MENTAL HEALTH BENCHMARKS *in the* US

An Unheeded Call to Action

COHEN VETERANS NETWORK, INC.

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INTRODUCTION

The establishment of standardized benchmarks for outpatient mental health care has been a long-standing goal of US service providers and policy advocates, as it would provide valid and objective data for decision-making, enable improved resource utilization, support mental health parity efforts, and reinforce transparency and accountability across the behavioral health field. The lack of fundamental information about what is realistic and achievable in real-world clinical settings continues to disadvantage both clients and service providers by weakening incentives to engage in best-practice measurement-based care, contributing to decontextualized outcome data, high dropout rates, and variable clinical quality.

OVERVIEW of the Behavioral Health Landscape (2025)

According to the Mental Health America 2025 Annual Report, common mental health conditions continue to inflict a substantial burden on the US population in terms of high rates of illness, with rates generally consistent from 2021-2024. Based on 2024 data, 23.4% of US adults (almost 1 in 4) experienced "any mental illness" 17.7% reported a substance use disorder in the past year, and 5.5% experienced serious thoughts of suicide (Reinert et al., 2025). Further, nearly 10% of US adults reported a mental health crisis during 2024-2025, with those screening positive for depression or PTSD experiencing such crises at a rate of 22.4% (Anderson et al., 2025).

ECONOMIC Impact of Mental Health Concerns

In addition to the significant cost in terms of disease burden and human suffering, macro-economic costs are alarming. In a published 2024 report, Abramson and colleagues note *"Mental health costs the US economy more than $280 billion annually, stymying investment, productivity, and wealth accumulation, among other measures of progress, with an impact comparable to that of a recession."* (2024). Given the substantial and pervasive impact of mental health conditions on the US population and economy, strengthening treatment outcomes through systematic measurement supported by an established set of valid and comparable benchmarks is clearly warranted.

The Case for **Mental Health Benchmarks**

The value of mental health benchmarks can hardly be overstated in terms of informing practitioners and clients and offering a mechanism to assess, compare, and improve healthcare quality across providers, settings, and the behavioral health field. Firstly, benchmarks allow for standardization. The use of standardized validated measures of symptoms, functioning, and well-being provides a means to assess the outcomes and effectiveness of care. Further benchmarking efforts both support and benefit from the implementation of measurement-based care (MBC), which involves systematically assessing symptoms based on objective measures at each session, reviewing with the client, and modifying the treatment plan accordingly (Lewis et al., 2019). Previous studies indicate that MBC is demonstrably superior to unaided clinical judgement in assessing symptom change over time and improves treatment outcomes (Guo et al., 2015; Connors et al., 2021). Ironically, the limited use of MBC in practice, which has been estimated at less than 25% (Benfer et al.,2022; Fortney et al., 2015), reduces both the field's ability to establish valid benchmarks and its incentives to do so. Benchmarks are critical to understanding and comparing the effectiveness of intervention within and across providers, treatment settings, diagnoses/conditions, and subgroups. Finally, benchmarks may facilitate the achievement of mental health parity with other medical specialties in terms of health insurance coverage and reimbursement, which, despite being enshrined in federal law under the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, has been historically undermined by a lack of objective, measurable treatment outcomes among other factors.

Despite the benefits described above and a robust expert consensus in support of the value of benchmarks (Benfer et al., 2022; Coombs, et al., 2011; Muir et al., 2019), minimal progress has been made toward their development and implementation during the past 15 years. There are no widely accepted standard benchmarks for outpatient mental health outcomes, rates of drop out from care, relapse, etc. While thresholds for assessing clinically significant change on individual measures do exist, data on rates of response/non-response and the average magnitude of change across diagnoses, demographics, interventions, and time are lacking.

Existing healthcare data reporting structures (e.g., HEDIS measures) do not align with outcomes that are optimized for mild-to-moderate-acuity outpatient mental health care across the lifespan. Additionally, significant repositories of agency level data, i.e., Centers for Medicaid and Medicare (Wadhera, et al., 2020), Department of Defense (Kincaid et al., 2021) and Veterans Health Administration (Siebert et al., 2015) have demonstrated some value in terms of internal benchmarking

efforts but have not been made available for review or comparison externally, remaining siloed within their respective agencies. Recent efforts to collect multi-site clinical data using common data elements (i.e., CCBHCs) represent meaningful progress but have failed to meet the need for broadly applicable and auditable clinical benchmarks. Research repositories (i.e., PCORNET) have contributed to improved data availability but consist primarily of research datasets, which lack external validity for comparison with clinically derived mental health outcomes. ⋆

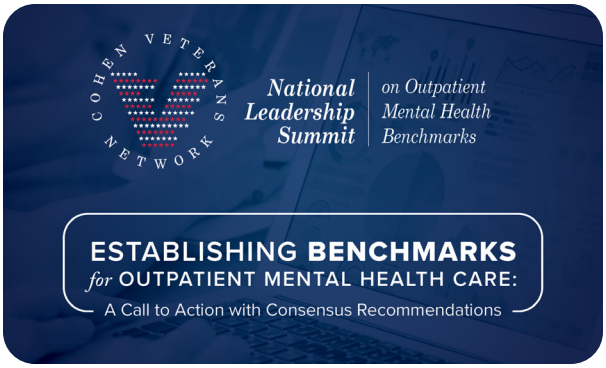
CVN's Quest for **Benchmarks**

BACKGROUND & HISTORY:

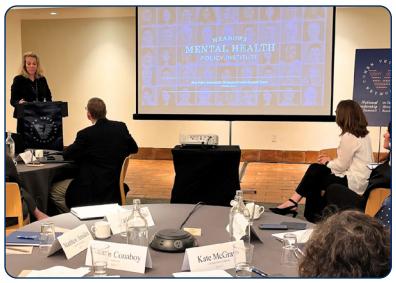
Between 2016 and 2025, as Cohen Veterans Network (CVN) established a national not-for-profit network of 22 outpatient clinics across the United States, Alaska, and Hawaii serving active-duty service members, veterans, and their families (Sullivan et al., in press), organizational leadership identified a substantial gap in available benchmarks for outpatient mental health care outcomes. Specifically, estimates of achievable rates of clinically meaningful change, remission, and loss of diagnosis had not been established even among the most common mental health concerns, and using the most common screeners and outcome measures, i.e., Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder 7 Item (GAD-7), Columbia Suicide Severity Rating Scale (CSSRS). Moreover, comparative outcome data across public, for-profit, and not-for-profit providers were not routinely available, shared, or aggregated at any level. The few treatment outcome estimates available were from controlled studies including randomized controlled trials, which are not replicable in real-world clinical care (Kennedy-Martin et al., 2015; Kirsch et al., 2018).

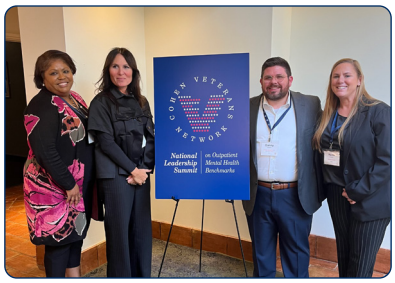
Following six years of efforts to address this issue, CVN issued a Request for Proposals (RFP) in 2021, which culminated in a contract with the Research Triangle Institute (RTI) for a CVN "Outcomes Validation" project. Despite significant experience in assessing healthcare quality and outcomes, RTI was able to identify only two publicly available data sets, which provided comparable data for the project: one from the military and one from the civilian sector, further illustrating the dearth of such data in the public domain.

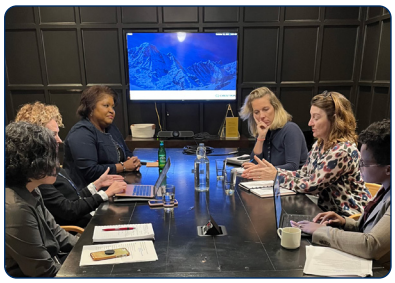
To address this troubling gap in the knowledge base, in 2022, CVN hosted a National Leadership Summit on Outpatient Mental Health Benchmarks, a convening of thirty-three mental health clinical, quality, and policy experts from across the US. Attendees embraced the need for benchmarks. The two-day event culminated in a call to action amplifying the imperative already identified by multiple established mental health advocacy/policy organizations, including the Kennedy Forum (Fortney et al., 2015), the Meadows Mental Health Policy Institute (Alter et al., 2021), and The National Council on Quality Assurance (Niles & Olin, 2021). The proceedings were captured in a white paper, which was disseminated through social media and posted on the CVN Institute for Quality website (Linkh et al., 2023). To date, while the call to action remains largely unheeded, the need has only increased.



Based on this persistent gap, in 2024, CVN launched a Mental Health Benchmarks Coalition, bringing together a cadre of mental health networks and expert consultants with a goal of sharing data from their respective networks periodically to develop a repository of standardized, comparable, real-world, clinical mental health data. The intent was to establish initial proof of concept to demonstrate coalition feasibility and value, serving as the foundation for subsequent expansion to achieve national-level impact. Despite broad agreement on coalition goals, the coalition quickly dwindled from eight participating "data contributors" to three, including CVN, rendering the effort untenable. Notably, the coalition's for-profit partners were the most tentative, based on rational self-interest and risk/benefit analysis. Despite their ideological alignment with coalition aims under existing conditions, the required effort was considerable while the risk/benefit ratio was dissuasive. ⋆







Moving the Needle: Why Can't We Get This Done?

BARRIERS & DISINCENTIVES:

The most significant barriers to the establishment of mental health benchmarks include the lack of incentives for service providers and independent clinicians to systematically track client outcomes in conjunction with a lack of infrastructure to capture and aggregate such data for the collective benefit of the field. The absence of a designated and accountable agency to address this gap represents an additional and potentially critical impediment. Whereas international efforts have been largely successful in countries including Australia (Coombs et al., 2011), New Zealand, the UK (Spaeth-Rublee et al., 2010) and the Netherlands (de Buers et al., 2015), the US has lagged behind its peers due to at best a lack of practical incentives and at worst a range of perverse incentives which discourage transparency and systematic measurement. Spaeth-Rublee and colleagues in their 2010 international review of mental health benchmarks made the following observations regarding the US effort "Despite increased activity in recent years in the development of mental health indicators, major challenges remain owing to the lack of coordination and oversight of the various initiatives and programs, the lack of clear responsibility for promotion of best practices, and limitations in the ability to capture more clinically textured data beyond insurance claims" (pg. 545).

Challenges to progress on benchmarks remain pervasive across the US mental health landscape and are further amplified within the for-profit sector, where the risk-benefit ratio is squarely aligned against participation in standardized benchmarking efforts. This was a key finding of CVN's recent bid to establish a sustainable benchmarks coalition and suggests that without intervention and inducements from one or more federal agencies and active participation from the non-profit sector, the goals of such efforts will remain unrealized.

TECHNOLOGICAL SOLUTIONS:

While technologies for data management, aggregation, and analysis have improved dramatically in recent decades, the implementation of secure data management platforms remain resource intensive. Further, these technologies represent only a tool vs. a solution to the benchmarks conundrum, due to other barriers currently in place. These data management capabilities will become increasingly critical as the field moves toward establishing, validating, and periodically updating national benchmarks in the United States. If the current resistance among service providers persists, there is

a substantial probability that third-party payers will take the lead in this area; however, their alignment with the interests of patients may be compromised by the profit motives that drive current US healthcare markets. The field and the public might be better served by a broad-based public-private coalition under the oversight of a federally chartered benchmarks champion.

LESSONS LEARNED:

- ★ While US efforts have stalled, many developed countries have established benchmarks, which have been facilitated by their nationalized healthcare and single-payer systems.
- ★ There is currently no accountable agency resourced to support the establishment of outpatient mental health benchmarks, and peer-led efforts face considerable challenges.
- ★ Measurement-based care (MBC) is a key facilitator of effective benchmarking efforts and remains the exception vs. the norm in behavioral health practice in the US.
- ★ Disincentives outweigh incentives for establishing mental health benchmarking coalitions and repositories in the absence of supportive policies and dedicated resources.
- ★ Absent financial inducements from payers, funders, or demand from consumers; benchmarks remain a "tough sell" to independent clinical providers, as well as public, non-profit, and for-profit agencies and networks.
- ★ US health systems, including the Defense Health Agency and Veterans Health Administration, have an opportunity to demonstrate leadership and transparency in this area to the benefit of the mental health field.
  - ▶ While military/veteran populations may not be fully comparable to the US population, both agencies are positioned to use their respective infrastructures to develop transparent data reporting/sharing protocols and contribute to this wider effort. ★

Recommendations

UNITED STATES CONGRESS

- ★ Establish a commission to study and make recommendations on the development of national mental health benchmarks to align the US with other developed countries.
- ★ Expand efforts to collect and report common data elements across behavioral healthcare with additional funding for programs such as the Certified Community Behavioral Health Clinics (CCBHCs) under the auspices of the Substance Abuse and Mental Health Services Administration (SAMHSA).

THIRD PARTY PAYERS/CMS

- ★ Approve higher reimbursement rates and codes specific to patient-reported outcome measures and applicable to both the comprehensive psychiatric evaluation and follow-up sessions to encourage widespread adoption of measurement-based care (MBC).
- ★ Require or incentivize objective screening and use of routine outcomes monitoring for reimbursement of behavioral healthcare.

MENTAL HEALTH PROVIDERS/PRACTITIONERS

- ★ Health systems to invest in measurement-based care by standardizing data collection, tracking, and reporting.
- ★ Behavioral health agencies/practitioners to engage in routine outcomes monitoring at a minimum.
- ★ Clinical providers should capitalize on free training to facilitate the implementation of measurement-based care in practice. https://www.cohenveteransnetwork.org/mbc/
- ★ Healthcare leaders to devise innovative methods for integrating standardized symptom and outcome measures into routine care "make doing the right thing the easy thing."
- ★ Agency administrators integrate MBC compliance into quality assurance and peer review processes as the expected standard of care.

Recommendations *(Cont.)*

MENTAL HEALTH POLICY ADVOCATES

- ★ Identify a champion, or champions, at the federal agency, i.e., HHS, CMS, SAMHSA, NIMH, and/or congressional levels who can influence federal regulations through the legislative process.
- ★ Educate and encourage clients/consumers and the public to expect and demand outcomes transparency and accountability from their behavioral healthcare providers.
- ★ Mobilize and partner with federal and non-profit healthcare agencies, i.e., Patient Centered Outcomes Research Institute (PCORI), Agency for Healthcare Research & Quality (AHRQ), National Committee for Quality Assurance (NCQA), to advance this agenda within their respective spheres of influence.

ACADEMIC TRAINING & CLINICAL RESEARCH SETTINGS

- ★ Ensure that routine outcomes monitoring and measurement-based care are included in intern, resident, and fellowship training across behavioral health disciplines.
- ★ Advance MBC implementation research focused on effective strategies and barriers.
- ★ Publish outcome/effectiveness studies prioritizing pragmatic trials conducted in real-world clinical settings.
- ★ Prioritize data sharing and availability for legitimate research to contribute to generalized knowledge and advance the mental health field.

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REFERENCES:

Abramson, B., Boerma, J., & Tsyvinski, A. (2024). *Macroeconomics of mental health* (No. w32354). National Bureau of Economic Research. http://dx.doi.org/10.2139/ssrn.4793015

Alter, C. L., Mathias, A., Zahniser, J., Shah, S., Schoenbaum, M., Harbin, H. T., McLaughlin, R., & Sieger-Walls, J. (2021). Measurement-based care in the treatment of mental health and substance use disorders. Dallas, TX: Meadows Mental Health Policy Institute. mmhpi.org

Anderson, A., Eisenberg, M. D., Kennedy-Hendricks, A., Castrucci, B. C., Galea, S., & Ettman, C. K. (2025). Mental health crises and help-seeking among US adults in 2024-2025. *Health Affairs Scholar*, *3*(9), qxaf166. https://doi.org/10.1093/haschl/qxaf166

Benfer, N., Rusowicz-Orazem, L., Fielstein, E. M., Darnell, B. C., Frankfurt, S. B., Mignogna, J., & Litz, B. T. (2022). Leveraging available metadata in VA PTSD clinics and generating benchmarks for clinically significant change. *Journal of Consulting and Clinical Psychology*. Advance online publication. https://doi.org/10.1037/ccp0000779

Blanco, C., Rafful, C., & Olfson, M. (2013). The use of clinical trials in comparative effectiveness research on mental health. *Methods for Comparative Effectiveness Research/Patient-Centered Outcomes Research: From Efficacy to Effectiveness*, *66*(8, Supplement), S29–S36. https://doi.org/10.1016/j.jclinepi.2013.02.013

Barber, J., & Resnick, S. G. (2023). Collect, Share, Act: A transtheoretical clinical model for doing measurement-based care in mental health treatment. *Psychological Services, 20* (Suppl 2), 150–157. https://doi.org/10.1037/ser0000629

Connors, E. H., Douglas, S., Jensen-Doss, A., Landes, S. J., Lewis, C. C., McLeod, B. D., Stanick, C., & Lyon, A. R. (2021). What gets measured gets done: How mental health agencies can leverage measurement-based care for better patient care, clinician supports, and organizational goals. *Administration and Policy in Mental Health*, *48*(2), 250–265. https://doi.org/10.1007/s10488-020-01063-w

Coombs, T., Walter, G., & Brann, P. (2011). Overview of the National Mental Health Benchmarking Project. *Australasian Psychiatry*, *19* (1), 37–44. https://doi.org/10.3109/10398562.2010.539221

de Beurs, E., Warmerdam, E. H., Oudejans, S. C. C., Spits, M., Dingemanse, P., de Graaf, S. D. D., de Groot, I. W., Houben, H., Kuyck, W. G. E., Noorthoorn, E. O., Nugter, M. A., Robbers, S. C. C., & van Son, G. E. (2018). Treatment outcome, duration, and costs: A comparison of performance indicators using data from eight mental health care providers in The Netherlands. *Administration and Policy in Mental Health*, *45*(2), 212–223. https://doi.org/10.1007/s10488-017-0818-x

Fortney, J., Sladek, R., Unutzer, J., Kennedy, P., Harbin, H., Emmet, B., Alfred, L., & Carneal, G. (2015). Fixing behavioral health care in America: A national call for measurement-based care in the delivery of behavioral health services. The Kennedy Forum.

Guo, T., Xiang, Y. T., Xiao, L. E., Hu, C. Q., Chiu, H. F., Ungvari, G. S., ... & Wang, G. (2015). Measurement-based care versus standard care for major depression: a randomized controlled trial with blind raters. *American Journal of Psychiatry*, *172*(10), 1004-1013. https://doi.org/10.1176/appi.ajp.2015.14050652

Jones, M. W. H., Cook, N., McGrath, B. M., Crist, R. L., Larson, A. E., Templeton, A., Nishiike, Y., Koroukian, S., Zyzanski, S., & Stange, K. C. (2024). Examining PTSD prevalence among underserved populations in the integrated community mental health setting 2019 to 2022. *Journal of Primary Care & Community Health*, *15* (21501319241291751), https://doi.org/10.1177/21501319241291751

Kennedy-Martin, T., Curtis, S., Faries, D., Robinson, S., & Johnston, J. (2015). A literature review on the representativeness of randomized controlled trial samples and implications for the external validity of trial results. *Trials*, *16*(1), 495. https://doi.org/10.1186/s13063-015-1023-4

Kincaid, M. W., Peters, Z. J., & Curry, J. C. (2021). Data-driven approaches to care delivery: Actionable informatics in the DoD's primary care behavioral health program. *Families, Systems, & Health, 39*(1), 66–76. https://doi.org/10.1037/fsh0000583

Kirsch, I., Huedo-Medina, T. B., Pigott, H. E., & Johnson, B. T. (2018). Do outcomes of clinical trials resemble those of "real world" patients? A reanalysis of the STAR*D antidepressant data set. *Psychology of Consciousness: Theory, Research, and Practice, 5*(4), 339-345. https://doi.org/10.1037/cns0000164

Lewis, C. C., Boyd, M., Puspitasari, A., Navarro, E., Howard, J., Kassab, H., Hoffman, M., Scott, K., Lyon, A., & Douglas, S. (2019). Implementing measurement-based care in behavioral health: A review. *JAMA Psychiatry*, 76(3), 324–335. https://doi.org/10.1001/jamapsychiatry.2018.3329

Linkh, D. J., Breetz, A, Neal-Walden, T. A., Chiarello, H. L. (2023). Establishing benchmarks for outpatient mental health care: Proceedings of the National Leadership Summit on Mental Health Benchmarks. [White paper]. Cohen Veterans Network. https://www.cohenveteransnetwork.org/our-impact/cvn-institute-for-quality/

Muir, H. J., Coyne, A. E., Morrison, N. R., Boswell, J. F., & Constantino, M. J. (2019). Ethical implications of routine outcomes monitoring for patients, psychotherapists, and mental health care systems. *Psychotherapy, 56*(4), 459–469. https://doi.org/10.1037/pst0000246

Niles, N. & Olin, S. (2021). Behavioral Health Quality Framework: A roadmap for using measurement to promote joint accountability and whole-person care [White Paper]. National Committee for Quality Assurance. https://www.ncqa.org/wp-Content/uploads/2021/07/20210701 Behavioral_Health_ Quality_Framework_NCQA_White_Paper.pdf

Reinert, M., Nguyen, T., & Fritze, D. (2025). *The state of mental health in America 2025.* Mental Health America.

Seibert, J., Fields, S., Fullerton, C. A., Mark, T. L., Malkani, S., Walsh, C., Ehrlich, E., Imshaug, M., & Tabrizi, M. (2015). Use of quality measures for Medicaid behavioral health services by state agencies: implications for health care reform. *Psychiatric Services*, *66*(6), 585–591. https://doi.org/10.1176/appi.ps.201400130

Spaeth-Rublee, B., Pincus, H. A., Huynh, P. T., & IIMHL. (2010). Clinical Leaders Group, Mental Health Quality Indicator Project. Measuring quality of mental health care: A review of initiatives and programs in selected countries. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *55*(9), 539–548.

Sullivan, K. S., Wortham, W., Lancaster, S. L., Linkh, D. J., & Hassan, A. M. (in press). Meeting the behavioral health needs of military service members, veterans, and their families: Cohen Veterans Network client population. *Clinical Social Work Journal.*

Wadhera, R. K., Figueroa, J. F., Joynt Maddox, K. E., Rosenbaum, L. S., Kazi, D. S., &Yeh, R. W. (2020). Quality measure development and associated spending by the Centers for Medicare & Medicaid Services. *JAMA, 323*(16), 1614–1616. https://doi.org/10.1001/jama.2020.1816

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343 (2008)

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