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FORUM 411
Engaging Arizona's Leaders

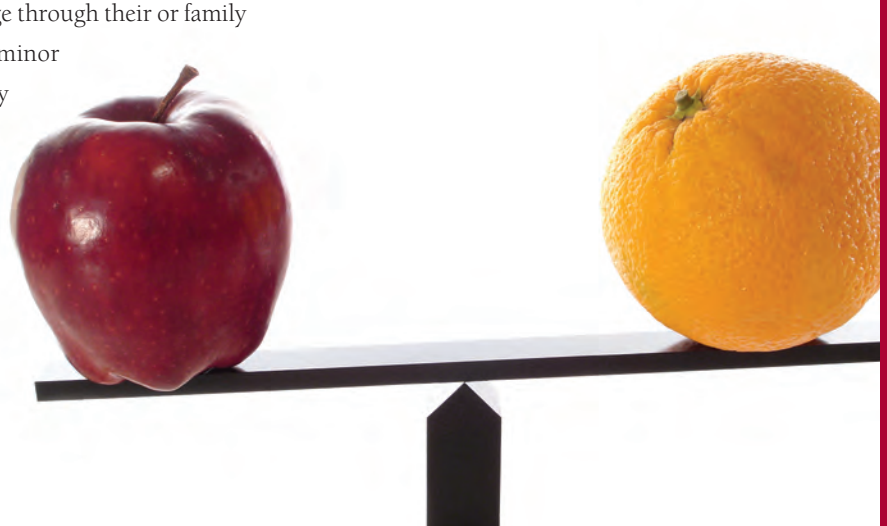
ARIZONA'S MIND-BODY PROBLEM

MENTAL HEALTH SYSTEMS AND CHOICES

When it comes to health, Arizona seems to be suffering from a chronic mind-body problem. That is, an entrenched conviction that matters concerning the mind and those concerning the body must be addressed separately. Sound like philosophical trivia? True, this "dualist" view is associated with the 17th century French philosopher René Descartes. But four centuries later, it continues to affect everyday life, shaping the way we treat – or fail to treat – some of the most common and debilitating illnesses. For one thing, it means we persist in supporting separate systems of health care for ailments like the flu and problems like depression – while research increasingly finds that physical and mental disorders are, as a U.S. Surgeon General's report said, "inseparable."[1]

As with many other dichotomies, one side is given more attention than the other. In this case, we have relegated behavioral health care to second-class status, denying sufficient attention and resources to a set of illnesses that are common, destructive to individuals and families, and costly to everyone – yet almost always treatable. The result: Mental health issues are separate and unequal. Advocates have campaigned for years to redress this imbalance by bringing "parity" to insurance coverage for both mental and physical disorders. The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act*, a 2008 federal statute which is set to take effect in January 2010, is expected to remedy this situation in part.

For the 56% of Arizonans who have health insurance coverage through their or family members' jobs,[2] this imbalance means that physical and minor behavioral health complaints are usually treated by primary care doctors and other health care professionals. These practitioners may have little training in seeking out behavioral health issues that can be linked to physical ones, and often limit treatment to prescribing anti-depressants or other medication. Residents with private insurance also often find available services to be restricted and expensive. Typical private insurance policies in



Forum 411 is a quarterly briefing series offering policy, business, and community leaders information on Arizona's critical issues. Forum 411 refers to Morrison Institute's location on the ASU Downtown Phoenix campus, at 411 North Central Avenue. Morrison Institute seeks to be a source of public policy ideas and provide a venue for discussion. Morrison Institute invites everyone to be part of Forum 411.

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ARIZONA STATE UNIVERSITY

Arizona limit the number of therapy sessions to 20 per year, and hospitalization to a maximum of 30 days per year, both with substantial co-pay requirements. Benefits for physical health care are usually more generous, although these also are often capped. Paying in full for behavioral health care is not a realistic option for most Arizonans. While costs for in-patient physical care are typically higher, behavioral care costs are substantial too. The average charge for in-patient behavioral health care in Arizona in 2007 was more than $18,000 per visit; emergency room visits averaged more than $2,000 each.[3] When private insurance benefits run out, many patients end up in the state's public behavioral health system.

It's Arizona's public health system that most clearly reflects the negative effects of our mind-body problem. The state's public system annually treats more than 150,000 individuals, most of whom are among the approximately 40% of Arizonans who are uninsured or have low incomes. The majority of these residents suffer from anxiety disorders, addictions, phobias, and other problems that are challenging but may not be disabling. However, approximately 38,000 Arizona adults in the public behavioral health system are diagnosed as seriously mentally ill (SMI), typically suffering from severely debilitating diseases such as schizophrenia, bipolar

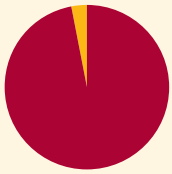
HEALTH INCLUDES MIND & BODY

Since 1948, the World Health Organization has defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

What are Mental Illness, Mental Health, and Behavioral Health?

- **Mental illnesses** or **mental disorders** are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination) associated with distress and/or impaired functioning. The Diagnostic and Statistical Manual (DSM-IV), the U.S. standard reference for psychiatry, includes over 300 different types of mental illness.
- **Mental health** describes either a level of cognitive or emotional well-being or an absence of a mental illness or disorder.
- **Behavioral health** is often used instead of "mental health" because of the stigma associated with mental illness. It is also sometimes used to indicate the inclusion of substance abuse disorders.
- **"Diseases of the brain"** is the phrase now considered by many scientists to be the most accurate label for mental illness. As a 1999 U.S. Surgeon General's report stated: "Everyday language encourages a misperception that mental health or mental illness is unrelated to physical health or physical illness."

PUBLIC OPINION ON INSURANCE FOR MENTAL HEALTH NEEDS



97% of Americans believe access to mental health care is important.

85% say health insurance should cover mental health services.

87% cite lack of insurance coverage as a top reason for not seeking mental health services.

81% of Americans say cost is an important reason for not seeing a mental health professional.

Source: *APA Facts and Statistics*, American Psychological Association, 2004.

ENROLLMENT IN ARIZONA'S STATEWIDE BEHAVIORAL HEALTH SYSTEM

March 2009

Children	43,756
General mental health	54,269
Substance abuse	21,610
Seriously Mentally Ill	37,819
TOTAL	**157,454**

Source: Division of Behavioral Health Services (BHS), Arizona Department of Health Services.

ADULTS WHO ARE SERIOUSLY MENTALLY ILL (SMI)

Estimated number of Arizonans who are SMI	118,869
SMIs served by BHS in 2007	39,867

CHILDREN AND ADOLESCENTS WHO ARE SERIOUSLY EMOTIONALLY DISTURBED (SED)

Estimated number of Arizonans who are SED	111,658
SEDs served by BHS in 2007	30,185

Source: State Plan for Mental Health Services, 2009, Arizona Behavioral Health Services, Arizona Department of Health Services.

disorder, and major depression. Another 30,000 children and adolescents in the system are classified as seriously emotionally disturbed, a diagnosis that is similar to SMI but with some added disease categories. These severely ill children and adults must seek governmental help through a complex bureaucratic system. It's a system operated by many skilled, dedicated people, yet has been criticized for years for being underfunded, understaffed, and uneven in its quality of care – and that remains embroiled in a lawsuit that has gone on for 28 years.

Thus arises Arizona's own version of the mind-body problem: We have a statewide system for *physical* health care – the Arizona Health Care Cost Containment System (AHCCCS) – that has been cited at various times as a national model. Not so for our behavioral health system, the Division of Behavioral Health Services (BHS) in the Arizona Department of Health Services. The system's 2008 audit found conditions that "raise serious questions about the behavioral health treatment, safety, and overall well-being" of Arizonans with serious mental illness.[4] A separate evaluation requested by BHS and completed in 2009 found problems in the division that included excessive turnover in leadership, bureaucratic gridlock, lack of accountability, lack of reliable data, serious staff shortages, and an antiquated data system.[5]

How did Arizona get here? Why are there separate physical and mental health care systems at all? The answers are not simple.

Most Arizonans would say they do not have a mental illness. They might add that they don't know anyone who does – but here they would likely be wrong. The stigma attached to even minor mental disorders remains strong, causing thousands of Arizonans to conceal their illnesses. Hidden or not, however, these illnesses are much more common than most people think.

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MOVING TOWARDS PHYSICAL-MENTAL PARITY

Most private group health insurance plans provide more generous coverage for physical disorders than mental ones. A 1996 federal statute prohibited plans from placing annual and lifetime dollar limits on benefits for behavioral disorders that were more restrictive than those offered for physical ones. In October 2008, the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* extended equitable coverage to treatment visits and all financial requirements, including deductibles, co-pays, numbers of visits, etc. The law also contains several limitations:

- It does not apply to firms with 50 or fewer employees.
- It does not require firms to offer behavioral health coverage.
- Health plans can seek one-year exemptions if they can show that it caused their coverage costs to rise initially by 2%, or thereafter by 1%.

The law is set to become effective on January 1, 2010.

Consider:[6]

- Approximately as many Arizonans suffer from depression as from diabetes.
- Mental disorders are the leading cause of disability in the U.S. for residents ages 15-44.
- An estimated one in four U.S. adults experiences a mental health disorder in a given year.
- One in 17 U.S adults lives with a serious mental illness.
- About one in 10 children have a serious mental or emotional disorder.
- Up to one-half of all doctor's visits in the U.S. are due to conditions caused or exacerbated by mental or emotional problems.
- A recent statewide survey found 12% of Arizonans reporting that they needed mental health services in the past year. The survey found that 6% of state residents take medication for anxiety and 6% for depression.
- Untreated mental disorders can lead to increased crime and homelessness, greater public costs for emergency services, lost productivity from ill individuals and their caregivers, self-medication with drugs and alcohol, and suicide, the 8th-leading cause of death in Arizona.

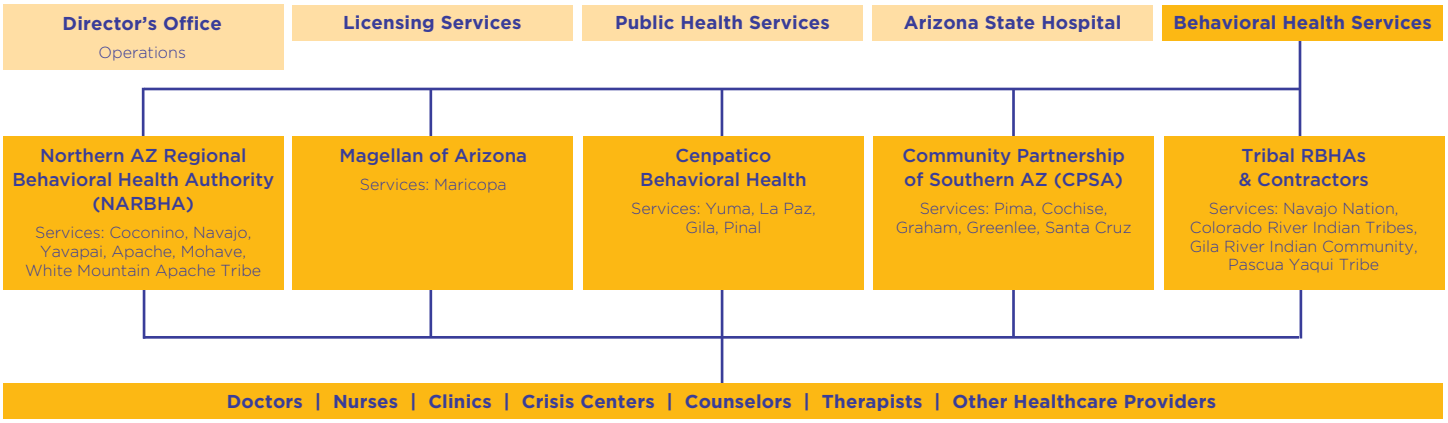
A Checkered History

Fifty years ago, most people with serious mental disorders in Arizona and other states were treated in hospitals, such as the Arizona State Hospital in Phoenix, and considered too disabled to be anywhere else. Then, breakthroughs in treatment combined with an enhanced concern for patients' rights bolstered the belief that those who are mentally ill should be treated in the "least restrictive setting." It was also cheaper than keeping them in the hospital. Nationally, thousands of patients were moved from hospitals back to their communities; those who could not afford private care – the vast majority – were supposed to be treated by networks of publicly supported clinics, group homes, and other facilities. The shift has been dramatic: The Arizona State Hospital, for example, housed nearly 2,000 patients in the 1960s; its census of "civil" (i.e., non-criminal) patients in fiscal year 2008 was 112 – despite the state's enormous population growth.

In Arizona and elsewhere, few well-planned, coordinated networks of community care arose. Instead, "systems" of community services sprouted up in unplanned, fragmented ways amid a lightly regulated array of agencies, clinics, therapists, group homes, and other actors. Some were private, others public. The latter were funded by local, county, state, or federal money. Many former hospital patients ended up homeless; others landed in jail. (Maricopa County's jail system even today is Arizona's second-largest in-patient "treatment" center.) The advent of Medicare and Medicaid in the 1960s provided a stable payment system, but mental health care costs began to rise quickly. In response, governments in the 1980s and 1990s began adopting a "managed care"[7] approach to behavioral health services, centered on health maintenance organizations (HMOs). Controlling costs became a major factor in behavioral health policy – as with physical health care – and remains so today.

Arizona developed its AHCCCS system in the early 1980s. But behavioral health care wasn't included with other AHCCCS health services; instead, it was "carved out" and made the responsibility of a separate agency, the Arizona Department of Health Services' Division of Behavioral Health Services. The "carve out," which most other states also employ, was meant to control costs and ensure that mental health patients received the special attention they needed. The consensus of experts is that carve outs have saved money. A debate continues, though, over how they have affected the quality of care. Arizona then took a further step that some experts

ARIZONA'S DEPARTMENT OF HEALTH SERVICES



Source: Arizona Department of Health Services, Division of Behavioral Health Services.

have called "a carve out of the carve out." Rather than supervise the delivery of health care itself – as the Arizona Department of Economic Security does for persons with developmental disabilities – Arizona's BHS contracts with four non-governmental organizations, called Regional Behavioral Health Authorities (RBHAs), in five regions. There are also three Tribal RBHAs and other tribal contractors. The RBHAs then contract either with smaller networks or directly with therapists, clinics, and other "providers," who actually treat patients.

This multi-layered system has been criticized for increasing costs and diminishing quality, especially since the last two RBHAs in Maricopa County, by far the state's largest service area, have been for-profit corporations headquartered out of state.

The Lawsuit Too Tough to Die

Since even before this system was formed, however, the issue of behavioral health care in Arizona has been dominated by a class action lawsuit that is still not resolved. Filed in 1981, the suit, generally known as *Arnold v. Sarn*, claimed that the state and Maricopa County were failing to fund a comprehensive behavioral health system for residents who are seriously mentally ill, as required by state law. In 1985, a county Superior Court judge ruled in favor of the plaintiffs that the government had in fact violated its legal duty. In 1989, the Arizona Supreme Court agreed, stating that "Arizona has failed to meet its moral and legal obligations to our state's chronically mentally ill population." But that didn't end things. In 1991, the state developed a plan to answer the suit's claims. In 1995, the parties to the suit agreed on "exit criteria" that would determine when the state had established an acceptable behavioral health care system. Those criteria remain unmet. The two sides also agreed that a "monitor" employed by the court would perform annual audits of the system to gauge its progress. The latest audit, released in January 2009, found "a pattern of regression and significant declines in a number of areas," and called for an extensive overhaul of the system.

Why has this legal ordeal not ended? BHS and its supporters argue that the plaintiffs are setting standards that are impossible to reach, and that fulfilling them would cost well over $500 million annually. The plaintiffs and their advocates note that the "exit criteria" have already been agreed to by BHS. They claim that Arizona simply refuses to expend the money and effort needed to do right by its seriously

FUNDING FOR BHS COMES FROM A MIX OF FEDERAL, STATE, AND COUNTY SOURCES

Fund Source	FY 2008 Funds	Percent
Title XIX (federal *Social Security Act*)	$640,329,185	55.7%
Proposition 204 (AZ ballot initiative)	$282,961,826	24.6%
Title XXI (federal *Social Security Act*)	$19,223,605	1.7%
Federal Grants	$41,577,800	3.6%
Non-Title XIX General Funds	$119,003,900	10.4%
County Funds	$42,028,800	3.7%
Other	$3,918,600	0.3%
Total	**$1,149,043,716**	**100%**

Source: Arizona Division of Behavioral Health Services.

mentally ill residents. As the lawsuit trudges into its second quarter century, the importance of resolving it – and freeing BHS to fully focus on its mission – only increases: BHS notes that the number of enrolled people with serious mental illnesses in Maricopa County has risen 94% since 2000, much faster than overall population growth, and is projected to increase by another 45% in the next seven years.[8]

What to Do?

There are, of course, no easy solutions. Our mind-body misperception has been centuries in the making. The stigma associated with mental illness remains strong. Arizona's BHS has been sued and repeatedly audited, evaluated, and reformed. Turf battles between some practitioners in the physical and behavioral health communities may make greater integration slow going. Despite recent advances in brain science, the field of behavioral health remains fraught with uncertain diagnoses and frequently involves subjective assessments that are open to dispute.

There is a wide range of possible public policy choices. Among them are three that Arizona could adopt immediately, and four worth serious consideration.

Even more compelling, however, are the reasons to act now. The weight of scientific opinion clearly states that integration of physical and behavioral health care will provide better quality services to everyone. Arizona's current public system continues to wrestle with tough problems. Behavioral health ailments among Arizonans will likely increase, given the stresses and strains of modern life. Continued inaction costs Arizona millions of dollars each year in lost productivity, ER visits, and jail costs. Parity in insurance coverage for physical and behavioral health continues to advance as a national policy. Governor Jan Brewer has made clear her determination to improve Arizona's standing. Last but not least is the moral issue: Hundreds of thousands of Arizonans need help.

There is a wide range of possible public policy choices. Among them are three that Arizona could adopt immediately, and four worth serious consideration. The first three:

- Make ending the *Arnold v. Sarn* lawsuit a top public health priority, either by meeting the agreed-upon "exit criteria" or by laying a foundation for the two sides to renegotiate, if necessary, to reflect changing conditions in Arizona. This will inevitably require spending more money on caring for Arizonans with severe illnesses of the brain, but it will also save money in other ways, free up BHS to pursue its mission, and likely salvage some lives as well.
- Accept, endorse, and broadcast the clear consensus of scientists, medical researchers, and practicing health care professionals that behavioral health illnesses are in fact real illnesses

and not character flaws. This de-stigmatizing of behavioral disorders is a public education effort that BHS is already pursuing, but greater efforts will encourage more Arizonans to seek treatment and to support others in doing so.

- Take the next step and combat the mind-vs.-body view that underlies the separate systems of care for physical and behavioral health. The 1999 U.S. Surgeon General's report calls this view "a profound obstacle to public understanding," and notes that "new and emerging technologies are making it increasingly possible for researchers to demonstrate the extent to which mental disorders and their treatment…are reflected in physical changes in the brain." Efforts to change mind-body outlooks must target health care professionals.

The second four:

- Promote efforts to maintain the national momentum towards achieving full parity in private insurance coverage of physical and behavioral health care. The *Wellstone-Domenici Act* will move the country closer to that goal, but more can be done to tighten up requirements for broad, equal coverage. It offers an opportunity to push for greater integration of care through such measures as cross-training and co-location of providers, development of multidisciplinary team approaches to care, changing curricula in health care education, and public information campaigns. This is a prime opportunity for Arizona to ease the division between diseases of the body and those of the brain, and to work with all employers, small and large, to find health care solutions.
- Evaluate the arguments for establishing a nonprofit community-based network as the RHBA in Maricopa County rather than another for-profit, out-of-state corporation. Advocates say the former would be more likely to keep revenues in the state, and reinvest excess revenue in the local community. Arizona's experience with its current Maricopa County RHBA, Magellan Health Services, and its previous one, Value Options, has been discouraging.
- An even more ambitious reform would be to eliminate the state's RBHA system and instead have BHS itself supervise the state's behavioral health care providers, as the staff of the Department of Economic Security does with Arizonans with developmental disabilities. There seems to be little evidence that the current RHBA system accomplishes anything other than placing another bureaucratic layer between ill Arizonans and the care they seek.
- A still more sweeping change would be to abolish Arizona's behavioral health "carve-out" and place part or all of the responsibility for public behavioral health services with AHCCCS. This would represent a giant step towards integration of mental and physical health care. It would also play to the state's strengths by harnessing AHCCCS's considerable administrative skills. Some might argue that this would benefit the majority of Arizonans with relatively minor disorders, but that those with severe mental illnesses should remain "carved out" in some fashion to ensure that they receive the specialized treatment they need. In any case, Arizona's need for improved care makes even this extensive reform worth serious consideration.

Four hundred years after René Descartes' famous but unfortunate conclusion, medical science has advanced to the point that the benefits of integrating physical and behavioral health care are virtually undisputed. For their part, the thousands of Arizonans suffering from stress-related headaches, debilitating anxiety, body-destroying addictions, and other ills certainly have no stake in dividing up their problems into separate boxes. Arizona could contribute to the national movement to end the mind-body duality, while cutting collateral costs borne by all residents and easing the misery of many.

The thousands of Arizonans suffering from stress-related headaches, debilitating anxiety, body-destroying addictions, and other ills certainly have no stake in dividing up their problems into separate boxes.

1 *Mental Health: A Report of the Surgeon General*, 1999, U.S. Public Health Service.

2 Jill Rissi, et.al, 2008, *Health Insurance for Arizona Adults*, St. Luke's Health Initiatives.

3 Arizona Department of Health Services, *Vital Statistics*, Tables 10 and 11: www.azdhs.gov/plan/hip/for/mental/index.htm.

4 *2008 Independent Review, Office of the Monitor, Arnold v. ADHS*, January, 2009.

5 Health Services Advisory Group, *Arizona Department of Health Services, Division of Behavioral Health Services, Independent Assessment*, February 2009.

6 The following statistics were compiled from the National Institute for Mental Health, St. Luke's Health Initiatives, Jose Ashford of Arizona State University, BHS State Plan, Mental Health America, www.nmha.org, and Milken Institute.

7 Managed care, common in physical as well as behavioral health systems, refers to any system that manages health care delivery with one aim being to control costs. Managed care systems typically rely on a primary care physician who acts as a gatekeeper through whom the patient has to go to obtain other health services such as specialty medical care, surgery, or physical therapy. Managed care plans also usually review decisions by doctors and other providers to prescribe costly treatments or medications.

8 Arizona Department of Health Services, Division of Behavioral Health Services, *Arnold v. Sarn* Status Report, 2008.

Heal the Mind-Body Split

- Do you think diseases of the brain still carry a stigma?
- What do you think public officials should do to improve mental health care in Arizona?

Talk to Morrison Institute at **morrison.institute@asu.edu**.

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