

Chapter 7. After the Mandates: Does Mental Health Care Law Need to Refocus on the Seriously Mentally Ill?

*David D. Johnson*¹

I. Introduction	248
II. The Early Focus of the Mental Health System on the Seriously Mentally Ill	249
A. The Origins of Our Mental Health Care System .	249
B. The Refuge on the Hill: The Rise and Decline of the Asylum Movement	251
III. The Shift in Focus to the Less Severe Mental Health Needs of the General Public	256
A. The Development of Mental Health Services for the General Community in the Early 20th Century	256
B. The Mid-20th Century: Community Treatment Supplants the Asylum	258
C. The Turn of the Millennium: The Provision of Mental Health Services to the General Community Vastly Expands	263
IV. The Mental Health Parity Mandates of 1996-2014	269
A. Early Mental Health Coverage Mandates	270
B. The Federal Mental Health Parity Act of 1996 ...	270
C. The State Mental Health Parity Acts of the Late 1990s	271

¹Counsel, Crowell & Moring, San Francisco, California. The author thanks Arthur Lerner and Joel Wood who read and provided comments on an earlier draft of this article, Dr. Bryna Siegel who provided insight into the current state of the mental health care system, and Marisa Adelson who provided research assistance.

D. The Increase in Prevalence of Childhood Mental Diseases and the State Autism Coverage Mandates of the 2000s	274
E. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)	276
F. The Affordable Care Act of 2010	279
G. The Primary Effect of the Mental Health Mandates: Continuing the Long-Term Trend of Expanding Services to the General Public	281
V. After the Mandates: Directions for Future Mental Health Care System Reform	283
A. The Mental Health Mandates Should Help, But Do Not Address All the Problems of the Seriously Mentally Ill	283
B. Should Deinstitutionalization Be Rolled Back? ...	284
C. Current Legislative Proposals Targeting Chronic Mental Illness	286
VI. Conclusion	288

I. Introduction

The country has just completed 20 years of new state and federal mental health care coverage mandates for virtually all forms of private health insurance. This legislative and regulatory wave began when the original Federal Mental Health Parity Act was enacted in 1996 and culminated when the final regulations for the Mental Health Parity and Addiction Equity Act (MHPAEA) took effect in 2014. Despite the efforts put into these reforms, they are unlikely to bring anything that might be termed a revolutionary change to the system.

The mental health coverage mandates of the past 20 years are part of a long-term change in the focus of mental health care services from the small portion of the population with severe mental illnesses to the broader mental health concerns of the general population. These trends have expanded the definitions of mental illnesses, and along with this, the number of people diagnosed with a mental illness. Over 15% of the adult population now receives mental health services each year. These services are increasingly provided to people with less severe conditions. In 2013, almost half of

all mental health services were provided to people with *no* present diagnosed mental illness.

Not a year goes by in which Americans are not shocked with news of an act of violence by a person with severe mental illness. The news also tells us that the jails and prisons are overflowing with mentally ill inmates. Some argue that this shows that we made a tragic mistake 60 years ago when we began to empty the state mental hospitals and that it is time to roll back deinstitutionalization. Others contend that putting more people in mental hospitals will not reduce violent crime or help the mentally ill. While the new coverage mandates may help some people with serious mental illnesses obtain treatment, they are not focused on the special needs of this group—some of whom cannot be helped with medication or psychoanalysis or are too impaired to seek treatment. Now that the cycles of mandate legislation appear to be concluding, the focus of mental health care reformation and legislation seems likely to turn to the special needs of this group.

In the first part of this article, we show that our mental health system originated in efforts to deal with the problems of the seriously mentally ill in state mental hospitals. In the second part, we show that during the 20th Century, mental health services were refocused on the needs of the general public with less serious conditions and that this, along with the development of effective drugs for mental health conditions, led to the emptying of the asylums and the treatment of even the seriously mentally ill in the community. In the third part, we discuss the past 20 years of mental health parity legislation and show that the primary effect will be to continue the prior trend of increasing the availability of mental health services to the community. In the fourth part, we discuss current criticisms of our treatment of the seriously mentally ill and highlight a current legislative proposal to deal with these issues.

II. The Early Focus of the Mental Health System on the Seriously Mentally Ill

A. The Origins of Our Mental Health Care System

The mental health care system and mental health care

law grew out of societal efforts to deal with the seriously mentally ill. From the earliest times until today, most mentally ill people have resided at home with their families—receiving whatever care was available to them at the time, if any. Mental illness can cause people to act in bizarre or threatening ways to their families or communities. Reports of violent acts by mentally ill people are continually in the news—and have been for generations.² For example, in the late 19th century, in a letter asking the Wisconsin Hospital for the Insane to admit his mother, a bank employee wrote as follows:³

Of late she has grown materially worse, so that we deem it unsafe for the female portion of the family to be left alone with her during the day and especially unsafe for the little 2 year old that is obliged to remain continually there, as she has stated several times of late that she or the children must be sacrificed. Should she destroy another us (sic) could never forgive ourselves if the state has a place provided for their comfort and possible need.

To prevent violence by or harm to the insane, it has long been a tradition for the local community to confine such persons in public institutions. In medieval England, people with severe mental illnesses could also be physically confined in hospitals, lazar houses, and almshouses (poorhouses).⁴ A 12th century hospital chronicle reports that a young man was admitted “who lost ‘his reasonable wyttys’ on his journey to London” and “wandered about running, not knowing whither he went.”⁵ The American colonies followed this tradition.⁶ There are several accounts from 17th century Massachusetts of towns building small stronghouses to confine the mentally ill.⁷

Early mental health law did more than protect the public. Another goal was to act as the guardian of the afflicted and

²For a recitation of recent violent acts by mentally ill persons, see E. Fuller Torrey, *American Psychosis*, 131–36 (2014).

³Gerald N. Grob, *Mental Illness and American Society, 1875–1940*, 9 (1983).

⁴Rotha M. Clay, *The Mediaeval Hospitals of England*, 31–34 (1909).

⁵*Id.*, 31.

⁶David J. Rothman, *The Discovery of the Asylum*, 38–39, 130 (1971).

⁷Edward Shorter, *A History of Psychiatry*, 7 (1997).

his property under the legal doctrine *parens patriae*.⁸ The doctrine of *parens patriae* was formalized in medieval English statutes that permitted the king or his representatives to take control over the property of the mentally ill and to conserve it for the afflicted and his family.⁹ The goal of societal protection, by confinement of the insane using even cruel means such as chains and shackles, however, was an equal concern.¹⁰

B. The Refuge on the Hill: The Rise and Decline of the Asylum Movement

The treatment of the mentally ill in America underwent a major reformation beginning around the 1820s with the development of state-run asylums.¹¹ The original purpose of asylums was to provide “moral treatment”—meaning treatment that would restore the patient’s ability to reason.¹² Leading psychiatrists in the early 1800s contended that a major cause of mental illnesses was the stress and disorder

⁸See *Lessard v. Schmidt*, 349 F. Supp 1078, 1084 (E.D. Wisc. 1972) (noting that involuntary commitment “has been justified on the premise that the state is acting in the role of *parens patriae*, and thus depriving an individual of liberty not to punish but to treat him. Additionally, it is said that the individual may be deprived of liberty under the police power because of society’s need to protect itself against the potential dangerous acts of persons who, because of mental illness, are likely to act irrationally.”)

⁹See discussion of the historical background of the doctrine of *parens patriae* in John B. Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 *Vill.L.Rev.* 367, 380–88 (1984).

¹⁰See R. Clay, 31–34 (describing the admission of mentally ill persons from the 12th through 16th centuries to hospitals and lazar houses and citing text indicating that they could be confined in these places with chains, locks, manacles and stocks); R. Rothman at 132 (citing Dorothea Dix’s description of the insane as confined with “iron chains and shackles.”) The number of insane persons confined to institutions in colonial America is likely to have been very small, probably well less than one in a 1,000. See Grob, 8.

¹¹A few asylums were constructed earlier, but the movement which resulted in the construction of hundreds of asylums around the United States began around 1820.

¹²Shorter, 12, 41–42.

of the afflicted's home and community environment.¹³ The cure was to create a refuge for the insane, apart from their families and communities, where they could recover their senses in a quiet and organized setting.¹⁴

Early asylums were established in bucolic settings, often outside the city. In an 1821 address, Matthew Clarkson, president of the board of governors of the New York Hospital, noted that the newly completed asylum had been set on an elevated site, commanding a "delightful view" of the harbor and bay and "in one of the most beautiful and healthy spots on New York Island."¹⁵ The buildings were designed to avoid resemblance to a prison but to provide personal comfort. Work and recreational activities were offered to patients "to dispel gloomy images, to break morbid associations, to lead the feelings into their proper current, and to restore the mind to its natural poise. . . ."¹⁶ To ensure the patients' isolation from their prior negative environments, asylums

¹³D. Rothman, 137–54.

¹⁴In an 1856 address on the occasion of the expansion of the Pennsylvania Hospital for the Insane, the superintendent George Wood stated that while medical opinion agreed that insanity is caused by some wrong action of the brain, "no man can tell" what the precise nature of the deranged action is. So instead of directly treating the disease, he stated that "[t]he great principle in the management of insanity" was to "operate on the mind as to produce as far as possible normal trains of thought and states of feeling." According to Wood: "What is required is simply that the patients should be surrounded with circumstances under which the desired mental condition, whether active or passive, shall arise spontaneously, as a natural result. Agreeable and healthful bodily and mental occupation, suitable social intercourse, and guarded exercise and indulgence of the aesthetic faculties and tastes, and the refined gratifications of sense; these, and such as these, are the required agencies; while everything must be sedulously avoided, which can have any tendency to bring the mind back to its morbid state." G. Wood, *Proceedings on the Occasion of Laying the Corner Stone of the New Pennsylvania Hospital for the Insane at Philadelphia*, 8–10 (1856).

¹⁵According to Clarkson, "The self-respect and complacency which may thus be produced in the insane, must have a salutary influence in restoring the mind to its wonted serenity." M. Clarkson, *Address of the Governors of the New-York Hospital to the Public, Relative to the Asylum for the Insane at Bloomingdale*, 3–6 (1821).

¹⁶*Id.* at 5–6.

often banned casual visitors and the patients' families, and limited correspondence.¹⁷

Asylums attempted to substitute regulation and discipline for the shackles and manacles used in almshouses and jails. The chief of Rhode Island's asylum system wrote that "quiet, silence, regular routine . . . would take the place of restlessness, noise and fitful activity."¹⁸ Asylums also took pride in reporting "how quickly they removed the rags and chains that so often bound a patient, how they bathed and dressed him, and gave him freedom of movement."¹⁹

The medical superintendents of the early asylums, or psychiatrists, as they eventually renamed themselves, reported high cure rates.²⁰ The early asylums also provided many of the mentally ill with a significant improvement in their living conditions, as well as greater personal dignity. Based on these promising circumstances, and with the activism of reformers such as Dorothea Dix, public asylums were quickly established throughout the United States. By 1860, 28 of the 33 states had established public asylums.²¹

During this early period, public faith in asylums was strong. State law often permitted persons to be committed to asylums at the request of their family members—and with the consent of the asylum superintendent who presumably had found that the patient was insane. While a patient could request discharge via a writ of habeas corpus, no judicial process was required for an initial commitment.²²

While the original goal of the asylums was to provide a

¹⁷Rothman at 137–38. Shorter reports that early French psychiatrist Esquirol "believed in the salutary effects of 'isolation' from the outside world in the institution, and felt that removal from family and friends would contribute greatly to diverting the patient from the previously unhealthy passions that had ruled his or her life." Shorter at 13, 18–20.

¹⁸D. Rothman, 138.

¹⁹*Id.* at 149.

²⁰*Id.*, 131.

²¹*Id.*, 130.

²²For example, in an 1861 Massachusetts Supreme Court case, a woman sought release from the McLean Asylum, claiming her husband had her committed because she told him she planned to file for divorce. The court denied the writ and rejected her claim that only a court-appointed guardian could commit an insane person. The court noted that the plaintiff had been committed based on the opinions of two physicians

place of recovery for the recently mentally ill, asylums very quickly became overcrowded repositories for the custodial care of chronic cases.²³ In the later 1800s, the effectiveness of the asylum and moral treatment as a cure for mental illness began to lose credibility. A widely read article published in 1876 questioned earlier claims of high cure rates made by the asylums. It argued that insanity “as a whole, is really becoming more and more an incurable disease . . . All estimates based on the assumption that either seventy-five, or seventy, or sixty, or even fifty percent of the persons attacked with insanity can . . . be cured and returned to the class of permanent producers . . . are necessarily false, and consequently both ‘a delusion and a snare.’”²⁴

Despite these criticisms, the use of asylums continued to grow. From the late 1800s through the 1950s, the percentage of the population in asylums increased from approxi-

that she was insane and reasoned: “If a person suffering under mental derangement had no near relatives or was among strangers . . . , it might be expedient and necessary to clothe someone with the legal authority and power to take charge of his person. But no such exigency exists in ordinary cases where a person of disordered intellect, who is capable of exerting no intelligent will or sound discretion in his own behalf, is placed by relatives or friends, acting in good faith, under such restraint as is necessary to the proper treatment of the disease under which he is suffering. Experience has shown that one of the most essential aids in the cure of insanity is the withdrawal of the patient from all ordinary and accustomed scenes and associations, and his entire seclusion and separation from all exciting and disturbing influences. As he is incapable of forming a judgment concerning his own condition or the means requisite for his security and restoration, it is absolutely necessary that others should act for him, and take such steps as may be needful to his proper care and custody.” *Denny v. Tyler*, 85 Mass. 225, 227, 3 Allen 225, 1861 WL 4828 (1861); *see also* *Davis v. Merrill*, 47 N.H. 208, 1866 WL 1983 (1866) (New Hampshire statute provided that “the parent, guardian, or friends of any insane person may cause him to be sent to the asylum, with the consent of the trustees, and there supported on such terms as they may agree.” While a prior certification by two physicians that the subject was insane might be desirable, the practice in New Hampshire was to permit commitment “where it becomes pretty certain” that the subject is insane).

²³Shorter, 40–52; Rothman, 239.

²⁴D. Rothman, 268 (citing article by Pliny Earle).

MENTAL HEALTH CARE LAW

mately 0.07% in 1850 to 0.33% by the mid-1950s.²⁵ This was a 500% increase in 100 years—although from a very low starting point to a relatively low end-point. Data from 1940 shows that the asylum patients tended to have serious and chronic conditions from which there was little possibility of recovery at the time as shown by the following table:

<u>Conditions of Patients</u>	<u>Percent of Patients</u>
General paresis (brought on by syphilis)	8.6%
Cerebral arteriosclerosis	15.5%
Senility	9.9%
Alcoholism	5.1%
Manic-depressive disorder	10.5%
Schizophrenia	23.6%
All other psychoses	26.8% ²⁶

Part of the increase in the rate of institutionalization was caused by the closure of other facilities, such as almshouses, which had previously housed the infirmed aged. Part was caused by demographic changes, such as the increase in the percentage of aged in the overall population which occurred during this time period. There also appears to have been an increase in the diagnosis of certain psychoses, such as schizophrenia. Scholars debate whether this represented a true increase in prevalence or merely a broadening of the definition of the disease.²⁷ Standards for commitment, which despite criticism generally remained low until the 1960s, also likely contributed to the increase.²⁸

²⁵Adapted from Grob, 8; see also Alan A. Baumeister, et al., Prevalence and Incidence of Severe Mental Illness in the United States: An Historical Overview, 20 *Harv. Rev. Psychology* 247, 251 (2012).

²⁶Grob, 192.

²⁷A. Baumeister, 255–256; Shorter, 45–64.

²⁸In the aftermath of the Civil War and the enactment of the 13th and 14th Amendments, legal scholars and activists questioned whether it was proper to permit commitment merely based on the request of a family member and the word of a physician. An 1879 article argued that a patient had a right to a trial before commitment. It reasoned: “No certificate of a physician, however honestly given, can determine the fact, for the physi-

III. The Shift in Focus to the Less Severe Mental Health Needs of the General Public

A. The Development of Mental Health Services for the General Community in the Early 20th Century

In the early 19th century, the practice of psychiatry was primarily tied to the mental hospitals.²⁹ Toward the close of the century, psychiatrists began to change their focus from the use of the asylum as a generalized treatment for mental illness to the scientific analyses and treatment of individual mental illnesses. They also began to establish outpatient clinics which often served less severely affected patients than the chronic mentally ill who had come to dominate asylum populations.³⁰

The rise of the mental hygiene movement also expanded the focus of psychiatry from custodianship of the chronically ill to addressing wider societal problems such as alcoholism and crime.³¹ These broader goals meant that the definition of what constituted a mental illnesses and the number of people

cian possesses no part of the State judicial power. His fiat cannot be 'due process of law,' to deprive any man of his liberty." Grob, 56. During the late 1800s, a few states enacted statutes requiring jury trial before involuntary commitment into an asylum. Grob, 47–48. These limits did not exist everywhere, and commitment was widely available merely on a finding of insanity, without a finding of dangerousness. *See Note, Commitment of the Mentally Ill-Superior Court of Los Angeles County*, 36 *S. Cal. L. Rev.* 109, 109–12 (1962–63) (noting that "[i]n recent years the definition of mental illness in commitment laws has been broadened by most states, including California, to include persons requiring treatment and care regardless of the danger to themselves or others" and citing statutes showing same); *Lessard* at 1086 (noting that few courts required a finding of dangerousness for civil commitment).

²⁹Grob, 31.

³⁰Shorter at 160–61 (noting that of psychiatrists attending the annual meeting of the American Psychiatric Association in 1910, 3.2% were in private practice, and by 1921, 7.3% were in private practice). Shorter explains the development of neurology in the 19th Century as an alternate pathway to treatment for mental illnesses in private hospitals and spas, away from the asylums. Shorter further describes how in the period prior to World War I, neurologists developed private office-practice psychotherapy. Shorter, 143–144. *See also* Grob, 52–55.

³¹Grob, 145.

MENTAL HEALTH CARE LAW

who would be diagnosed with these new illnesses greatly expanded. For example, a 1917 study added a number of social maladjustments, such as truancy, sexual immorality, vagrancy, criminal tendency, dependency, drug addiction, and domestic maladjustment to traditional categories of mental illnesses. The conclusion of this study was not surprising—that the bulk of individuals requiring psychiatric treatment were not in institutions.³²

To address the needs of these and other less severely impaired patients, mental hospitals began to establish outpatient clinics, general hospitals began to establish psychiatric wards, and psychopathic hospitals were created to provide short-term care and triage for acute and less-severe cases.³³ The effect of all of these changes was that throughout the first half of the 20th century, psychiatrists increasingly developed practices outside the asylum setting. In 1910, only 3% of psychiatrists had private practices. By 1941, 38% did.³⁴

The variety of mental health professions also expanded to meet the changed focus of mental health services. For example, the profession of clinical psychology was developed to provide mental health services directly to the general public. The first clinical psychology practice, which was established at a university in the 1890s, provided services to children with learning difficulties.³⁵ During World War II, the U.S. government employed psychologists to work alongside psychiatrists in providing psychotherapy to help soldiers deal with the stress of battle. After the war, psychologists came to increasingly dominate the provision of psychotherapy and by the 1970s were its principal providers.³⁶

³²*Id.*, 161.

³³See H. Pollock, *Outpatient Mental Clinics and Family Care*, 104 *Review of Psychiatric Progress*, 487–89 (1947).

³⁴Shorter, 181.

³⁵Ludy T. Benjamin, Jr., *A History of Clinical Psychology as a Profession in America (and a Glimpse at its Future)*, 1 *Amer. Rev. Clin. Psychol.*, 1, 4–5 (2005).

³⁶*Id.* at 19–20.

B. The Mid-20th Century: Community Treatment Supplants the Asylum

The effect of all of these changes was that by the mid-20th Century, mental health care services were increasingly available in the community—outside of a residential stay in a traditional asylum or state mental hospital. This created one of the preconditions for the revolution in mental health care known as deinstitutionalization, which brought an end to the asylum era.

The primary catalyst for this revolution was the development, beginning in the 1940s, of a series of drugs that provided the first effective treatments for the serious diseases treated in the asylums. The discovery of penicillin in the 1940s provided a truly effective treatment for syphilis, a common disorder of asylum patients.³⁷ The development of Thorazine (Chlorpromazine) in the early 1950s provided the first effective treatment for schizophrenia. This drug astonished psychiatrists, who saw large numbers of schizophrenics become symptom-free, with hallucinations, delusions, and thought disorders gone with a few weeks of commencing treatment.³⁸ The development of effective drugs for other serious mental illnesses followed quickly.³⁹ Because these treatments could be provided in the community by hospitals and outpatient clinics, after reaching a peak in 1955, residency in asylums began to fall rapidly.⁴⁰

Professional and public opinion quickly turned against the very concept of the asylum. Many mental health professionals contended that removing a mentally ill individual from his home and community reduced his chances for effective treatment.⁴¹ Others criticized asylum care as abusive,

³⁷See discussion in Shorter, 192–96.

³⁸*Id.* at 252–55.

³⁹*Id.* at 255–62.

⁴⁰Baumeister, 256.

⁴¹See sources cited in Leona Bachrach, *Deinstitutionalization: An Analytical Review and Sociological Perspective*, U.S. Dept. of Health & Human Services, 4 (1976). See also Gary Sutnick, “Reasonable Efforts” Revisited: Reforming Federal Financing of Children’s Mental Health Services, 68 *New York University Law Review* 136, 138 (1993) (citing

degrading, and stigmatizing.⁴² In the aftermath of World War II, the U.S. entered an era of heightened awareness of civil rights. Asylums were increasingly viewed as mere places of incarceration that provided no benefit to the patients.

The law followed these changes in medicine and societal values. State legislatures passed laws creating barriers to institutionalization. In 1967, California passed the Lanterman-Petris-Short Act which significantly curtailed involuntary commitment. The law, which is still in effect, requires a finding of “insanity plus” dangerousness to self or others or grave disability for involuntary commitment.⁴³ It permits a police officer or the staff of a mental hospital to take a person into custody and to temporarily confine him in a state mental hospital for 72 hours for treatment and evaluation. During this period, the hospital staff is required to either decide to release the patient or to certify him for additional treatment.⁴⁴ If the hospital staff decides to certify the patient for additional treatment, a certification review hearing must be held within days.⁴⁵ If the hearing officer decides that certification is proper, the patient may only be held for a limited period of time before another right to a hearing is triggered.⁴⁶ The Lanterman-Petris-Short Act became a model for similar acts around the U.S.⁴⁷

The courts also raised barriers to institutionalization. The leading 1972 case *Lessard v. Schmidt* reflected the shift in public opinion on the efficacy of asylum care. The district court for the Eastern District of Wisconsin noted that involuntary commitment had long been justified on *parens patriae* and police power grounds. But the *parens patriae*

sources in support of thesis that inappropriate placement of children in residential programs can cause life-long harm).

⁴²Bachrach, 4–5.

⁴³Cal. Welf. & Inst. Code § 5150.

⁴⁴*Id.*

⁴⁵Cal. Welf. & Inst. Code § 5276.

⁴⁶*Id.* at § 5257.

⁴⁷See R. Reisner, et al., *Law and the Mental Health System: Civil and Criminal Aspects*, 4th ed., 671–72 (2004). While in law school in Texas in the 1990s, the author of this article represented a number of patients in such “72 hour” hearings at the Austin State Hospital.

justification rested on whether the patient actually would obtain better treatment in the asylum. The court contended that this was questionable, noting that many mental illnesses are untreatable and that there was⁴⁸

. . . substantial evidence that any lengthy hospitalization, particularly when it is involuntary, may greatly increase the symptoms of mental illness and make the adjustment to society more difficult.

The court also stated that commitment carried with it “an enormous and devastating effect on an individual’s civil rights,” including a rebuttable presumption of incompetency, restrictions on making contracts and the right to sue, restrictions on professional licensure, and loss of rights to vote, to drive a car, or to serve on a jury.⁴⁹ The court found that given the potential harm to the patient, to justify commitment, the State must prove that the person is mentally ill and “if the person is not confined he will do immediate harm to himself or others.”⁵⁰ If these conditions were not met, a patient should be permitted to exercise a rational choice to forgo treatment—especially commitment, which carried the loss of so many rights.⁵¹ Moreover, the court should not require inpatient commitment if less drastic means existed for achieving the goals of the commitment.⁵²

In its 1975 decision in *O’Connor v. Donaldson*, the U.S. Supreme Court agreed with *Lessard* and held that:⁵³

A finding of “mental illness” alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the ‘mentally ill’ can be defined with a reasonable accuracy, there is still no constitutional basis for confining such persons invol-

⁴⁸*Lessard* at 1087.

⁴⁹*Id.* at 1088–89.

⁵⁰*Id.* at 1093.

⁵¹*Id.* at 1094. The court also found that while emergency detention of a mentally ill person was permissible, a hearing must be held as soon as possible after detention to determine whether the standards for commitment were met. *Id.* at 1090–93.

⁵²*Id.* at 1096.

⁵³*O’Connor v. Donaldson*, 422 U.S. 563, 95 S. Ct. 2486, 45 L. Ed. 2d 396 (1975).

untarily if they are a danger to no one and can live safely in freedom.

The Court concluded: “[i]n short, a State cannot constitutionally confine without more a non-dangerous person who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”⁵⁴

The enactment of the federal social welfare programs Medicare and Medicaid had an even greater ultimate impact on the structure of mental health system. Medicaid, which was enacted under President Johnson in 1965, provides federal funds for state-managed programs that provide a wide range of health-related services to the poor, including mental health services. Today the Medicaid program is the largest payer of mental health care services, funding approximately 27% of all such services.⁵⁵

The Medicaid Act included what has become known as the “IMD exclusion,” which prohibits states from using Medicaid funds for individuals under age 65 who are patients in an institution for mental diseases.⁵⁶ Medicaid funds can be used to provide long-term care for mentally ill persons in other settings, such as in nursing homes that are not devoted to treatment of the mentally ill. To maximize federal Medicaid revenues, states accelerated the discharge of mentally ill adults from asylums and placed them in general hospitals and nursing homes.⁵⁷ In 1963, the population of state and county mental hospitals was 504,604; six years later, it had

⁵⁴*Id.* This “something more” might, for example, include cases where a patient is gravely disabled—one of the permissible bases for commitment under many state statutes. In its most recent pronouncement on the subject, the Court stated that “unjustified isolation . . . is discrimination based on disability,” but did not substantially alter the standards for involuntary commitment. *Olmstead v. Zimring*, 527 U.S. 581 (1999).

⁵⁵SAMHSA, *Behavioral Health, United States, 2012*, page 257. Table 124. (Figures are for 2009). *See also* R. Garfield, *Mental Health Financing in the United States: A Primer*, Kaiser Family Foundation, iii (April 2011) (estimating 2005 Medicaid expenditures at 28% of total mental health care spending).

⁵⁶42 U.S.C. § 1396d(a). This provision was amended to permit, beginning in 1973, such payment for persons under age 21. The term “institution for mental diseases” was amended to only apply to institutions with over 16 beds.

⁵⁷*See* discussion in J. I. Davoli, *No Room at the Inn; How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for*

declined to 369,969. During this same period, the number of persons with mental disorders in nursing homes increased from 221,721 to 426,712.⁵⁸ By 1980, there were 750,000 people with serious mental illnesses living in nursing homes.⁵⁹

The federal government also increasingly provided direct income support to the mentally disabled under the Social Security Disability and Supplemental Security Income programs. In 2012, 2,732,645 adults received Social Security Disability Insurance (SSDI) and 4,648,334 adults under age 65 received Supplemental Security Income (SSI) for mental disorders.⁶⁰ These recipients comprised approximately 3% of the U.S. adult population under age 65. These payments, along with many other state and federal programs for the mentally ill, made it increasingly feasible for people with chronic serious mental health conditions to live in community settings such as nursing homes, board and care homes, adult foster homes, halfway houses, and family homes.⁶¹

The combined effect of these varying forces was a speedy exit of patients from state mental hospitals. In 1955, there were approximately 559,000 patients in state mental

the Indigent Mentally Ill, 29 *American Journal of Law & Medicine*, 159, 170–71 (2003).

⁵⁸G. Grob, 316.

⁵⁹C. Koyanagi, Learning from History: Deinstitutionalization of People with Mental Illness as a Precursor to Long-Term Care Reform, Kaiser Family Foundation, 6 (August 2007).

⁶⁰Not including intellectual disability. See Social Security Administration, *Annual Statistical Report on the Social Security Disability Insurance Program, 2012*, Table 15; Social Security Administration, *SSI Annual Statistical Report, 2012*, Table 34.

⁶¹Koyanagi, 17. In a further stage of deinstitutionalization, some activists are now arguing that nursing and group homes do not constitute the last restrictive housing environment for the mentally ill and are pushing to require states to house them in apartments or single family homes in ordinary residential neighborhoods. See S. Barenstos, The Past and Future of Deinstitutionalization Litigation, 32 *Cardozo Law Review*, 1, 29–30, 49–51 (2012).

hospitals. As of 2006, state mental hospitals operated only approximately 49,000 beds.⁶²

C. The Turn of the Millennium: The Provision of Mental Health Services to the General Community Vastly Expands

As the state mental hospitals went through a long-term decline, the quantity and variety of mental health providers for the general population vastly increased. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2008–2011, there were 40,125 psychiatrists in the United States.⁶³ Starting from a very small base in the 1940s, by 2008–2011 there were also 95,545 psychologists, and 413,622 clinical social workers, psychiatric nurses, substance abuse and mental health counselors, and marriage and family therapists.⁶⁴

Before the 1940s, almost all inpatient psychiatric services were provided by the state hospitals.⁶⁵ This began to change with deinstitutionalization. During the 1970s–1990s, the number of psychiatric hospitals as well as psychiatric units in general hospitals increased sharply.⁶⁶ Bed capacity retreated in the late 1990s but recovered in the 2000s.⁶⁷ As of 2008, there were a total of 79,796 beds in private psychiatric hospitals and psychiatric units in general hospitals. The care provided in these hospitals is very different than that provided by the state mental hospitals. It is “acute”

⁶²W. Fisher, et al., The Changing Role of the State Psychiatric Hospital, 28 *Health Affairs*, 676, 678 (2009).

⁶³SAMHSA, *Behavioral Health, United States, 2012*, 192, Table 93.

⁶⁴*Id.* In addition, primary care physicians have increasingly become the primary prescribers of psychotropic drugs. According to one study, they are responsible for approximately 59% of all such prescriptions. See Ryan DuBosar, Psychotropic drug prescriptions by medical specialty, *ACP Internist* (Nov. 2009) (available at <http://www.acpinternist.org/archives/2009/11/national-trends.htm>) (last visited Dec. 1, 2014).

⁶⁵B. Liptzin, et al., Commentary: The Future of Psychiatric Services in General Hospitals, 164 *Am. J. Psychiatry*, 1468 (2007).

⁶⁶E. Salinsky and C. Loftis, Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?, National Health Policy Forum, Issue Brief No. 823, Aug. 1, 2007, 8.

⁶⁷*Id.* at 10, Figure 3; SAMHSA, *Behavioral Health, United States, 2012*, 202, Table 96.

care that provides a short-term response to a patient's mental health care crisis.⁶⁸ The use of the emergency departments in general hospitals rooms for mental health conditions also increased to around 2.5 million visits annually during the 2000s.⁶⁹

New types of nonhospital mental health facilities were also developed, such as residential treatment centers for children, and partial hospitalization programs for adults, which can also incorporate a residential option.⁷⁰ The availability of beds in these facilities rose from 24,435 beds in 1970 to 78,967 in 2002.⁷¹

Despite the increase in private inpatient capacity, mental health care services have become increasingly dominated by outpatient delivery. According to a 2011 survey, 40.8% of people diagnosed with a mental illness received mental health care. Of this 40.8%, only 3.3% received inpatient care, with the remainder being served by outpatient care.⁷² Surveys conducted in the 2000s indicated that the percentage of patients using inpatient care continued to slowly decline, while the percentage receiving outpatient care remained stable, and the percentage receiving prescription medication increased.⁷³

The increased availability of community services meant that the quantity of mental health services provided to the general population had also vastly expanded. According to SAMHSA, in 2013, 34.6 million adults—14.6% of the popula-

⁶⁸E. Salinsky at 3, S. Sharfstein and F. Dickerson, Hospital Psychiatry for the Twenty-First Century, 28 *Health Affairs*, 685 (2009).

⁶⁹E. Salinsky at 11, Figure 4. There is also evidence of the increased placement of mentally ill patients in general hospital wards—termed “scatter beds”—although statistics on the use of scatter beds is not available. *Id.* at 12.

⁷⁰*Id.* at 12.

⁷¹*Id.* SAMHSA reports that in 2010, there were 31,895 beds in residential treatment centers for children and 14,980 in residential treatment centers for adults. SAMHSA, *Behavioral Health, United States, 2012*, 207, Table 99.

⁷²*Id.* at 100, Table 40.

⁷³*Id.* at 92, Table 37.

MENTAL HEALTH CARE LAW

tion—received mental health treatment or counseling.⁷⁴ According to a survey by pharmacy benefits manager Medco, in 2011, 20 % of adults were prescribed at least one psychotropic medication.⁷⁵ This is a vast expansion over the 0.33% of the population that received treatment in the asylum system in 1955. The conditions for which people are now receiving treatment are also on a different magnitude than the chronic psychoses served by the asylums. In 2013, people receiving mental health services were reported as having the following illness severities:

Adults Receiving Mental Health Services in 2013 by Severity of Mental Illness⁷⁶

	<u>Number that received ser- vices</u>	<u>% of total that received ser- vices</u>
Severe mental illness	6,857,000	19.8%
Moderate mental illness	5,572,000	16.1%
Mild mental illness	7,129,000	20.6%
No mental illness	<u>15,086,000</u>	<u>43.5%</u>
Total	34,644,000	100.0%

In other words, at present, over 80% of mental health services are being obtained by persons with moderate to no mental illnesses. The most common treatment received by persons at all levels of mental illness, including those with no mental illness, is prescription drugs. 81% of persons with no mental illness who received treatment received prescription drugs.⁷⁷

The increase in both the number of persons diagnosed with mental illnesses and/or receiving mental health services has many causes. These include government outreach

⁷⁴SAMHSA, *Results from the 2013 National Survey on Drug Use and Health: Mental Health Detailed Tables* (Nov. 14, 2014), Tables 1.22A and 1.22B. These figures do not include treatment for substance abuse.

⁷⁵Medco, *America's State of Mind* (available at <http://apps.who.int/medicinedocs/documents/s19032en/s19032en.pdf>) (last visited Dec. 1, 2014).

⁷⁶Based on SAMHSA, *Results from the 2013 National Survey on Drug Use and Health: Mental Health Detailed Tables* (Nov. 14, 2014), Tables 1.22A and 1.22B.

⁷⁷*Id.* at Table 1.28B.

and case-finding programs, broadened definitions of mental health disorders, and changes in culture.⁷⁸

Both the number and breadth of mental health conditions for which treatment is currently being sought have significantly increased over the past 50 years. The number of mental conditions listed in the Diagnostic and Statistical Manual (DSM) increased from 106 in DSM-I to 297 in DSM-IV.⁷⁹ Definitions have also been broadened to include less severe cases. Taking another example from autism—a mental health condition that has occupied much of my attention as a lawyer over the past five years—before the 1980s, autism was thought to be rare, affecting one in every 2,000 children.⁸⁰ National surveys conducted in 2006 and 2007 found that the prevalence of “autism spectrum disorders” (ASDs) in children now ranges from approximately 1-1.1%.⁸¹ That is a 2,200% increase in 25 years. Studies link much of this increase to the broadening of the definition of autism to ASD that occurred with the publication of DSM-IV, which resulted in many more children with milder symptoms being diag-

⁷⁸It is also possible that the true prevalence of certain mental health disorders may have increased. The reported prevalence rates for many mental illnesses (e.g., major depression, autism, ADHD, childhood bipolar disorder) have increased since the 1950s. See references for autism, ADHD, and bipolar disorder below. For major depression, see W. Compton, et al., Changes in the Prevalence of Major Depression and Comorbid Substance Use Disorders in the United States Between 1991–1992 and 2001–2002, 163 *Am J. Psychiatry*, Dec. 2006, 2141–47 (Dec. 2006).

⁷⁹R. Rosenberg, Abnormal Is the New Normal, *Slate*, April 12, 2013 (available at http://www.slate.com/articles/health_and_science/medical_examiner/2013/04/diagnostic_and_statistical_manual_fifth_edition_why_will_half_the_u_s_population.html) (last visited Nov. 21, 2014); see also D. Mechanic, *More People Than Ever Are Receiving Behavioral Health Care in the United States, But Gaps and Challenges Remain*, 33 *Health Affairs* 1416, 1421 (2014) (noting that “[e]pidemiological studies show that approximately half of all services used are for those who do not meet criteria for the disorders measured.”).

⁸⁰C. Rice, “Prevalence of Autism Spectrum Disorders – Autism and Developmental Disabilities Monitoring Network, United States, 2006,” 58 *MMWR Surveillance Studies* 1–20 (December 18, 2009) (available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5810a1.htm>) (visited March 23, 2010) at 2.

⁸¹*Id.* at 1; Kogan, M.D., et al., “Prevalence of parent-reported diagnosis of autism spectrum disorder among children in the US, 2007,” 124 *Pediatrics* 5:1395-403 (Nov. 2009).

MENTAL HEALTH CARE LAW

nosed with the disorder.⁸² For example, in 1997, over 80% of children with autism were also diagnosed with a comorbidity of mental retardation. In 2007, however, only about 30% of children diagnosed with ASD had a comorbidity of mental retardation.⁸³

Federal outreach and case-finding programs also had an impact on the increase in mental health services. In 1961, President Kennedy created an Interagency Committee on Mental Health to develop a new national mental illness program. The committee proposed the creation of community mental health centers to provide aftercare to patients discharged from mental hospitals and preventative care to the general population.⁸⁴ In 1963–64, Congress passed what became known as the Community Mental Health Centers Act. Over the next 13 years, 789 community mental health centers were constructed around the country.⁸⁵ The centers did not primarily focus on patients with severe illnesses. According to a National Institute of Mental Health study, between 1968–1978, former mental hospital patients comprised no more than 7% of Community Mental Health Center patients. Rather, the centers focused on providing services to persons with less severe mental conditions, such as neuroses and personality disorders, childhood behavioral problems,

⁸²See National Institutes of Health (NIH) and National Institute of Mental Health (NIMH), Autism Spectrum Disorders (Pervasive Developmental Disorders) (available at <http://nimh.nih.gov/health/publications/autism/complete-index.shtml>) (visited July 8, 2010) at 2; C. Johnson, et al., “Identification and Evaluation of Children with Autism Spectrum Disorders,” 120 *Pediatrics* 1183, 1185–86 (2007); Morton A. Gernsbacher, et al., Three Reasons Not To Believe in the Autism Epidemic, 14 *Current Directions in Psychological Science* 55–58 (2005).

⁸³C. Johnson, 1194. A 2007 report by the California Department of Developmental Services similarly found that the “[r]ates of people with autism who also have some degree of mental retardation dropped by almost half, from 79.6 percent in 1987 to 35.6 percent in June 2007.” Andrew T. Cavagnaro, *Autistic Spectrum Disorders: Changes in the California Caseload An Update: June 1987 – June 2007*, California Department of Developmental Services (2007) at 19 (available at www.dds.ca.gov).

⁸⁴E. Fuller Torrey, *American Psychosis*, 41–52. The centers were to provide five essential services, many of which focused on severe mental illnesses, including partial hospitalization, 24-hour emergency evaluation, outpatient services and consultation/education.

⁸⁵E. Fuller Torrey at 62.

depression, and substance abuse.⁸⁶ The centers thus had become a major instrument for expanding mental health services to the general population. The centers, however, enjoyed decreasing political support, and in 1981, President Reagan signed an act effectively terminating the program and block granting its funds to the states.⁸⁷

Case-finding programs with greater longevity have been the Medicaid Early and Periodic Screening, Diagnostic, Treatment (EPSDT) and the Department of Education Individuals with Disabilities Education Act (IDEA) programs.⁸⁸ The EPSDT program, which was included in the original Medicaid Act in 1965, requires states to perform periodic developmental and behavioral screening of children, as well as to provide mental health services for conditions uncovered in this screening.⁸⁹ This program has significant reach since at present around 34 million children under age 21 are eligible for Medicaid.⁹⁰ Behavioral health screening standards and methodologies differ from state to state.⁹¹ But at least one study has found that where EPSDT requirements were vigorously enforced, they significantly increased the use of mental health care services by children.⁹²

IDEA, which was initially enacted in 1974, requires states to identify and evaluate all children with disabilities and to provide them with a free appropriate public education and related services, including a variety of mental health ser-

⁸⁶*Id.* at 77–78.

⁸⁷*Id.* at 88.

⁸⁸These programs are well-funded. For example, Congress appropriated \$26 billion for IDEA for fiscal year 2011. 20 U.S.C. § 1401.

⁸⁹42 U.S.C. § 1396a(43); 42 U.S.C. § 1396d(r).

⁹⁰U.S. Dept. of Health and Human Services, *2014 CMS Statistics*, 16, Table I.17.

⁹¹For a discussion of the screening programs in use in different states, see R. Semansky, et al., Behavioral Health Screening Policies in Medicaid Programs Nationwide, 54 *Psychiatric Services*, 736–38 (2003).

⁹²L. Snowden, et al., Effects on Outpatient and Emergency Mental Health Care of Strict Medicaid Early Periodic Screening, Diagnosis, and Treatment Enforcement, 97 *American Journal of Public Health*, 1951–56 (2007).

vices, to meet their developmental needs.⁹³ IDEA has been used to require services for many mental health conditions, such as ADHD and autism spectrum disorder. The number of children diagnosed with a mental or developmental disorder and receiving IDEA services has risen sharply since it was implemented. In 1976–77, less than 0.1% of children received IDEA services because of a diagnosis of autism. By 2010–11, 0.8% of children were receiving services under this diagnosis. In 1976–77, 0.3% of children received IDEA services because of “other health impairments”—a category commonly used for ADHD. By 2010–11, 1.4% of children received services under this category.⁹⁴

IV. The Mental Health Parity Mandates of 1996–2014

As the use of mental health care services by the general population has increased, there have been continual calls for even greater coverage of mental health care services by governmental and private payers. Private payer mandate legislation has repeatedly bounced between Congress and state legislatures—with Congress enacting mental health parity mandates that originally applied only to large-

⁹³This original act was known as the Elementary and Secondary Education Act Amendments of 1974 (P.L. 93-380). The act was expanded in 1975 with the Education for All Handicapped Children Act (P.L. 94-142). The term “related services” includes mental health services such as “psychological services, physical and occupational therapy, recreation, including therapeutic recreation, social work services . . . counseling services, including rehabilitation counseling, orientation and mobility services, and medical services.” 20 U.S.C. § 1401(26). Medical services may be provided for diagnostic and evaluation purposes only. IDEA broadly defines “children with disabilities” to include children with “serious emotional disturbance” and “autism.” 20 U.S.C. § 1401(3). The regulations define “serious emotional disturbance” to include a broad variety of conditions, such as an inability to build satisfactory interpersonal relationships with peers and teachers, inappropriate types of behavior or feelings, a general pervasive mood of unhappiness or depression or a tendency to develop physical symptoms, or fears about personal or school problems. 34 C.F.R. § 300.8.

⁹⁴National Center for Education Statistics, Fast Facts, Students with Disabilities, available at <http://news.ed.gov/fastfacts/display.asp?id=64> (visited on No. 14, 2014). Children with mental illnesses can also receive accommodations from their schools under the Rehabilitation Act.

employer plans and the states enacting parity and other mandates that applied only to state-regulated insurers.

A. Early Mental Health Coverage Mandates

The first wave of mental health coverage legislation occurred in the 1970s and 80s when a number of states passed laws mandating minimum benefits for alcoholism, drug abuse, and mental health treatment.⁹⁵ These mandates, however, did not apply to most employer plans, which provide the bulk of private coverage, because these are governed by federal law (the Employee Retirement Income Security Act of 1974 (ERISA)) and if self-insured are exempt from state mandates.⁹⁶

In addition, a number of suits were filed under section 504 of the Rehabilitation Act and under the Americans with Disabilities Act to require employer health plans to offer equal benefits for mental as for physical conditions. The courts rejected these attempts, finding that these civil rights acts were not intended to require employers to offer equal benefits for all health conditions.⁹⁷

B. The Federal Mental Health Parity Act of 1996

The efforts to enact mental health mandates at the federal level gained traction when advocates began framing increased coverage as a matter of civil rights. Mandate bills were recast as “parity” legislation—that sought public recognition of mental illness as having its roots in human biology and sought coverage for such illnesses on the same basis as coverage for physical conditions.

In 1996, Senators Domenici and Wellstone obtained pas-

⁹⁵C. L. Barry, et al., A Political History of Federal Mental Health and Addiction Insurance Parity, 88 *Milbank Quarterly*, 404, 408 (2010).

⁹⁶*Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728, 6 Employee Benefits Cas. (BNA) 1545, 119 L.R.R.M. (BNA) 2569, 102 Lab. Cas. (CCH) P 55497 (1985) (holding that a Massachusetts mental health coverage mandate law applied to contracts of insurance purchased by ERISA plans but not to ERISA plans themselves).

⁹⁷*See, e.g., Alexander v. Choate*, 469 U.S. 287, 105 S. Ct. 712, 83 L. Ed. 2d 661, 8 Soc. Sec. Rep. Serv. 6, 1 A.D.D. 204 (1985).

sage of the Federal Mental Health Parity Act (MHPA).⁹⁸ Despite its ambitious title, the Act did not require plans to provide any mental health coverage.⁹⁹ Rather, it only prohibited large employer plans that did provide both medical and mental health coverage from applying different annual or lifetime limits for the two types of coverage.¹⁰⁰ This limited mandate provide some benefit to plan members because it prevented unusually large mental health care expenses from bankrupting a plan member. However, plans were free to restrict coverage in other ways, such as by limiting the mental health conditions covered by the plan or by imposing greater cost-sharing limits, such as higher deductibles, coinsurance, or day and office visit limits.¹⁰¹

C. The State Mental Health Parity Acts of the Late 1990s

While the MHPA was limited in scope, it had the effect of prompting similar and more comprehensive parity legislation in the states. Only a handful of states had enacted parity legislation prior to 1996.¹⁰² Thirty states introduced parity legislation in 1997 alone.¹⁰³ As of January 2014, 49 States and D.C. had enacted some sort of mental health parity or mental health coverage legislation.¹⁰⁴

Despite the name given to this legislation, the State acts

⁹⁸C. Barry, 409.

⁹⁹The MHPA is currently codified, as amended, at 26 U.S.C. § 9812; 29 U.S.C. § 1185a; and 42 U.S.C. § 300gg-26. The MHPA also did not apply to substance abuse coverage and permitted employers an exemption if compliance increased their health care costs by more than 1%.

¹⁰⁰Large employers were originally defined as those with over 50 employees.

¹⁰¹G. A. Jensen, et al., Mental health insurance in the 1990s: are employers offering less to more?, 17 *Health Affairs*, 201 (1998); C. Barry, 409–10.

¹⁰²See H. Varmus, Parity in Financing Mental Health Services: Managed Care Effect on Cost, Access, and Quality, Dept. of Health and Human Services, NIH, NIMH (1998), Appendix D; G.A. Jensen, et al., 202.

¹⁰³See Roland and Sturm, “State Mental Health Parity Laws: Cause or Consequences of Differences in Use?” 18 *Health Affairs* 182 (1999).

¹⁰⁴See National Conference of State Legislatures, State Laws Mandating or Regulating Mental Health Benefits, available at <http://www.ncsl.org>

rarely if ever required full equality in coverage between mental and physical conditions. States parity acts can be classified into three major groups: (i) Parity or equal coverage laws,¹⁰⁵ that essentially require rough parity between coverage of physical and mental health conditions; (ii) minimum mandated benefit laws,¹⁰⁶ which require that some level of coverage be provided for mental illnesses, but permit different benefit limits; and (iii) mandated offering laws,¹⁰⁷ that

[g/research/health/mental-health-benefits-state-mandates.aspx](#) (last visited November 15, 2014).

¹⁰⁵*See, e.g.*, Rhode Island, General Laws 1956 § 27-38.2-1 (“Mental illness coverage. Every health care insurer that delivers or issues for delivery or renews in this state a contract, plan, or policy except contracts providing supplemental coverage to Medicare or other governmental programs, shall provide coverage for the medical treatment of mental illness and substance abuse under the same terms and conditions as that coverage is provided for other illnesses and diseases. Insurance coverage offered pursuant to this statute must include the same durational limits, amount limits, deductibles, and co-insurance factors for mental illness as for other illnesses and diseases. ‘Mental illness’ includes any mental and substance abuse disorder listed in DSM that substantially limits the life activities of the person with the illness, but excludes tobacco and caffeine addiction, mental retardation, learning disorders, motor skills disorders, communication disorders and others. ‘Mental illness coverage’ excludes methadone maintenance services or community residential care services for mental illnesses other than substance abuse disorders.”)

¹⁰⁶*See, e.g.*, Kentucky, K.R.S. § 304.17-318 (“Coverage for treatment for mental illness. (1) For purposes of this section, ‘mental illness’ means psychosis, neurosis or an emotional disorder. (2) Any offer to sell a policy or contract of general health insurance to be issued, delivered, issued for delivery, amended or renewed in this state after January 1, 1987, shall include an offer of coverage for the inpatient and outpatient treatment of mental illness, at least to the same extent and degree as coverage provided by the policy or contract for the treatment of physical illnesses.”)

¹⁰⁷*See, e.g.*, Kansas, K.S.A. 40-2,105 (“ . . . every insurer which issues any individual policy of accident and sickness insurance or group policy of accident and sickness insurance to a small employer . . . which provides medical, surgical or hospital expense coverage . . . must provide for reimbursement or indemnity . . . which shall be limited to not less than 45 days per year for in-patient treatment of mental illness . . . and not less than 30 days per year when such person is confined for treatment of alcoholism, drug abuse or substance use disorders . . . Such . . . policy . . . shall also provide for reimbursement . . . of the costs of treatment of . . . mental illness, alcoholism, drug abuse and substance use disorders subject to the same deductibles, copayments, coinsurance, out-of-pocket expenses and treatment limitations as apply to other covered services,

MENTAL HEALTH CARE LAW

like the Federal MHPA do not require plans to provide mental health care coverage, but require that if coverage is offered, it must be on par with that offered for physical conditions.¹⁰⁸

Regardless of the classification, most states also permitted other restrictions on mental health care services. Many statutes limited mandated coverage to severe mental illnesses. For example, California's parity act was limited to nine listed conditions—schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa, and severe emotional disturbances in children.¹⁰⁹ This scheme excluded serious mental illnesses with significant populations, such as Alzheimer's and substance use disorders.¹¹⁰

One of the major arguments against the enactment of state mental health parity laws at the time was that these would raise the cost of health plan coverage, permitting fewer people to afford it at all. The solution offered by the MHPA was to permit employers to exclude themselves from the act if compliance increased their health plan costs by more than 1%. A number of articles were published at the time which

limited to not less than \$15,000 in such person's lifetime, with no annual limits . . . when in-patient treatment is not necessary").

¹⁰⁸For a 50-state survey, see Nat'l Conf. State Legs., *State Laws Mandating or Regulating Mental Health Care Benefits*, *op. cit.* For an alternative 50-state survey and taxonomy, see NAMI, *State Mental Health Parity Laws* (July 2009), available at http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/Parity1/State_Parity_Chart_0709.pdf (last visited Nov. 15, 2014).

¹⁰⁹Cal. Health & Safety Code § 1374.72.

¹¹⁰For discussions of the policy and political reasons behind such limitations on the definition of mental illness, see M. Peck, *Mental Health Parity for California*, 52 *Psychiatric Services* 743 (2001); M. Peck and R. Scheffler, *An Analysis of the Definitions of Mental Illness Used in State Parity Laws*, 53 *Psychiatric Services* 1089–95 (2002); H. Goldman and G. Grob, *Defining 'Mental Illness' in Mental Health Policy*, 25 *Health Affairs* 737, 744–45 (2006). See also SAMHSA, *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, 1, Table 1.1; J. Klick and T. Stratmann, *Subsidizing Addiction: Do State Health Insurance Mandates Increase Alcohol Consumption?* 35 *J. Legal Studies* 175, 180 (2006), Table 1 (noting state parity acts which excluded substance use disorders).

contended that the use of managed care could drop the cost of mental health care coverage, so that if plans simultaneously shifted to managed care when they implemented parity, the new parity mandates would cost nothing.¹¹¹ As a result, some state mental health parity statutes specifically authorized plans to use managed care for mental health coverage even if managed care was not used for physical health coverage.¹¹²

D. The Increase in Prevalence of Childhood Mental Diseases and the State Autism Coverage Mandates of the 2000s

Throughout the 1970s–2000s, the prevalence of childhood mental health disorders such as ADHD, bipolar disorder, and autism rose sharply.¹¹³

- ADHD: Grew from 1% in the 1970s, to 3-5% in the 1980s, to 4-5% in the mid-1990s, and has recently been estimated at 9-11%.¹¹⁴ This is a 1,000% increase in prevalence in 40 years.¹¹⁵

¹¹¹R. Sturm, How Expensive Is Unlimited Mental Health Care Coverage under Managed Care?, 278 *JAMA* 1533–37 (Nov. 12, 1998); R. Frank, et al., The politics and economics of mental health “parity” laws, 16 *Health Affairs* 108–119 (1997); Alan Otten, Mental Health Parity: What Can It Accomplish in a Market Dominated by Managed Care?, Milbank Memorial Fund (June 1998) (available at <http://www.milbank.org/mrparity.html>) (last visited Sept. 10, 2011); H. Varmus and S. Findlay, Managed behavioral health care in 1999: an industry at a crossroads, 18 *Health Affairs* 116, 122 (1999); H. Goldman and G. Grob. 745.

¹¹²*See, e.g.*, Cal. Health & Safety Code § 1374.72. *See also* SAMHSA, *The Costs and effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, 8. Many plans had already “carved-out” management of mental health benefits to Managed Behavioral Health Organizations (MBHOs). State parity laws specifically permitting use of managed care increased this trend. T. Lake, et al., A Snapshot of the Implementation of California’s Mental Health Parity Law, Mathematica Policy Research, Inc., 6–8 (Feb. 20, 2002).

¹¹³R. Perou, et al., *Mental Health Surveillance Among Children – United States, 2005–2011*, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, Supplement, 62:2:16 (May 17, 2013).

¹¹⁴Daniel Connor, Problems of Overdiagnosis and Overprescribing in ADHD, *Psychiatric Times* (Aug. 11, 2011) (available at <http://www.psychia>

MENTAL HEALTH CARE LAW

- Bipolar disorder: Prevalence in teenagers was 25 per 100,000 people in 1994–95, but by 2002–03, jumped to 1,003 per 100,000 people (1% of the population).¹¹⁶ This is a 4,000% increase in less than 10 years.
- ASD: Before the 1980s, ASDs were thought to affect one in 2,000 children.¹¹⁷ By 2006–2007, the prevalence increased to 1-1.1%.¹¹⁸ That is a 2,200% increase in 25 years.¹¹⁹

Bipolar disorder and ADHD are commonly treated with medication. However, the most in-demand intervention for autism is applied behavioral analysis (ABA). The most common form of ABA has traditionally been a preschool type program that is delivered one-on-one by a behavioral therapist to a child for between 20–40 hours per week for

[tractimes.com/adhd/problems-overdiagnosis-and-oveprescribing-ADHD](http://www.tractimes.com/adhd/problems-overdiagnosis-and-oveprescribing-ADHD) (last visited Nov. 2, 2014); S. Visser, et al., Trends in the Parent-Report of Health Care Provider-Diagnosed and Medicated Attention-Deficit/Hyperactivity Disorder: United States, 2003–2011, *J. American Academy of Adolescent Psychiatry*, 1, 3 (in press, 2013). Approximately two-third of children with a current diagnosis of ADHD were taking ADHD medication in 2007—a total of 2.7 million individuals.

¹¹⁵S. Visser, 2.

¹¹⁶C. Moreno, et al., National trends in the outpatient diagnosis and treatment of bipolar disorder in youth, 64 *Arch. Gen. Psychiatry* 9:1032-30 (2007); NIMH Press Release, Rates of Bipolar Diagnoses in Youth Rapidly Climbing, Treatment Patterns Similar to Adults (Sept. 3, 2007) (available at <http://www.nimh.nih.gov/news/science-news/2007/rates-of-bipolar-diagnosis-in-youth-rapidly-climbing-treatment-patterns-similar-to-adults.shtml>) (last visited Dec. 4, 2014).

¹¹⁷C. Rice, “Prevalence of Autism Spectrum Disorders – Autism and Developmental Disabilities Monitoring Network, United States, 2006”, 58 *MMWR Surveillance Studies* 1-20 (December 18, 2009) (available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5810a1.htm>) (visited March 23, 2010) at 2.

¹¹⁸*Id.* at 1; M.D. Kogan, et al., “Prevalence of parent-reported diagnosis of autism spectrum disorder among children in the US, 2007,” 124 *Pediatrics* 1395–403 (Nov. 2009).

¹¹⁹Some contend that these increases in prevalence are a “false epidemic,” largely caused by the broadened definitions given to these disorders in DSM-IV. See, e.g., Allen Frances, *Saving Normal*, 140–49 (2013).

two or more years.¹²⁰ While ABA therapists have traditionally not been highly trained or licensed, the cost of ABA therapy can often amount to \$30,000 to 75,000 per year. Many health plans did not cover ABA on the grounds that it was experimental, educational in nature, and delivered by unlicensed providers.

During the 2000s, activists pushed states to adopt ABA mandate legislation. As of November 2014, 38 states had adopted ABA coverage mandates.¹²¹ As with the state mental health parity acts, autism mandate statutes typically allowed for limits on coverage. Many states set maximum dollar limits on mandated benefits—a common limit was \$36,000 per year.¹²² Other states included nonquantitative treatment limitations, such as a requirement that mandated benefits be provided under a treatment plan.¹²³ As with its parity act, California specifically permitted ABA to be provided *via* managed care.¹²⁴

E. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

While the state parity acts and mandates affected coverage by private insurers, they did not apply to employer plans. Accordingly, during the 2000s, momentum grew for a comparable federal parity act.¹²⁵ In 1998, Congress passed a major

¹²⁰O. Ivar Lovaas, Behavioral Treatment and Normal Educational and Intellectual Functioning in Young Autistic Children, 55 *Journal of Consulting and Clinical Psychology* 1:3, 5 (1987).

¹²¹See Autism Votes, Washington Becomes State #38 To Require Autism Benefits, available at <http://www.autismspeaks.org/advocacy/advocacy-news/washington-becomes-state-38-require-autism-benefits> (last visited Nov. 15, 2014).

¹²²See, e.g., Colorado, C.R.S.A. § 10-16-104 (limiting annual mandated benefits for children through age eight to \$34,000 per year); Illinois, 215 ILCS 5/365z.14 (limiting mandated benefits to \$36,000 per year).

¹²³See, e.g., Connecticut, C.G.S.A. § 38a-514b; California, Health & Safety Code § 1374.73; Missouri, Revised Statutes 376.1224.

¹²⁴Cal. Health & Safety Code § 1374.73.

¹²⁵See the detailed account of the political history behind the passage of MHPAEA at C. Barry, *op. cit.*

expansion of MHPA known as the Mental Health Parity and Addiction Equity Act of 2008.¹²⁶

Like its predecessor, MHPAEA does not require health plans to offer any coverage for mental health or substance abuse disorders at all. Rather, it merely provides that if plans do offer mental health or substance abuse coverage, this coverage must comply with MHPAEA by providing parity with similar coverage for physical conditions—amplifying other plan provisions or laws requiring coverage for mental health conditions.

The primary change in MHPAEA was that it now required parity for “financial requirements and treatment limitations.” The text of MHPAEA defined financial requirements as dollar limits, including deductibles, copays, coinsure, and out-of-pocket limits. It defined treatment limitations as number limits, including limits on the frequency of treatment, number of visits, days or coverage, or similar limits on the scope and duration of treatment.¹²⁷ The joint regulations issued for MHPAEA by the Departments of Labor, Treasury and Health & Human Services (in interim final form in February 2010 and as final regulations in November 2013) greatly expanded these requirements.¹²⁸ The regulations divided the “treatment limitation” category into two subcategories—quantitative and nonquantitative treatment limitations. The regulations defined nonquantitative treatment limitations to include virtually all of the tools that health plans had traditionally used to manage benefits, such as standards for determining medical necessity and the use of step therapy and fail-first protocols, as well as standards relating to providers, including reimbursement rates.¹²⁹

Under the MHPAEA regulations, treatment limitations

¹²⁶Codified at 26 U.S.C. § 9812; 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-26.

¹²⁷*Id.*

¹²⁸75 Fed. Reg 5410 (Feb. 2010); 26 C.F.R. § 54.9812-1T; 29 C.F.R. § 2590.712; 45 C.F.R. § 146.136.

¹²⁹The illustrative lists in the preambles to the regulations include medical management standards based on whether a treatment is medically necessary or experimental; formulary designs for prescription drugs; standards for provider admission to a network (including reimbursement rates); methods for determining usual, customary, and reasonable charges; refusal to pay for higher cost therapies until it can be shown that a lower-

for mental health conditions must conform to treatment limitations for physical conditions. If a financial requirement or quantitative treatment limitation is not used for at least two-thirds of physical conditions in a particular category of services, it cannot be used for comparable mental health conditions.¹³⁰ For example, if a health plan doesn't require copays for in-patient office visits for physical conditions, it cannot require copays for in-patient office visits for mental health conditions.¹³¹

Similarly, if a nonfinancial/quantitative treatment limitation is not applied to physical conditions, it cannot be applied to mental health conditions.¹³² This regulation, which is not found in the text of the statute, could cause problems for management techniques that are commonly used for mental health services but not commonly used for medical services. The regulation, however, provides that management techniques do not have to be used with equal frequency for physical and mental health conditions—so long as the

cost therapy is ineffective (step or fail-first protocols); exclusions based on failure to complete a course of treatment; network tier design; restrictions based on geographical location, facility type, provider specialty, or other criteria that limit the scope or duration of benefits. Depts. of Treasury, Labor, HHS, Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity And Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68246 (Nov. 13, 2013). For a fuller exposition of MHPAEA and the final regulations, see D. Johnson and J. Wood, "Doubling Down on Coverage: The Mental Health Parity and Addiction Equity Act (MHPAEA) in Light of the Final Rules," *BNA Insights: Health Law Resource Center* (December 5, 2013). Several suits have been filed that could require court review of the regulations; however, as of the date of this writing, none has resulted in a significant merits ruling.

¹³⁰Under the regulations, parity is determined on a category-by-category basis for each of six classifications of services: emergency, out-patient in-network, out-patient out-of-network, in-patient in-network, in-patient out-of-network, and prescription drugs. Plans are allowed to use a few specified subcategories, as well.

¹³¹See 45 C.F.R. § 146.136(c)(2) and (3). Plans may not use any type of financial requirement or treatment limitation for mental health and substance abuse services unless the type of limitation applies substantially all medical surgical benefits in the same classification. "Substantially" all means that the type of limitation applies to at least two-third of medical/surgical benefits in the classification.

¹³²See 78 Fed. Reg. 68245 ("the MHPAEA specifically prohibits separate treatment limitations that are applicable only with respect mental health or substance use disorder benefits").

“strategies, processes, evidentiary standards and other factors used in applying” a particular medical management technique are at parity.¹³³ Many management techniques for mental health care services have their basis in principles that could also apply to services for physical condition and thus may not create a parity problem.¹³⁴

A common criticism of the “one size fits all” logic of MHPAEA is that it only requires plans to cover benefits for mental health conditions to the extent benefits are offered for physical conditions. During the rulemaking process, some advocates attempted to convince the Departments to interpret MHPAEA as an “all services” mandate and require plans to provide all modes of care for mental health conditions if they were offered for physical conditions.¹³⁵ The Departments refused to adopt this interpretation, and plans are not required to provide, for example, subacute forms of care, such as partial hospitalization and residential care, if these are not provided for physical conditions.¹³⁶

F. The Affordable Care Act of 2010

Until the passage of the Affordable Care Act (ACA) in 2010, federal law did not require employer plans or private insurers to provide mental health care benefits. This changed with the enactment of the ACA, which for the first time required all nongrandfathered individual and small group plans—including health plans offered on the newly created exchanges as well as those not offered through the exchanges—to provide a list of “essential health benefits” (EHBs) for plan years beginning on or after January 1,

¹³³ See 45 C.F.R. § 146.136(c)(4).

¹³⁴ See Examples 2 and 8 at 45 C.F.R. § 146.135(c)(4)(iii).

¹³⁵ See discussion at 78 Fed. Reg. 6826.

¹³⁶ See *id.* (“ . . . the Departments did not intend to impose a benefit mandate through the parity requirements that could require greater benefits for mental health conditions than for medical surgical conditions. In addition, the Departments’ approach defers to States to define the package of insurance benefits that must be provided in a State through EHB”). See also 45 C.F.R. § 156.136(c)(4)(iii), Example 9 (plan’s exclusion of all nonhospital services for both mental health and physical conditions would not necessarily violate MHPAEA).

2014.¹³⁷ The list of EHBs specifically includes “mental health and substance use disorder services, including behavioral health treatment.”¹³⁸ It also includes “rehabilitative and habilitative services and devices,” a category that was likely intended to include physical, occupational, and speech therapy—services that are often provided to persons with mental disorders such as autism.¹³⁹ The EHB statute does not necessarily require exchange plans to cover all mental health conditions or to cover all possible benefits for the conditions covered—rather, it only requires plans to offer coverage similar to that in “typical employer plan.”¹⁴⁰ On the other hand, the antidiscrimination rules in the statute require benefits to be nondiscriminatory. For example, plans are prohibited from designing benefits in ways that discriminate against people based on their age, disability, expected length of life, degree of medical dependency, or quality of life.¹⁴¹

In addition to mandating that exchange plans provide mental health benefits, the ACA also expanded the coverage of MHPAEA to many additional plan types. MHPAEA now covers: (i) large group employee plans, including partnerships,¹⁴² (ii) nongrandfathered small group plans,¹⁴³ (iii)

¹³⁷ HHS, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits; Actuarial Value, and Accreditation; Final Rule, 78 Fed.Reg. 12384, 12385 (Feb. 25, 2013); 45 C.F.R. 147.150(a).

¹³⁸ 42 U.S.C. § 18022.

¹³⁹ *Id.*, see also D. Johnson, The EHB Habilitative Services Mandate: How States Are Doing on Converting an Exclusion into a Category of Covered Services, 21 *BNA Health Care Policy Report* 1313 (Aug. 5, 2013).

¹⁴⁰ 42 U.S.C. § 18022.

¹⁴¹ *Id.* See also 45 C.F.R. § 156.125. Department of Health & Human Services regulations permitted the states to pick a plan to establish the benchmark for benefits provided by all exchange plans in the state. States were also permitted to augment the benefits in this plan with any state-mandated services that were enacted by December 31, 2011. See 75 FR 12834, 12846 (Feb. 25, 2013).

¹⁴² 42 U.S.C. § 300gg-26 and 21. The term “group health plan” generally refers to those issued by employers, so it would not include a retiree-only group. 42 U.S.C. § 300gg-91(a)(1). The term “group health plan” however, is defined to include those issued for partnerships. 42 U.S.C. § 300gg-21(d).

nongrandfathered individual coverage,¹⁴⁴ (iv) nonfederal government employee plans (unless they exercise an opt-out);¹⁴⁵ (v) church plans,¹⁴⁶ and (vi) Medicaid managed care plans.¹⁴⁷ This list now includes almost all forms of private health coverage.

The ACA also contains other provisions that expand coverage for groups which traditionally have often been uninsured. These provisions include the expansion of Medicaid eligibility to persons with incomes up to 133% of the Federal Poverty Level (adopted by about half the states) and the requirement that plans and issuers make dependent coverage available until a child reaches age 26.¹⁴⁸

G. The Primary Effect of the Mental Health Mandates: Continuing the Long-Term Trend of Expanding Services to the General Public

The use of mental health care services by the general public has already become pervasive so that by 2013, prior to the implementation of much of the ACA and the MHPAEA, 15–20% of the population was already receiving mental health care services annually. The new coverage mandates and ACA Medicaid expansion should continue this trend and result in an increase in the amount of mental health care services consumed by the general public at all levels of the spectrum of mental health—from no diagnosed mental illness to severe mental illness.

¹⁴³MHPAEA contains an exclusion for small group employer plans. 42 U.S.C. § 300gg-26(c)(1), 300gg-91(e)(4). However, the final regulations for MHPAEA note that small group plans are required to comply with EHB requirements, and the EHB rules require plans to comply with MHPAEA. As a result, according to the EHB regulations, all nongrandfathered small group plans must comply with MHPAEA. *See* 78 Fed. Reg. 68240 to 68241.

¹⁴⁴42 U.S.C. § 300gg-26; 78 Fed. Reg. 68240 to 68241.

¹⁴⁵42 U.S.C. §§ 300gg-21; 300gg-91(d)(8)(C); 300gg-21(a)(2).

¹⁴⁶42 U.S.C. § 300gg-21.

¹⁴⁷42 U.S.C. § 1396u-2(b)(8); 42 U.S.C. § 1397cc(f)(2); 42 U.S.C. § 1396u-7(b)(6).

¹⁴⁸Other changes to the Medicaid that encourage case management and collaborative care may also improve mental health care. *See* discussion in D. Mechanic, *Seizing Opportunities Under the Affordable Care Act for Transforming the Mental Health and Behavioral Health System*, 31 *Health Affairs* 376–382 (2012).

Despite their already pervasive use, there is evidence of a pent-up demand for even more mental health care services. A survey by SAMHSA found that in 2013, 43.8 million adults (18.5% of the population) had a diagnosable mental, behavioral, or emotional disorder.¹⁴⁹ Of this group, only 19.6 million (45% of persons with mental illness) received treatment.¹⁵⁰ This would mean that over 24 million adults with a diagnosable mental illness did not receive mental health services during the year.¹⁵¹ The findings of this survey are consistent with a 2011 survey conducted by SAMHSA which found that 15.1% of adults had received mental health or substance abuse treatment during the year but that 12.2% of adults (about 28 million people) still indicated that they had not received some needed mental health or substance abuse treatment (and hence had an “unmet need”).¹⁵²

Part of the unmet need likely represents a demand for a broader range of services, such as for psychotherapy in addition to prescription medication. A 2001–02 study found that “most mental health or substance abuse treatment does not meet guidelines to be minimally adequate.”¹⁵³ A 2008 study found that few children receiving medication for depression also received psychotherapy in the recommended time period after starting medication.¹⁵⁴ The mandates seem likely to make coverage for these types of services more available.¹⁵⁵

To look at this from the standpoint of spending: in 2009,

¹⁴⁹SAMHSA, Results from the 2013 *National Survey on Drug Use and Health: Mental Health Detailed Tables* (Nov. 14, 2014) Tables 1.1A and 1.1B. These figures do not include developmental or substance use disorders.

¹⁵⁰*Id.* at Table 1.21A.

¹⁵¹While 34.6 million adults received mental health care services or counseling in 2013, 15.1 million of those who had received services had no diagnosable mental illness.

¹⁵²SAMHSA, *Behavioral Health, United States, 2012*, 109–111, Table 45.

¹⁵³*Id.* at 23.

¹⁵⁴*Id.* at 29.

¹⁵⁵However, the degree to which it will make usage of psychotherapy more frequent has not yet been determined. See B. Saloner and B. Le Cook, An ACA Provision Increased Treatment for Young Adults With Possible Mental Illnesses Relative to Comparison Group, 33 *Health Affairs* 1425, 1429 (2014) (finding that there were “no significant changes be-

51% of all health expenditures were financed by private payers such as health insurance and 49% state and federal sources. However, only 40% of mental health and 31.5% of substance abuse services were paid for by private sources.¹⁵⁶ In theory, the parity requirements for private insurance would be expected to equalize the portions of spending for physical and mental health borne by the private sector.

V. After the Mandates: Directions for Future Mental Health Care System Reform

A. The Mental Health Mandates Should Help, But Do Not Address All the Problems of the Seriously Mentally Ill

Most mental health and ACA mandates are not targeted at, but nevertheless should increase coverage for, persons with severe mental illness. For example, the expansion of private and employer coverage for children up to age 26 should result in more coverage for schizophrenia, which commonly presents at ages 20–30. The expansion of Medicaid and the introduction of subsidized private insurance on the Exchanges under the ACA should disproportionately benefit persons with severe mental illnesses since these people are more likely to have incomes that qualify for these programs than the general population.¹⁵⁷ The mental health coverage mandate and parity legislation—like the proverbial rising tide that lifts all boats—should also increase coverage for the severely mentally ill who have private coverage.

However, increased coverage mandates by themselves will not solve many of the problems attendant with serious mental illness. They will not create outreach to locate and

tween 2008–2012 among people age 18–25 relative to people ages 26–35 in the type or setting of treatment in the previous twelve months”). Taking medication takes less patient commitment and time than psychotherapy.

¹⁵⁶SAMHSA, *Behavioral Health, United States, 2012*, 257, Table 124.

¹⁵⁷Rachel L. Gardfield, et al., *The Impact of National Health Care Reform on Adults with Severe Mental Disorders*, 168 *Am. J. Psychiatry* 486, 488 (2011) (finding that adults with severe mental disorders were more than twice as likely to have incomes under 133% of the federal poverty level than persons without severe mental disorders).

bring care to unserved patients. They will not induce patients to comply with treatment regimes. Not all serious mental illnesses even have effective treatments, so the new coverage mandates may have little effect on such persons. Now that the cycles of mandate legislation seem to have concluded, there are efforts to refocus mental health care reform on the needs of the severely mentally ill.

B. Should Deinstitutionalization Be Rolled Back?

For at least a generation, many have argued that deinstitutionalization was a tragedy that merely resulted in the abandonment of societal responsibility for the seriously mentally ill. In the 1980s, the frequent argument was that deinstitutionalization had resulted in homelessness and *transinstitutionalization* of the mentally ill to nursing homes.¹⁵⁸ Psychiatry professor E. Fuller Torrey, who is perhaps the leading advocate for this point of view today, contends that deinstitutionalization has resulted in an increase in violent crimes and the transformation of prisons and jails into mental health care institutions.¹⁵⁹

Torrey contends that while drug therapy works for many people with serious mental illnesses, a small percentage require “intensive care in specialized facilities.” These people are unaware of their illness, are dangerous to themselves or others, or have an illness so chronic they cannot function outside a hospital.¹⁶⁰ Torrey’s solution is to increase the number of public psychiatric beds to 40–60 per 100,000 for treatment of patients who do not respond to or take their medications and for patients who are a danger to themselves or others.¹⁶¹ The number of state mental hospital beds cur-

¹⁵⁸J. Myers, 403–11; Grob, 317–21.

¹⁵⁹E. Fuller Torrey, *American Psychosis*, 117–23; E. Salinsky, 13. See also S. Bagenstos, 2–3 (summarizing arguments in support of a rollback of deinstitutionalization).

¹⁶⁰E. Fuller Torrey, et al., *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals*, Treatment Advocacy Center, 7 (2012).

¹⁶¹E. Fuller Torrey, *American Psychosis*, 145–46.

rently stands at around 40,000 to 50,000.¹⁶² Torrey's proposal would represent a three to fourfold increase in the number of beds to perhaps 150,000 to 200,000.¹⁶³ Torrey envisions this as a revival of the original concept of the asylum as a place of refuge and safety.¹⁶⁴

Others disagree and renew older arguments that long-term institutionalization harms persons with psychiatric disabilities and that the seriously mentally ill are better cared for in community settings. They also contend that the evidence is mixed on the relationship between deinstitutionalization and violent crime and incarceration rates. Studies have noted that incarceration rates began to increase during the same historic period that the population of mental hospitals decreased.¹⁶⁵ However, some studies have concluded that the contribution of deinstitutionalization to the incarceration rate was small and that other factors, such as an increase in the number of young males in the population, caused most of the increase in incarceration.¹⁶⁶ The evidence for a direct relationship between violent crime and deinstitutionalization is also uncertain.¹⁶⁷

Many proponents of deinstitutionalization admit that it

¹⁶²Koyanagi, 17.

¹⁶³E. Fuller Torrey, *American Psychosis*, 145–46.

¹⁶⁴*Id.* at 146.

¹⁶⁵H. Steadman, et al., The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations, 1968–1978, 75 *J. Crim. L. & Criminology* 474 (1984); B. Harcourt, From the Asylum to the Prison: Rethinking the Incarceration Revolution, 84 *Texas L. Rev.* 1751, 1755 (Table 1) (2006).

¹⁶⁶H. Steadman, 487–90; S. Raphael and M. Stoll, Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate (March 2010) (available at <http://ist-socrates.berkeley.edu/~raphael/IGERT/Workshop/mental%20illness%20raphael%20and%20stoll%20march%202010.pdf>) (last visited Dec. 4, 2014).

¹⁶⁷See Bazelon Center for Mental Health Law, The Relationship between the Availability of Psychiatric Hospital Beds, Murders Involving Firearms, and Incarceration Rates (Jan. 15, 2013) (available at <http://www.bazelon.org/portals/0/Archives/Statements%20&%20Releases/Relationship%20Between%20Psychiatric%20Hospital%20Beds%20and%20Firearm%20Murder1.15.13.pdf>) (last visited Dec. 4, 2014) (finding no statistically significant relationship between murder by firearms or incarceration and the number of psychiatric beds); B. Harcourt, The Institutionalization Effect: the Impact of Mental Hospitalization and Imprisonment on

has failed to provide care to many people with severe mental illnesses. But they contend that the response should not be a return to long-term confinement in a mental hospital.¹⁶⁸ Rather, they recommend the provision of better services in the community, such as supported housing and employment and assertive community treatment (also known as involuntary outpatient treatment).¹⁶⁹

C. Current Legislative Proposals Targeting Chronic Mental Illness

Now that the tide of mental health coverage mandates is receding, legislative attention appears to be turning to the problems of the seriously mentally ill. One piece of such legislation that has received some attention is H.R. 3717, which was introduced by Pennsylvania Republican Congressman Timothy Murphy, a former clinical psychologist in the 2013-14 Congressional Session.¹⁷⁰ The bill embraces solutions from both proponents and opponents of deinstitutionalization. Among leading provisions in the bill are:

- An exception to the Medicaid Institutions for Mental Disease (IMD) rule to increase the number of state mental hospital beds.

H.R. 3717 would allow for a limited exception to the IMD rule to permit Medicaid funds to be used at state mental hospital stays of up to 30 days.¹⁷¹ According to Rep. Murphy, this provision is directly aimed at rolling back the “shortage of inpatient psychiatric beds.”

Homicide in the United States, 1934–2001, 40 *J. Legal Studies* 39 (2011); Raphael at 9–10 (finding that among state inmates, the mentally ill are only slightly more likely to serve time for a violent crime but that among federal inmates, the mentally ill were considerably more likely to be held for violent crimes than those without a diagnosis).

¹⁶⁸See the recent summary of these arguments and sources in S. Bagenstos, 3–4.

¹⁶⁹D. Mechanic, More People Are Receiving Behavioral Health Care in the United States, But Gaps and Challenges Remain, 33 *Health Affairs* 8:1416, 1421–22 (2014).

¹⁷⁰Rep. Murphy’s office has informed me that Rep. Murphy intends to reintroduce this bill in the 2015-16 Session.

¹⁷¹H.R. 3717, Title III, section 301.

- An exception to HIPAA rules to permit providers to disclose protected information to family members without the patient's consent.

Family members of the mentally ill often express frustration at HIPAA regulations which forbid healthcare providers from giving them information about a patient's condition without the patient's consent. This can mean that family caregivers lack information about the patient's diagnosis, medication, or psychotherapy schedule, and hence are unable to assist the patient in complying.¹⁷² H.R. 3717 would, among other things, amend HIPAA to permit healthcare providers to disclose protected health information to the caregiver of a patient, even if the patient does not consent, if the provider believes disclosure is necessary to protect the health, safety, or welfare of the patient.¹⁷³

- Conditioning state receipt of block grants on their adoption of stricter involuntary outpatient commitment laws.

H.R. 3717 would encourage states to strengthen their involuntary outpatient commitment (IOC) laws by conditioning receipt of certain grants on their adoption of stricter IOC laws. IOC laws were developed in the 1980s as a midway alternative to involuntary inpatient commitment versus deinstitutionalization.¹⁷⁴ The laws differ, but many states permit IOC where a patient is mentally ill, is a danger to himself or others or gravely disabled, and is unwilling or unable to accept voluntary treatment.¹⁷⁵ Some states require a

¹⁷²See Statement of Leon Rodriguez, Director, Office for Civil Rights, U.S. Dept. of Health and Human Services, Testimony before the Energy & Commerce Committee, Subcommittee on Oversight and Investigations, U.S. House of Rep., April 26, 2013 (Under HIPAA, "a health care provider is not permitted to share personal health information with the family members or friends of an adult individual who tells the provider not to do so").

¹⁷³H.R. 3717, Title III, section 301.

¹⁷⁴See history in J. Myers, 418–33.

¹⁷⁵For "50-state" summaries of state IOC laws (although not all states have enacted them), see Bazelon Center for Mental Health Law, *Involuntary Outpatient Commitment, Summary of State Statutes*, April 2000; Treatment Advocacy Center, *Assisted Psychiatric Treatment Inpatient and Outpatient Standards by State*, June 2011, (available at <http://www.t>

finding of clear and present or imminent danger.¹⁷⁶ H.R. 3171 would require states to adopt laws making IOC mandatory if a mentally ill person is “a danger to self, is a danger to others, is persistently or acutely disabled or is gravely disabled and in need of treatment, and is either unwilling or unable to accept voluntary treatment.”¹⁷⁷ A finding of imminent danger could not be required.

Opponents of the bill contend that imposing a mere “need for treatment” standard greatly erodes patient autonomy. Some also contend that involuntary outpatient commitment laws are high-cost, have not been shown to be effective, and that fear of involuntary commitment can actually drive patients away from seeking mental health care treatment.¹⁷⁸

According to Rep. Murphy’s office, H.R. 3717 has drawn bipartisan support, as well as support from a number of mental health professional and advocacy groups. Other legislative proposals that are focused on the severely mentally ill include jail diversion programs.¹⁷⁹

VI. Conclusion

The focus of mental health care law and legislation over the past 50 years has been on increasing the availability of mental health services in the community and to the general public. The recent waves of state and federal mental health coverage mandates seem likely to continue these trends and provide a greater quantity and breadth of mental health ser-

treatmentadvocacycenter.org/storage/documents/new_the_updated_state_standards_chart.pdf (last visited Nov. 22, 2014).

¹⁷⁶See, e.g., Hawaii R.S. § 334-121 (requiring a finding that “[t]he person, based on the person’s treatment history and current behavior, is now in need of treatment in order to prevent a relapse or deterioration which would predictably result in the person becoming imminently dangerous to self or others.”).

¹⁷⁷H.R. 3717, Title VII, § 704.

¹⁷⁸Bazelon Center, Response to Murphy’s Bill, (available at www.bazelon.org/News-Publications/Press-Releases/12-12-13-Murphy-PR.aspx) (last visited Oct. 24, 2014).

¹⁷⁹For a nationwide survey of current mental health legislation, see NAMI, State Legislation Report, 2013 (available at http://www.nami.org/Content/NavigationMenu/State_Advocacy/Tools_for_Leaders/2013StateLegislationReportFinal.pdf) (last visited Dec. 4, 2014).

MENTAL HEALTH CARE LAW

vices to the general public—including to an increasing percentage who have no diagnosable mental illness.

Many contend that the time has come to refocus on needs of the smaller segment of the population with severe mental illnesses. While the recently enacted coverage mandates will provide medical treatment to a portion of this group, coverage mandates alone cannot address critical problems faced by people with chronic severe mental illnesses. Expect the next phase in mental health care law and legislation to focus on this population.