Guide to Equity in Behavioral Health Care

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ABOUT THIS GUIDE

This guide equips advocates and other changemakers with key information about **behavioral health care**, including an overview of the system's inequities. It also highlights the policy and accountability levers that can **advance equity.**

This guide is part of a larger project on inequities and policy levers in the US health care system. For the complete guide, visit **urbn.is/4054rNQ.**

The other topics **covered include the following**:

- Children's Health Insurance Program
- health care for the uninsured
- Indian Health Service
- Marketplace insurance
- Medicaid
- Medicaid-Medicare
- Medicare
- pharmacy services
- Veterans Health Administration

OVERVIEW

In the United States, mental health and substance use services—also known as behavioral health services—tend to be separated from the physical health care system, which has resulted in less emphasis on health insurance coverage and workforce capacity in behavioral health services and little coordination between the two. This separation of physical and behavioral health can create barriers to accessing appropriate care. Moreover, stigma and discrimination associated with mental health and substance use conditions have led to punitive, rather than health care responses to behavioral health needs, such as criminalization of drug use. Americans with untreated mental illness are at high risk of being killed in interactions with law enforcement and are more likely to be incarcerated than treated in a psychiatric hospital. Furthermore, people from racial and ethnic minority groups who have behavioral health needs experience greater barriers to treatment and are far more likely than white people to be incarcerated or face other punitive outcomes such as family involvement with the child welfare system. The worsening drug overdose epidemic and growing mental health needs during the COVID-19 pandemic underscore the need for improving access to and quality of comprehensive and evidence-informed behavioral health services.

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POPULATION

Mental health and substance use conditions are prevalent in the population, regardless of race, ethnicity, class, gender, income, and other factors. Key facts about the prevalence of these conditions in the US include the following:

- On average, one in five adults and one in six children and teens (ages 6-17) report experiencing mental illness each year. In addition, one in 20 adults are diagnosed with serious mental illness annually.
- While the prevalence of mental health conditions is relatively similar across adults from most racial and ethnic groups (at about one in five), one in four American Indian/Native Alaskans and one in three people who are multiracial report mental health problems.
- Furthermore, people who identify as LGBTQIA+ are more likely to experience depression, anxiety, substance use problems, and suicidal ideation than heterosexual people.
- Almost eight in 10 Americans ages 12 and above (78 percent) reported consuming alcohol at some point in their lifetime.
- About 13 percent of Americans ages 12 and above reported using drugs in 2020.
- Marijuana is the most used drug in the US, with about 10 percent of youth ages 12–17 and 18 percent of adults reporting using marijuana at least once.
- An estimated 3.4 percent of Americans aged 12 and older reported misusing opioids, such as prescription painkillers, at least once in the last year.
- About 20 million Americans 12 and older have been diagnosed with substance use disorder (SUD), most often related to marijuana and prescription opioids.
- About 9.5 million adults (or about 3.8 percent of US residents) have both SUD and mental health conditions.
- Tobacco use is the leading cause of disease, disability, and death in the US. While the overall prevalence of cigarette smoking has declined to about 11 percent of all adults, some communities are disproportionately affected by smoking, including people living in rural areas, people with low levels of education and income, people without health insurance, tribal communities, and people with anxiety and depression.

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PROVIDERS AND SERVICE DELIVERY

Specialty behavioral health providers include Certified Community Behavioral Health Clinics, which operate in communities and offer comprehensive services to everyone regardless of insurance coverage or ability to pay, and Opioid Treatment Programs, which are certified to treat substance and opioid use disorders with medications. With a recognition of the importance of addressing whole-person care, health care providers have started to focus on the coordination or integration of physical and behavioral health care. For example, primary care providers and hospital emergency room departments may screen patients for behavioral health needs and refer them to treatment if needed (in some cases, emergency departments can initiate substance use treatment as part of emergency visits). Some providers may offer integrated services where patients can access physical and behavioral health care services in one location, improving access and engagement in care.

Comprehensive behavioral health care consists of prevention; screening, early identification, and brief interventions for acute and emerging issues; and treatment and recovery support for chronic, often life-long mental health or substance use disorders. This suit of services is often referred to as a continuum of care, reflecting the idea that services are tailored to meet the varied intensity or level of patients' needs. Increasingly, the continuum of care includes harm reduction services for people who are active substance users but not in treatment. Harm reduction includes services such as syringe exchange and naloxone distribution (lifesaving medication that can reverse overdose), in addition to medical care and social services to encourage people to stay as healthy as possible and facilitate access to treatment.

Behavioral health services may include counseling and behavioral health therapy (such as psychotherapy), prescription medications (such as for depression or substance use), case management and care coordination services, hospital inpatient or residential treatment, mobile crisis services, and other crisis response interventions. Services can be provided in clinical settings and the community, such as schools. The pandemic led to a rise in technology-facilitated access to behavioral health care, such as telehealth and text-based mental health therapy. A wide range of providers can deliver behavioral health care, from psychiatrists and psychologists to psychiatric nurse practitioners and licensed counselors, to social workers, family and marriage therapists, community health workers, and peer support specialists who are people in recovery from mental health and substance use conditions supporting others with the same conditions.

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FINANCING

Behavioral health care services are paid for by public and private resources. More than half (58 percent) of behavioral health services are funded by public health insurance programs, such as Medicaid and Medicare, and federal and state grants for behavioral health services. The Substance Abuse and Mental Health Services Administration is a federal agency administering behavioral health care grants to states and other entities, with

a $6.4 billion discretionary budget in 2022. Public funding may include behavioral health services provided to people in carceral settings.

About a third (34 percent) of spending on behavioral health care is covered by private health insurers. Other funding sources for behavioral health services include settlement funds from tobacco or more recent lawsuits brought against opioid manufacturers and distributors. Finally, patients may incur out-of-pocket costs or self-pay for behavioral health care.

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BARRIERS

Steady advocacy has forced policymakers, researchers, providers, and consumers to recognize the importance of mental health. A major step toward greater prominence of behavioral health services is the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which requires that large-group health insurance plans cover mental health and substance use services at the same level and without the same restrictions as physical health care. The Affordable Care Act of 2010 expanded and strengthened access to behavioral health care by mandating that all public and private insurers (including individual and small-group plans) comply with MHPAEA and by banning insurers from denying coverage to people with preexisting health conditions, including behavioral health conditions. More recently, the Consolidated Appropriations Act of 2021 introduced new requirements for insurers to demonstrate compliance with MHPAEA.

Despite these laws, there remain many barriers to accessing high-quality, evidence-informed, and culturally and linguistically effective behavioral health services, including the following:

Coverage and affordability

Despite federal laws requiring health insurance coverage for behavioral health services, the enforcement of and compliance with the parity laws has been lacking. People with health insurance continue to encounter barriers to accessing behavioral health services, including narrower behavioral health provider networks than those for physical health care services. Many insured adults who need mental health services report not accessing care because their insurance does not cover it. For example, health plans may limit the duration of covered treatment or only cover services if a patient has an official diagnosis of mental illness or substance use disorder. Often, services like prevention counseling and brief intervention for people who are at risk of developing a behavioral health condition are not covered by insurance. Providers and patients may not be aware of their rights under MHPAEA, so problematic insurer practices may not be identified and corrected.

Moreover, reimbursement for behavioral health services tends to be lower than for primary care and other specialty services, further restricting access to care as behavioral health providers may not accept certain or all types of insurance. Available data suggest that psychiatrists are less likely than other physicians to accept any health insurance, including private insurance. Having to see an out-of-network provider or pay for the full cost of care may not be affordable, and many people who need behavioral health services do not seek care because of cost concerns.

Workforce shortages

The US faces large health care workforce shortages that have been accelerated by the pandemic and provider burnout, including an inadequate supply of behavioral health providers to respond to the growing mental health needs of the population. Nearly half of the US population lives in mental health care deserts, with 570 US counties having no mental health care providers, forcing patients to travel long distances and experience long wait times for care. Even though telehealth can alleviate some of the access concerns, unequal access to broadband internet and computer literacy poses barriers for many patients, particularly those from underserved communities.

Furthermore, access to culturally and linguistically effective behavioral health services is limited because of the underrepresentation of providers of color in behavioral health professions. Because of severe shortages of behavioral health treatment in the community, many patients seek care from their primary care providers, who may be unprepared to treat more severe mental health and substance use concerns. Furthermore, some states have same-day billing restrictions, making it challenging and sometimes impossible for providers to get reimbursed for primary care and behavioral health services delivered to patients within the same visit.

Stigma and punitive responses

In the US, mental illness and substance use disorders have been highly stigmatized and treated as a moral failing of the individual rather than a chronic health condition, leading to an overemphasis on punitive and legal system responses instead of health-based responses to behavioral health conditions. This stigma may be manifested as shame, bias, and discrimination from friends and family, employers, landlords, and sometimes even health care providers. Because of this stigma, people who have mental health and substance use problems often delay or avoid seeking help. For example, pregnant women who use substances, especially if they are from communities of color, may avoid seeking prenatal care because of fear they would be judged and, instead of receiving treatment and support, would be reported to a child welfare agency and lose custody of their child.

Some substance use services are stigmatized for both patients and providers, such as the case of opioid treatment programs that dispense methadone medication, which, despite strong evidence of its effectiveness, is highly misunderstood. Furthermore, methadone treatment is strictly regulated; for example, patients must come to the clinic daily to receive their medication, which presents a barrier to treatment and can further stigmatize patients. Harm reduction services, particularly syringe exchange programs, have faced fierce opposition from state and local officials and community members.

At the policy and systems levels, the stigma associated with mental health and substance use conditions has resulted in an unbalanced system where large-scale efforts and resources are devoted to punitive and criminal-legal responses, but investments in behavioral health research and services are smaller compared with other health care. For example, youth with behavioral health conditions may be facing zero-tolerance policies and harsh school discipline, such as suspension or expulsion, rather than counseling. Adults with mental illness are disproportionately represented in carceral settings, where access to comprehensive and high-quality treatment is very limited. The criminalization of drug possession has resulted in millions of Americans with substance use disorder being incarcerated, which, besides inadequate access to health care, also results in permanent damage to their reputation, job prospects, and social relationships.

Overcoming Stigma and Access Barriers to Therapy

"At 29 years old, I was diagnosed with ADHD and OCD. I quickly realized that I had been living with both disorders since some of my earliest memories. This was a crushing discovery, and I felt a deep despair that I had been ignored and invalidated by everyone in my life. I was labeled as 'Lazy,' 'Stubborn,' and 'Selfish,' when in reality I was struggling to understand and live in the world around me. When I was growing up in the 90s, mental health was stigmatized. I remember my grandma telling me that if you went to a doctor for depression, you were automatically labeled as 'crazy.' I believed that I was crazy for a lot of my life. I started to take my mental and physical health seriously following the birth of my daughter because I made an enormous commitment to be there for my child. I started therapy and have attended consistently for almost 4 years now.

I remember seeking out therapists that I was told accepted my insurance. I felt challenged at every turn though, as if it was going to be near impossible to get the help I wanted. I faced many obstacles and spoke to various professionals who all gave me different answers. I can understand how so many people give up on therapy, or seeing a doctor regularly. The process is confusing, almost daunting when you continue to seek help to no avail. I persevered and learned how to advocate for myself. I know that there is also a communication barrier in conveying symptoms to a doctor. They speak a different language, and the same can be said for paperwork in health care. My story is one of success, but many have given up. If anything, I'd like to use my knowledge to help others receive the care they deserve."

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DISPARITIES

The barriers discussed above are prevalent, and only about a third of US residents with diagnosed behavioral health conditions received treatment in 2021. Moreover, a large body of evidence documents significant racial and ethnic disparities in access to behavioral health services, quality of care, and outcomes. A few examples of these disparities include the following:

- People of color face more barriers to treatment and are less likely to receive treatment for mental health and substance use conditions than white people.
- Even if people of color can access behavioral health services, they are more likely to receive poor-quality treatment, end treatment prematurely, and have worse outcomes from care than white patients.

- Behavioral health disorders may be underdiagnosed among people of color and may be more likely characterized as disruptive or criminal among youth and adults compared with their white counterparts. Black students are disproportionately more likely than their white counterparts to face school discipline, sometimes referred to as the "school-to-prison pipeline." Similarly, people from racial and ethnic minority groups are more likely to be incarcerated for drug-related offenses than white people.

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OVERSIGHT AND ACCOUNTABILITY

Federal and state agencies are responsible for administering and overseeing behavioral health services and ensuring compliance with laws that guarantee access to behavioral health care, including the following:

- **The Substance Abuse and Mental Health Services Administration** within the US Department of Health and Human Services is responsible for leading public health efforts to address mental health and substance use, including overseeing block grant funding for state and local behavioral health prevention, treatment, and recovery programs.
- **The Centers for Medicare & Medicaid Services (CMS)** is an agency within the US Department of Health and Human Services responsible for oversight, policy development, and guidance, including coverage and access to behavioral health services in Medicare and Medicaid programs.
- **The Centers for Disease Control and Prevention** conducts and disseminates research and evidence to promote the health and wellness of Americans.
- **Employee Benefits Security Administration**, an agency within the US Department of Labor, enforces insurers' compliance with the mental health parity law.
- **State behavioral health agencies** are responsible for the public mental health and substance use service delivery system in each state, including functions such as developing policy, allocating resources, overseeing facilities and providers, and collecting and reporting data on the prevalence and treatment of behavioral health conditions.
- **State insurance departments** monitor group and individual health plans sold by insurers in their states, including those offered on the Marketplaces. Insurance departments are responsible for overseeing insurers' compliance with federal behavioral health parity laws (MHPAEA).
- **Advocacy organizations** at the national and local level work to highlight and advocate for issues affecting people with mental health and substance use conditions, including providing support and resources to people and families facing behavioral health challenges. These groups include the American Foundation for

Suicide Prevention, Black Emotional and Mental Health Collective, Mental Health America, National Alliance for Mental Health, National Association of Addiction Treatment Providers, Shatterproof, Young Invincibles, and many others.

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POLICIES AND ACTIONS TO LESSEN BARRIERS AND DISPARITIES

Increased national attention to the opioid epidemic and mental health crisis has led to a recent flurry of federal and state efforts to strengthen the behavioral health care system. To ensure that all US residents have equitable access to high quality, evidence-informed, and culturally and linguistically effective continuum of mental health and substance use services, federal and state policymakers could consider the following:

Strengthening oversight and enforcement of behavioral health parity

- Provide detailed federal guidance, tools, and funding to state and federal agencies responsible for oversight and enforcement of insurers' compliance with MHPAEA. This could include guidance and resources to systematically collect and analyze data on utilization management practices (such as prior authorizations) and provider reimbursement to effectively identify and address factors that may restrict meaningful access to mental health and substance use services.
- Improve provider and consumer education about insurers' obligations under MHPAEA, including how to report potentially problematic practices and compliance violations.

Expanding and supporting the behavioral health workforce

- Expand federal and state investments in various workforce initiatives to increase entry and retention of people of color in behavioral health professions, such as creating and expanding health profession pathway programs and expanding scholarship and loan repayment programs.
- Reassess the scope of practice and credentialing or certification requirements for midlevel clinical practitioners (such as licensed addiction counselors and nurse practitioners) and nonclinical practitioners (such as peer support specialists and community health workers) to allow such professionals to deliver and get reimbursed for certain behavioral health services.
- Provide support and training to primary care and emergency care providers to effectively screen and deliver brief interventions to patients with emerging mental health and substance use concerns, including by addressing administrative barriers, such as restrictions on same-day billing.
- Assess and increase reimbursement for behavioral health services to cover the cost of care and improve provider participation in health insurance plans.

Improving access to high-quality, evidence-informed behavioral health services

- Address provider shortages in behavioral health deserts, including by creating behavioral health residency opportunities and removing regulatory barriers for opioid treatment programs and other providers to operate in communities.
- Promote greater integration of behavioral health with primary care by improving payment models and removing regulatory and administrative barriers to integration.
- Ensure availability of behavioral health in community settings, including by expanding funding and technical assistance for school-based behavioral health services.
- Monitor and evaluate emerging new care delivery models such as telehealth, text-based counseling, and mental health apps to ensure high-quality care and equitable access to and outcomes from these models for all patients, including by removing digital divide barriers.

Shifting away from punitive response to behavioral health

- Review and revise or eliminate policies and practices that lead to inequities. This may include well-intended policies such as universal screening for substance use and parental depression that may nevertheless result in inequitable outcomes, such as people of color being reported to authorities while white people are referred to treatment.
- Ensure that all health care providers and emergency responders are trained and equipped to deliver culturally effective and trauma-informed behavioral health crisis interventions, and invest in the expansion of culturally effective mobile crisis intervention services as an alternative to law-enforcement responses.
- Expand effective diversion programs that minimize or avoid criminal legal system involvement by offering mental health care, substance use treatment, and social services and supports to people who commit low-level, nonviolent offenses.

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GLOSSARY

Accountability is an assurance that an individual or organization is evaluated on its performance or behavior related to something for which it is responsible.

The **Affordable Care Act** (sometimes known as ACA, PPACA, or "Obamacare") is a comprehensive health care reform law enacted in March 2010. The primary goals of the ACA are to make health insurance more affordable by providing financial assistance (also known as subsidies) to people to purchase health insurance and expand the Medicaid program to cover more people with low incomes.

Brief interventions are a technique used to counsel patients to help them change unhealthy or risky behaviors such as smoking or excessive drinking.

Discipline refers to the rules, practices, and strategies schools use to manage student behavior and encourage self-discipline.

Health disparities are preventable differences in disease, health status, or opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities.

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

LGBTQIA+ is an abbreviation for lesbian, gay, bisexual, transgender, questioning, intersex, asexual, and others. These terms are used to describe an individual's sexual orientation or gender identity.

Overdose is taking an excessive amount of drugs that can be harmful to health, but not all overdoses are fatal or life-threatening.

Oversight is the responsibility for a job or activity and ensuring it is done correctly.

Prior authorization is a required approval from a health plan before a patient receives a service or fills a prescription for the service or prescription to be reimbursed.

Provider burnout is caused by long-term stress and can include emotional exhaustion, lack of empathy for or negative attitudes toward patients, and feelings of decreased personal achievement.

Stigma is a strong lack of respect, disapproval, or bad opinion associated with a particular circumstance, quality, or people.

Substance use disorder is a chronic health condition that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications. Symptoms can range from moderate to severe, with addiction being the most severe form.

Suicidal ideation is the thought process of having ideas or thoughts about the possibility of ending one's own life.

Telehealth is the use of electronic information and communications technologies to provide and support health care when distance separates the patients.

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