



The U.S. Mental Health Delivery System Infrastructure: A Primer

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Summary

In the past decade, four federal reports have offered insight into the nation's mental health care system and recommended a fundamental transformation of the system. According to these reports, transformation of the mental health care system would require timely incorporation of evidence-based practices in routine practice, resolution of workforce shortage issues, removal of financial barriers, coordination of mental health care with general health and social services, and systematic measurement and improvement of the quality of care delivered. While each of these recommendations may result in some benefits, the findings suggest that a comprehensive transformation of the mental health system could be necessary to ensure the availability and accessibility of quality mental health care to all individuals who need it.

In 2007 about 11% of adults (23.7 million) in the United States experienced serious psychological distress, such as anxiety and mood disorders, that resulted in functional impairment that impeded one or more major life activities. Different types of providers deliver care in a range of settings and are financed by various combinations of public and private payers. Congress has been increasingly interested in transforming the mental health system in the aftermath of tragedies involving mentally ill individuals—such as the shootings at Columbine and Virginia Tech, which led to heightened public interest in the adequacy of the mental health care system. Two federally funded efforts, one through the Agency for Healthcare Research and Quality (AHRQ) and the other through the Substance Abuse and Mental Health Services Administration (SAMHSA), attempt to measure the quality of mental health care on an annual basis. At this time, neither effort is adequately developed to guide the transformation of the system.

SAMHSA estimates that less than half of individuals with serious psychological distress receive mental health care due to various social, financial, and systemic barriers. While there have been advances in treatment options, the delivery system and financing mechanisms have been slow to transform and apply these findings in routine practice. For this reason, despite substantial investments that have increased the knowledge base about mental illness and have led to the development of many effective treatments, experts agree that many Americans are not benefiting from these investments. Mental health care is often not coordinated with other care that an individual may be receiving or may need. Access to competent mental health providers is scarce in rural areas and even some urban areas. Coverage for mental illness provided by private health insurance, Medicare and Medicaid, is sometimes less comprehensive than that for physical illnesses, negatively affecting access. In addition, some issues, such as social stigma around mental illness, and inadequate public awareness that mental health problems are treatable create disincentives for individuals to seek care. These issues affect both the access to, and the quality of, care delivered and, by consequence, the mental health outcomes achieved.

In the past decade, Congress passed two far-reaching laws on mental health care. The first law, the Children's Health Act, reauthorized the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2000 and called for greater focus on measurement of mental health care outcomes. The second law, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, expands federal requirements for mental health coverage. Congress could consider transformation of the mental health system as part of larger health care reform efforts.

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Introduction

According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), in 2007 about 11% of adults (23.7 million) experienced serious psychological distress, such as anxiety and mood disorders, that resulted in functional impairment that impeded one or more major life activities.¹ It is estimated that less than half of these individuals received mental health care due to various social, financial, and systemic barriers. Even among those individuals who received mental health care, some did not receive the best possible care due to lack of trained mental health providers and other issues affecting quality of care.

The term “mental health care” has been used in various contexts to encompass a wide variety of services, ranging from commonly used services, such as family and marital counseling, to specific treatment options for severe mental conditions, such as bipolar illness. In this report, “mental health care” includes care for all levels of severity of mental illness as well as treatment of mental conditions that are common in certain age groups—including Alzheimer’s and other dementias among older adults, post-partum depression and other mood disorders among middle-aged adults, and autism and attention-deficit disorders (ADD) among children. It includes counseling, inpatient care, outpatient care, and prescription medications for problems with emotions or anxiety, and within this report, it does not include alcohol or drug treatment.

This report begins with a historical perspective on delivery of mental health care services. Next, it describes the health care delivery system within which mental health care is currently provided and presents the various mechanisms that finance the current system. In describing the mental health system, this report considers three aspects: Who provides care? Where is the care provided? Who pays for the care? Finally, this report analyzes the barriers to receiving mental health treatment and workforce training issues, and presents possible options for Congress to address these barriers. While it is recognized that mental health care is also provided within the Department of Veterans Affairs (VA) and the Department of Defense’s (DOD’s) Military Health system, a detailed analysis of these systems is beyond the scope of this report. Instead, this report focuses on the civilian mental health care delivery system.

Congress has been increasingly interested in transforming the mental health system in the aftermath of tragedies involving mentally ill individuals—such as the shootings at Columbine² and Virginia Tech,³ which led to heightened public interest in the adequacy of the mental health care system. In the past decade, Congress passed two far-reaching laws on mental health care. The first law, the Children’s Health Act, reauthorized the SAMHSA in 2000 and called for greater focus on the measurement of mental health care outcomes.⁴ The second law, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, expands federal

¹ Department of Health and Human Services: Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health*, 2007, <http://www.oas.samhsa.gov/NSDUHlatest.htm>.

² On April 20, 1999, two students at Columbine High School in Columbine in Jefferson County, Colorado, embarked on a school shooting, killing 12 students and a teacher, as well as wounding 23 others, before committing suicide.

³ On April 16, 2007, a student at Virginia Polytechnic Institute and State University (Virginia Tech) carried out two separate attacks approximately two hours apart, on the campus of Virginia Tech in Blacksburg, Virginia. The student killed 32 people and wounded many others before committing suicide.

⁴ P.L. 106-310.

requirements for mental health coverage and requires health insurers who choose to cover mental illness to provide mental health benefits on par with that for physical health.⁵

Background

Mental Illness in the United States

In the United States, mental illnesses are diagnosed and coded in administrative databases based on the Diagnostics and Statistical Manual-IV (DSM-IV).⁶ Mental illnesses are common in the United States.⁷ An estimated 26.2% of Americans aged 18 and older—about one in four adults or 57.7 million people—suffer from a diagnosable mental illness in a given year. Even though mental illnesses are widespread in the population, the main burden of illness is concentrated in a much smaller proportion—about 6%, or 1 in 17—who suffer from a serious mental illness. Many people suffer from more than one mental illness at a given time. Nearly half (45%) of those with any mental illness meet criteria for two or more illnesses, with severity strongly related to comorbidity.⁸ The most common mental illnesses in the United States are anxiety and mood disorders.⁹

Society generally has a negative perception of individuals with mental illness.¹⁰ The stigma attached to mental illness is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. It is a barrier that discourages people from seeking treatment, especially in rural areas. According to the Surgeon General's report, in order to address the issue of stigma, there needs to be a change in society's perception of mental illness through greater availability of effective treatment options, provider attitude toward recovery for individuals with mental illness, and public awareness that mental illness is not only common but treatable.¹¹

⁵ P.L. 110-343.

⁶ The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association and provides diagnostic criteria for mental disorders. It was first published in 1952. DSM-IV, the latest version, was published in 1994, with a text revision in 2000. DSM-V is expected to be published in 2012.

⁷ National Institute of Mental Health, *The Numbers Count: Mental Disorders in America*, 2008, <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml>.

⁸ Kessler RC, Chiu WT, and Demler O, et al., "Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R)," *Archives of General Psychiatry*, vol. 62, no. 6 (June 2005).

⁹ United States Public Health Service Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999, <http://www.surgeongeneral.gov/library/mentalhealth/home.html>. (Hereinafter this report is cited as *Mental Health: A Report of the Surgeon General*.)

¹⁰ News and Notes, "MHA Survey Shows Progress in Public Knowledge About Mental Disorders, but Stigma Remains a Problem," *Psychiatric Services*, vol. 58 (July 2007).

¹¹ *Mental Health: A Report of the Surgeon General*.

History of Mental Health Care Delivery in the United States¹²

In order to understand the issues currently facing the contemporary mental health care delivery system, it is useful to trace its evolution. Care for individuals with mental illness has long been a challenging issue largely due to the historical lack of effective treatment options. While there have been recent advances in treatment options, the delivery system and financing mechanisms have been slow to transform.

Mental health care has been seen primarily as the responsibility of state and local governments. The earliest record of a mental health care system in the United States dates back to the 18th century, when the state of Virginia built the first “asylum”¹³ and the state of Pennsylvania set aside the basement in Pennsylvania Hospital to house individuals with mental illnesses. Treatment consisted of attempts to return an individual to reason by using physical and psychosocial techniques. While some of these techniques, such as hiring intelligent and sensitive attendants to work closely with patients or reading and talking to the patients and taking them on regular walks, were considered humane, some techniques such as bloodletting (bleeding), purging (forced vomiting), and hot and cold baths were considered inhumane.¹⁴

In the early part of the 19th century, other states built asylums too. While the asylum is reported to have been instrumental in restoring the mental health of many individuals, it could not prevent mental illnesses from becoming chronic conditions. Because of this failure, by the middle of the 19th century, asylums primarily housed individuals with untreatable and chronic mental illnesses. The failure resulted in deteriorating quality of care for mental illnesses, overcrowding in these asylums, and underfunding for treatment. In the second half of the 19th century, the mental health care delivery system began to incorporate the newly emerging principles of “public health,” which focused on prevention and early intervention. These did not help improve the mental health care system because its funding was left to the cash-strapped local governments. Care in asylums deteriorated even further, leading to media exposés about the conditions in these settings. By the end of the 19th century, states passed laws requiring the states to assume financial responsibility for asylums.

Treatments continued to be largely ineffective at the turn of the 20th century. The scientific study and treatment of mental illnesses, called neuropathology, was just beginning. In 1946, Congress passed the National Mental Health Act,¹⁵ which, for the first time in U.S. history, provided federal funding for psychiatric education and research. This Act led to the creation in 1949 of the National Institute of Mental Health (NIMH). In the meantime, conditions in asylums had worsened even further during the Great Depression and World War II. In the middle of the 20th century, mental health care was transformed with the advent of “deinstitutionalization” or providing mental health care in communities, rather than in asylums. This led to the building and funding of community mental health care centers. Federal support for these centers was

¹² Unless otherwise indicated, information in this section of the report has been obtained from Prof. Gerald Grob’s three-volume history of mental health policy. Gerald N. Grob (Ph.D., Northwestern, 1958), the Henry E. Sigerist Professor of the History of Medicine (Emeritus), is historian of mental health policy and medicine at Rutgers University.

¹³ An asylum is defined as a hospital for the care and treatment of patients affected with acute or chronic mental illness.

¹⁴ National Institutes of Health, *History of Medicine, Diseases of the Mind: Highlights of American Psychiatry Through 1900*, February 2008.

¹⁵ P.L. 79-487.

authorized under the Community Mental Health Act of 1963.¹⁶ This was the first time federal funds were used to provide for the treatment of mental illnesses.

The effects of deinstitutionalization were mixed. On one hand, individuals with mental illnesses were no longer subject to the poor conditions in asylums. On the other hand, community support was inadequate to provide for the treatment and social needs of the mentally ill. Deinstitutionalization shifted many individuals with mental illnesses from asylums to institutions such as the criminal justice system and homeless shelters. Beginning in the mid-1970s, emphasis shifted toward providing social supports to the mentally ill through housing and vocational training. In 1977, President Jimmy Carter’s Commission on Mental Health was established in order to review the mental health needs of the nation and recommend policies to overcome deficiencies in the mental health system. However, when the commission’s report, the *National Plan for the Chronically Mentally Ill*, was completed in 1980, bureaucratic rivalries between successive administrations, tensions and rivalries within the mental health professions, and the difficulties of distinguishing the roles played by social issues such as poverty, racism, stigmatization, and unemployment influenced the commission’s deliberations and subsequent enactment of the commission’s recommendations within the short-lived Mental Health Systems Act.¹⁷

As newer and more effective treatment approaches were discovered, they were used to complement social services. President George H.W. Bush declared the 1990s as the Decade of the Brain.¹⁸ In this decade, progress was made through federal investment in research—in basic neuroscience, behavioral science, and genetics—about the complex workings of the brain and mental illnesses.

In the 21st century, despite advances in the understanding of mental illnesses and their treatments, policymakers and mental health experts assert that the system is fragmented and difficult to use to effectively meet the needs of individuals with mental illness. Many problems remain, including the lack of health insurance by 17.2% of the U.S. population,¹⁹ underinsurance for mental illnesses even among those who have health insurance, access barriers for members of many racial and ethnic groups, discrimination, and the stigma about mental illness, which is one of the factors that impedes help-seeking behavior. These issues are analyzed later in this report. The 110th Congress passed a law (P.L. 110-343) that will expand federal requirements for mental health coverage and require health insurers who choose to cover mental illness to provide mental health benefits on par with physical health.

Advances in Mental Health Treatment

At least two federal reports indicate that most of the advances in the treatment of mental illnesses have occurred since the 1980s. In 1999, the U.S. Department of Health and Human Services (HHS) released *Mental Health: A Report of the Surgeon General*,²⁰ which reviews scientific

¹⁶ P.L. 88-164.

¹⁷ P.L. 96-398.

¹⁸ U.S. President (Bush), “Presidential Proclamation 6158,” *Public Papers of the Presidents of the United States* (Washington: GPO, 1990).

¹⁹ Committee on Health Insurance Status and Its Consequences, *America’s Uninsured Crisis*, Institute of Medicine, 2009.

²⁰ *Mental Health: A Report of the Surgeon General*.

advances in the understanding of mental health and mental illnesses. In 2005, the Institute of Medicine released a report titled *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*,²¹ which examines the mental health care treatment system and recommends a comprehensive strategy to improve its quality.

The earliest drugs used to treat individuals with mental illness in the 18th century were sedatives; they were used mostly as a chemical way to restrain the patient. As mentioned earlier, the scientific study of mental illnesses and treatment options began in the early part of the 20th century. It was in the middle of the 20th century that drugs showing promise in the treatment of schizophrenia and depression were discovered. These drugs were widely used in the 1960s. The next major advance in treatment of mental illness was in the 1970s, when lithium was used to treat manic depressive illness. This was followed by the discovery of drugs called Selective Serotonin Reuptake Inhibitors (SSRIs) in the 1980s, which were more effective than earlier drugs in treating depression. With increased interest in brain research in the 1990s, more effective drugs emerged to treat psychosis and schizophrenia. Experts believe that effective, state-of-the-art treatments vital for quality care and recovery are now available for most serious mental illnesses and serious emotional disorders.²²

Despite substantial investments that have enormously increased the scientific knowledge base and have led to developing many effective treatments, a commission established under President George W. Bush reported that many Americans were not benefiting from these investments. To improve access to quality care and services, the commission recommended fundamentally transforming how mental health care is delivered in America.²³

Current Mental Health Care Delivery System

In the United States, mental health care is delivered by a range of providers in a range of settings. The 1999 Surgeon General's report provided an overview of the U.S. mental health care delivery system.²⁴ Providers may be formally trained mental health specialists, general health care providers, human services providers, or volunteer support group leaders. Settings in which mental health care is provided also vary in their formality. Financial resources may determine the provider and setting for a patient's mental health care. Providers, types of setting, and financial resources have a bearing on the quality of mental health care a person receives and their health outcomes.

This section discusses several characteristics related to the mental health care delivery system, such as the types of providers of mental health care and their licensing and training requirements, the settings in which mental health care is provided, and the manner in which this system is

²¹ Institute of Medicine Committee on Quality of Health Care in America, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, 2005. (Hereinafter this report is cited as *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*.)

²² Ibid..

²³ The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003, <http://www.mentalhealthcommission.gov/reports/reports.htm>. (Hereinafter this report is cited as *Achieving the Promise: Transforming Mental Health Care in America*.)

²⁴ *Mental Health: A Report of the Surgeon General*.

financed. Finally, this section describes two federally funded efforts to measure quality of mental health care.

Providers and Settings²⁵

Mental health care may be delivered by a range of providers with varying levels of expertise. Providers of mental health care fall roughly into one of four categories depending on the care being provided. They may be (1) highly trained providers, (2) generalists, (3) social service providers, or (4) informal volunteers. Mental health care may be delivered in one of three categories of settings. The settings may be (1) a hospital, (2) an outpatient clinic, or (3) an informal venue. The severity of an individual's mental illness may determine the setting in which care is provided. While mild mental illness may be treated using medication on an outpatient basis, severe mental illness may preclude an individual from being a functional member of the community. For instance, the type of mental health care provided for an individual suffering from mild eating disorders or mild depression would be quite different from that provided to an individual with severe bipolar illness.

The first category of providers of mental health care are highly trained specialists, such as psychiatrists, psychologists, and psychiatric nurses. These providers have generally received specialized training in mental health care, are licensed by a state to provide this care, and have to take regular training and receive continuing education credits in order to keep their license. For example, specialty mental health providers may be licensed to permit them to require involuntary hospitalization and treatment of a suicidal individual. It is estimated that in 2005, there were 41,598 psychiatrists²⁶ and 398,000 mental health therapists in the United States.²⁷ Specialty mental health providers generally have their own professional associations (e.g., American Psychiatric Association, American Psychological Association) and accreditation body (e.g., American Board of Medical Specialists). It is estimated that in 2004, there were 2,891 organizations that delivered specialized mental health care in the United States.²⁸ Specialty mental health care is generally delivered in a clinic or hospital that is specifically designed for such care. This could include outpatient care in the provider's office or inpatient care under the constant supervision of a provider. Inpatient care is generally reserved for acute situations when an individual is perceived to be a threat to himself or others around him. In addition, psychiatric care for the elderly may be provided in nursing homes by mental health specialists. Recent trends indicate a shift from inpatient care for older adults with certain mental illnesses to less expensive settings, such as skilled nursing facilities.²⁹

The second category consists of providers with training in general health care, such as family practitioners, pediatricians, and nurse practitioners. These providers are trained in a field that is broader than mental health and are also licensed by the state to provide more general health care.

²⁵ Unless otherwise indicated, information on providers and settings has been obtained from *Mental Health: A Report of the Surgeon General*.

²⁶ American Medical Association, *Physician Characteristics and Distribution in the US*, 2007.

²⁷ U.S. Department of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook*, 2008.

²⁸ National Center for Health Statistics, *Health, United States*, 2007, p. Table 114, <http://www.cdc.gov/nchs/data/healthus07.pdf>.

²⁹ Donald R. Hoover, Ayse Akincigil, and Jonathan D. Prince, et al., "Medicare inpatient treatment of elderly non-dementia psychiatric illnesses 1992-2002; length of stay and expenditures by facility type," *Administration and Policy in Mental Health*, vol. 35 (2008).

They need to take regular training and receive continuing education credits on health-related issues; however, the training need not be related to mental health. This group of providers is a common source of care in areas where there is a shortage of specialized mental health providers. Mental health care for children and youth is generally provided by pediatricians. This includes treatment for most forms of Attention Deficit Disorders (ADD), autism, and childhood mood disorders. Depending on the pediatrician's training and the availability of specialists, youth with severe mental illness may be referred to mental health specialists for care. General health care providers may belong to a broad-based provider association (e.g., American Medical Association) and are accredited as a general provider (e.g., by the National Board of Medical Examiners). A general health care provider may deliver mental health care in the provider's office on an outpatient basis. Mental health care is sometimes delivered in hospital emergency departments where an individual is treated by emergency care professionals. These professionals are trained to stabilize acute illnesses rather than treat chronic conditions, such as mental illnesses. Once the patient is discharged from the emergency department, he or she may receive a referral to a mental health specialist. However, there is rarely any follow-up to ensure that the patient receives recommended outpatient care.

The third category consists of providers who are trained to provide social services, such as school-based counselors and criminal justice workers. These providers are trained in a human services field and may not be licensed to provide any health care services. While they may need to take regular training and receive continuing education credits related to their field, they are not required to receive training to provide mental health care. Providers in this category may belong to a social service-related professional association (e.g., American School Counselor Association), but may not be associated with a medical accreditation body. A human services provider generally delivers care within a non-medical institution (e.g., school, prison). Support groups are usually held in public meeting spaces or in a private home. Some individuals use these services to complement care they get in one of the two settings mentioned above. Others, usually individuals with mild mental illness, may get care solely in this type of setting.

The fourth category of providers includes informal volunteer groups, such as support groups and peer counselors. These providers generally have no formal training or license to provide mental health services. Hence, there are no regular mental health training or continuing education credit requirements.

Rural areas suffer shortages in the supply of trained mental health professionals. The Health Resources and Services Administration (HRSA), an agency within the Department of Health and Human Services (HHS), designates geographical areas with less than one mental health provider per 10,000 population as a Health Professional Shortage Area (HPSA) for mental health. In 2008, 66% of HPSAs for mental health were in rural areas. Also that year, there were 3,059 HPSAs for mental health with 77 million people living in these areas. According to HRSA, it would take 5,145 practitioners to meet their need for mental health providers.³⁰ Due to the lack of specialty mental health providers in rural areas, primary care providers who practice in non-metropolitan areas play a large role in mental health care.

Where a person receives care is a reflection of the payer for these services as well as personal preferences. Even if an individual has health insurance that would cover specialty care, he or she

³⁰ Health Resources and Services Administration, <http://bhpr.hrsa.gov/shortage/index.htm>.

may prefer to get care from his primary care provider because of the stigma that the individual may associate with being seen at a psychiatrist's office.

Financing Mental Health Care

The Centers for Medicare and Medicaid Services (CMS), an agency within HHS, compiles the National Health Expenditure Accounts (NHEA), which estimate the annual health spending for the entire U.S. population, by source of funding for those services.³¹ Estimates include expenses from private (such as private health insurance and out-of-pocket spending) and public sources (such as Medicare and Medicaid). Researchers who analyzed data from the NHEA reported that in 2005 the national health expenditure on treatment of mental illness was \$142 billion.³² Expenditures for the treatment of mental illness were second only to those for circulatory diseases.³³

As shown in **Figure 1**, private insurance accounts for the largest share of expenditure for mental health services. Private funding for mental health care may also be provided through individual out-of-pocket payment for services, employer-based or individual health insurance, or private philanthropic foundations.³⁴ Health insurance coverage for mental illnesses is often less generous than that for other physical illnesses. This disparity can include non-coverage of mental illnesses, or higher copayments and lower treatment limits for mental illnesses. The mental health parity law that was enacted in 2008 (P.L. 110-343) aims to eliminate these disparities.³⁵ For reasons discussed later in this report, some advocates for individuals with mental illnesses believe that disparities may exist even after the enactment of this law.

³¹ The National Health Expenditure Accounts (NHEA) reflects total annual U.S. health care spending. The estimates include only direct costs of providing care and do not include the indirect costs such as those associated with lost productivity or lost tax revenue.

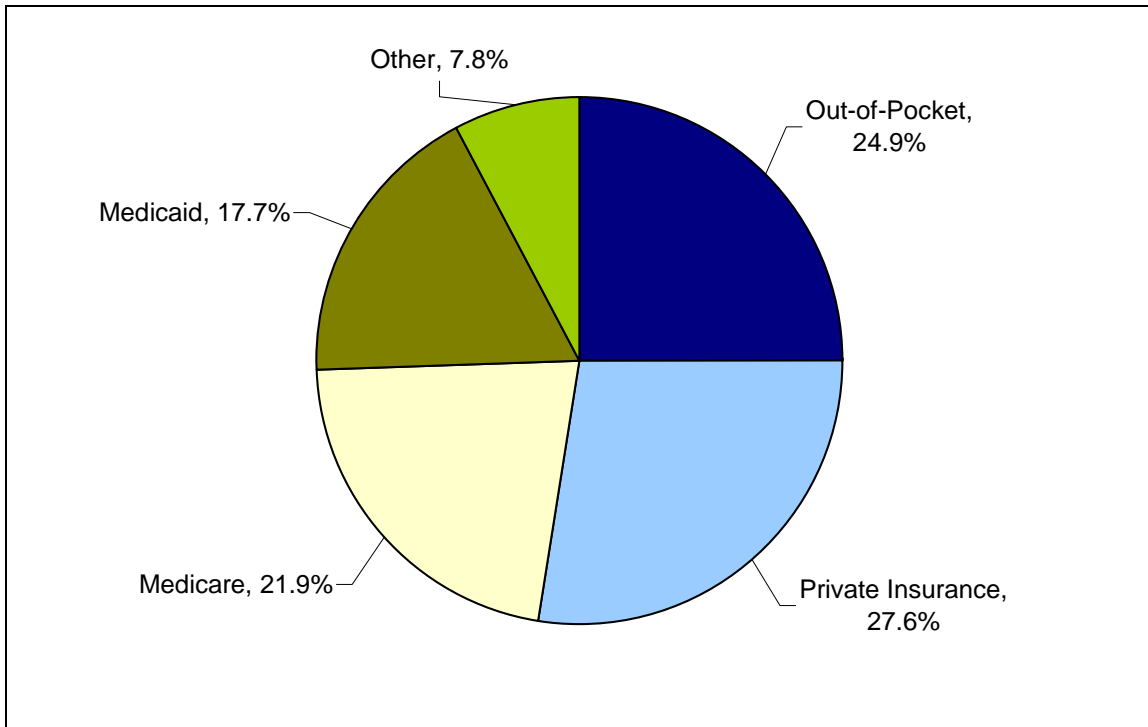
³² Charles Roehrig, George Miller, and Craig Lake, "National Health Spending By Medical Condition, 1996-2005," *Health Affairs*, vol. 28, no. 1 (February 2009).

³³ Nearly half of circulatory system expenditures are attributable to heart conditions, which consist primarily of coronary heart disease, congestive heart failure (CHF), and dysrhythmias. Hypertension, cerebrovascular disease, and hyperlipidemia account for most of the remainder.

³⁴ Some organizations, such as Mental Health Inc. of Tampa, FL, provide free care to needy individuals with mental illness, using foundation donations to pay for their costs.

³⁵ For an overview of mental health parity, see CRS Report RS22958, *Mental Health Parity: An Overview*, by Ramya Sundararaman.

Figure 1. Percentage of U.S. Public and Private Mental Health Expenditures, 2006



Source: AHRQ, Medical Expenditure Panel Survey, 2006.

State and local government funding for mental health care services is second only to federal funding, as described below. This reflects in part the historical reality of states carrying the responsibility for low-income individuals with serious mental illness. State- and county-funded mental health services have long served as a safety net for people unable to obtain or retain access to privately funded mental health services.³⁶ Federal funding, the largest source of public funding, is provided by a range of agencies, each with a different mission, focus, or target population. Federal funding for mental health care research is provided through NIMH, and mental health care treatment is provided through VA, DOD, SAMHSA, HRSA, and CMS. Generally, VA and DOD provide mental health benefits within their delivery system.³⁷ In contrast, SAMHSA provides for treatment through formula-based block grants and discretionary grant programs to states and communities,³⁸ while HRSA provides for treatment by funding the federal community health centers.³⁹ CMS administers the Medicaid, CHIP, and Medicare programs. Generally, the Medicaid program provides health insurance for certain low-income individuals, the CHIP program provides health insurance to certain uninsured children in families with modest income, and the Medicare program provides health insurance for individuals aged 65 and older and for

³⁶ For an overview of mental health issues and treatment resources within a state, see <http://www.samhsa.gov/statesinbrief/>.

³⁷ For more information on healthcare benefits for veterans and active-duty members, see CRS Report RL34598, *Veterans Medical Care: FY2009 Appropriations*, by Sidath Viranga Panangala, and CRS Report RL33537, *Military Medical Care: Questions and Answers*, by Don J. Jansen.

³⁸ For more information on SAMHSA's funding of mental health services, see CRS Report RL33997, *Substance Abuse and Mental Health Services Administration (SAMHSA): Reauthorization Issues*, by Ramya Sundararaman.

³⁹ For more information on community health centers, see CRS Report RL32046, *Federal Health Centers Program*, by Barbara English.

certain disabled beneficiaries.⁴⁰ The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) requires Medicaid and CHIP programs to provide mental health services on par with their physical health services. Medicare partially covers certain inpatient and outpatient mental health services and home health services. Currently, Medicare requires a 50% coinsurance for outpatient psychotherapy services, whereas it requires a 20% coinsurance for other health services. The Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) requires this difference in coinsurance to be phased out between 2010 and 2014.⁴¹

Quality of Care

The Institute of Medicine defines health care quality as “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” Each of the elements considered in this report—providers, settings, and financing—has implications for the quality of mental health care delivered. Measuring the quality of mental health care requires data on multiple measures collected over a sustained period of time. The measures need to reflect patterns in at least two areas: (1) the process of obtaining care and (2) the outcome of the care received. Federal entities that attempt to measure the quality of mental health care are those that provide for mental health care (VA, DOD, SAMHSA, HRSA, CMS) and the Agency for Healthcare Research and Quality (AHRQ). This section describes the indicators used by SAMHSA, HRSA, CMS, and AHRQ.

SAMHSA has developed mental health specific indicators, called National Outcome Measures (NOMs), for use by its grantees to measure the outcomes of mental health care provided. The NOMs are based on a report by a public-private partnership, Mental Health Statistics Improvement Program (MHSIP) Consumer-oriented Report Card Task Force.⁴² SAMHSA’s indicators include reduced morbidity, employment, education, housing stability, social connectedness, access to care, and retention in and perception of care.⁴³ At this time, reports assessing the quality of mental health care using these indicators are in the preliminary stage.

The only mental health-specific measure that HRSA requires states to report on is suicide rates among 15- to 19-year-olds. The Medicare program and many private health insurers use the Healthcare Effectiveness Data and Information Set (HEDIS) to measure mental health care quality. The measures in HEDIS include medication management for anti-depressants, follow-up after hospitalization for mental illness, and utilization of mental health care services.

AHRQ produces two congressionally mandated reports on the quality of health care annually.⁴⁴ It tracks quality across nine health conditions, including mental illness, to determine the

⁴⁰ CRS Report RL32362, *Key Benefits Under Medicaid and the State Children's Health Insurance Program (SCHIP) for Children With Mental Health and Substance Abuse Problems*, by Elicia J. Herz.

⁴¹ CRS Report RL33820, *The Mental Health Parity Act: A Legislative History*, by Ramya Sundararaman and C. Stephen Redhead.

⁴² SAMHSA, *Mental Health, United States*, Chapter 9, 2004, <http://mentalhealth.samhsa.gov/publications/allpubs/SMA06-4195/chapter09.asp>.

⁴³ Substance Abuse and Mental Health Services Administration, *National Outcome Measures for Mental Health System Transformation*, March 2008, <http://www.nationaloutcomemeasures.samhsa.gov/outcome/Accessible/NOMsMHST2k8.asp?CDDID=1>.

⁴⁴ Agency for Healthcare Research and Quality, *2007 National Healthcare Quality Report*, February 2008, (continued...)

effectiveness of health care in the United States using existing national data sources.⁴⁵ The indicators that AHRQ uses to measure effectiveness of mental health care are suicide death rate, based on data from the HHS's National Vital Statistics System, and receipt of treatment for major depression, based on the HHS's National Survey on Drug Use and Health.

There are two federally funded inventories of mental health care quality measures: the National Inventory of Mental Health Quality Measures (NIMHQM) and the National Quality Measures Clearinghouse (NQMC). NIMHQM is a searchable database of over 300 measures for quality assessment and improvement in mental health and substance abuse care that may be used by payers, patients, and providers to measure quality of care. NQMC is an inventory 89 process and outcome measures of the quality of mental health care.⁴⁶

Issues and Options for Congress

With numerous providers, treatment settings, and payment mechanisms, the mental health care delivery system in the United States is complex, and some policymakers and other stakeholders believe that the system has gaps that make it difficult for some populations to navigate. In view of recent focus on the reform of the general health care system, Congress may consider opportunities to transform the mental health care delivery system. Policy discussions may address the following findings and assertions:

- While great advances have been made in the discovery of evidence-based treatment practices, the practical application of these findings has been slow.
- Access to competent mental health providers is scarce in rural areas and even some urban areas.
- Health insurance coverage of mental illness is often less comprehensive than that of physical illnesses.
- Mental health care is often not coordinated with other care that an individual may be receiving or may need.
- Measurements of the quality of mental health care are inadequate to improve quality and transform the system.

In the 1990s, a number of federal reports on the state of the nation's mental health system have called for its reform:

- *Mental Health: Report of the Surgeon General (Surgeon General's report)*, 1996.⁴⁷
- *President's New Freedom Commission Report (Freedom Commission report)*, 2003.⁴⁸

(...continued)

<http://www.ahrq.gov/qual/nhqr07/Chap2b.htm#mental>.

⁴⁵ AHRQ measures effectiveness of care specifically for mental illness. For other quality of care measures such as safety, timeliness, and patient centeredness of health care, AHRQ does not collect data specifically for mental illness.

⁴⁶ AHRQ, *National Quality Measures Clearinghouse*, <http://qualitymeasures.ahrq.gov/browse/browsecondition.aspx>.

⁴⁷ *Mental Health: A Report of the Surgeon General*.

⁴⁸ *Achieving the Promise: Transforming Mental Health Care in America*.

- Transforming Mental Health Care in America report (Action Agenda), 2005.⁴⁹
- Improving the Quality of Health Care for Mental and Substance-Use Conditions report (IOM report), 2005.⁵⁰

These reports are consistent in their recommendations for reforming the mental health care system. They recommend improving the evidence-base for treatment practices, overcoming stigma, improving quality of mental health care and its measurement, addressing workforce shortage issues, coordinating care, and addressing financial barriers to mental health care. The reports differ in their area of primary focus and the extent to which they assign specific roles to the public and private entities in order to reform the mental health care system. For example, the Surgeon General's report and the Freedom Commission report provide general guidelines for reform, whereas the Action Agenda and the IOM report attempt to translate the guidelines into action steps.

This section analyzes the issues facing the mental health care delivery system, including evidence-based practices, access to care, financing mental health care, coordination of care, and quality of care. Options that Congress may consider are described in each area. Congress may, of course, also decide not to take any additional steps to address mental health care delivery, given other priorities. A crosswalk of the recommendations of the four federal reports mentioned above in the context of the issues facing the mental health care delivery system is included in the **Appendix**.

Evidence-Based Practices

Significant advances have been made in the understanding and treatment of mental illness. Despite these advances, experts believe that many Americans are not benefiting from improved mental health care.⁵¹ The lag between discovering effective forms of treatment and incorporating them into routine patient care is long, lasting on average about 15 to 20 years.⁵² The following points may help to explain the disconnect between research and practice. First, use of evidence-based practices can be affected by coverage decisions. Payers can be reluctant to cover new treatment modalities, even when there is evidence for their effectiveness, possibly because the new modalities are not yet considered to be mainstream or may be more expensive. Second, providers are often not trained in the newly discovered evidence-based practices. Research findings are not disseminated in a manner that enables providers to easily incorporate them in their practice. Third, experts believe that there is a shortage of research in at least five areas: (1) disparities between minorities and whites in seeking and receiving mental health care, (2) long-term effects of medications used to treat mental illness, (3) mental health effects of exposure to traumatic events, (4) effective options for acute care of mental illnesses, and (5) effectiveness of alternative treatment practices, such as faith-based care.⁵³ An area of mental health treatment that has a small evidence-base to date is that of complementary and alternative medicine (CAM) for

⁴⁹ SAMHSA, *The Federal Action Agenda: First Steps*, Transforming Mental Health Care In America, 2005, http://www.samhsa.gov/Federalactionagenda/NFC_TOC.aspx.

⁵⁰ *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*.

⁵¹ Wang, P. S., Demler, O., and Kessler, R. C., "Adequacy of treatment for serious mental illness in the United States," *American Journal of Public Health*, vol. 92 (2002).

⁵² *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*.

⁵³ *Achieving the Promise: Transforming Mental Health Care in America*.

mental illness, such as faith-based therapy. Data from HHS's 2007 National Health Interview Survey show that CAM was used by 2.8% of adults for treating anxiety and by 1.9% of adults for treating depression. In addition, CAM was used by 4.8% of children for treating anxiety, by 2.5% of children for treating ADD, and by 1% of children for treating depression.⁵⁴ Such alternative therapies may be practiced by non-formal providers of care, and there is little research on measuring their effectiveness.

Options for Congress

As the field of mental health treatment is relatively new, the Freedom Commission report recommends more research in order to address the knowledge gaps mentioned above. Experts recommend efforts to increase the use of practices that have been shown to be effective in order to improve the quality of mental health care. Application of the current advances in mental health treatment would require appropriate training for providers. Support for emerging evidence-based treatment modalities would require changes in financing mechanisms. The IOM report suggests that delays in the application of evidence-based practices may be reduced by the use of quality improvement tools and information technology.

In response, Congress could consider requiring HHS and CMS to collaborate with private insurers to encourage the application of emerging research findings into practice through grants and payment incentives. In addition, Congress could consider requiring SAMHSA to work with accreditation boards to provide more training and continuing education opportunities for providers to use the latest evidence-based practices and information technology. Congress has appropriated funds to promote the use of information technology in general health care.⁵⁵ While this funding may improve reporting on mental health care that is delivered by general health providers, it is not targeted toward specialty mental healthcare providers.

Access to Care

In rural areas, individuals who seek mental health care often need to travel great distances. Scarcity of providers also makes it difficult for individuals to seek mental health care without being noticed by others in their community. The perceived social stigma associated with receiving mental health care and the need to travel large distances to get this care lead to fewer mental health visits by patients in these areas, thus decreasing the likelihood of such individuals receiving the care they need.⁵⁶

Mental health provider shortages are not restricted to rural areas. Even in urban areas, there is a shortage of mental health care providers who are culturally competent⁵⁷ or linguistically diverse.⁵⁸

⁵⁴ National Center for Complementary and Alternative Medicine, National Institutes of Health, *Complementary and Alternative Medicine Use Among Adults and Children: United States, 2007*, December 2008, <http://www.cdc.gov/nchs/data/nhsr/nhsr012.pdf>.

⁵⁵ CRS Report R40181, *Selected Health Funding in the American Recovery and Reinvestment Act of 2009*, coordinated by C. Stephen Redhead.

⁵⁶ Rost, K., Smith, G.R., and Taylor, J.L., "Rural-urban differences in stigma and the use of care for depressive disorders," *Journal of Rural Health*, vol. 9, no. 1 (1993); Fortney J.C., Owen, R., and Clothier, J., "Impact of travel distance on the disposition of patients presenting for emergency psychiatric care," *Journal of Behavioral Health Services and Research*, vol. 26, no. 1 (1999).

⁵⁷ Culturally competent services are services that are responsive to the cultural concerns of racial and ethnic minority (continued...)

In addition, research on the integration of cultural competence into practice and measures of effective implementation is lacking. Without concerted efforts to remedy the shortage of culturally competent care, researchers believe the situation could intensify the disproportionate burden of mental illnesses on racial and ethnic minorities.⁵⁹

When faced with a shortage of mental health providers, the primary care practitioner often provides care for a patient's mental illness. Primary care practitioners, however, face a number of practice and professional constraints in treating mental illness, including insufficient training and skills, heavy patient case load, lack of time, and lack of specialized backup.⁶⁰ When mental health provider shortages are combined with an anticipated increase in demand for care, such as in the current economic crisis, some suggest that individuals who need mental health care may not receive it.⁶¹

Options for Congress

The Surgeon General's report indicates that in order to provide access to quality care for all individuals with mental illness, the capacity of the mental health care system would need to be increased. The Freedom Commission report recommends that the mental health workforce be developed to support changes in demand for care and treatment options, and that workforce competencies be developed in order to respond to the demand for culturally competent and sufficiently diversified range of services.

Congress could consider addressing this issue by asking the professional associations of health care providers to assess the mental health training needs for mental health providers who work in various settings such as primary care, as well as needs for training in cultural competence for mental health providers. Once the training needs are identified, Congress would have the option of providing funding to SAMHSA to address those needs.

Financing Mental Health Care

The expanded federal mental health parity law, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,⁶² requires health insurers who choose to cover mental illness to provide coverage for mental illness on par with that for physical illness.⁶³

(...continued)

groups, including their language, histories, traditions, beliefs, and values.

⁵⁸ *Mental Health: A Report of the Surgeon General*.

⁵⁹ *Achieving the Promise: Transforming Mental Health Care in America*.

⁶⁰ Geller, J.M., "Rural primary care providers perceptions of their roles in the provision of mental health services: Voices from the plains," *Journal of Rural Health*, vol. 15, no. 3 (1999); for more information on federal programs addressing mental health workforce issues, see CRS Report RL32546, *Title VII Health Professions Education and Training: Issues in Reauthorization*, by Bernice Reyes-Akinbileje.

⁶¹ National Alliance on Mental Illness, *Economic Crisis and Mental Health*, October 2008, http://www.nami.org/Template.cfm?Section=Whats_New43&template=/ContentManagement/ContentDisplay.cfm&ContentID=68323.

⁶² P.L. 110-343.

⁶³ Mental health parity refers to equitable health insurance coverage for mental and physical illnesses. P.L. 110-343 requires insurers who choose to provide coverage for mental illnesses to provide that coverage on par with their coverage for physical illnesses. For more information on mental health parity legislation, see CRS Report RS22958, *Mental Health Parity: An Overview*, by Ramya Sundararaman.

Advocates for individuals with mental illness believe that several factors may lead to continued disparity in mental health coverage and persistent barriers to access mental health care.

First, federal mental health parity law does not require a health plan to provide coverage for mental health. It requires parity coverage for any mental illnesses that an insurer chooses to cover. Some analysts believe this could lead insurance companies to drop coverage for mental health, rather than provide on par coverage. Second, the law allows insurers to provide parity coverage within the context of managed care. Some advocates for people with mental illnesses believe this will cause more aggressive management of mental health benefits, such as requiring referrals, because insurers can no longer impose differential limits on treatment and financial coverage. Third, it is challenging for regulators to determine parity in treatment options for mental health and physical health. For example, Cognitive Behavior Therapy (CBT) is one treatment option that has been shown to be effective for treating some mental illnesses, but CBT is not comparable to treatment for any physical illnesses.⁶⁴ Fourth, the federal parity laws do not address quality of care issues such as training for providers of behavioral health care as well as basic mental health training for primary care providers. As a result, some analysts believe this law could lead to an increase in the quantity of mental health care provided, without a corresponding improvement in health outcomes. Fifth, the federal mental health parity law does not address the issue of mental health care needs of the uninsured. Some believe that the current downturn in the economy coupled with the absence of mental health coverage for the uninsured could increase the need for mental health services, thus straining the behavioral health care delivery system.

Options for Congress

Research is needed to determine the effectiveness of the new mental health parity requirements in improving mental health coverage. Authors of the four national reports mentioned earlier recommend the need for increased federal support for mental health research.

Congress could consider how to improve, for example, leadership and vision, with a public-private partnership that involves federal and state entities, providers, insurers, researchers, and advocates for individuals with mental illnesses. Such leadership at the national level could help illuminate the changes needed to transform the U.S. mental health delivery system.

Coordination of Care

According to the Office of the Surgeon General, effective functioning of the mental health service system requires connections and coordination among public and private sectors, various specialty services, and a range of institutions in housing, criminal justice, and education.⁶⁵ Individuals with mental illnesses may receive social services and general health care services from various agencies or providers. Lack of effective communication between these service providers could result in missed opportunities to ensure that individuals with mental illness, who may come in

⁶⁴ From the British Association of Behavioral and Cognitive Psychotherapies: “CBT is based on concepts and principles derived from psychological models of human emotion and behavior. The cognitive component in CBT refers to how people think about and create meaning about situations, symptoms and events in their lives and develop beliefs about themselves, others and the world. The behavioral component in CBT refers to the way in which people respond when distressed.” Due to the psychological nature of this treatment modality, it is not comparable to treatment for physical illnesses.

⁶⁵ *Mental Health: A Report of the Surgeon General*.

contact with any of these systems, get routed to appropriate care. The report asserts that such coordination at the systems level, or with financial mechanisms, is necessary to ensure that an individual, whose cognitive ability may be diminished as a result of his or her mental illness, is able to navigate the system's bureaucracy and receive the mental health care he or she needs.

Individuals often pay for the mental health care they receive with more than one funding source. Different payers may require different processes for seeking and paying for care. Some providers may not accept all the mechanisms that are outlined above for financing mental health care. Individuals with mental illness often suffer from multiple behavioral health conditions, including substance abuse disorders. The situation is further complicated because the mental functioning of an individual needing this care is often reduced. Hence, without coordination, care can soon become fragmented, creating barriers to access.

Options for Congress

Experts and advocates for individuals with mental illness recommend patient-centered mental health care that is focused on an individual's recovery to health. This requires coordination and integration of mental health care with general health care and other sectors. As recommended by the IOM report, consumers and caregivers need to be more involved in planning for their mental health services, so that it is fully responsive to individual needs and preferences and appropriately coordinated with other social and rehabilitation activities

In order to address this issue, Congress could consider requiring SAMHSA, working with federal and state agencies that could provide social or health services to individuals with mental illness, to develop a coordinated system of care model. Then, such a model could be adapted to function at the state or community level. This may be based on SAMHSA's Systems of Care for children with serious emotional disorders where a wide range of mental health and related services, such as educational services, social services, and substance abuse services, are coordinated to provide care.⁶⁶

Quality of Care

Inadequate evidence-based practices, inconsistent access to mental health care, numerous financing mechanisms, and poor coordination of care all have a negative impact on the quality of mental health care provided. Yet, measuring and assessing these quality issues is a challenge. According to the IOM report, mental health care has a number of unique characteristics that combine to distinguish it from quality measurements for other conditions. The distinguishing characteristics include the greater use of involuntary commitment into treatment for mental illness,⁶⁷ a less-developed quality measurement infrastructure, separate delivery systems, and a differently structured marketplace.

⁶⁶ SAMHSA, *Systems of Care*, November 2003, <http://mentalhealth.samhsa.gov/publications/allpubs/CA-0014/default.asp>.

⁶⁷ Unlike other illnesses, individuals with mental illness may be unable to recognize their need for treatment. When these individuals with mental illness are perceived by providers to be a danger to themselves or others around them, they may be forced to remain in a hospital and receive treatment.

The administrative data collection systems that are widely used to monitor quality of care do not include mental health assessment and treatment practices, as these have not been standardized. For reasons mentioned earlier, practitioners do not always use the latest evidence-based treatment modalities. The development of performance measures for mental health care has not received significant attention in the private sector, and efforts in the public sector have not yet achieved widespread consensus. At the national level, administrative and surveillance systems do not adequately capture data on the indicators needed, such as those developed by SAMHSA, for transforming the mental health care delivery system. Further, even when the systems are developed and can obtain data on a comprehensive set of indicators, greater efforts may be needed to translate the outcomes data into recommendations for system transformation. The understanding and use of modern quality improvement methods have not yet permeated the day-to-day operations of organizations and individual mental health care providers in general or specialty health care sectors.⁶⁸

Options for Congress

While improvements in the individual areas outlined in this report may have an impact on the quality of care, a comprehensive strategy that transforms the mental health care delivery system could ultimately lead to improved outcomes for individuals with mental illness. Specifically, the IOM report recommends that the system needs improved diagnostic and assessment strategies, a stronger infrastructure for measuring and reporting the quality of mental health care, and support for quality improvement practices. The IOM report also states that development of mental health information technology infrastructure will help in measurement and improvement of quality of mental health care.

Congress could require providers to develop the systems that are needed to collect data on mental health care quality. In addition, Congress could require SAMHSA to work with national experts to translate the NOMs into recommendations for transforming the system. Finally, Congress could require coordination among federal agencies involved with mental health research, care delivery, and financing.

Conclusion

Historically, mental illness has not been as well understood as other physical illness. This has led to disparities in the treatment and financing of mental illness. The mental health care system currently faces a number of structural and functional issues. Experts have called for its transformation and provide numerous recommendations. Transformation of the mental health care system, in this view, would require incorporating in a timely fashion evidence-based practices as part of routine practice, resolving workforce shortage issues, ensuring access to care by removing financial barriers, coordinating mental health care with general health care and social services, and developing a way to systematically measure and improve the quality of care delivered. While each of these recommendations may result in some benefits, evidence suggests a comprehensive transformation of the mental health system could be necessary to ensure the availability and accessibility of quality mental health care to all individuals who need it.

⁶⁸ *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.*

Appendix. Comparison of Recommendations of Four Federal Reports on Mental Health Care

	Surgeon General's Report, 1999	Freedom Commission Report, 2003	Action Agenda, 2005	IOM Report, 2005
Access to care	Overcome stigma Ensure the supply of mental health services and providers Improve public awareness of effective treatment	Americans understand that mental health is essential to overall health.	Respect the constitutional role of the states and Indian tribes	Develop a stronger mental health care workforce
Financial barriers	Reduce financial barriers to treatment	Americans understand that mental health is essential to overall health.	Maximize existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers	Enact mental health parity
Evidence-based practices	Continue to build the science base Tailor treatment to age, gender, race, and culture Ensure delivery of state-of-the-art treatments Early mental health screening, assessment, and referral to services become common practice	Excellent mental health care is delivered and research is accelerated	Use mental health research findings to influence the delivery of services	Deliver health care for general, mental, and substance-use problems and illnesses with an understanding of the inherent interactions between the mind/brain and the rest of the body. Build and disseminate the evidence base for mental health care and improve quality of care
Coordination of care	Facilitate entry into mental health treatment	Mental health care is consumer and family driven.	Focus on community-level models of care that coordinate multiple mental health and human service providers and private and public payers	Promote patient-centered care Coordinate services provided to patient

	Surgeon General's Report, 1999	Freedom Commission Report, 2003	Action Agenda, 2005	IOM Report, 2005
Quality of care	Eliminate disparities in mental health services	Eliminate disparities in mental health services Excellent mental health care is delivered and research is accelerated. Technology is used to access mental health care and information	Focus on the outcomes of mental health care, including employment, self-care, interpersonal relationships, and community participation Ensure innovation, flexibility, and accountability at all levels of government	Adapt and apply IOM's "Crossing the Quality Chasm" to mental health care Incorporate Health Information Technology Improve quality of mental health care

Sources: Compiled by CRS based on recommendations from United States Public Health Service Office of the Surgeon General, *Mental Health: A Report of the Surgeon General, 1999*, <http://www.surgeongeneral.gov/library/mentalhealth/home.html>; The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003, <http://www.mentalhealthcommission.gov/reports/reports.htm>; SAMHSA, *The Federal Action Agenda: First Steps*, Transforming Mental Health Care In America , 2005, http://www.samhsa.gov/Federalactionagenda/NFC_TOC.aspx; and Institute of Medicine Committee on Quality of Health Care in America, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, 2005.

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