. The micro level—facilities and providers

**Essential steps to implementing the program:**

1. Identify priority populations and set population-level goals

2. Develop bundles of evidence-based quality measures at each level aligned with each goal and publicly report them

3. Invest in data infrastructure, collaboration tools, workforce development, and cultural sensitivity, and improve behavioral health financing structures

### Figure 7.2 Showing Metric Association with an Opioid-Related Mortality Reduction Goal

| MEASURE BUNDLE FOR POPULATION GOAL: *Reducing Opioid-Related Mortality* | |
|---|---|
| **Federal & State** | **Outcome:** Opioid-related death |
| | **Process:** Follow-up post emergency department for OUD |
| | **Structure:** Prior authorization for MOUD, reimbursement for telehealth |
| **Managed Care** | **Outcome:** Repeat opioid overdose/poisoning events |
| | **Process:** Treatment continuity, care coordination for high-risk members |
| | **Structure:** BH network adequacy, coverage of non-opioid pain therapy |
| | Member experience |
| **Facility/Provider** | **Outcome:** Treatment dropout/show rates |
| | **Process:** Access to MOUD, treatment engagement, preventive and chronic care management for patients with OUD, care coordination |
| | **Structure:** Waivered providers, telehealth infrastructure, care team communication infrastructure |
| | Patient experience |

*(Left axis label: Purposeful Data/Information Exchange Across System)*

# CONCLUSION: A SYSTEM READY FOR CHANGE

**The widespread emotional distress brought on by the COVID-19 pandemic has prompted unprecedented attention on the United States mental health care and substance use treatment system.** More Americans are discovering what providers, advocates, patients, and their families have long known: mental health care, though essential and often life-changing, can be taxing to navigate, difficult to afford, and disconnected from other health care.

The spotlight on the system and the billions in new federal investment present opportunities to transform mental health care and substance use treatment. Experts and other leaders in every corner of the system have formulated hard-won and deeply researched recommendations for developing a system that works for everyone. Collaborating with stakeholders, policymakers can help establish a system that is accessible, coordinated, sustainable, equitable, and measured for quality.

## RESOURCES

### MENTAL HEALTH CARE LANDSCAPE

The Alliance for Health Policy Summit on Mental Health in America https://www.allhealthpolicy.org/signatureseries_summit_mentalhealth_agenda.

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