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Mental Health Care Disparities Now and in the Future

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Abstract In 2014, the USA spent $3 trillion dollars in health care the most per capita in the world. However, the USA lacks universal health coverage, and lags behind other highly developed and wealthy countries in life expectancy (even some "non wealthy" countries have better outcomes). The USA also has deficits in other health outcome measures. Health care costs in the USA continue to rise annually and many patients receive only mediocre care. In addition, clear disparities exist across different communities, socioeconomic groups, and race and ethnicity groups. As a result, individuals with mental illness are at an increased risk of being homeless, committing suicide, and having problems maintaining a job. This paper will address mental health disparities and review the efforts some states are taking to improve the lifesaving services offered to citizens with mental illness, in order for them to recover and reach their full potentials.

Keywords Mental health care disparities · Mental illness · And legislation

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Mental Health Landscape in the United States

Mental health disorders are prevalent across the USA. Approximately one in five Americans will have a mental health disorder in any given year. However, only approximately one in three people with a mental health disorder will receive mental health services [1]. Sixty-seven percent of people with mental health disorders who do not seek treatment is regrettable, as treatment offers real hope. One third of individuals with severe mental illnesses who receive community mental health services after a lengthy stay in a state hospital achieve full recovery in psychiatric status and social function, and another third improve significantly in both areas [2].

For example, nearly half of young adults do not receive needed mental health services [3]. Based on data from 2009 to 2013 National Survey on Drug Use and Health (NSDUH) data, a yearly average of 1.5 million young adults aged 18 to 25 felt they needed mental health services but did not receive any services during 2013. They were asked to list one or more reasons why they did not obtain treatment that they felt they needed. Cost and insurance issues were the most common reason given by 692,000 young adults [3]. Approximately 545,000 young adults believed that getting services would cause them to face discrimination from other individuals, such as employers, friends, or family. Many young adults (570,000) had "structural barriers" to receiving care, such as lack of transportation [3]. Although these young adults believed that they had an unmet need for services, 534,000 reported that they had a low perceived need, and 180,000 noted they did not think treatment would benefit them.

There are clear disproportions among the demographic of individuals seeking treatment. The highest numbers of people who sought treatment were non-Hispanic white

females (21.8%), and the lowest number was among non-Hispanic Asian men (4.8%) [4]. Across every racial and ethnic group except non-Hispanic American Indian/Alaskan Native people, women utilized mental health services more than men. Treatment of mental health disorders is costly, and impacts the youngest patients in the most harmful ways. For example, between 2007 and 2009, the average expenditure per adults ages 18–26 for the treatment of mental health disorders was about 2000 dollars. [4]. Of this population, average expenditure for treatment was higher for young adults ages 18–21 estimated at $2300 per year than for those ages 22–26 estimated at $1800. In 2013, adults aged 18 or older who were covered by Medicaid or Children's Health Insurance Program (CHIP) were more likely to use mental health services in the past year (23.1%) versus the percentage of adults with private health insurance (14.3%), adults without health insurance coverage (10.1%), and adults with other forms of health insurance coverage (15.7%) [4].

The decline in the number of patients served by state-run hospitals compared to the increase in patients served by community services begins to elucidate the disparity in treatment received based on access to care [5]. Overall, the number of people receiving treatment at state-run hospitals decreased from .17 to .15 million, while the number receiving treatment at community run agencies increased from 5.5 to 6.5 million.

Mental Health: Disparity and Race

African-American men are disproportionately exposed to social and environmental conditions which adversely affect their mental health [6]. These institutions manifest as poverty, low levels of education, and community violence. Despite the increased need, disparity is seen in treatment rates overall, as well as ability to receive adequate treatment. Of the 41% of African Americans who do seek treatment for depression, only 12% will receive adequate care [7]. Women are often twice as likely to suffer from depression but men are less likely to seek treatment [8]. The tradtional male sterotypes encourages men to "remain strong" and "stick it out" may discourage them from seeking help.

Depression and anxiety levels are directly correlated with a person's poverty level [9]. The greater the poverty level, the greater the levels of depression and anxiety. Additionally, chronic health problems such as hypertension, diabetes, and lung disorders also contribute to depression and anxiety show the highest rate of occurrence difference based on poverty level, asthma, obesity, hypertension, and myocardial infarction all occur more frequently in those living below the poverty level than those living above it [10].

Mental Health: Disparity and Suicide

More than 35,000 Americans commit suicide each year. Serious thoughts of suicide increase the risk of suicide attempts and eventual death by suicide [11]. According to the 2008 to 2012 National Surveys on Drug Use and Health (NSDUHs), 8.6 million adults aged 18 or older had serious thoughts of suicide in the past year. Half of adults who have had serious thoughts of suicide over the last year did not receive mental health services. Receiving timely and appropriate mental health treatment can be a critical prevention tool for helping people with serious thoughts of suicide. Almost 40% neither received services nor felt they needed them. In 2006, 1106 North Carolinians died by suicide [12].

Individuals in the USA, who suffer from serious mental illness (SMI) and a coexisting substance disorder, on average, only have a 43-year lifespan which is 35 years shorter than the average life span of Americans who do not have mental illness [13]. Walker (2015) estimated that the median reduction in life expectancy among those with mental illness was 10.1 years [14]. Based on the prevalence of mental illness worldwide, they concluded that fully 8 million deaths occur each year which could be averted if people with mental illness were to die at the same rate as the general population. For the USA, this means roughly 350,000 deaths averted each year [14]. People with co-occurring mental illness and substance abuse disorders have life expectancies 35 years shorter than individuals without these illnesses. The average reduction in life expectancy in people with bipolar disorder is between 9 and 20 years, while it is 10 to 20 years for schizophrenia, between 9 and 24 years for drug and alcohol abuse, and around seven to 11 years for recurrent depression. The loss of years among heavy smokers is eight to 10 years [15].

Mental Health: Disparity and Employment

Mental illness can make it difficult to obtain or hold a job, and the strain of unemployment can exacerbate the mental illness. According to combined data from the 2008 to 2012 National Surveys on Drug Use and Health (NSDUHs), 12.8 million adults aged 18 to 64 were unemployed and 36.8 million persons some type of or any mental illness (AMI) in the past year. Approximately 3.1 million adults aged 18 to 64 (1.6%) both were unemployed and had AMI [4]. In 2013, the percentage of adults with AMI over the last year was the greatest among unemployed adults (22.8%), followed by adults who worked part time (20.3%), and lastly among those who were employed full time (15.4%). The percentage of adults in 2013 with AMI in the past year was the highest among those with a family income that was below the Federal poverty level (26.1%), subsequently by those with a family income at 100 to 199% of the Federal poverty level (20.9%), afterwards by

adults with a family income at 200% or more of the Federal poverty level (16.0%) [16].

Kessler et al. (2008) examined the indirect cost of mental illness that is the costs from loss of earnings. The analysis was based upon the National Comorbidity Survey Replication (NCS-R), a population-based epidemiological study of mental disorders [17]. In this investigation, data was obtained from almost 5000 individuals to estimate the loss in earnings by comparing earnings in the previous 12 months of individuals who suffered from a mental disorders compared to yearly earnings of individuals who did not have a mental disorder. The analysis focused on persons with a SMI. The results found demonstrate a mean reduction in earnings of $16,306 in persons with serious mental illness (both with and without any earnings) and also that about 75% of the total reduction in earnings came from individuals who had some earnings in the prior year (versus those who did not have any earnings at all) [17]. By extrapolating these individual results to the general population, the authors estimated that serious mental illness is associated with an annual loss of earnings totaling $193.2 billion [17]. In 2006, 186,000 young adults received social security disability benefits because they were considered unable to engage in substantial gainful activity as a result of the severity their mental condition [15]. Of the more than six million people treated by state mental health facilities across the country, only 21% are employed [15]. Data from Substance Abuse and Mental Health Administration estimated that the US national expenditure for mental health care was $147 billion in 2009 [4]. Summing this amount with updated projections of lost earnings and public disability insurance payments associated with mental illness, an estimate for the financial cost of mental disorders was at least $467 billion in the USA in 2012 [16].

Integrated Care and Early Intervention

Thirteen state legislatures have recently enacted policies to monitor and improve mental health service delivery. The State of Utah (HB 57) is a bellwether, requiring the state mental health authority to promote integrated health care programs that address substance abuse, mental health, physical health care needs, as well as evaluation of the effectiveness of integrated programs while encouraging local mental health authorities to do the same. Wyoming (SF 60) is proceeding with Medicaid reform, strengthening mental health services for people living with serious and persistent mental illness or serious psychological distress.

After the Newtown tragedy, a shift was seen toward proactive policy which focused on early intervention. For example, National Alliance on Mental Illness (NAMI) advocates for policies supporting early identification and intervention, training for school personnel, families and the public, mental health services in schools and increased access to care. Additionally, states' legislation aimed at providing increased mental health screening services for several populations primarily to identify emerging mental illness in children and adolescents and to ensure adequate access to care.

In addition, several states enacted related legislation focused on early intervention, school-based services and staff training to prevent potential tragedies such as the Sandy Hook shootings. Nebraska enacted LB 556 to develop behavioral health screenings and provide education and training on children's behavioral health, Nevada passed AB 386 to establish a pilot program for the administration of mental health screenings to students enrolled in selected secondary schools, and Minnesota enacted HF 359 requiring that case management services continue to be available to youth living with mental illness after they turn 18 years of age. Similarly, Virginia (SB 1342) now requires the governing board of each public four-year institution of higher education to establish a written memorandum of understanding with its local mental health system and with inpatient facilities in order to expand the scope of services available to students seeking treatment. Texas enacted SB 460 to require training for public school teachers and students in recognizing and responding to signs of suicide or mental health disorders and the inclusion of mental health concerns in coordinated school health efforts. In Utah, HB 298 will require school districts to offer an annual seminar to parents with information on mental health, depression, and suicide awareness. Minnesota passed two bills to strengthen school-linked mental health services (HB 2756), and Oregon enacted HB 2756 calling for removal of seclusion rooms from all public schools.

With the increased focus on integrated care and early intervention, concern for the civil rights of people who live with mental illness has remained a focus and is typically an undercurrent for legislation. For example, Oklahoma (SB 755) established the role of "treatment advocate" to include guardians, persons granted general health care decision-making authority, and those designated as health care proxies in an advance directive granted durable power of attorney with health care decision-making authority. The bill also provides for release of information to the treatment advocate.

Families, who are more knowledgeable and informed about their options and the medical conditions that their loved ones endure, often have better mental health outcomes. In addition, more promising legislation is emerging. South Carolina enacted SB 117 which strengthens requirements for health care providers to give individuals the opportunity to authorize disclosure of information to designated family members or others. Tennessee passed SB 442 which allows family members and friends to transport individuals in mental health crisis to regional mental health institutes for civil commitment when safety would not be compromised.

Two states recently passed bills addressing language and practices that address the stigma of people living with mental illness. Tennessee (SB 1376) changed how the state code refers to people who live with mental illness to comply with ADA standards. Additionally, West Virginia (HB 2463) repealed the law permitting sterilization of persons deemed mentally incompetent. While no one has tried to use the law to sterilize an individual in West Virginia since 1956, the 1929 law, which allowed circuit courts to approve sterilizations for "mental defectives," had remained on the books. ++++*North Carolina also had this law repealed.* ++++.

Mental Health Policy: Crisis and Inpatient Treatment

Public inpatient mental health facilities were dramatically reduced during the recession as states struggled to stretch resources in the face of rising demand for services. From 2007 to 2012, the number of patients served in state psychiatric facilities dropped by 30, 079, and 17% [17]. In some states, inpatient capacity is unable to meet the demand. As a result, patients suffering from an acute psychiatric episode often have longer wait times and are at an increased risk of emergency room boarding. As a result, the Virginia legislature enacted HB 2118 strengthened the state's inpatient psychiatric bed dashboard system. It mandates that all public and private inpatient and crisis stabilization facilities update their bed availability at least once daily.

State legislation related to psychiatric inpatient care covered a wide array of topics, including donation of property to community mental health services (AR SB 801), staff functions (IA SF 406), complaint investigations (MO HB 351), a study of inpatient capacity (MT HJ 16), geropsychiatric facilities (ND HB 1089), deinstitutionalization (RI S680B), and limitations to restraint and seclusion (TX SB 1842).

A number of states also enacted legislation addressing civil commitment, court-ordered outpatient treatment (assisted outpatient treatment), crisis response, mental health facilities, and suicide prevention. Civil commitment legislation, including SF 406 in Iowa, expanded the scope of providers qualified to authorize inpatient admission from solely examining physicians to other professionals including physician assistants and psychiatric advanced registered nurse practitioners. Indiana passed HB 1130 which allows law enforcement to detain and transport persons with mental illness who are gravely disabled. HB 16 in Montana clarified that the emergency detention standard in the civil commitment process includes individuals who are substantially unable to provide for their basic needs. Washington passed three civil commitment bills: HB 1114 to strengthen rights of people with mental illness during civil commitment and criminal incompetency procedures; SB 5480 requiring consideration of a person's history of symptoms or behavior when making a civil commitment decision; and SB 5732 which improves planning and care coordination associated with discharge from inpatient civil commitment. In Nevada, AB 287 broadened the use of assisted outpatient treatment by permitting courts to order outpatient treatment when it is determined that a person has a mental illness and is likely to harm self or others if left untreated. The law mandates that courts must place individuals in the most appropriate course of community-based treatment available. In Hawaii, SB 310 established an assisted community treatment program for individuals not deemed dangerous to self or others. And in Virginia, HB 1423 stipulates that, pending the conclusion of a course of voluntary or involuntary treatment, the community services board in any county where an individual is to reside may petition the court for an order of mandatory outpatient treatment.

In a crisis, psychiatric crisis response services help people stabilize, access care, and resume daily activities. Elements of a comprehensive crisis response system are reflected in Colorado's legislation (SB 266) which establishes a 24-h telephone crisis service to perform assessment and referrals, walk-in crisis services and crisis stabilization units for immediate evidence-based clinical intervention, triage and stabilization, mobile crisis units linked to the walk-in and crisis respite services, residential and respite crisis services, and a public information campaign. Minnesota (SF 1458) allotted $8 million to establish a statewide crisis line, set up a statewide pool of experts, increase mobile crisis services, improves state standards and crisis beds. The provision also necessitates private health plans to pay for mental health crisis services under the emergency services category.

Mental Health Policy: Health Information Privacy

Tennessee enacted SB 28 which allows a court hearing a child custody case to order disclosure of mental health information. As amended, the bill restricts release of confidential mental health information for the purpose of litigation and requires return or destruction of records at the conclusion of the case. Oklahoma (SB 581) allowed access to court records related to treatment to a person having valid power of attorney with health care decision-making authority, valid guardianship with health care decision-making authority, an advance health care directive, or an attorney-in-fact as designated in a valid mental health advance directive.

Mental Health Policy: Prescription Medications

People who get the right treatment have greater success in managing their mental illness. In order to choose the treatment regimen that will work best and enhance adherence,

individuals and their prescribers need access to the full range of medications.

In an effort to contain costs, a number of states enacted legislation limiting access to psychiatric medications in public programs. Arkansas set a troubling precedent with HB 1185 which authorizes a pharmacist to substitute a therapeutically equivalent, less costly medication, upon authorization by the prescriber. The pharmacist must inform the patient of the right to refuse the substitution. The term "therapeutically equivalent" extends beyond substituting a generic for its brand name equivalent to substituting a chemically different medication from the same class. Within its 2013 budget bill (SB 402), North Carolina imposed prior authorization and a restricted Preferred Drug List (PDL) for mental health medications prescribed to Medicaid and Health Choice recipients. The budget bill specifically *includes* off-label prescriptions for treatment of Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD) in youth. On a more positive note, New York retained its "provider prevails" standard for prescribing psychiatric medications despite efforts to enact a more restrictive standard.

Mental Health Policy: Provider Credentials

Bills governing provider licensure and scope of practice were enacted in a number of states. Louisiana (HB281) authorized development of a behavioral health license to facilitate the provision of integrated mental health and substance use care. Minnesota (HF 358) added family peer specialists (FPS) to the list of mental health practitioners covered by Medicaid for children's mental health services. FPS must be parents of a child living with mental illness and they must undergo specialized training. Oklahoma (HB 1109) provided for certification of peer recovery support specialists who are employed by a behavioral services provider.

Conclusion

Mental illness affects everyone despite race, sex, ethnicity, gender, or sexual orientation. The health disparity issues discussed in this manuscript are of great importance to rebalancing mental health inequality. The focus at the state and national level must move mental health care disparity toward parity.

The response by states has been mixed at best but progress is possible. Some states have funds invested in mental health services and passed legislation to ensure that tax dollars finance the most effective services. While simultaneously, other states are maintaining or reducing mental health funding. Primarily, states should expand coverage to Medicaid and simultaneously include all mental health care benefits that are available in traditional Medicaid. Next, states should provide 24/7 psychiatric response services with mobile crisis response teams or crisis response specialists, crisis stabilization units and respite services. Lastly, states should require health plan transparency concerning mental health benefits, medical necessity criteria needed for the definition of mental health, substance use and primary care, out-of-pocket costs, provider networks for mental health and substance use and consumer protections.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval This article does not contain any studies with human participants or animals performed by any of the authors.

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