

## What did we learn?

### Trends

In reviewing the status of mental health and substance abuse nationally, a number of themes and trends emerge.

#### National Picture

*Note: This information excerpted from the Mental Health: A Report of the Surgeon General, (1999, U.S. Department of Health and Human Services) unless noted. Page numbers are cited in parentheses.*

#### National Trend #1: Mental illness and substance abuse are pervasive, disabling and lethal, but funding is not proportional to burden.

- One in five Americans experience a mental health disorder in the course of a year. Twenty-eight percent have a diagnosable mental or substance abuse disorder and approximately 15% of those with mental health disorders will also experience a substance abuse disorder. (p. 102)
- Mental illness emerged from a massive Global Burden of Disease study as a surprisingly significant contributor to disease burden. The combined burden of mental illness and alcohol use was higher than the burden of any other disease, including all cardiovascular conditions, all cancer, respiratory disease and all infectious and parasitic diseases. (p. 4)
- Despite carrying over 20% of the disease burden, only 10% of national health dollars are spent on mental, addictive and dementia disorders. (p. 412) (See chart at right.)
- 90% of people who die by suicide have at least one major mental illness diagnosis (The Report of the Governor's Suicide Prevention Advisory Commission, State of Colorado, 1998, pg. 10)

#### National Health Care Expenditures, 1996 (\$943 billion total)

Mental Disorders	7%	\$69 B
Alzheimer's/dementias	2%	\$18 B
Addictive Disorders	1%	\$13 B
Other Physical Disorders	90%	

#### National Trend #2: Death by suicide is a serious and increasing health problem, especially among younger Americans.

*The following information is excerpted from The Surgeon General's Call to Action to Prevent Suicide, (1999, Department of Health and Human Services U.S. Public Health Service).*

- The number of deaths by suicide is 50% higher than the number of homicides in the United States.
- Over the last 40 years the reported rates of suicide among adolescents and young adults nearly tripled.
- From 1980 to 1996, the rate of suicide among 10-14 year olds increased by 100%.
- More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease **combined**.

#### National Trend #3: A large number of prison inmates have a mental illness.

The following information excerpted from the Committee on the Treatment of Persons with Mental Illness in the Criminal Justice System, Executive Summary, State of Colorado, 2000.

- At mid-year 1998, an estimated 283,800 inmates nationally had a mental illness
- National estimates indicate that 61% of state prison inmates and 41% of local jail inmates had received counseling, medication, or other mental health services prior to their incarceration.

**National Trend #4: There is a complex, patchwork financing and service delivery system**

- The majority of mental health expenditures are public. Sixty percent are covered by insurance (public and private); 17% by the consumer and the rest must be made up from other sources. (p. 414) (See chart below left.)
- The largest expenditures go to multi-service mental health centers and psychiatric hospitals (p. 414). (See chart below right.)
- The complex patchwork of mental health services has become so fragmented that it is referred to as the “de facto mental health system.” (p. 73)

**Mental Health Expenditures by Payer, 1996 (Total \$69 billion)**

<b>Public</b>	
Medicaid	19%
Other state/local	18%
Medicare	14%
Other federal	2%
<b>Public Total</b>	<b>53%</b>
<b>Private</b>	
Private insurance	27%
Out-of-pocket	17%
Other private	3%
<b>Private Total</b>	<b>47%</b>

**Mental Health Expenditures by Provider Type, 1996 (Total \$69 billion)**

Multi-service mental health centers	18%
Psychiatric hospitals	17%
Psychology/social work	14%
hospital psychiatry units	10%
Psychiatrists	10%
Outpatient Rx drugs	9%
Nursing home/home health	7%
GM Hospitals	6%
GM Physicians	5%
Child RTC	4%

**National Trend #5: There have been significant advances in treatment, yet gaps exist between effective treatment and what many individuals receive.**

- Effective treatment exists for most mental disorders. (p. 65)
- There have been significant advancements in medications. (p. 68)
- There is significant research in “integrative neuroscience,” promising better identification and intervention. (p. 31)
- There are efforts to identify useful outcome measurements.

However:

- Only about 1/3 of those with a diagnosable mental disorder receives treatment in one year. (p. 75)

**"You have to bring the fire storm in my brain under control first, access to medication is essential."**

-Consumer

**National Trend #6: Mental health benefits in health insurance coverage have eroded significantly.**

There has been a 54.7% drop in the value of mental health benefits, 1988 to 1998. (*Fiscally Challenged: Psychiatric Industry's Hope is in Consolidation, Focusing Services,* Modern Healthcare, 3/27/00, p. 66.)

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### **National Trend #7: A multitude of challenges to traditional “safety net providers” has left them at risk of not being able to survive.**

*Note: This trend is derived from state and local experience, not the Surgeon General's report. When specific data is used, the source is noted.*

- Safety net providers are providers that organize and deliver a significant level of healthcare and other related services to uninsured, Medicaid and other vulnerable patients.
- There is no national mandate or funding source for the provision of mental health care for the non-Medicaid, low income population. In the absence of a universal system of healthcare, the U.S. has long relied on a patchworked safety net system, comprised of hospitals, clinics, financing and programs that vary dramatically across the country.
- The funding and organization of the safety net have always been tenuous and subject to the changing tides of politics, available resources and public policies. Today, there are new and unprecedented challenges to the safety net system due to several trends:
  1. The full impact of Medicaid managed care in a more competitive healthcare marketplace.
  2. The separation of care for Medicaid patients from care for uninsured individuals.
  3. The erosion of direct and indirect subsidies that providers have relied upon to help finance uncompensated care (e.g., the Balanced Budget Act, Medicaid dollars previously used to support infrastructure, growth of managed care which prohibits cost-shifting, etc.).
  4. The shifting tides of the managed care market (the percentage of HMOs reporting a profit was in the 80<sup>th</sup> percentiles from 1990-94, but has been in the 40<sup>th</sup> percentiles in 1996-97) which mean that many communities have plans coming and going.
  5. Increasing numbers of the uninsured and growing demand for care.
  6. The increasing concentration of care for the uninsured population among fewer providers.

*(Adapted from "America's Health Care Safety Net: Intact by Endangered," from the Institute of Medicine's committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, 2000.)*

- Constantly varying interpretations in Medicare billing have made billing for (and therefore providing) certain services, such as partial hospitalization, not viable.

### **National Trend #8: Managed care has significantly impacted the delivery of services.**

- Managed care introduced dramatic changes: strictly limiting access, length of treatment and medications. Longer treatment in substance abuse produces better outcomes. Managed care runs counter to this concept.
- Managed care excludes the uninsured and ratchets down compensation so there are fewer dollars to support the infrastructure of services or to cover uncompensated care, threatening the continuation of “safety net” services for those with no paying source.
- Psychiatrists are compensated for medication management, not therapy.
- Local providers have been forced to assume more risk.
- Seventy-five or more freestanding psychiatric hospitals closed in 1999 — 50 in 1998 alone. About 530 psychiatric hospitals exist, down from 674 in 1990. (*Modern Healthcare*, see site on previous page.)

## State Picture

In addition to being impacted by all of the national trends, there are five major additional trends in Colorado impacting mental health and substance abuse services.

### **State Trend #1: There is a high and growing number of mental health and substance abuse patients without insurance and without the ability to pay for their own care.**

- Three times as many psychiatric patients (21%) fell into the “self-pay” and “Colorado medically indigent” categories (no paying sources, or inadequate mental health benefits) upon hospital discharge as all other practice areas combined (7%). (From the 1999 Payer Mix, All Colorado Hospital Discharges, Colorado Health and Hospital Discharge Database, 1999.) See Appendix G.
- Colorado Health and Hospital Association data indicate a 42% increase in number of self-pay mental health patients being seen in emergency rooms, 1996-1999.
- There is no mandate to for insurance companies to provide substance abuse benefits. Insurance providers are only mandated to "offer" this coverage.

### **State Trend #2: Suicide rates in Colorado continue to exceed the national average.**

*The following information excerpted from the Suicide Prevention and Intervention Plan, (1998, Governor's Suicide Prevention Advisory Commission, State of Colorado)*

- Colorado's suicide rate has exceeded the national average since 1910, when suicide data were first collected.
- Colorado's rate of suicide between 1990 and 1998 was 40% higher than the national average.
- In 1995 Colorado ranked fifth in the nation in suicide.
- 55 Coloradans die from suicide every month.
- More people die each year from suicide than automobile accidents in Colorado.

### **State Trend #3: The number of prison inmates in Colorado with serious mental illnesses is increasing and is higher for juveniles than for adults.**

The following information excerpted from the Committee on the Treatment of Persons with Mental Illness in the Criminal Justice System, Executive Summary, State of Colorado, 2000.

- The number of state prison inmates with serious mental illnesses has increased 5 to 6 times since 1988.
- 11% of state prison inmates have a serious mental illness.
- 22% of juveniles in the legal custody of the Division of Youth Corrections have moderate to severe mental health problems.

### **State Trend #4: The cost of health insurance is increasing rapidly in Colorado, especially for small-group employers.**

- The annual cost of an average, comprehensive group family health insurance plan in 1999 was approximately \$6,000 per year, or \$500/month.
- Health insurance rates for small group employers are rising fast, putting their employees at risk of being uninsured:

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- Between 1998 and 1999, the number of employers offering health insurance for groups of 50 or less declined 8% and the number of people covered by small group health plans fell 12%.
- Humana, the states largest small group carrier (28% of the market) was approved to raise rates 17-58% **mid-year** in 2000, an unprecedented event. (*Rocky Mountain News*, 6/15/00, p. 1B).
- As an example, a local employer, Poudre Health Services District, whose group family plan cost \$4,812 annually in the plan ending 10/31/99, received a rate increase to \$7,284 on 11/01/99. A second rate increase was set on 8/01/00, increasing the plan cost to \$9,708, more than doubling the cost of care in less than a year.
- Rate increases of 35-45% are regularly being delivered to small group employers. (Testimony, health insurance broker, to legislative Health Care Task Force, 8/00).
- A recent study, "Prices and Affordability of Health Insurance for Colorado's Uninsured Population," revealed that people living at up to 185% of federal poverty guidelines (FPG) do not have funds to pay for healthcare after they cover essentials such as food, housing, transportation and child care. The study also found that those living in households where incomes range from 185-300% of FPG need assistance in paying the full cost of health insurance.

### **State Trend #5: Psychiatric hospitals and clinics in Colorado are closing or scaling back, resulting in a decrease of available psychiatric beds.**

- Closures or scale-backs have taken place in the following systems: HealthONE, Exempla, University Hospital and CU's Psychiatric Health Clinic (*Denver Post*, 6/1/00; *Rocky Mountain News*, 6/2/00).
- In the early 1990s, Denver was host to 3,000 mental health beds; now there are less than 300 (*Denver Post*, 6/1/00).

### **State Trend #6: Changes at the state level (state legislature, Colorado Department of Health Care Policy & Finance and Mental Health Services) may significantly impact local mental health services (analyzing unintended consequences to safety net services will be critical).**

- **Immediate**
  - The manager of Medicaid mental health dollars is being changed from Mental Health Services to Health Care Policy and Finance, so that they can be managed with other Medicaid funds.
  - A priority concern of the Colorado State Legislature is controlling growth of Medicaid costs. The Medicaid budget for 2001 *may* be limited to the percentage allowed statewide by TABOR, resulting in severe cost containment measures.
  - The most recent RFP process for mental health services through Medicaid was highly competitive and encouraged a ratcheting down of costs to the state which results in a decrease of local funding and a loss of federal matching dollars to the state. Losses to the mental health systems are estimated to be \$3.7 million in FY 2000-2001 and \$7.8 million in FY 2001-2002.
  - The decreased local funding (as a result of the recent RFP process) will negatively impact services to non-Medicaid, low income mental health clients.
  - The Colorado Department of Health and Human Services, which oversees Mental Health Services, is expected to request only a minimal increase (1.5%) in funding for Mental Health Services (which helps provide care for those who are uninsured and have limited or no ability to pay) during the upcoming budget review process, not even enough to cover inflation.

- **Future**

- Mental health Medicaid funding may be blended with physical health Medicaid managed care.
- During the recent bidding process for Medicaid mental health contracts, local Mental Health Assessment and Service Agencies (MHASA) retained contracts throughout the state. However, in future bidding cycles the contract for the entire state may be given to one mental health Medicaid contractor. A change to one contractor could change the regional MHASA approach, leaving local mental health services to contract directly with the state contractor, and possibly funneling off more of the already limited mental health dollars.
- Colorado is still one of just three states that do not provide a substance abuse benefit through Medicaid.

**State Trend #7: TABOR and other tax revenue restrictions limit monies available to governments for health and human services, which in turn may limit growth or expansion of mental health and substance abuse services.**

## What did we learn?

### Local Picture

#### Local Estimates of Extent of Mental Illness and Substance Abuse

In an extensive analysis of local health burdens, similar to the Global Burdens of Disease Study, major depression was the #1 health burden in our community (by a wide margin). We also found that six of the top 15 health burdens were mental illnesses or substance abuse issues. These findings mirror the results of the Global Burdens of Disease Study and further highlight the importance of addressing mental health and substance abuse issues locally.

The following information is based on localized national estimates of incidence as reported in the Surgeon General's Report and information from the 1998 Community Health Survey (Poudre Health Services District):

- Over 60,000 people in Larimer County are likely affected by a mental health or substance abuse disorder:
- Of adults with a mental health or substance abuse disorder:
  - 68% have a mental health disorder.
  - 22% have an addiction disorder.
  - 10% have both a mental health and an addiction disorder.
- Approximately 20,000 people have a **significant functional impairment** due to a mental health illness. An estimated 3,000 of those are uninsured.
- Local data indicate that 36% of those who needed services did not use them for a variety of reasons. *See Appendices H and I for more details on these data.*

#### Local Trend #1: People with below average mental health status report worse access to healthcare and are putting off care more than those with average or above average mental health status.

In 1998, 1,631 Health District residents completed a standardized set of twelve questions (SF-12) that was used to determine average, below average, and above average mental health status among respondents. When comparing respondents whose scores were below average for mental health status to those with average and above average mental health scores, there were significant issues for those with below average mental health status. Forty-six percent of those with below average mental health scores on the SF12 reported putting off mental health visit because of cost compared to 11% of those with average mental health SF12 scores and 4% for those scoring above average on the mental health component of the SF-12.

**Table 1: Local Residents Reporting Delaying Healthcare Due to Cost, Comparison by SF-12 Mental Health Component Score**

	Below Average Score	Average Score	Above Average Score
Put off mental health visit because of cost**	46%	11%	4%
Have put off health care because of expense**	50%	28%	19%
Haven't been able to buy a prescription due to cost**	18%	6%	3%
Skip medication/treatment because of expense**	37%	14%	11%

**Table 2: Local Residents Reporting Healthcare Access Problems, Comparison by SF-12 Mental Health Component Score**

	Below Average Score	Average Score	Above Average Score
Access to health care, poor/very poor*	13%	5%	2%
Do not have health insurance*	12%	8%	2%
Do not have a regular provider*	31%	25%	14%

\*\*Statistically significant difference ( $p \geq .05$ ) when the below average scoring group to the average score group and to the better than average scoring group

**Local Trend #2: Local suicide rates continue to exceed the national average.**

*Source: The Center for Disease Control, Wonder Mortality Query*

- Suicide rates in Larimer County mirror the rates in Colorado and are nearly 40% higher than the national average
- Suicide rates for 10-19 year olds have increased dramatically over the last 10 years; In the last 30 years ten, 10-14 year old children died from suicide, 8 of those deaths occurred between 1991 and 1998.

**Local Trend #3: Need for mental health services among inmates at the Larimer County Detention Center is high.**

- 24% of inmates are on psychotropic medications; this accounts for 80% of the total medication expenses.
- Mental health services cost the Larimer County Detention Center \$805 per day
- The number of female inmates at the Larimer County Detention Center has tripled in the last four years. According to statewide data, 75% of these inmates have a need for mental health services.

**Local Trend #4 There has been an exodus of psychiatrists from admitting inpatient psychiatric care, and from taking the corresponding rotating call required of all admitting physicians.**

- Over the course of two years (1998 to 2000), the number of community psychiatrists willing to admit patients and take corresponding call has dropped from 13 to two. While most of those psychiatrists remain in the community, they have limited their practices to outpatient work.
- The burden of rotating call had fallen in early 2000 to just four physicians (2 from Mountain Crest, 2 from Larimer Center for Mental Health), and the future of local inpatient services were in question when two of those physicians resigned mid-year. A temporary partnership of four local organizations was developed to fund short-term solutions using temporary psychiatrists while longer term solutions were pursued. (See Appendix F.)

**Local Trend #5: The number of local psychiatric inpatient beds has decreased dramatically.**

- Mountain Crest Behavioral Healthcare Center, which serves the Northern Colorado region, cut the number of available inpatient beds from 52 to 24 within the last 18 months.

**Local Trend #6: Services in the community appear to be shifting towards adolescent residential treatment, and may be “following the money” as state funding opportunities present themselves.**

- Four new or expanded adolescent residential treatment services were reported within the last year.

**Local Trend #7: Consumers are repeatedly frustrated with challenges to receiving timely, appropriate care**

- Consumers report difficulties in finding, understanding and paying for appropriate care.
- Consumers report frustration with remaining stigmas, lack of understanding of mental illness within the court and school systems and the use of the term “behavioral health” because it suggests that mental illness is not a disease.

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**Local Trend #8: Consumers and providers report that waiting lists are a major barrier to effective treatment.**

- There are currently waiting lists for outpatient care, prescriptions, treatment for substance abuse and transfer of treatment from inpatient to outpatient.

**"A four month waiting list for psychiatric services is horrific!"**

-Consumer in discussion group

**Local Trend #9: Primary care physicians (PCPs) are increasingly being expected to manage care and medications for patients with mental illness.**

- PCPs report that consumers need and expect assistance in treating mental health disorders, but many PCPs need more training in order to provide effective treatment.

**Local Trend #10: As a result of national and state trends, local funding for non-Medicaid, low income patients is inadequate, and safety net providers have little or no source of reimbursement for their care.**

Managed care and the state emphasis on Medicaid consumers (rather than those who are uninsured and have low incomes) have reduced or endangered the ability of agencies to fund care for those with low incomes who are not eligible for Medicaid. Previously, Medicaid payments helped support the infrastructure necessary to provide care to those who are not eligible for Medicaid and can't afford the full cost of care.