Barriers to Behavioral Health Treatment

Changing the Conversation

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Editor's note: *Behavioral Health is a vital component of comprehensive health care. This journal has previously published articles about integrating behavioral health into primary care practices,[1] and about the behavioral health aspects of obesity.[2] In response to the growing need for behavioral health services in our region, the Lancaster Behavioral Health Hospital (LBHH) opened in July 2018 as a partnership between Penn Medicine Lancaster General Health (PMLGH) and Universal Health Services. The 126-bed facility will provide inpatient and outpatient services to adolescent, adult, and older adult patients.*

Notwithstanding the growing recognition of the vital role of behavioral health in comprehensive health care, stigma and discrimination still provide obstacles to behavioral health treatment. In the following informative article, the CEO of LGBHH discusses what health care providers can do to impact this scenario.

INTRODUCTION

Mental illness impacts everyone; nearly 20% of Americans experience a mental illness in any given year,[3] and the national suicide rate is the highest it has been in decades, up 33% between 1999 and 2017.[4] Mental illness affects everyone's family, everyone's friends, and everyone's co-workers.

Indeed, the most frequent health concern googled in the state of Pennsylvania is stress.[5] College counseling centers describe being overrun with requests for services, with one of three college freshman reporting symptoms consistent with a diagnosable behavioral health disorder.[6,7] In Lancaster county alone, individuals report 3.9 days of poor mental health in a 30-day period; death rates from suicide and drug use have increased; the number of adolescents reporting feelings of sadness or depression within the past year has seen an uptick; and the Medicare population more frequently reports feelings of depression.[8]

Yet, despite these troubling statistics, mental illness is often not disclosed and/or treated. In fact, research reveals there is traditionally a lag of a decade or more between the emergence of behavioral health symptoms and its treatment.[9] This trajectory can create lifelong disability, so it is imperative that mental illness be recognized and attended to promptly.

Access to needed behavioral health services is impeded by a lack of providers, suboptimal insurance coverage, and – despite all efforts to the contrary – persistence of shame about seeking mental health services.

SHORTAGE OF PSYCHIATRISTS

The United States is suffering from a severe shortage of psychiatrists nationwide. Merritt Hawkins, the largest physician search firm in the United States, reports that psychiatrists are the second most sought after specialty.[10] This shortage only seems to grow as the population of psychiatrists ages; psychiatrists as a group are the third oldest specialty. Sixty percent of currently licensed psychiatrists are more than 55 years old, so a wave of retirements seems imminent.[11]

Moreover, the specialty of psychiatry does not always receive the respect it deserves. Jeffrey Lieberman, M.D., former president of the American Psychiatric Association (APA), said it well when he declared, "Psychiatry has the dubious distinction of being the only medical specialty with an 'anti' movement. You have never heard of an anti-cardiology movement, or an anti-orthopedics movement." [12] Yet, an anti-psychiatry movement has been led by such notables as the late Dr. Thomas Szasz, fueled by the Scientologist L. Ron Hubbard, and sustained by an angry population of individuals who received long-term treatment solely with psychiatric medications, which may have negatively impacted their physical health. These sentiments likely influenced the fact that, according to the National Institute for Mental Health, only 50% of the people living with some form of mental illness received treatment in 2017.[13]

Further, among physicians, the profession of psychiatry is not always viewed with the same esteem as other specialties. In my personal experience, it was even difficult for an outstanding chief of psychiatry to

be elected president of a hospital's medical staff, just because that coveted position needed to be held by a surgeon.

Unfortunately, the shortage of providers will not be mitigated by current training programs. As with other specialties, the federal government's funding support for psychiatry residencies was capped 21 years ago; only some hospitals have expanded their residencies and taken on the added training costs themselves.[14]

The limited number of behavioral health providers has clearly impacted access to behavioral health care, and has spurred the expansion of telepsychiatry and the utilization of family practice providers to manage mental illness. Creative enhancements to these services include the availability of on-call, university-based psychiatrists to consult with family practice physicians. Unfortunately, these services are typically funded by grants or states, and they will not endure without a permanent funding structure.

INSURANCE COVERAGE

The Affordable Care Act mandated that health plans for individuals and small groups must provide behavioral health as an equivalent essential health benefit. The ACA built on the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, which required larger insurers to provide the same amount of coverage for behavioral health as for medical and surgical procedures. Prior to these protections, many health plans carried no or limited behavioral health benefits.

In 2016, the Mental Health Treatment and Research Institute commissioned actuarial consultant Milliman Inc. to examine parity and disparities in treatment.[15] The researchers mined three years of insurance claims covering 42 million Americans, and analyzed both inpatient and outpatient care. Access restrictions resulted in individuals with behavioral health concerns being significantly more likely to receive out-of-network benefits, and incur higher out-of-pocket costs, which provided clear evidence of reduced access to behavioral health care.

The ACA and MHPAEA legislation had equalized copay charges and annual/lifetime limitations between medical and behavioral health care, but differences continue to be pervasive in terms of utilization management practices, rates for services, and network adequacy.

The proportion of behavioral health care provided out of network was 3.6 to 5.8 times higher (and therefore costlier), than medical/surgical care.[15] For Pennsylvania, in 2015, use of out-of-network behavioral health inpatient care was more than 10 times as common as out-of-network medical/surgical inpatient care.[16]

Milliman also identified reduced payment rates for behavior health specialists compared with primary care physicians or medical/surgical specialists for similar services. Primary care providers were reimbursed about 20% higher than psychiatrists for the same or similar CPT behavioral health codes.[17] Inadequate rates are a major driver of insufficient access to care, and they contribute to the shortage of providers, since psychiatrists will not join networks where they are not reimbursed for the cost of providing treatment. This situation also supports the proliferation of psychiatric practices that accept no insurance, further limiting access to care. This inequity has spurred the development of movements such as #Don'tDenyMe (www.Don't DenyMe.org), an effort by the APA, MHA, NAMI, the National Council, and others to galvanize the public to push back.

Since 2016, mental health conditions have taken up the largest share of U.S. health care spending for the first time.[18] Yet, reimbursement and insurance coverage continue to lag behind other illnesses, and discrimination remains rampant.

COMPARTMENTALIZATION AND DISCRIMINATION

Americans with depression, bipolar disorder, or other serious mental illnesses, die 15 to 30 years younger than those without mental illness – a disparity larger than for race, ethnicity, geography, or socioeconomic status.[19] Yet, what is arguably the single largest health disparity today does not attract much public attention, funding, or research.

This inequality is due in part to the compartmentalization of health; physical and behavioral health are separated, and their interplay in regard to wellness is not prioritized. Historically, behavioral health care providers focused on their patients' mental health, and did not always take the time to understand their physical symptoms and needs.

Unfortunately, physical health symptoms are sometimes left untreated because some primary care providers believe the patient will not adhere to treatment recommendations.[20] Further, when an individual with a significant behavioral health concern presents to an ER, oftentimes they are relegated to a psych area even when their presenting symptoms are clearly medical.

STIGMATIZATION

Stigma is an important influence on patients' behavior when they seek care. No one bakes you casseroles when your child or parent is hospitalized for a behavioral health concern, and the patient's hospital nightstand is not adorned with flowers and get-well cards. The shame in seeking behavioral health care is real, and is magnified by the way we speak about mental health in general. Person-centered care models advise us that we should place the person before the illness. However, with behavioral health we still label individuals by their diagnosis. Calling people "schizophrenic" or "bipolar" is saying in effect they ARE their illness; it implies some sort of permanence, yet the trait does not define the person.

CHANGING THE CONVERSATION

Historically, sensational media depictions linking mental illness to violence were widespread. More recently, however, the media have begun sharing the stories of the struggles and recoveries of high-profile athletes, movie stars, and musicians. Public policy, law, and the media are all useful mechanisms to modify stereotypes.

We can promote an unbiased view of behavioral health via the language we use. What we say and how we say it, matter. Words can unintentionally reinforce stereotypes. Every one of us has some responsibility, especially those of us with good mental health. You are one of the lucky ones if you are fortunate enough to wake up each day without the terror of leaving your house, or the frustration of trying to quell voices in your head, or the need to overcome the dark sadness that envelopes your being. Every day, with every individual we care for, we can make a difference by making the choice to treat mental illness within the same scope of practice as any other diagnosis.

THE LBHH PHILOSOPHY OF CARE

The physicians, staff, and leadership of Lancaster Behavioral Health Hospital believe recovery is possible for every person with a behavioral health diagnosis. Providing optimal care is a matter of identifying the unique needs of each person, and providing a treatment plan that addresses the whole person, not merely a list of symptoms. Together with the individuals in our care, we will create stories of hope, with the understanding that *hope is the seed for change*. Our values to provide strength-based, trauma-informed, recovery-oriented care, is the difference that sets LBHH apart from other psychiatric hospitals.

We are recruiting and/or creating a workforce of staff that are trained in evidence-based practices (e.g., cognitive behavioral therapy, dialectal behavioral therapy, motivational interviewing, etc.), and have a passion for behavioral health and making a difference. The individuals in our care receive tailored, personalized treatment under the care of their board-certified psychiatrist. The staff of LBHH consists of interdisciplinary teams of doctors, nurses, social workers, recreation therapists, creative arts therapists, a dietitian, a chaplain and others. In addition, a family nurse practitioner is available daily to treat the person's concurrent physical ailments. Together the team members will work to develop comprehensive, customized, therapeutic treatments plans to help our individuals in care recover mentally and physically.

LBHH has agreements with a dozen or more colleges and universities to send students to LBHH, where we can help train the next generation of behavioral health staff and providers. We also strive to improve the community's understanding of mental health. We advocate for some of the most stigmatized, neglected, and misunderstood people in our community. We empower the people we treat to respect themselves and take responsibility for their lives. We partner with individuals in care to help them reach their goals. At LBHH, we treat the whole person using a comprehensive, dynamic, evidenced-based approach. Everyone can get better, and getting better is different for everyone.

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