Financing Mental Health for Children & Adolescents

INFORMATION RESOURCE

Data on financing for mental health (MH) services and programs are difficult to amass. The difficulty arises from many factors. For one, the figures depend on whether the focus is on mental illness, psychosocial problems, and/or the promotion of general wellness. Other difficulties stems from variations in funding sources (e.g., public- private; national, state, or local levels), to whom the funds go (e.g., agencies, schools, or community based organizations), and for what purposes they are used (e.g., direct, administrative, and evaluative costs related to programs, services, initiatives, projects, training, research).

Data

Most information on MH expenditures focuses only on direct treatment of mental disorders, substance abuse, and dementias (e.g., Alzheimer's disease). Adult and child data are not separated. As summarized in the 1999 Surgeon General's report on MH:

- total expenditures in 1996 were above $99 billion – about 7 percent of total U.S. health spending estimated at $943 billion a percentage decline over the decade
- more than two-thirds ($69 of the $99 billion) was consumed by MH services, with outpatient prescription drugs among the fastest-rising expenses (accounting for about 9 percent of total direct costs)
- treatment of substance abuse was almost $13 billion (about 1 percent of total health spending)
- public sector per capita costs for treating the 5.1 million individuals with serious mental illness (about 1.9 percent of the population) is estimated at $2,430 per year, leaving about $40 per year for persons without insurance and with problems not seen as severe.

Who paid? Approximately $37 billion (53 percent) for MH treatment came from public payers. Of the remaining $32 billion, $18 billion came from private insurance. Most of the rest was direct payment (including copayments related to private insurance, prescription costs not covered by Medicare, supplementary insurance, as well as direct payment by the uninsured or insured who chose not to use their insurance coverage for MH care.)

Another Perspective Is Provided By What Is Spent in Schools

- Federal government figures indicate that total spending to educate all students with disabilities found eligible for special education programs was $78.3 billion during the 1999-2000 school year (U.S. Department of Education, 2005). About $50 billion was spent on special education services; another $27.3 billion was expended on regular education services for students with disabilities eligible for special education; and an additional $1 billion was spent on other special needs programs (e.g., Title I, English language learners, or gifted and talented education.) The average expenditure for students with disabilities is $12,639, while the expenditure to educate a regular education student with no special needs is $6,556. Estimates in many school districts indicate that about 20% of the budget is consumed by special education. How much is used directly for efforts to address learning, behavior, and emotional problems is unknown, but remember that over 50 percent of those in special education are diagnosed as learning disabled and over 8 percent are labeled emotionally/behaviorally disturbed.
- Looking at total education budgets, one group of investigators report that nationally 6.7 percent of school spending (about 16 billion dollars) is used for student support services, such as counseling, psychological services, speech therapy, health services, and diagnostic and related special services for students with disabilities. Again, the amount specifically devoted to MH is unclear, and the figures do not include costs related to time spent on such matters by other school staff, such as teachers and administrators. Also not included are expenditures related to special initiatives such as safe and drug free schools programs and special arrangements such as alternative and continuation schools and funding for special school-based health, family, and parent centers.

FINANCING POLICY

The following are some conclusions about current status and future needs based on available studies:

- The public sector (particularly state and local government) is responsible for the greatest proportion of financing of MH services.
- The vast proportion of public and private funding for MH is directed at severe, pervasive, and/or chronic psychosocial problems. For those in crisis and those with severe impairments, current financing is only sufficient to provide access to a modicum of treatment, and even this is not accomplished without creating major inequities of opportunity. Few programs and services are available for children and youth, and those that are available too often are inadequate in nature, scope, duration, intensity, quality, and impact.
- Expansion of Medicaid funding for MH care has reduced direct state funding and profoundly reshaped delivery of care.
- In the private sector, insurance and the introduction of managed care are reshaping the field, with an emphasis on cost containment and benefit limits and with expanded coverage for prescription drugs.
- There is a trend toward tying significant portions of public financing for MH and psychosocial concerns to schools and a related trend toward encouraging school and community collaborations.
- Future funding for MH and psychosocial concerns needs to be less marginalized in policy and practice, less categorical in law and related regulations, less fragmented in planning and implementation, and more equitable with respect to access and to insurance coverage.

(http://smhp.psych.ucla.edu/pdfdocs/financing mh.pdf)

The emerging program vision. A central financing principle is that funding should not drive programs, rather the program vision should drive financing. For communities and schools, the range of MH and psychosocial concerns confronting young people require a vision that encompasses much more than providing services for those with mental disorders. The activity must entail a multifaceted continuum of programs and services including those designed to:

- promote healthy social and emotional development (assets) and prevent problems (by fostering protective factors and resiliency and addressing barriers to development and learning)
- intervene as early after the onset of a problem as is feasible, and
- provide specialized assistance for persons with severe, pervasive, and/or chronic problems.

Establishing the full continuum and doing so in an integrated, systematic manner requires weaving community and school resources together and requires financing for start-up costs and underwriting for ensuring that programs and services are available and accessible to all who can benefit.

Funding sources. Another basic funding principle is that no single source of or approach to financing is sufficient to underwrite major systemic changes. Thus, in addition to general agency and school funding, programs to address youngsters' MH related concerns increasingly are seeking access to many funding sources including:

- Medicaid and Supplemental EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
- Maternal and Child Health (Title V) block grants
- ESEA (Elementary and Secondary Education Act) Title I and Title XI
- IDEA (Individuals with Disabilities Education Act)
- Community MH Services block grant
- Programs from the several agencies concerned with promoting health, reducing violence and substance abuse, and preventing pregnancy, dropouts, and HIV/AIDS
- Titles IV-B, IV-E, and XX of the Social Security Act
- After school programs and job programs
- State-funded initiatives for school-linked services
- And, as feasible, private insurance reimbursements and private fee for services.

Opportunities to Enhance Funding

- reforms that enable redeployment of existing funds away from redundant and/or ineffective programs
- reforms that allow flexible use of categorical funds (e.g., waivers, pooling of funds)
- health and human service reforms (e.g., related to Medicaid, TANF, S-CHIP) that open the door to leveraging new sources of MH funding
- accessing tobacco settlement revenue initiatives collaborating to combine resources in ways that enhance efficiency without a loss (and possibly with an increase) in effectiveness (e.g., interagency collaboration, public-private partnerships, blended funding)
- policies that allow for capturing and reinvesting funds saved through programs that appropriately reduce costs (e.g., as the result of fewer referrals for costly services)
- targeting gaps and leveraging collaboration (perhaps using a broker) to increase extramural support while avoiding pernicious funding
- developing mechanisms to enhance resources through use of trainees, work-study programs, and volunteers (including professionals offering pro bono assistance).

For More Information

The Internet provides ready access to info on funding and financing.

Regarding funding, see:

>*School Health Program Finance Project Database* – http://apps.nccd.cdc.gov/HYFund
>*School Health Finance Project of the National Conference of State Legislators* – http://www.ncsl.org/programs/health/pp/strvsrch.htm
>*Snapshot from SAMHSA* – http://www.samhsa.gov
>*The Catalog of Federal Domestic Assistance* – http://www.gsa.gov/
>*The Federal Register* – http://www.access.gpo.gov/GPOAccess
>*The Foundation Center* – http://fdncenter.org
>*Surfin' for Funds – guide to internet financing info* http://smhp.psych.ucla.edu *(search Quick Find)*

Regarding financing issues and strategies, see:

>*The Finance Project* – http://www.financeproject.org
>*Center for Study of Social Policy* – http://www.cssp.org
>*Center on Budget and Policy Priorities* – http:www.cbpp.org
>*Fiscal Policy Studies Institute* – http://www.resultsaccountability.com
>*Making the Grade* – http://www.healthinschools.org/about/overview.htm

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