The 2008 presidential election has placed healthcare in the spotlight, causing the nation to evaluate how healthy America really is. Mental health has long been ignored by health professionals and insurance companies alike but since the 1996 HIPAA legislation is making its way to the forefront of healthcare debates. The 1996 Mental Health Parity Act required private insurance companies to spend the same amount of annual dollars on mental health coverage as physical health coverage. The government's attempt to increase mental health coverage caused a barrage of research and debate over the importance of mental health coverage, it's attraction for consumers, and it's costs. The 1996 legislation did not require mental health coverage, exempted companies with less than fifty employees, and exempted insurance companies whose costs would increase by 1% if they increased mental health dollars. It was a weak bill, but a start. In early March 2008 the House passed a stronger bill to improve mental health coverage (Pear, 2008). If the new bill is signed into law it would ban higher co-payments and stricter limits on the number of visits to a mental health facility. High co-payments and stricter limits are currently common features of state's mental health care coverage.

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The new bill gets at the greater problem with current mental health coverage: cost and limits. Many mental illnesses require long-term care that is not covered by insurance and costs too much to pay out-of pocket. The new bill will help people with private insurance receive better access to mental health care. Those in poverty, who experience mental illnesses at rates two to three times higher than those not in poverty[1], would not benefit if they have Medicaid or no insurance at all (Siefert et al., 2000). Both Barack Obama and Hilary Clinton propose mental health parity for Medicaid matching the private insurance legislation. (candidate websites). Arguments about the increased cost of Medicaid, which has increased an average of 6% per year

[1] Poverty is correlated with increased rates of all kinds of mental illness and averages at two to three times higher but it different for each mental illness.

over the past seven years, from mental health parity do not take into account the benefits of treating mental illness (KFF). Having a mental illness increases the number of physical ailments a person develops as well. Leaving mental illness untreated contributes to the increasing costs of health care.

Depression and anxiety are the two most common mental illnesses in the country. Depressive disorders represent approximately 40% of all mental illnesses and anxiety disorders represent roughly 15%. Both have extensive physical symptoms such as fatigue, muscle soreness, and decreased immune functioning that leads to more colds and infections (DSM-IV). Anxiety disorders cost the country over $42 billion to treat and half of that cost comes from treating physical ailments instead of the anxiety disorder itself (ADAA). Improved mental health coverage could significantly reduce the nation's health care costs and improve the overall health of Americans. Simply increasing funding, as the Mental Health Parity Act attempted to do, is not enough. Each mental illness must be understood and how insurance coverage affects the type of care a person will get. The variety of mental illnesses is too great to look at all of them and treatment needs are too varied to analyze coverage. Depression and anxiety will be the focus of the following paper because of the prevalence and the discovery of highly successful treatment methods. In addition, depression and anxiety differ for children so the focus will be on adults, whose depression and anxiety have more stable symptomalogy and treatment protocols.

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Depression

Wendy was born into poverty. She spent thirty years of her life below the poverty line. While she may not have been able to do anything about her parent's income, she did not have to spend so much of her adult life struggling to make ends meet. Her relationships with men were consistently abusive and as a result she withdrew from the world. She lost an interest in school-

work through high school and even though she was a capable worker, she eventually quit her job and remained bedridden all day. As she describes it,

> Sometimes I would sit and just cry, cry, cry. Over nothing. I had nothing to say to my own children. After they left the house, I would get in bed with the door locked. I feared when they came home, 3 o'clock, and it just came so fast. I was just so tired (Solomon, 2002).

When Wendy's sister went to jail for crack cocaine use, Wendy became responsible for her children. In order to avoid adding more children to the family, Wendy went to a free clinic for family planning help. She was lucky. A psychiatrist was at the clinic screening people for a study on depression. Wendy was quickly diagnosed and put in group therapy. It took months, but Wendy ended up leaving her abusive husband, holding a consistent job, and improving her relationship with her children. As she says,

> They [Wendy's children] want to do things all the time now. We talk for hours every day. We read and do homework all together. We joke around. We all talk about careers, and before they didn't even think careers (Solomon, 2002).

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Wendy's story shows the immensely positive outcome from treating mental illnesses like depression. Wendy was completely crippled in all aspects of her life. She spiraled from simply withdrawing and talking very little to remaining in bed all day long. She experienced the common physical symptoms of fatigue and muscle soreness. She had severe anhedonia, a lack of interest in anything usually found pleasurable, uncontrollable crying, and cessation of personal care routines like eating and showering. Her symptoms are very common among the over 20 million people affected by depression in America.

It is difficult to determine the rate of depression among the poor because different studies use different definitions of poor. Since Medicaid covers all people who receive TANF, a good starting point is the rate of depression among welfare recipients. These studies tend to focus on female heads of households. The lifetime rate, meaning how many mothers receiving welfare

will have clinical depression during their lives, is 42% compared with 18% for non-poor women. The 12-month rate, meaning how many mothers receiving welfare will have clinical depression in the next twelve months, is 25% compared with 11% for non-poor women (Siefert et al., 2000). Non-poor men have an 8.5% lifetime rate for depression and a 2.5% 12-month rate (mental health). These rates are about half those found for women and we estimate that poor men suffer from depression at about half the rate of poor women. These numbers indicate a very real problem as depression affects all areas of a person's life and places a significant burden on society.

The most frightening aspect of the rates of depression for the poor is that they only represent clinical depression. The official term for clinical depression is Major Depressive Disorder and is defined by the most recent Diagnostic and Statistical Manual (DSM) of the American Psychological Association as having at least five of the following ten symptoms:

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- Persistent depressed, sad, anxious, or empty mood
- Feeling worthless, helpless, or experiencing excessive or inappropriate guilt
- Hopeless about the future, excessive pessimistic feelings
- Loss of interest and pleasure in your usual activities
- Decreased energy and chronic fatigue
- Loss of memory, difficulty making decisions or concentrating
- Irritability or restlessness or agitation
- Sleep disturbances, either difficulty sleeping, or sleeping too much
- Loss of appetite and interest in food, or overeating, with weight gain
- Recurring thoughts of death, or suicidal thoughts or actions (DSM-IV)

Many more people experience a lesser number of these symptoms throughout the year and can experience negative effects because of these depressive symptoms. They can still lose their jobs or neglect their families. The symptoms of major depressive disorder make work, raising a family, and personal care extremely difficult and sometimes impossible. In order to get people back to work, as the welfare system emphasizes so strongly, we must treat depression. Much of the rhetoric during the 1996 welfare reform debates hinged on the increase in self-esteem and

happiness that can result from work (Haskins, 2006: 10). The benefits of work will not be felt by a person experiencing major depressive disorder so the treatment for depression must come before work can help lift people out of poverty.

Treatment for depression differs for every person but the most effective type of therapy is Cognitive-Behavioral Therapy (CBT). The psychologist works with the patient to identify negative thoughts that contribute to feelings of hopelessness and then develops a plan to change those thoughts. One method is that every time a person had a negative thought they have to come up with three reasons why that thought is not true. Usually the patient will keep a record to discuss at future meetings. The therapy also identifies negative behaviors that contribute to isolation and develops ways to change those behaviors. Work on effective communication and social skills occur to put the depressed person in a better position to engage in society. The psychologist discusses the patient's life in order to help him or her work through family and work problems that could be holding him or her back. The length of treatment varies with the severity of the depression, but 75% of patients reported feeling significantly better after 20-30 sessions. They require more sessions before they are considered free of depression.

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While CBT works on changing the life situations that exacerbate and in many cases cause a person's depression, some people have symptoms like chronic fatigue that make addressing personal behavior and life situations very difficult. Medication helps alleviate those symptoms so that a depressed person can make necessary changes in his or her life. In a small number of cases, medication is necessary as a permanent treatment. The most common type of antidepressant is the selective serotonin uptake inhibitor (SSRI) which helps keep healthy amounts of serotonin in the brain. Serotonin has been found to be very important to regulating mood. People without enough serotonin tend towards depression. Appropriate insurance

coverage of depression would reflect that the use of medication can be short or long term and that therapy can be required for more than a year to be effective.

Anxiety

Around 40 million Americans suffer from an anxiety disorder, which includes Generalized Anxiety Disorder (GAD), Post-traumatic Stress Disorder (PTSD), Obsessive-Compulsive Disorder (OCD), Social Phobia, specific phobias, and Panic Disorder. A study in 2001 by researchers in Colorado found that poverty more than triples the likelihood of someone having an anxiety disorder. People were considered in poverty if they were below 150% of the poverty line. Only 11% of the non-poor group suffered from an anxiety disorder while 33% of the poor group had a diagnosable anxiety disorder. Just like depression, anxiety disorders stop people from functioning in daily life. One person describes her struggle with OCD like so,

> Getting dressed in the morning was tough, because I had a routine, and if I didn't follow the routine, I'd get anxious and would have to get dressed again. I always worried that if I didn't do something, my parents were going to die. I'd have these terrible thoughts of harming my parents. That was completely irrational, but the thoughts triggered more anxiety and more senseless behavior. Because of the time I spent on rituals, I was unable to do a lot of things that were important to me (ADAA).

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Another person describes his struggle with GAD like so,

> I'd have terrible sleeping problems. There were times I'd wake up wired in the middle of the night. I had trouble concentrating, even reading the newspaper or a novel. Sometimes I'd feel a little lightheaded. My heart would race or pound. And that would make me worry more. I was always imagining things were worse than they really were: when I got a stomachache, I'd think it was an ulcer (ADAA).

The worst part about anxiety disorders is that they are ego-dystonic, which means the people are aware that their thoughts and feelings are irrational but they can not stop them. Anxiety disorders

cause significant physical health problems because of high levels of cortisol. Keeping cortisol levels too high for too long causes heart and kidney problems[2].

Each type of anxiety disorder has a different definition in the DSM and slightly different treatment programs that have been effective. The common factors among all anxiety disorders are:

- General worry either about an another attack, a specific event, or everything
- Physical symptoms of a racing heart, trembling, sweating
- Intense irritation or fear depending on the disorder
- Withdrawal from others because of decreased functioning (DSM-IV)

The effects of anxiety on a person's daily functioning are often more subtle and living conditions deteriorate more slowly than with depression. Losing a job, neglecting family life and personal care tends to result from the slow withdrawal from others and activities in order to avoid anxious feelings or attacks of intense anxiety. Phobias and Panic Disorder cause people to avoid places where they have encountered the source of their anxiety or had an attack, limiting the number of places they go. As a person withdraws he or she also limits the number of people who could notice and help them. The negative physical effects of anxiety get worse and more permanent the longer a person suffers from an anxiety disorder. Early diagnosis and treatment are essential to offset the future costs of heart, liver, and kidney problems that have been associated with extended high levels of cortisol. People with an anxiety disorder are four times more likely to go to a doctor for physical illnesses than people without an anxiety disorder. Effectively treating anxiety disorders could significantly reduce medical costs. An added element of anxiety disorders is that they are highly co-morbid with substance abuse disorders. The Anxiety Disorders Association of America reports that 20% of people diagnosed with an anxiety disorder are also diagnosed with a substance abuse disorder. Drugs tend to take away the negative

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[2] Cortisol is a hormone related to adrenaline that is helpful for concentration and energy in low quantities but begins to cause lowered immune functioning and fatigue in high quantities

physical symptoms of anxiety, and yet substance abuse disorders cause their own set of physical problems.

Effective treatment for anxiety is similar to treatment for depression and refined techniques over the years have produced impressive success rates. The National Mental Health Association reports that 70-90% of people suffering from Panic Disorder who receive CBT and medication feel significantly better in six to eight weeks. Over 50% of people with GAD are significantly better after 3-6 months of receiving CBT and medication (Durham, 2005). OCD and all types of phobias are difficult to put into remission, but treatment can make them manageable and allow people to function. The CBT for anxiety is similar to that for depression. It emphasizes relaxation techniques such as deep breathing and visualization. These techniques help a person deal with anxiety in the moment, and over time people are able to start relaxing before the anxiety even starts just by identifying the potential for it to start. Some anxiety disorders also respond to antidepressants like the SSRIs discussed above. Newer medications that are anxiolytic, or anti-anxiety, target anxiety better than the SSRIs.

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For a health care provider there are two important things to understand. The first is that medications for anxiety should not be taken for very long. Once the correct medication is found it should only be used until the person can control his or her anxiety through techniques learned in therapy. Anxiolytics are highly addictive and can lead to drug dependence problems. Second, initial therapy can be needed for up to six months, but return visits in the years after have been shown to be important for the maintenance of good mental health. Currently, 30-40% of people with an anxiety disorder deteriorate after 5 years out of therapy (Durham, 2005). Appropriate insurance coverage would reflect the need for follow-up therapy visits and impress upon physicians the short-term use of medications.

State Coverage of Mental Health Care

Medicaid is a national program run by the Department of Health and Human Services that mandates covering groups of people who can't afford private health insurance. The mandated coverage group is called the categorically needy. These are people who fit into at least one of the following categories:

1) Families who meet 1996 AFDC eligibility requirements
2) Pregnant women or children under 6 whose income is 133% of the poverty line
3) Children 6-19 whose family income is up to 100% of the poverty line
4) Caretakers of children who meet above requirements
5) SSI recipients
6) People living in medical institutions with incomes up to 300% of the poverty line (Medicaid-at-a-glance)

People who do not meet the income-based requirements of the categorically needy may qualify in some states as medically needy or in a special group. The medically needy must always include pregnant women up to 60 days postpartum, children under 18 with a chronic illness, newborns for one year, and certain blind people. States can choose to cover full-time students up to age 21, caretakers of children, people over 65 years old, all blind people, or all disable people. States are also allowed to cover people on Medicare whose income is up to 135% of the poverty line and expand access to Medicaid for working disabled people beyond the rules of SSI (DHHS). States can decide entirely what to offer the medically needy and even have a list of optional services for the categorically needy.

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National Medicaid also mandates covering preventative screening for children, family planning, laboratory and x-rays, dental services, physician services, and inpatient hospital services. Beyond those services, the states have a lot of flexibility in what they cover. Mental health care is an optional service under federal Medicaid guidelines and therefore varies considerably from state-to-state. Instead of attempting to analyze mental health coverage in Medicaid on a national level I have selected three states that represent high quality, mediocre quality, and low quality mental health coverage. Quality of mental health coverage is judged by a

combination of the number of services offered in the state, the restrictions on those services, and the percent of people within the state reporting poor mental health. Particular focus is placed on psychologist services, mental health clinics, and prescription drugs coverage because these are the most pertinent services to people suffering from depression or anxiety. Substance abuse coverage is also analyzed because of the link between depression and anxiety and substance abuse. People in poverty suffer from both a psychiatric and substance abuse disorder more often than the general population. Medicaid covers on average 75% more cases of both disorder together than private insurance (Substance Abuse Policy Research Program, 2007). In analyzing each state attention is focused on restrictions on visits to mental health care facilities, requirements for authorization to see mental health professionals, prescription drug limits and preferred drug lists, number of mental health facilities available, and the cost-benefit ratio of the state's current system. The low quality state analyzed is Utah, the mediocre quality state is Rhode Island, and the high quality state is North Carolina.

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Utah. The Utah Department of Health administers the Medicaid program and identifies three major groups. The first group is people who qualify under federal guidelines listed above. They receive all the benefits discussed here. The second group qualifies under a federal waiver Utah received in 2002 to cover adults up to 150% of the poverty line who wouldn't otherwise be eligible for Medicaid. Mental health and substance abuse services are not included for this group. The third group, high-risk pregnant women whose income is up to 133% of the poverty line but have too many other assets to qualify for Medicaid, receive all the benefits (NIMH).

Utah places a 30 visit per year limit on outpatient treatment and a 30 day per year limit on inpatient stays. One visit is considered any therapy or evaluation that occurs from 20 to 80 minutes. Depression and most anxiety disorders require at least three months of therapy for patients to begin feeling better. The thirty visit limit would allow up to seven months of care.

This should be enough to get many patients on the road to recovery, but people requiring longer than seven months in therapy to begin improving could face constant disruptions in treatment. Utah provides a targeted case management service for people who are identified as chronically mentally ill by taking the Utah Scale on the Seriously and Persistently Mentally Ill. Case management helps streamline services but does not allow people to take more than the 30 visits per year to a mental health professional. In addition, meetings with the case manager count towards the 30 visit total making case management a bad choice for people who need longer term care (DRMHS, 2008). Utah identifies who would need extra services but doesn't provide them

The requirements for receiving mental health care in Utah are particularly onerous. The method for authorizing care is vague, the patient must enroll in multiple systems to receive care, and Utah offers a very small number of services to adults. This combination of factors leaves people with mental illness with inadequate care that increases medical costs for everyone. First, a physician, psychologist, or social worker must deem going to a treatment center medically necessary. Utah does not provide a definition for medically necessary leaving the physician, psychologist, or social worker to decide what it means. Each specialty will have a different view of what medically necessary is. Physicians are more likely to view medication as medically necessary but not therapy. Medication for depression and anxiety are for short-term use only except in a very small number of cases. By not defining medically necessary Utah leaves people with mental illness open to improper treatment.

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Second, inpatient mental health coverage is handled through Prepaid Inpatient Health Plans (PIHP) that all beneficiaries must use. There are nine PIHP treatment centers in Utah to choose from and two others that still cost something out-of-pocket. Utah Medicaid recipients must enroll in a separate program, a Managed Care Organization (MCO), for inpatient

detoxification. Finally, a person needing outpatient mental health care must enroll in a Prepaid Mental Health Plan (PMHP). The same nine mental health treatment centers under PIHPs are those that can be used for people enrolled in a PMHP. The limits on where a person can go for care and requiring three separate programs to handle mental health care is inefficient and ineffectual. In a study of Utah's mental health, 42% of people diagnosed with a substance abuse disorder also had another mental illness (CHMS, 2006). Hence, almost half of Utah's mental health patients will need to be in two or three of Utah's mental health programs. Poor communication between doctors and delays in getting treatment are common when two separate programs handle one patient. The inefficiencies can cause people to feel that getting treatment is more trouble than its worth.

Third, adults are afforded a small number of services. They may receive acute psychiatric treatment, as in suicidal tendencies or attempts, through a general hospital. They can not attend psychiatric facilities that specialize in help for emergency issues like suicide. People diagnosed with depression are two to three times more likely to attempt suicide than the general population and having appropriate care for those people is essential (Mayo, 2003). Adult Medicaid recipients are also restricted to seeing psychologists in one of nine mental health treatment centers. The mental health treatment centers do cover a wide range of individual and group therapy services. Private practices are not covered so people with mental health issues are restricted to a small set of care providers. The patient-therapist relationship is important for people with depression and anxiety. The fragile state of those individuals causes them to withdraw and be less likely to fight for good health care. They could simply stop receiving treatment if they don't think the therapist is helping.

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Compared to therapy services, Utah's coverage of medication is very good. They cover generic versions of all drugs deemed highly effective for depression and anxiety. In the rare case

that a person needs a drug that was not covered they would have to pay full price but that is true of almost all insurance plans. Utah Medicaid charges a reasonable $3.00 for a one-month supply. A patient who loses medication can not refill early without paying full price, a common policy for insurance plans. The Utah medication system is beneficial to patients who need medication, it encourages doctors to choose medication instead of a more difficult therapy regime that the patient needs (DRMHS, 2008).

Rhode Island. The Department of Mental Health, Retardation, and Hospitals (DMHRH) manage the mental health side of Medicaid. Rhode Island received a federal waiver in 1993 and expanded Medicaid eligibility to families with children with an income up to 185% of the poverty line, pregnant women up to 250% of the poverty line, and children whose family incomes were up to 250% of the poverty line. Medicaid beneficiaries must enroll in a Managed Care Organization (MCO) in order to receive services and pay on a fee-for-service system. The fee-for-service system means more out-of-pocket expenses for patients. The amounts a patient must pay are very low and can be waived for people with chronic mental illness. Rhode Island offers more services and a simpler authorization process than Utah but still has drawbacks that prevent people with mental illness from receiving the best care.

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There are not true limits on how many times a year a person can use one of Rhode Island's mental health services. Once authorized to receive treatment, a person receives anything that his or her treatment plan deems necessary. In order to develop a treatment plan, a physician, psychologist, or social worker must consider mental health treatment medically necessary. Like Utah, Rhode Island does not define medically necessary and leaves the patient open to ineffectual treatment. Rhode Island does operate a crisis intervention service that people can use without authorization and receive care without cost while a treatment plan is developed. Either through an office visit or crisis intervention, the physician, psychologist, or social worker then

creates a treatment plan based on a diagnosis. The plan is approved by the DMHRH. The treatment plan must contain a diagnosis within the most recent DSM. It is not guaranteed that the physician or social worker will know the most effective treatment for depression or anxiety. They could create a treatment plan based on medication, therapy for too short a time period, or an intensive inpatient program that is unnecessary.

Rhode Island offers a comprehensive group of services for adults that, if the treatment plan says the service is necessary, are very well developed for the needs of patients with depression and anxiety. Clinician services are offered for individuals, families, and groups. The Community Psychiatric Supportive Treatment (CPST) states goal is to “ensure the client's stability and continued community tenure by monitoring and providing medically necessary interventions to assist them to manage the symptoms of their illness and deal with their overall life situations” (DMHRH). The CPST also comes in a Mobile Treatment form to continue service for people with more severe problems who refuse treatment in a traditional office setting. CPST is excellent for people with depression and anxiety who can use it to maintain the techniques they learned during cognitive-behavioral therapy and prevent a relapse. The use of CPST is reviewed every month to ensure that the service is still necessary. Many people recovering from depression and anxiety could lose their services because they may seem completely better after a year of therapy and support. If they are cut off from their source of support, they could end up back where they started, requiring far more intensive care. Rhode Island also has two long-term treatment programs called Rhode Island Assertive Community Treatment I and II (RIACT). These two programs serve people with severe and persistent mental illness requiring longer term treatment and potentially more intensive treatment. RIACT-I is for the very severely mentally ill who can receive 8 hours a day of treatment while RIACT-II is for moderately severe mental illness with up to 4 hours a day of treatment and most likely what a

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person with severe depression or anxiety would need. The RIACTs provide streamlined services for people with multiple diagnoses. Treatment plans are reviewed every 6 months.

Rhode Island's biggest pitfall is that people can't receive substance abuse services without a primary mental illness diagnosis. Depression and anxiety qualify as primary mental illness diagnoses and if a person with depression or anxiety also has a substance abuse disorder they can receive inpatient and outpatient treatment. If a review of the treatment plan indicates that the person no longer needs treatment for depression or anxiety, they would stop receiving treatment for substance abuse, even if they still needed it. Continued drug abuse can easily pull a person back into depression or anxiety and start the cycle all over again. A person with a substance abuse disorder and depression or anxiety needs to complete treatment for everything in order to be successful.

Rhode Island has more treatment facilities than Utah and covers 911 separate psychologists and psychiatrists offering far more choice to the person with depression or anxiety. There are seven community mental health centers and sixteen mobile treatment programs. Rhode Island has 225 inpatient beds and 150 supervised apartments for long-term inpatient care. There are eight regions for crisis intervention with multiple centers in each region. Once a person is approved to receive mental health services there are a lot of options that make the likelihood of finding an appropriate therapist or mental health center much higher than in Utah. Rhode Island still restricts people to finding a service within their county which could be a problem for people living on the edge of a county who are closer to a service in another county and would prefer to receive treatment there.

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Rhode Island's prescription drug benefits are similar to those in Utah. A preferred drug list requires doctors use the generic version of a drug when it is available. Physicians are allowed to appeal for the use of non-preferred drugs. A three prescription limit can be waived for people

with multiple illnesses so a person with two mental illnesses or a mental and physical illness can receive as many medications as necessary. While the ease of the prescription drug system can give doctors an incentive to prescribe drugs and not therapy, the greater availability and simpler authorization process for therapy reduces this incentive. Rhode Island does not have as large a difference in the two services as Utah does.

North Carolina. The Division of Medical Assistance runs the North Carolina Medicaid program. North Carolina received permission to expand its Medicaid coverage to pregnant women and infants up to 185% of the poverty line, children up to age 5 whose family income is up to 133% of the poverty line, and children aged 6 to 18 whose family income is 100% of the poverty line. Everyone meeting these income requirements receives medical care, and if they exceed these limits they can retain Medicaid coverage for a deductible based on their extra income. This allows families to retain their medical coverage as they transition out of poverty (DMA). All of the expansion groups can receive full Medicaid benefits. A wide range of mental health services are covered \including assertive community treatment, community support, mobile crisis management, multi-systemic therapy, facility-based care, and medical and non-medical substance abuse treatment. The treatment is not limited to what is recommended in the DSM. Doctors and psychologists can choose to go beyond the DSM allowing longer term treatment if necessary (NCDHHS).

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In order to receive treatment in the long term a person must have a Person-Centered Plan (PCP). These are similar to the treatment plans of Rhode Island but much more flexible. The PCP places the patient in control of the process. A person with depression or anxiety decides what is an acceptable level of functioning to reach and the treatment provides for that level. A person with a PCP must have a diagnosable disorder, based on the DSM, to begin but treatment continues until the PCP is fulfilled. The framework for the North Carolina PCP makes it far more

effective than the Rhode Island treatment plan because it does not stop treatment before the person is considered fully functional. In addition, North Carolina defines "medically necessary" as

> …provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems (DMA).

This definition for medically necessary means that physicians, social workers, and psychologists use the same guidelines to create an effective treatment plan. If a physician does not know the most effective treatment for depression, the definition of medically necessary requires that he find out before creating a treatment plan. The doctor will not be able to show that the service will improve the patient's health if they do not know enough about the treatment.

North Carolina also allows a number of visits to a mental health professional before the PCP is in place. A person can have 4 visits to a Community Support service and 32 days of crisis management services without any authorization (NCDHHS). Access to psychologists without authorization means that people do not have to rely on physicians or social workers to develop their PCPs. They can see a specialist and begin receiving treatment before a crisis or hospitalization is required. The only limits on treatment, even once there is a PCP, restrict inpatient services to 30 days in a 12-month period. People with severe depression or anxiety requiring inpatient treatment will not likely need more than 30 days but the restriction could certainly be a problem for other disorders. Once a PCP is developed, it is reviewed every 3-months and treatment is ends when all goals have been met.

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North Carolina's variety of services offers effective treatment for people in need of mental health services. The language used in the provider's manual for billing mental health services emphasizes that treatment should be based on the patient's PCP, and that the first

priority is to help the patient gain the ability to function independently. Instead of focusing on symptom reduction or whether the person fits the diagnostic criteria, the provider's manual focuses on the person's ability to live a productive life. People with depression and anxiety can become very productive as long as they receive all necessary treatments without interruption. The first part of North Carolina's system, composed of the Community Support, Inpatient services, and Mobile Crisis Management are accessible without authorization and address the acute early stages of depression and anxiety. North Carolina also offers very comprehensive substance abuse treatment, is both inpatient or outpatient, and medical or non-medical. People can receive treatment for co-occurring disorders like depression, anxiety, and substance abuse even when treatment for one exceeds treatment for the other. Once the initial phase has passed and a person has a PCP, he or she can continue with an intensive Community Support team or the less intense Psychosocial Rehabilitation. These services are used to work towards the goals in the PCP and to continue a relationship with the patient. The literature indicates that continuing periodic treatment is the most effective way to prevent relapsing into depression or anxiety. For people who have persistent or severe disorders the Assertive Community Support Team that is available 24 hours a day (NCDMA). The program is not as comprehensive as Rhode Island's RIACT I and II but helps anyone with severe mental illness receive uninterrupted necessary treatments.

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North Carolina Medicaid covers over 700 psychologists and treatment centers giving patients choices for their treatment. North Carolina still has fewer providers than Rhode Island, a smaller state, and could improve access by increasing the number of providers. Overall however, North Carolina places fewer restrictions on who a person chooses for treatment and does not assign patients to specific county service areas the way Rhode Island and Utah do. Those who have the means to travel further or who live on the edge of a county may seek treatment in

another area. This kind of mobility helps people with depression or anxiety who are sensitive to the relationship they develop with care providers.

North Carolina's Outpatient Pharmacy Program allows eight drugs per person per month which is more than a person with depression or anxiety would typically need. Each prescription a person fills costs $3.00 regardless of the medication. Free and effective therapy is better for people with depression and anxiety than medication that only reduces symptoms and should be used for a short period. North Carolina does cover brand-name drugs unless an equally effective generic can be found. This policy can help people who find that only a brand-name drug works for them. Little is known about how many anxiolytics and anti-depressants work, and many patients find that a specific drug is most effective. The North Carolina Pharmacy Program is not difficult, but the cost and ease of therapy will encourage doctors to use both to treat depression and anxiety.

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Cost-Benefit Analysis

Spending on mental health care is not reported specifically for Medicaid. A State Mental Health Agency (SMHA) is the agency primarily responsible for mental health care in the state. These agencies run the publicly funded mental health care such as Medicaid and programs for people who cannot afford private insurance. The spending reported for each state SMHA gives a close approximation of what is spent on Medicaid recipients. The spending per person receiving mental health care from the SMHA is actually lowest in North Carolina, at $49.64 for the 2004 fiscal year indicating that greater access to mental health care doesn't necessarily have to come with a greater cost. Utah spends $73.56 per capita and Rhode Island $92.92 per capita but both still have problems with penetration and positive outcomes for users of mental health services.

The information on spending per capita reported above is best framed in terms of overall Medicaid spending growth in each state. While North Carolina spends less than Utah and Rhode

Island per person using mental health services mental health care may still be increasing Medicaid spending too much. National Medicaid spending growth rate has decreased from 10.9% per year from 1990 to 2001 to 2.8% per year from 2004 to 2006. In fact, North Carolina has steadily reduced its Medicaid spending growth rate from at high of 14% per year from 1990 to 2001 to 4.5% per year from 2004 to 2006 when mental health care was expanded. Rhode Island reached a peak of 11.6% growth per year from 2001 to 2004 but decreased that to 1% per year from 2004 to 2006. Utah has not made nearly as much progress with a high of 14% per year from 2001 to 2004 and still has a growth rate of 8.5% each year from 2004 to 2006 (KFF). Both Rhode Island and North Carolina have managed to decrease Medicaid spending growth despite expanding mental health coverage.

The benefits of mental health are difficult to measure. There is a scarcity of data on the costs and benefits of increased mental health coverage because the increase in mental health services by private insurance and state Medicaid programs has occurred recently. Information on recipients of mental health services includes the penetration rate, percentage of people in the state reporting poor mental health, and feelings of social connectedness after receiving mental health care. These statistics indicate how well services are working for people using public mental health services. In addition, the employment status and housing stability of people receiving mental health services help give some economic data on how well people receiving mental health services are doing in other areas of their lives. Beyond these numbers, quality mental health care improves people's lives through increased productivity and better family lives. Increasing people's functioning also helps the children and colleagues who interact with those with mental illnesses.

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North Carolina has a higher penetration rate than Utah or Rhode Island. The penetration rate is the number of people who receive services out of all the people who have been identified

as needing services. The penetration rate is affected by how easy it is to get authorized for service, the number of facilities available for services, and limits on how much service a person can receive. The states report their penetration rate to the Center for Mental Health Statistics (CMHS). Utah only reaches 17 people out of every 1,000 in need of services. This is below the 19 people per 1,000 in need of services reached in the United States overall. Rhode Island fairs significantly better reaching 24 people per 1,000 in need of services. North Carolina reaches a high 29 people per 1,000 in need of services. All of these numbers point towards an overall problem with penetration. With each increase in ease of access to services, there is a corresponding increase in the penetration rate. Rhode Island significantly increases the number of facilities covered by Medicaid and makes authorization for treatment easier than Utah. North Carolina offers a definition of "medically necessary" that emphasizes effective treatment and allows visits to psychologists before authorization.

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Improved mental health services also increase people's daily functioning. The Center for Mental Health Statistics (CMHS) reported on feelings of social connectedness of people who have received mental health services. North Carolina had 73% of people respond that they felt increased social connectedness after mental health services. Rhode Island had 69% of people respond they felt improved social connectedness. Utah did not report. Social connectedness is a large part of people's ability to succeed in society, especially for people in poverty. Social supports help people get through difficult times. Increases in social connectedness improve people's ability to maintain their mental health and decreases the likelihood of relapsing into depression or anxiety. Social connectedness also increases a person's social network that they can draw from to help them with future problems. As Amartya Sen shows, social capital is a large part of how people become successful in life and the poor lack social capital and the ability

to develop constructive social capital (1997: 386). State that can increase social connectedness are helping people with their family problems and develop constructive friendships.

Improvements in family functioning from effective mental health care are not measured but are probably the most important part of therapy. A person with depression or anxiety has most likely withdrawn from the family, suffered abuse or neglect, or has behaved in a way that has injured others in the family. The family must be rebuilt in order for the person with depression or anxiety to move forward. In order to qualify for Medicaid as an adult, a person must be the caretaker of a child with a low family income or have a disability. These requirements mean that a large portion of Medicaid recipients are parents whose parenting abilities are severely constrained if they are suffering from depression or anxiety. The negative effects of depression and anxiety then also affect the children. A study by Spence et al. (2002) found that children whose mothers suffered from depression or anxiety were more likely to have behavior problems or depression and anxiety themselves. The study also found that depression and anxiety increase the risk for marital discord and divorce which also increases the likelihood of depression and anxiety in the children. These findings mean that effective treatment of mental illness is particularly important for adults on Medicaid whose mental illness negatively affects children and continues the cycle of mental illness and poverty.

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Employment and housing are good economic indicators of the effectiveness of mental health services are. Both these statistics must be used in the context of other variables that affect them. The employment of people treated for mental illness is also affected by the economy and availability of jobs at the person's education level. In addition, these statistics include employment for people with private insurance. Depression and anxiety increase the likelihood of losing a job or housing because of social withdrawal and fatigue. Utah actually had higher levels of employment among recipients of mental health services with 26% employed. North Carolina

and Rhode Island had the same employment rate at 23% of mental health service recipients (CMHS). North Carolina has a higher rate of unemployment in general at 21% compared to 18% and 11% in Rhode Island and Utah respectively (KFF). Mental illness seriously impacts a person's ability to function at a job as indicated by the stories told above. As most Medicaid recipients have low-wage jobs they are more likely to be fired for decreases in productivity. They are also less likely to have a positive relationship with their boss that would make them go for help before they were fired. Job loss among those suffering from depression and anxiety is a major problem because it exacerbates the feelings of worthlessness or anxiety over what is going to happen next. These feelings, along with increasing withdrawal, make a person even less likely to find another job and therefore remain chronically unemployed. The costs of increased unemployment resulting from poor mental health care are not currently measured but certainly don't help the individuals involved or society.

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The housing data gives a sense of the kind of stability people receiving mental health care have. North Carolina had the lowest rates of homelessness and people living in prison among mental health service recipients at 2.3% and .6% respectively. Rhode Island had slightly higher rates of homelessness, at 2.9%, and similar but lower rates of people living in prison at .2%. Utah had significantly higher rates of homelessness and people living in prison at 2.6% and 4.2% respectively (CMHS). Both Rhode Island and North Carolina have systems for maintaining contact with recipients of mental health services to stop them from ending up in dangerous situations. If Utah maintained contact with people who used mental health services they could intervene before people end up in prison or homeless. Homelessness and prison represent significant costs to society. People suffering from depression and anxiety are particularly vulnerable to relapse if they are also dealing with the stress of homelessness or being in prison.

Recommendations

Medicaid covers 15 million adults representing 25% of all Medicaid recipients and 5% of America's population (KFF). The effects of poverty make Medicaid recipients significantly more likely to suffer from mental illness. Mental health care is essential to get the most out of those 15 million adults and help move people out of poverty. Legislation over the past decade has helped but a lot more can be done. Even states like North Carolina, which was cited by Health Affairs as a state to watch for dealing with spending cuts while maintaining higher quality care, are still woefully deficient in reaching Medicaid recipient's with mental illnesses. North Carolina's penetration rate is one of the highest of all states and yet is only 2.9%. In order to improve mental health coverage there needs to be education for social workers and physicians, national standards, an emphasis on acute care, and more providers.

The first step to improving mental health care is providing education to social workers and physicians who create treatment plans for patients frequently. Social workers and physicians see Medicaid recipients more frequently than psychologists and are more likely to be the people creating treatment plans. However, social workers and physicians are not trained in diagnosing or treating mental illness. There needs to be an easy way to find out the best methods for treating the mental illnesses of their patients. There has been a trend toward telemedicine, implemented in Utah, which allows people in remote locations to talk with a psychologist through teleconferencing. The U.S. Department of Health and Human Services has encouraged the use of telemedicine in all states (DHHS). There are many potential problems with such an impersonal service for people with mental illness, but it could be a very useful too for physicians and social workers. They could connect with psychologists to create effective treatment plans and learn about treatment of mental disorders they may not have been trained to treat. An effective treatment plan creates better outcomes for the patient and a higher likelihood of the person remaining healthy.

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The second step is a set of national standards for the treatment plan and evaluation of outcomes. North Carolina has been able to improve its mental health care for Medicaid recipients by having clearly defined standards for who is authorized to receive care. They provide a definition of medically necessary that emphasizes the patient's level of functioning. A uniform definition of medically necessary combined with knowledge of treatment helps doctors create treatment plans that are based on best practices for the mental illness in question. The effectiveness of Cognitive-Behavioral Therapy for depression and anxiety should be widely known and therefore used by doctors when creating treatment plans. There also need to be national standards for evaluating treatment based on North Carolina's model. The Person-Centered Plan focuses on overall functioning with goals that include long-term maintenance of mental health. Utah and Rhode Island focus on reducing symptoms below the threshold for a diagnosed mental illness. People lose their mental health services once their symptoms are reduced enough even if they are not yet fully capable of managing their mental health on their own. A national standard of focusing on long term functioning is most beneficial to employment, housing, family life, and most cost effective.

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The third step is funding the right kind of service. There are emergency services like hospitals and rehabilitation centers and then there are more long-term services like psychologist visits and public mental health facilities (KFF). Severe mental illnesses that require emergency care like schizophrenia only occur in 1% of the population (NIMH). The prevalent mental illnesses like depression and anxiety do not require a lot of emergency care and yet states cover more emergency care services than acute care services. Psychologist services are only covered in 31 states and mental health facilities are covered in 49 states but only 26 without out-of-pocket expenses. Emergency care such as inpatient hospital and rehabilitation are covered in 49 states and 39 states without expenses (KFF). The emergency services are also more costly. Long-term

care through mental health facilities is only 3.7% of the national Medicaid budget while inpatient hospital care represents 24% of the national Medicaid budget. Emergency care is more expensive than long-term care but the current system encourages people to use emergency services for their depression and anxiety. Hospitals are not good facilities for treating depression and cost more to use. Costs could be reduced and more effective treatment given if people always used the appropriate service for their mental illness.

Finally, in order to transition to a more effective system with more acute care and appropriate treatment services the number of providers needs to increase as well. Medicaid needs to work with private practices in psychology and psychiatry to provide more options to patients. More providers also increase the penetration rate, as seen in the comparison between Utah, Rhode Island, and North Carolina. The goal should be to have enough providers of all the different types of mental health services for all the people identified as needing services. Each state may face different rates of mental disorders and should plan accordingly but the types of providers should be based on the prevalence rates of mental illness within the state. Simply adding providers without an understanding of what is needed will not improve care or increase the penetration rate. The Substance Abuse Policy Research Program found that people with a psychiatric disorder and a substance abuse disorder were most likely to receive treatment in emergency rooms in hospitals even though they need treatment in a mental health facility over a long period. The article recommended providing the appropriate services in more areas so that people can get the right kind of care (2007).

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The increasing realization among the general population and policy makers that mental health care is important has helped improve insurance coverage. However, the Mental Health Parity Act, even in its newer form, can only do so much. Taking away visit limits and funding restrictions is only part of the problem. If society wants to decrease health care costs and

improve the lives of the mentally ill the above recommendations would be a more effective start. Education about effective mental health treatment is needed so that people aren't using public health care dollars inefficiently. National standards for treatment and outcomes measures will allow states to track their progress and place the emphasis on long-term recovery and stability instead of just symptom reduction. Increases in the right kind of services in the right areas will make people more likely to seek treatment when they have a problem and allow the state to treat everyone who suffers from a mental illness instead of just a very small percentage. Again, it is inefficient to treat depression or anxiety in a hospital and costs could be reduced by sending people to the right places for treatment. Mental health care needs to be improved in a meaningful way to reap the benefits to both individuals and society.

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