Better But Not Best: Recent Trends In The Well-Being Of The Mentally Ill

Sherry A. Glied and Richard G. Frank

Cite this article as:
Sherry A. Glied and Richard G. Frank
Better But Not Best: Recent Trends In The Well-Being Of The Mentally Ill
Health Affairs 28, no.3 (2009):637-648
doi: 10.1377/hlthaff.28.3.637

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/28/3/637

For Reprints, Links & Permissions : http://content.healthaffairs.org/1340_reprints.php

Email Alertings : http://content.healthaffairs.org/subscriptions/etoc.dtl

To Subscribe : https://fulfillment.healthaffairs.org

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.
Better But Not Best: Recent Trends In The Well-Being Of The Mentally Ill

Americans with the most serious mental illnesses continue to be primarily affected by changes in mainstream social policies.

by Sherry A. Glied and Richard G. Frank

ABSTRACT: Mental illness and its treatment are largely invisible. We use multiple publicly available data sources to evaluate changes in the well-being of Americans with mental illnesses over the past decade. We find that access to care, including specialty psychiatric and inpatient care, and financial protection have improved. However, not all people with mental health problems have shared in these improvements. Access to care among those with mental health impairments appears to have declined, and we estimate that because of continued increases in incarceration, at least 7 percent of the population with serious and persistent mental illnesses are incarcerated in jail or prison each year. [Health Affairs 28, no. 3 (2009): 637–648; 10.1377/hlthaff.28.3.637]
ple with less disabling mental health conditions. With respect to policy, passage of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) has expanded drug coverage for seniors. MMA also shifted drug coverage and utilization management for people who receive both Medicare and Medicaid benefits (dual eligibles) from Medicaid to Medicare Part D. Continued expansion of the State Children’s Health Insurance Program (SCHIP) has increased the extent of public insurance coverage for children. The movement toward parity in insurance benefits has continued, most recently with passage of the Wellstone-Domenici Parity Act in 2008. However, cost sharing for all health services has risen, and the number of uninsured people has increased. The availability of pharmaceutical treatments has increased as many antidepressants move off patent, but new concerns have emerged about the relative efficacy of some of these treatments. The social policy environment also has changed. Until recently, housing prices and rents climbed, making shelter less affordable for many people with impairments related to mental illness. There have also been some important innovations in policies to diminish homelessness. Here, we update data described in Better but Not Well to assess the broad impacts of this rapidly changing environment on the well-being of people with mental illnesses.

Study Data And Methods

The analyses reported here are based on new analyses of data from several publicly available data sets: the National Ambulatory Medical Care Survey (NAMCS), the National Hospital Ambulatory Medical Care Survey (NHAMCS), the National Health Interview Survey (NHIS), and the National Hospital Discharge Survey (NHDS), all from the National Center for Health Statistics; the Medical Expenditure Panel Survey (MEPS), from the Agency for Healthcare Research and Quality (AHRQ); the Healthcare Effectiveness Data and Information Set (HEDIS) survey, from the National Committee for Quality Assurance (NCQA); the National Household Survey of Drug Use and the National Survey on Drug Use and Health, from the Substance Abuse and Mental Health Services Administration (SAMHSA); the Social Security Administration; the Department of Housing and Urban Development; and the Department of Justice Bureau of Justice Statistics.

None of these data sets includes the validated instruments needed to accurately identify people who meet diagnostic criteria for mental illness. In using these data, we relied on the assumption, examined in our prior work and consistent with the findings of the National Comorbidity Survey replication, that the underlying prevalence of mental illness (overall) has not changed appreciably over the ten-year period we are examining.3 The data we used report either the presence of a diagnosis of mental illness recorded by a medical professional at any medical visit (primary care or specialty) or the presence of a self-reported functional limitation associated with a mental health or substance use problem.4 We report results separately for three population segments: children (ages 4–17), adults, and seniors.
We define mental health–related service use as use of services linked to a mental health diagnosis or a prescription for a psychotropic drug or service that involves a visit to a specialty mental health service provider. We generally report results for 1996–2006. In making population estimates, we used the sampling weights and stratification variables associated with each survey.

**Diagnosis And Treatment Rates**

Over the past half-century, the rate at which providers diagnosed mental health problems in the general population increased. By the mid-1990s, however, rates of diagnosed cases were still well below the estimated prevalence of illness. Under-diagnosis (and therefore undertreatment) remained a problem. And although diagnosis is often the first step in treatment, effective treatment did not necessarily follow from the issuing of a diagnosis. Appropriate care was not always delivered to people who met diagnostic criteria. We used the data sets described above to examine how these patterns changed during 1996–2006.

**Diagnosis.** The rate of diagnosed cases of mental disorders (referred to as treated prevalence) has increased since 1996 for all groups, especially the elderly. We computed the treated prevalence rate by calculating the proportion of the noninstitutionalized population that had a diagnosis of mental illness recorded during a visit to a health professional.

Treated prevalence increased the fastest—roughly doubling over this eleven-year period—among seniors. In 2006, nearly 16 percent of adults age sixty-five and older had a mental health diagnosis recorded at a medical encounter (Exhibit 1). Rates are about twice as high among non-Hispanic white seniors and Hispanic seniors as among black seniors. Rates also increased rapidly—by about 60 percent—among adults ages 18–64, to nearly 13 percent. In this age group, diagnosis rates are roughly comparable for blacks and Hispanics but are about twice as high for whites. Among children, those diagnosed with a mental health problem in-

---

**EXHIBIT 1**

**Percentage Of The U.S. Population With A Mental Health Diagnosis, 1996–2006**

<table>
<thead>
<tr>
<th>Percent</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**Seniors (age 65+)**

**Adults (ages 18–64)**

**Children (ages 4–17)**

**SOURCE:** Authors’ analysis of data from the Medical Expenditure Panel Surveys, 1996–2006.
creased more than 40 percent between the mid-1990s and 2006, to about 7 percent of the population. Rates of diagnosis are highest among non-Hispanic white children, about 9 percent of whom have a recorded diagnosis, compared to about 5 percent for black and Hispanic children.

To put these figures in context, the U.S. surgeon general’s review of epidemiologic studies concluded that about one in five adults and children meet criteria for a mental health diagnosis over the course of a year. Increases in the rate of diagnosis bring treated prevalence rates closer to epidemiologic estimates, but even at today’s rates, treated prevalence is well below the underlying population prevalence of diagnosable mental health conditions.

**Outpatient treatment.** Over this period, the increase in rates of diagnosis has been accompanied by increases in treatment rates. Among children and adults (but not seniors), increases in treatment have occurred through increased rates of diagnosis of mental health problems in primary care settings. For children, the rate at which such a diagnosis was recorded at a primary care visit doubled between 1996 and 2006 (Exhibit 2). For adults, the rate increased by about 30 percent. There has been no consistent increase among seniors.

This expansion of treatment through primary care appears to be concentrated among populations with less serious mental health–related impairments. The trend among people with a mental health activity limitation is more troubling. After increasing through 2000, the proportion of adults and seniors with self-reported activity limitations caused by mental disorders who report contact with a mental health professional has declined slowly but continuously. In 2000, 51 percent of those ages 18–64 with a mental health activity limitation reported such contact; by 2006, only 44.6 percent had had professional contact. The decline was even steeper among seniors: in 2002, 30.4 percent of seniors with a mental health activity limitation reported contact with a professional; in 2006, only one-fifth did.

### Exhibit 2

**Percentage of U.S. Primary Care Physician Visits that Included a Mental Health Diagnosis, 1996–2006**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults (ages 18–64)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seniors (age 65+)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children (ages 4–17)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source:* Authors’ analysis of data from the National Ambulatory Medical Care Survey, 1996–2006.
so (Exhibit 3). This pattern of increasing treatment rates in primary care (where cases are likely less severe) and continued declines in utilization among those with functional limitations suggests that the trend toward the “democratization of mental illness” may be excluding some of the sickest people, while care of those with less limiting conditions expands.

- Access to specialty care. Mental health treatment typically takes the form of psychotropic medication use or psychotherapy. There has been an explosion in the supply of providers of psychotherapy: the number of psychologists and social workers has more than quadrupled over the past five decades. But psychotropic prescribing has been mainly the province of the more stable population of psychiatrists and primary care physicians.

There has been concern about psychiatrists’ reluctance to participate in insurance plans. One measure of tight supply is psychiatrists’ ability to avoid such participation. In such practices, patients pay for their own visits and may then seek reimbursement from their insurers or absorb the cost out of pocket. Among all medical specialties, psychiatry has always had the highest rate of nonparticipation in insurance, and the rate has always been highest in urban areas in the Northeast, where psychiatrists are most plentiful. Cross-sectional data have documented that a minority of psychiatrists are willing to take new patients from managed care plans. The trend in this dimension of access, however, is positive. The share of psychiatrists who reported self-payment as the source of payment for all of their patients (that is, they did not accept any insurance) fell to a nine-year low in 2005 and remained at about the same level (2.4 percent of office-based psychiatrists) in 2006. Consistent with this pattern, all three age groups increased their rate of mental health visits to psychiatrists over this period.

- Emergency and inpatient care. In most circumstances, mental illness can be managed in community settings. Limited availability of community care may result

---

**EXHIBIT 3**

Rates Of Contact With A Mental Health Professional For Those With A Mental Health–Related Activity Limitation, 1997–2006

<table>
<thead>
<tr>
<th>Percent</th>
<th>50</th>
<th>40</th>
<th>30</th>
<th>20</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults (ages 18–64)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seniors (age 65+)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>30</td>
<td>20</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>40</td>
<td>50</td>
<td>40</td>
<td>30</td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ analysis of data from the National Health Interview Survey, 1996–2006.
in increased use of emergency services and possibly of inpatient care. Some people require inpatient care, though, and advocates are concerned about its availability for those who could benefit from it.\textsuperscript{15}

Our data suggest that there has been a slight upward trend in the use of emergency department (ED) care for mental health problems. Rates of ED visits that include a mental health diagnosis were generally higher in the period from 2001 forward than they had been in the late 1990s (the pattern for seniors is less clear).\textsuperscript{16}

By contrast, there has been a substantial and continuing increase in the rate of hospitalization for mental illnesses. Data collected from hospitals suggest that the overall rate of mental health–related hospital discharges has increased steadily—by about 50 percent—in all three age groups. By 2006, there were about six mental health–related hospital discharges per 1,000 children, about thirty per 1,000 adults, and about forty-five per 1,000 seniors—rates that are, in each case, about 50 percent higher than in 1996 (Exhibit 4).\textsuperscript{17}

In the past, private hospital use, especially among children, has been particularly sensitive to changes in demand.\textsuperscript{18} The share of private hospital use in total inpatient mental health service use has been growing for both children and adults (but not for seniors), particularly since 2000. By 2006, more than 40 percent of child hospitalizations and about 15 percent of adult hospitalizations occurred in private hospitals. Together, these patterns of rising hospital use and an increased private share suggest that concerns about lack of availability of hospital beds may stem from an increase in the demand for such beds.

**Nature And Quality Of Treatment**

Use of effective mental health treatments expanded through the 1990s.\textsuperscript{19} Recent studies, however, have raised concerns about some prescribing patterns, especially in the treatment of children. Studies have also documented continued deficiencies in the availability of evidence-based psychotherapy.\textsuperscript{20}

---

**EXHIBIT 4**

Rates Of Mental Health–Related Hospital Discharge Per 1,000 Patients, 1996–2006

<table>
<thead>
<tr>
<th>Rate per 1,000</th>
<th>Seniors (age 65+)</th>
<th>Adults (ages 18–64)</th>
<th>Children (ages 4–17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ analysis of data from the National Hospital Discharge Surveys, 1996–2006.
Pharmacotherapy in the outpatient setting. For both children and adults with a diagnosis, the rate of growth in rates of prescription drug use slowed since 2001, following a decade of rapid growth. Nonetheless, by 2006, rates of psychotropic medication use among children were nearly 50 percent higher than they had been in 1996: a mental health–related prescription was reported for more than one in twenty children. Prescription rates among adults were 73 percent higher in 2006 than in 1996, and more than one in ten adults reported a mental health prescription. Among seniors, mental health prescription rates continued to rise throughout the post-2000 period, so that by 2006, 15 percent of seniors reported having a prescription for psychotropics—twice the share as in 1996.21

Treatment quality. Routinely collected data on the quality of mental health services are sparse, but the NCQA has collected information on four quality measures from participating health plans. Analysis of these data suggests that there have been recent improvements in the quality of pharmacotherapy in the acute and continuation phases of depression treatment in privately insured populations, and in follow-up care after mental illness hospitalizations. By contrast, rates of appropriate provider contact among people in the acute phase of depression have not improved. Treatment quality, particularly nonpharmacologic, remains of concern.22

Cost, Affordability, And Financing Of Care

Access to care depends critically on cost. Costs faced by individuals depend on the overall cost of mental health care and on the distribution of these costs between third-party payers and patients. Analyses of data on financing show that during 1996–2006, for both children and adults, cost-related access barriers to mental health care generally declined or remained stable. For seniors, the situation is more complicated—before the Medicare Part D drug benefit was implemented, cost-related access barriers had been increasing, but the trend has now reversed.

In sharp contrast to the situation for general health care, the cost of mental health care per service user remained relatively stable or, in some cases, declined (after adjustment for economywide inflation) during 1996–2006.23 The data on service use and quality suggest that this cost stability was not principally a consequence of a decline in access and quality. At the same time, mental health insurance coverage remained roughly stable for both children and adults over this period. Finally, the financial generosity of insurance coverage for mental health services improved, especially for children.

Insurance coverage. Health insurance for mental health services improves access to care and provides financial protection against the costs of treatment. Insurance coverage rates among children with a psychiatric diagnosis have remained steady or increased, with shifts over time between public and private coverage. Private insurance continues to be the source of payment for the plurality of specialty mental health and hospital services for children, but the share paid by public insurance has increased over time. Private health insurance remains the main source of
coverage among adults with a mental health activity limitation, but although more than half of those with a limitation had held private coverage in 1996, that percentage declined steadily to less than 42 percent by 2006. In its place, the share of the adult population holding Medicare coverage has grown. Consistent with this pattern, the share of adult psychiatric hospitalizations paid for by Medicare has increased steadily, while private payments have fallen.24

**Out-of-pocket spending and affordability.** While overall mental health spending for children rose during this period, family out-of-pocket spending on behalf of children with a mental health disorder remained essentially flat since 1997 to 2005, at about $250 per year, but rose sharply in 2006 (Exhibit 5).25 For adults with a mental disorder, real out-of-pocket mental health spending declined through 2000 and has remained roughly constant, at about $340 per year. The share of family income spent on mental health in families that include an adult with a mental health diagnosis is about 6 percent.

Although average costs have not increased, a growing proportion of adults with a mental health activity limitation report difficulties in gaining access to mental health professional care or pharmaceuticals. Since 2002, the percentage of this population describing access difficulties has consistently exceeded 30 percent.

Out-of-pocket spending trends have been quite different for seniors. Before Medicare Part D and Medicare parity legislation, Medicare had limited coverage and high cost sharing for most ambulatory mental health care. Despite the decline in total mental health spending for seniors over this period, seniors’ out-of-pocket spending for mental health increased from 1996 through 2000. Since 2000, and particularly since 2003, their out-of-pocket spending on mental health care has declined slightly, as has the share of family income spent on mental health care in families that include a senior with a mental health diagnosis. The percentage of seniors with mental health activity limitations reporting difficulty in gaining access to mental health professional services and prescription drugs increased through 2002 but has fallen since. In 2006, about 11 percent of seniors with a mental health activity limitation reported difficulty affording pharmaceuticals.26

**EXHIBIT 5**

**Per Capita Out-Of-Pocket Mental Health Expenditures, In 2005 Dollars, 1996–2006**

<table>
<thead>
<tr>
<th>Year</th>
<th>Adults (ages 18–64)</th>
<th>Seniors (age 65+)</th>
<th>Children (ages 4–17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ analysis of data from the National Hospital Discharge Surveys, 1996–2006.
Living Circumstances

Many effective treatments for mental illness exist, but even those who receive evidence-based treatments may continue to experience functional limitations. For this group, living circumstances depend critically on access to publicly funded benefits, but benefits are meager and leave most people with severe illnesses in poverty. Some people with mental illnesses fall through the cracks in these programs and become ill or are incarcerated, leaving them much worse off.

- **Income and receipt of public benefits.** People reporting serious psychological distress are much poorer than the rest of the population. They are about 60 percent more likely than others to report incomes below $20,000 per year. Recent economic growth benefited most segments of the population, including people with mental illnesses. The relative distribution of income between those with serious psychiatric distress and others converged slightly during 1996–2006.

  The increase in income may have been a consequence, in part, of growth in the receipt of public benefits among those with mental illnesses. Over this period, the number of people receiving Supplemental Security Income (SSI) benefits because of a mental illness rose, as did the number receiving Social Security Disability Income (SSDI) benefits. In the SSI group, growth in benefit receipt was primarily due to an increase in the share of all applicants with a mental health disorder. By contrast, growth in the number receiving SSDI reflects primarily growth in the overall program. The share of SSDI recipients with a mental illness remained constant between 2000 and 2006. The increasing number of people with mental illnesses receiving disability benefits can be viewed as positive, because it improves their living circumstances. To the extent, however, that growth in SSI and SSDI receipt reflects an increase in functional limitations and inability to find paid employment among the population with impairing mental illnesses, it is a more troubling sign.

- **Housing and incarceration.** Improvements in living conditions that might have been generated by increases in receipt of public benefits were offset by the increase in housing prices in many areas. The supply of subsidized housing did not increase enough to keep housing affordable for people living on public benefits. The mismatch between housing costs and public benefits would have been expected to lead to a deterioration in housing conditions over this period. However, estimates of the size of the homeless population—which are always contentious and fraught with error—do not suggest a systematic increase in the size of this group. This apparent paradox may indicate that new homelessness prevention programs, such as supported housing, have done a better job of targeting housing at those most at risk.

  A disproportionate share of incarcerated Americans have mental illnesses. Recent studies applying consistent methods to estimates of the prevalence of mental illness in prison and jail over time suggest that the rate of mental illness in these
populations may have risen slightly over time. More importantly, increases in
general incarceration rates—which occurred during this period—mean that more
people with mental illnesses are incarcerated. In consequence, we estimate that
the number of people with serious and persistent mental illnesses who were in-
carcerated is likely to have risen over this period by nearly 90,000. By 2006, as
many as 7 percent of those with such illnesses may have been incarcerated.

Concluding Comments

■ Positive trends. The well-being of people with mental illnesses advanced
along several important dimensions during 1950–1996. Many of these gains were
sustained during 1996–2006. Access to care continued to expand for less impaired
segments of the population. The burden of out-of-pocket costs for people with men-
tal disorders either remained constant or declined. Providers' willingness to serve
insured people expanded. Quality of care for major mental disorders continued to
improve, especially in the area of pharmacotherapy, but it was uneven and sluggish
in other areas of treatment. Finally, despite pressures on the availability of low-in-
come housing, homelessness has remained steady in recent years, and the relative in-
comes of people with mental illnesses show marginal improvement.

■ Disturbing trends. The period 1996–2006 also displayed some disturbing
trends. For adults impaired by a mental illness, rates of treatment remained essen-
tially constant through 2006; for the elderly, they actually declined. The beneficial
effects of continued growth in managed behavioral health care, which facilitated ac-
tess to care for people with less serious illnesses, may simply have bypassed this
group. Alternatively, the expansion of managed care may have diverted resources
from those with serious illnesses toward the less seriously ill.

Psychiatric hospitalization rates have been rising since 2000 for children and
adults, which may reflect either a lack of community care or a return to a more bal-
anced mix of treatment modalities. The most disturbing trend has been growing
incarceration of people with serious mental illnesses. People with mental illnesses
have been swept up in the tide of incarceration nationwide.

■ Impact of broad social policies. The well-being of people with mental ill-
nesses continues to depend on the broader health and social policy environment.
For children, SCHIP expansions during the early part of the decade studied here are
likely to have contributed to increases in treated prevalence by improving access to
primary care. Further expansions in SCHIP enacted in January 2009 also extended
mental health parity to children covered by the program. These recent develop-
ments suggest the potential for an expansion in children's receipt of specialty mental
health care—including both pharmacological and behavioral treatment providers.
Parity and coverage expansions may also further bolster the demand for inpatient
hospitalization among children.

For adults with less severe illnesses, financial protection through insurance im-
proved, and the increased availability of lower-cost pharmacotherapy provided
through primary care providers led to an expansion in treated prevalence. The economic downturn may threaten some of these gains, through losses of insurance coverage and further tightening of benefit structures.

For seniors, the introduction of Medicare Part D has reduced the financial burden of mental health care. Unfortunately, this change alone has not resulted in an expansion of access to care. Unlike the case for adults and children, primary care practitioners have not increased the rate of mental health care of seniors, and access to professional care among seniors with activity limitations stemming from mental disorders has eroded. Passage of the Medicare Improvement for Patients and Providers Act (HR 6331) in summer 2008, which will phase in a reduction in Medicare beneficiaries’ copayments for mental health services to parity levels by 2014, should contribute to an increase in access to professional care for seniors.

As in 1950–2000, the well-being of the most seriously ill population with mental illnesses has been primarily affected by changes in mainstream social policies. The well-being of such people is now bound up with societal patterns of incarceration. New policies are desperately needed to reduce the flow of people whose primary problem is a mental disorder into the criminal justice system.

The analyses presented here show that routinely collected data can provide a picture of the well-being of an “invisible” population. This picture highlights how dynamic the system of mental health care delivery is. Trends change rapidly, and conventional wisdom is often at odds with systematic analysis of data. Policymakers and advocates must be aware of the changing performance of institutions that serve many of our most vulnerable neighbors.

This research was made possible by a grant from the John D. and Catherine T. MacArthur Foundation. The authors gratefully acknowledge the assistance of Sarah Elizabeth Downs, Ashwin Prabhu, Emily Miller, Douglas Gould, and Bisundev Mahato.

NOTES
3. Ibid.; and Kessler et al., “Prevalence and Treatment of Mental Disorders.”
4. See Appendix 1 for data descriptions and information on the prevalence of mental health problems as measured in these data, online at http://content.healthaffairs.org/cgi/content/full/28/3/637/DC1.
5. See Appendix 2 online for a drug classification list; ibid.
6. Frank and Glied, Better but Not Well, 112; and Kessler et al., “Prevalence and Treatment of Mental Disorders.”
10. Analysis of data from the National Health Interview Survey (NHIS), 1996–2006.
13. Analysis of data from NAMCS, 1996–2006. The share reporting that 75 percent or more of all patients were either self-pay or in Medicare has also dropped over time (currently about 13 percent).
16. Analysis of data from the National Hospital Discharge Survey (NHDS), 1996–2006. Supplemental analysis of MEPS data suggests that the number of hospitalizations per user did not change systematically.
19. Ibid., 114–119.
25. Based on analyses in Frank and Glied, *Better but Not Well*, 123–128; and BJS data described in Note 30.