Vanderbilt Law Review

Volume 50
Issue 3 *Issue 4 - May 1997*

Article 4

4-1997

Current Issues in Mental Health Care

David A. Skeel, Jr.

SPECIAL PROJECT

Current Issues in Mental Health Care

INTRODUCTION

When America was founded in the late eighteenth century, doctors treated mental illness with beatings, isolation, and physical restraint—all thought to help the patient regain inner reason.[1] People exhibiting strange behavior were often forced onto the streets, run out of town, or thrown into jail.[2]

Today we think we know a lot more about mental health care than our country's founders did. Yet in many ways we are in no better position than our eighteenth-century predecessors. Certainly, the decisions we as a society face about mental illness are just as difficult. The vocabulary we employ is more complex—"behavioral health organization," "psychopharmacology," "cost containment"—but

1. William E. Baxter and David W. Hathcock III, *America's Care of the Mentally Ill: A Photographic History* 14 (American Psychiatric Press, 1994).
2. Id. at 1.

the issues are the same: Who should pay for mental health care? How much care is appropriate? And, more fundamentally, what exactly is mental health?

This year's Special Project addresses these issues. The Notes focus on particular legal issues in the mental health care field, but in doing so, they necessarily implicate the larger national debates about mental health care and health care in general. Policymakers are currently making crucial decisions in both areas. These Notes seek to inform those decisions.

Until recently, most insured individuals received mental health benefits under the traditional fee-for-service reimbursement system.[3] Physicians made the essential treatment decisions, particularly those concerning psychiatric hospitalization.[4] In the 1980s, however, mental health care experienced a period of rapid competitive expansion, leading to the rise of for-profit psychiatric hospitals.[5] These hospitals, which typically target adolescents and substance abusers, dramatically increased inpatient care, and thus dramatically increased mental health care costs.[6]

The need to control those costs led to the emergence of managed care, which seeks to prevent providers from overutilizing health care resources by giving them an incentive to limit services. Most managed care entities, however, do not have the staff or capability to deal with mental health problems directly.[7] Instead, they typically contract with large companies that specialize in mental health care.[8]

Mental health care is very different under this managed care system. Under most plans, an individual who needs mental health care calls a toll-free, twenty-four-hour hotline and talks to a case reviewer.[9] The reviewer then uses pre-established diagnostic criteria to decide what sort of caregiver the patient should see.[10] In a typical plan, twenty percent of the available treatment staff for mental

---

3. Michael S. Jellinek and Barry Nurcombe, *Two Wrongs Don't Make a Right: Managed Care, Mental Health, and the Marketplace*, 270 JAMA 1737, 1737 (Oct. 13, 1993).

4. Id.

5. Id.

6. Id.

7. John K. Iglehart, *Health Policy Report: Managed Care and Mental Health*, 334 New Eng. J. Med. 131, 131-32 (Jan. 11, 1996).

8. Id. These companies have been rapidly consolidating in the past few years. Id. at 132. At the beginning of 1996, the ten largest managed behavioral health care entities controlled 90% of the industry. Id.

9. Id.

10. Id.

illness are psychiatrists, forty percent are psychologists, and forty percent are social workers.[11]

Proponents of managed mental health care emphasize its potential for reducing costs and preventing the waste of health care resources.[12] They also point out that managed care providers are likely to be held accountable not only for costs, but for quality.[13] Thus managed care may improve our knowledge of mental illness as companies systematically gather and evaluate information about treatment plans in order to remain competitive.

But there is a great deal of opposition to managed mental health care.[14] First, there is the criticism leveled against all forms of managed care—that a system that allows companies to make money by providing less service will not provide patients with adequate care.[15] In addition, critics charge that managed care destroys the traditional doctor-patient relationship.[16] This concern exists in all areas of medicine, but it may be particularly serious in the mental health field.

The first break in the traditional doctor-patient relationship occurs at the beginning of the process when the individual consults a case reviewer instead of a doctor. This compromises traditional doctor-patient confidentiality. It further undermines the doctor-patient relationship by giving the doctor less control over treatment decisions. Indeed, the patient may never actually see a physician.[17] Many psychiatrists feel that the increased use of non-medical personnel and the prospect of having to justify treatment decisions to a managed care company also threaten the doctor-patient relationship.[18]

Despite these criticisms, however, the current trend is decidedly toward managed care. The task now is to see that this

---

11. Id.

12. See Carol Hymowitz, *Debate: Has Managed Care Hurt Mental-Health Care? It Depends on Whom You Ask*, Wall St. J. R19 (Oct. 24, 1996) (quoting Dr. Peter Panzarino, chairman of the Department of Psychiatry at Cedars-Sinai Hospital in Los Angeles, California).

13. Id. (quoting Dr. Panzarino).

14. Much of this opposition comes from medical docters. See, for example, Jellinek and Nurcombe, 270 JAMA at 1737 (cited in note 3) (discussing the "destructive potential of managed care approaches" in mental health care); Iglehart, 334 New Eng. J. Med. at 133-34 (cited in note 7) (discussing the "unprecedented turmoil" the advent of managed care has caused in the mental health care profession). See generally Arthur Lazarus, ed., *Controversies in Managed Mental Health Care* (American Psychiatric Press, 1996) (collecting essays by mental health care professionals on managed care issues).

15. Jellinek and Nurcombe, 270 JAMA at 1737-38 (cited in note 3).

16. Hymowitz, Wall St. J. at R19 (cited in note 12).

17. Id. (noting a patient that reported she had to pay for her own therapy because the only care her managed care plan offered her was through an unlicensed therapist).

18. Iglehart, 334 New Eng. J. Med. at 133-34 (cited in note 7).

movement towards managed care improves mental health care in terms of both cost and quality. The first Note in this Special Project, *The Early and Periodic Screening, Diagnostic, and Treatment Program and Managed Medicaid Mental Health Care: The Need to Reevaluate the EPSDT in the Managed Care Era*,[19] analyzes managed care's effect on the Medicaid requirement that state governments provide eligible children with comprehensive screening and treatment for certain diseases, including mental illnesses.[20] State compliance with the broad mandate has been poor.[21] Compliance with the mental illness requirement has been even worse.[22] The Note describes how the advent of managed care has the potential to exacerbate the problem in the name of cost containment.[23] The Note then suggests ways to reconcile the goals of managed care with the goals of the Medicaid mandate.[24] In doing so, the Note provides a model of how managed care can be used to improve health care delivery in America.

Another area in which states are responsible for providing certain forms of mental health treatment is special education. The second Note, *Returning to the True Goal of the Individuals with Disabilities Education Act: Self-Sufficiency*,[25] examines both a state's duty to provide certain services and its power to deny educational services to children with mental illnesses manifested as discipline problems.[26] In order to receive federal funds, states are required to provide certain services to individual students with special needs, including those suffering from "mental retardation" and "serious emotional disturbance."[27] The Note analyzes the jurisprudence defining the scope of the services that states are required to provide.[28] It then discusses recent proposals that would allow states to limit or deny educational services to students with certain discipline problems caused by mental illness.[29]

---

19. John A. Flippen, Note, *The Early and Periodic Screening, Diagnostic, and Treatment Program and Managed Medicaid Mental Health Care: The Need to Reevaluate the EPSDT in the Managed Care Era*, 50 Vand. L. Rev. 683 (1997).

20. Id. at 689-92.

21. Id. at 692.

22. Id. at 691.

23. Id.

24. Id.

25. Robert Caperton Hannon, Note, *Returning to the True Goal of the Individuals with Disabilities Education Act: Self-Sufficiency*, 50 Vand. L. Rov. 715 (1997).

26. Id.

27. Id. at 720 n.36.

28. Id. at 724-45.

29. Id. at 745-50.

The special education issue highlights one of the most enduring problems with mental health treatment: people are often afraid of or offended by those who suffer from mental illness.[30] This fear and aversion can make it difficult for people to accept the need to allocate scarce resources, like state educational funds or private insurance dollars, to mental health treatment. For several years, medical and legal commentators have called for "parity" in insurance coverage for mental and physical health problems.[31] Congress responded last year with the Mental Health Parity Act of 1996.[32] Theoretically, the Act should elevate insurance coverage for mental health care to the same level as coverage for physical health care. The third Note, *Legislative "Subterfuge"?: Failing to Insure Persons with Mental Illness Under the Mental Health Parity Act and the Americans with Disabilities Act*,[33] however, argues that the Mental Health Parity Act was eviscerated through legislative compromise and is unlikely to provide any meaningful benefits to the mentally ill.[34] The Note further describes how the mentally ill also find little protection in the Americans with Disabilities Act.[35]

As these three Notes demonstrate, mental health care is a serious and urgent issue in this country. For the insured, the move to managed care has created new controversies and potential problems. These problems should be addressed now, while the system is still evolving. For the uninsured, mental health care is woefully inadequate. As in the eighteenth century, an unacceptable number of people with mental illnesses are on the streets or confined to jails, where they cannot receive adequate treatment. This year's Special Project challenges us to confront these issues. The Notes both describe problems and suggest solutions, in the hope that through this

30. Mental illness is often perceived as fundamentally different from physical illness. Epilepsy, for instance, is treated very differently than schizophrenia. In 1994, *U.S. News and World Report* ran a story about a couple who exhausted their insurance resources and went into severe debt trying to care for their daughter, who had been diagnosed as schizophrenic. After six years, it was discovered that the girl in fact was epileptic, and suddenly their insurance company started paying for everything. Erica E. Goode, *How Much Coverage for Mental Illness? Many Want Full Benefits; Others Fret Over Costs*, U.S. News & World Rep. 56, 56-57 (Mar. 14, 1994).

31. Christopher Aaron Jones, Noto, *Legislative "Subterfuge": Failing to Insure Persons with Mental Illness Under the Mental Health Parity Act and the Americans with Disabilities Act*, 50 Vand. L. Rev. 753, 756 n.15 (1997).

32. Pub. L. No. 104-204, 110 Stat. 2294 (1996).

33. Jones, 50 Vand. L. Rev. 753 (cited in note 31).

34. Id. at 758-71.

35. Id. at 771-83.

and other academic commentary, the mental health care system in the United States will improve.

Tamsen Douglass Love
Special Project Editor