Questions before memos

Attached is the list of initiatives that can be announced at the mental health conference. We have divided these proposals into different topic areas, including anti-stigma, parity, and improving community responses to mental illness. A few of these have outstanding issues to be worked out, but we believe they can be ready in time for the conference. Given the number of proposals, we have put asterisks by those we believe are the best ones to emphasize. Clearly, any of these can be dropped, modified or announced at another time.

MENTAL HEALTH PARITY

****Assuring that the Federal Employees Health Benefits Plan (FEHBP) -- the nation's largest private insurer – implements full mental health parity.** The Office of Personnel Management will send a letter to the 285 participating health plans informing them that starting next year they will have to offer full mental health parity to participate in the program. OPM will work with these plans throughout the year to evaluate to what extent they need to make modifications to come into compliance. This step will assure that the nine million beneficiaries receive full mental health parity and assure the Federal government leads the way to providing parity. (*OPM lead agency).*

Educating Americans about current mental health parity laws. Many Americans with mental illnesses may not be aware that the Mental Health Parity Act of 1996 required health plans that cover mental health benefits to guarantee equal lifetime and annual benefits for mental and physical treatments. To help assure that consumers and insurers are fully aware of the current protections under the law, the Department of Labor will launch a new outreach campaign to educate Americans about their existing parity rights. This campaign will include: (1) new public service announcements on local radio stations nationwide to promote awareness; (2) an outreach campaign to inform consumers they can call the Department's 1-800 number to understand these protections; and (3) assuring that all local Department of Labor offices, insurers, and consumer advocates have information about this law. (*DOL lead agency).*

REDUCING STIGMA AND PROMOTING AWARENESS

****Announcing a new nationwide anti-stigma campaign to dispel the myths and promote awareness about mental illness.** You can announce that this fall you will launch a major anti-stigma campaign to dispel the myths and promote awareness about mental health. This campaign will be chaired by you and will include a whole range of private sector partners including the Ad Council, community organizations, leading consumer and physician organizations, the media and others. You may want to use the myths that we are releasing at the conference as a basis of this campaign. *(You may want to make this announcement at a radio address with the President the Saturday prior to the conference).*

****Educating older Americans and their health professionals about the risks for depression.** The National Institutes of Mental Health (NIMH) estimates that five million Americans over the age of 65 suffer from some form of depression. However, many of these Americans do not

recognize their symptoms as depression and do not receive the treatment they need. NIMH and the Administration on Aging (AoA) will launch an outreach initiative to educate the elderly and their health professionals that they may be at risk for or suffer from a mental illness. AOA will work to get this information throughout the aging network, including the AOA website, the AOA newsletter (that goes to 600 older adult agencies), the State Units on Aging, that run a range of programs serving millions of older Americans including meals on wheels, and adult day care centers.

Helping teachers and parents identify kids at risk. We are working on developing an announcement to host a series of meetings, held this Fall, in every state, where teachers and faculty from schools could come together to receive training on spotting troubled youth and advise on how to help them. Participating organizations might be NEA, American Psychological Association, PTA, HHS, DOJ, and Department of Education. HHS will also work with the AFT to place 100,000 posters in every school around the nation to encourage children and these communities to raise issues of mental illness. This outreach campaign will reach an estimated 4.8 million children. *(This is ~~clearly~~ early in devleopment and it is unclear whether the agencies will be prepared to announce this at the time of the event).*

needs vetting

IMPROVING COMMUNITY RESPONSES TO MENTAL HEALTH NEEDS

Announcing a national 1-800 number to provide people with mental illness a place to turn for help. Millions of Americans have no idea where to turn when they believe that they or a family member or friend suffers from mental illness. We can announce our intention to develop a new 1-800 number that Americans can call if they are concerned that they or a family member or friend may be at risk for or suffering from a mental illness. This 1-800 number would serve as a resource center that provides information about where to go in their community they can go to get help finding appropriate services and help. The 1-800 number builds on some of the information that is highlighted on the HHS mental health website that provides a range of resources for people with mental illness. *(Given the complexity of developing and funding a 1-800 number and assuring that it provides consumers the right information, this number will not be up and running on the day of the conference).*

need to figure out what we are saying

Implementing new strategies to the mental health needs of crime victims. Communities that are victims of terrorism or mass violence have enhanced needs for mental health services following these types of emergencies. To assure that part of any comprehensive response to these crises includes a strong mental health component, the Administration is announcing a new interagency partnership between the Department of Justice's Office for Victims of Crime and the Substance Abuse and Mental Health Services Administration (SAMSHA). Part of this effort ill will include appointing someone within the Emergency Disaster Relief Branch of SAMHSA to work with the Office for Victims of Crime to assure that there is a strategy in place address the mental health needs of victims of Federal crime. This new partnership will assure that the response to these crises include mental health training, technical assistance, and consultation services to communities for assisting victims of crime. *(DOJ and SAMSHA lead agencies)*

$ amount what will they do?

Implementing a new comprehensive approach to address combat stress in the military. Combat stress reactions are extremely common as those in combat are usually in different environments and under extreme conditions. *(add stats about the problem. add family).* The importance of addressing combat stress reduction is extremely timely given the Kosovo crisis. The President is directing the Department of Defense to report back within 180 days on an implementation plan for a comprehensive combat stress program throughout the military. DOD will also hold a conference this fall to develop strategies and educate personnel throughout the military about the need to change current practice to assure that those who serve in combat have the support they need during and after their service. *(DOD lead agency).*

IMPROVING TREATMENT FOR AMERICANS WITH MENTAL ILLNESS

New efforts to encourage states to offer more coordinated Medicaid services for people with mental illness. While millions of Americans with severe mental illness rely on Medicaid, few states have implemented a well coordinated system that assures these Americans with severe mental illness receive the type of treatment and care they need. To encourage states to improve treatment for Americans with mental illness, the Health Care Financing Administration (HCFA) will send a letter to all state Medicaid directors:

- *Endorse Assertive Community Treatment (ACT) programs that target people with people with the most severe and persistent mental illness.* This approach uses multi disciplinary treatment teams and assertive outreach. HCFA will also evaluate more fully the efforts to implement this approach in states that have already adopted it so that they can provide technical assistance to those who want it.

- *Clarify to states what Medicaid pharmacy benefits they must provide.* HCFA will send a letter to state Medicaid directors to assure that they incorporate in their reimbursement policies the most recent advancements in schizophrenia and other new medications. HCFA will also work to determine and follow up with states that are not following this guidance.

~~Waiting for additional information HCFA will send out.~~

Launching a pilot program to help people with mental illness get the quality treatment they need to return to work. Of the 4.7 million Americans that receive Social Security Disability Insurance (SSDI), the Social Security Administration estimates that approximately one in nine (about 500,000) has an affective disorder (such as depression or a bipolar disorder). Research suggests that many of these affective disorders cases could be effectively treated and perhaps could return to work. The Administration will launch a new 5-year, $10 million demonstration to provide treatment for SSDI beneficiaries with affective disorders. Up to 1,000 SSDI beneficiaries with affective disorders will participate in this pilot, and SSA will monitor this study to determine if it enables these beneficiaries to return to work and determine to the extent this can be launched on a broader scale. This complements the Jeffords-Kennedy legislation that allows people to buy into the Medicaid or Medicare program when they return to work *(SSA lead agency).*

PROMOTING FAIR TREATMENT AND REDUCING DISCRIMINATION

****Releasing a new regulation to prevent seclusion and restraint and endorsing broader legislation on this issue.** A series of cases of highly publicized cases in Connecticut in 1998 highlighted several mentally ill children residing in psychiatric institutions who died after being restrained by facility staff. The Harvard Center for Risk Analysis estimates that between 50 and 150 such deaths occur annually across the country. There are indications that frequently the restraining holds are not used as a last resort, but rather as a routine method of discipline. To address this problem, HCFA will issue a final regulation to assure that as a condition for participating in Medicare, hospitals must prohibit the use of seclusion or restraints except when in accordance with a patient's plan of care and should be used only as a last resort. They will also announce that they are going to pursue regulations in this area for Medicaid (in particular the psychiatric-under 21 facilities where some of the problems in this area have occurred). The Administration will also endorse legislation that imposes further restrictions co-sponsored by Senators Lieberman and Dodd that assures further protections in this area. (*These Senators raised this issue to you in your meeting with them. We are seeking your guidance as to whether you want to unveil this at the conference or at a separate event).*

Developing and implementing new strategies to address mental illness in the criminal justice system. HHS and DOJ are hosting a conference later this summer to focus on how all aspects of the criminal justice system can better address the needs of mentally ill offenders. The conference will bring together mental health experts, leaders in the juvenile justice system, law enforcement officials from around the country and focus on a range of topics including, model prevention strategies; treatment and support needs of juvenile offenders, how institutional and community corrections can better address the needs of those with mental illnesses. Following up on promising strategies learned at this conference as well as other community practices that have proven effective, DOJ will launch an outreach campaign to educate the law enforcement community about how it can better serve people with mental health needs. This campaign will include a new guide that discusses community based strategies as well as a partnership with the National GAINS center so communities interested in pursuing these approaches can get technical assistance and ideas about how to implement successful strategies. *(DOJ lead agency)*

Reducing discrimination and stigma in housing. The Department of Housing and Urban Development (HUD) will hold three training and awareness sessions led by Secretary Cuomo and facilitated by community partners in HUD's 81 offices to reduce stigma and discrimination in housing and to help assure that housing facilities are help address the needs of consumers will mental illness. HUD will require that all their employees and its tens of thousands of grantees to participate in one of these sessions by satellite. *(HUD lead agency).(need definition of the problem).*

Eliminating stricter standards currently applied to federal hiring practices for adults with psychiatric disabilities. Currently, there are excepted appointment authorities that are explicitly designed to encourage the Federal government to hire individuals with disabilities by exempting them from the competitive appointment process. However, these appointments have traditionally

been stricter standards for mental applied to adults with psychiatric disabilities. In January you announced that the President was asking OPM to look into this disparity. At the conference, the President will issue an Executive Order to direct OPM to change their policy to assure that Americans with mental disabilities are afforded the same hiring opportunities currently available to individuals with mental retardation and severe physical disabilities. At the conference the Administration can also call on all employers to reexamine their hiring authorities. *(OPM lead agency).*

IMPROVING PROGRESS IN RESEARCH

****Launching landmark study to determine nature of mental illness and treatment nationwide to help guide strategies and policy for the next century.** NIMH will announce that in July they will launch a major new study to get never-before-collected information on mental illness, including the prevalence and duration of mental illness, the types of treatment that are most commonly used. This study of 10,000 Americans will provide information that will help guide how the nation allocates resources and designs policies for the 21st century. *(HHS lead agency).*

Developing two new clinical trials to improve mental health treatment. The National Institute of Mental Health is announcing that this fall they will launch to new clinical trials to build on effective treatments for those affected by mental illness including: new antipsychotic medications that have fewer side effects for the treatment of severe mental illnesses and intervention strategies for the treatment of patients who have depression that is resistant to available treatments, including older adults who have less than optimal responses to initial treatment of their depression. *(HHS lead agency).*

REACHING OUT TO THE MOST VULNERABLE POPULATIONS

Encouraging Communities to create safe havens: A bridge for homeless with mental illness. The Department of Housing and Urban Development will announce a new initiative to encourage communities to create safe havens -- places for homeless mentally ill Americans to get treatment and care. Efforts to encourage communities to develop this effort include: a best practices guide on how to set these up and communities and a resource to contact those that have already developed effective models. HUD will also host a satellite conference for communities to learn strategies and develop ways to create these safe havens. *(HUD lead agency). (need better definition of this and what are we doing).*

Doubling the number of "stand downs" to reach out to homeless veterans with mental illness. Nearly 45 percent of veterans suffer from mental illness. VA has hosted a number of "stand downs" – or events that bring together all of the resources in the community to reach out to homeless veterans and help them locate the appropriate services, including crisis services, counseling, and other services that may help assist in job searches. This year VA will double the number of "stand downs" throughout the country to a total of 200. *(VA lead agency).*

CHALLENGE FOR CONGRESS TO PASS LEGISLATION TO IMPROVE CARE AND SERVICES FOR PEOPLE WITH MENTAL ILLNESS.

Fund an historic increase in the mental health block grant. We are calling on the Congress to pass the historic $70 million increase in the mental health block grant. We can also issue a challenge to the states to bolster their programs in this area. In an era of surpluses, states should renew their commitment to providing quality mental health proposals.

Pass a strong enforceable patients' bill of rights. We can call on the Congress to pass a strong enforceable patients' bill of rights that assures that people with mental health needs have critical protections such as access to specialists and continuity of care protections and an independent appeals process to address grievances with their health plans.

Pass strong comprehensive privacy protections and legislation to eliminate genetic discrimination. We can also urge Congress to pass comprehensive legislation to assure medical records privacy, so that information, including sensitive information about mental illness is protected. In addition, researchers continue to unlock the genetic code, there is great potential to enhance treatment options, but also to discrimination. The Administration urges the Congress to pass legislation that prevents people from being discriminated against based on genetic discrimination.

Challenge Congress to hold legislation on mental health parity legislation and to review the strengths and weaknesses of the current law. The Administration is urging the Congress to hold hearings right away on the strenghts and weaknesses of the current mental health parity laws and to review Congress legislation that would expand these proposals.

Pass Kennedy-Jeffords legislation to enable people with disabilities return to work. Access to affordable health insurance is the biggest barrier preventing people with disabilities from returning to work. Congress should move to pass this legislation that helps people with disabilities buy into Medicare and Medicaid so they can return to work.

National Mental Health Association

FAX

1021 Prince Street, Alexandria, VA 22314-2971 ▪ Phone (703) 684-7722 ▪ Fax (703) 684-5968 ▪ TTY (800) 433-5959 ▪ www.nmha.org

Monty Moeller, Chair of the Board ▪ Michael M. Faenza, President and CEO

To: Sarah Bianc

At: Chris Jennings Office

Phone: —

Fax: 202-456-5585

From: Ali Guidi

Direct Line: 703-838-7502

Date: 5/18/99

Time: 1:37 pm

Pages: 3 *(including cover)*

Comments: As I promised...

National Mental Health Association

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Monty Moeller, Chair of the Board ▪ **Michael M. Faenza**, President and CEO

MEMORANDUM

TO: Sarah Bianci

FROM: Al Guida

DATE: May 18, 1999

SUBJECT: Intensive Mental Health Community Treatment Option

Statement Of Problem: A proposal to create a new mental health community treatment option in Medicaid is designed to address several discrete problems:

Hospital vs. Community Imbalance: Despite some slowly developing positive trends, states still spend far more for state psychiatric hospitals than they invest in community-based services for adults with severe mental illnesses and children with serious mental and emotional disturbances. In 1992, states were obligating over $8 billion to serve about 68,000 people in state and county inpatient psychiatric facilities; as much as $3 billion of that total flows through the Medicaid DSH Program. By contrast, the latest data indicates that combined state and federal Medicaid spending for community-based care total about $3.5 billion – to provide intensive services to literally millions of Americans with severe and persistent mental disorders.

This illogical spending pattern reflects historical factors and local political considerations. It utterly fails as public mental health policy. Our overmatch proposal is designed to address the funding imbalance by providing states with a financial incentive to invest in community-based programming.

Financing Complications: In order for a state to finance the array of services needed by individuals with severe mental illnesses, Medicaid agencies must piece together financing from as many as six (6) different Medicaid options. This has resulted in a patch work of state and county programs marked by lack of coordination, inflexible funding streams and missing service components. Given the structure of Medicaid, some states (New York, Massachusetts, Wisconsin) do a good job of piecing the financing together, while others (Illinois, Montana, West Virginia, Texas) perform poorly.

Schizophrenia PORT Study: One of the few comprehensive studies done on this issue clearly showed that a relatively small percentage of people with schizophrenia actually receive the community services they need.

Policy Objectives: The overall policy objective to finish the work of deinstitutionalization, which began in the late 1960's and early 1970's. Since its is no longer politically feasible to create additional Community Mental Health Centers (there are now 1,600 CMHCs, but the 1963 legislation that authorized them envisioned double that number), the only way to enhance community-based mental health care is through the Medicaid program.

There are two more discrete goals:

1.) Permit states – with a single policy decision – to finance the entire community-based service array needed by children and adults with serious mental disorders.

2.) Enhance the resources available to address the needs of the homeless mentally ill, high risk individuals who heavily utilize state psychiatric hospital facilities, people with co-occurring mental health and substance abuse problems (who pose a high risk of violence) and individuals recently released from state penal systems.

HCFA Letter: NMHA would strongly oppose a HCFA State Medicaid Director letter that solely endorsed the financing of the PACT model. There are at least four or five assertive community treatment models that are proven to be effective, and a Medicaid letter restricted to PACT is likely to be counterproductive.

Instead, we would recommend a letter which states that the regulations governing the **existing Medicaid rehabilitation option** are sufficiently board to permit states to finance many of the components commonly associated with intensive community mental health treatment programs. Those components include:

- 24 hour intensive case management
- psychiatric rehabilitation
- hospital discharge planning
- integrated mental health and substance abuse treatment for individuals with co-occurring disorders.
- crisis residential services
- medication management and education
- intensive community services, including partial hosptialization

Sarah, thanks for your help on this.

Member	Breakfast	Briefing	Breakout Sessions	Plenary Session	Lunch	Town Hall	Recep
Rep. DeLauro	no	✓	✓	✓	no	no	no
Rep. Baird	no	✓	✓	✓	✓	✓	✓
Rep. Rodriguez	no	✓	✓				
Rep. Strickland	no	✓	✓	✓	no	no	no
Rep. Roukema	no	✓	✓	✓	✓	no	✓
Rep. Kaptur	no	✓	✓	✓	✓	✓	no
Rep. Kennedy	no	✓	✓	no	no	no	no
Rep. Jackson-Lee	✓	✓	✓	✓	✓	✓	✓
Rep. Miller	no	✓	✓	no	no	no	✓
Rep. Capps	no	✓	✓	✓	no	no	no
Rep. Johnson	no	✓	✓	✓	no	no	no
Rep. Rivers	✓	✓	✓	✓	✓	✓	no
Rep. Brown	no	✓	✓	no	no	no	no
Rep. McDermott	no	✓	✓	✓	✓	✓	✓
Rep. Christensen	no	✓	✓	✓	✓	✓	✓
Rep. Jackson	no	✓	✓	no	no	no	no
Rep. Farr	no	✓	✓	✓	no	no	no
Sen. Wellstone	no	maybe	✓	no	no	no	no
Sen. Reid	no	✓	✓	no	no	no	no
Sen. Lieberman	no	maybe	✓	maybe	no	no	no
Sen. Specter	no	maybe	✓	no	no	no	no
Sen. Chafee	no	✓	✓	maybe	maybe	maybe	maybe

PLEASE RETURN TO THE OFFICE OF THE VICE PRESIDENT, S-212.

Mental Health: A Report of the Surgeon General 1999

Executive Summary

Department of Health and Human Services

Mental Health

A Report of the Surgeon General
Executive Summary

DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. Public Health Service

Message from Donna E. Shalala

Secretary of Health and Human Services

The United States leads the world in understanding the importance of overall health and well-being to the strength of a Nation and its people. What we are coming to realize is that mental health is absolutely essential to achieving prosperity. According to the landmark "Global Burden of Disease" study, commissioned by the World Health Organization and the World Bank, 4 of the 10 leading causes of disability for persons age 5 and older are mental disorders. Among developed nations, including the United States, major depression is the leading cause of disability. Also near the top of these rankings are manic-depressive illness, schizophrenia, and obsessive-compulsive disorder. Mental disorders also are tragic contributors to mortality, with suicide perennially representing one of the leading preventable causes of death in the United States and worldwide.

The U.S. Congress declared the 1990s the Decade of the Brain. In this decade we have learned much through research—in basic neuroscience, behavioral science, and genetics—about the complex workings of the brain. Research can help us gain a further understanding of the fundamental mechanisms underlying thought, emotion, and behavior—and an understanding of what goes wrong in the brain in mental illness. It can also lead to better treatments and improved services for our diverse population.

Now, with the publication of this first Surgeon General's Report on Mental Health, we are poised to take what we know and to advance the state of mental health in the Nation. We can with great confidence encourage individuals to seek treatment when they find themselves experiencing the signs and symptoms of mental distress. Research has given us effective treatments and service delivery strategies for many mental disorders. An array of safe and potent medications and psychosocial interventions, typically used in combination, allow us to effectively treat most mental disorders.

This seminal report provides us with an opportunity to dispel the myths and stigma surrounding mental illness. For too long the fear of mental illness and people who experience mental illness has been profoundly destructive to people's lives. In fact mental illnesses are just as real as other illnesses, and they are like other illnesses in most ways. Yet fear and stigma persist, resulting in lost opportunities for individuals to seek treatment and improve or recover.

In this Administration, a persistent, courageous advocate of affordable, quality mental health services for all Americans is Mrs. Tipper Gore, wife of the Vice President. We salute her for her historic leadership and for her enthusiastic support of the initiative by the Surgeon General, Dr. David Satcher, to issue this groundbreaking Report on Mental Health.

The 1999 White House Conference on Mental Health called for a national antistigma campaign. The Surgeon General issued a Call to Action on Suicide Prevention in 1999 as well. This Surgeon General's Report on Mental Health takes the next step in advancing the important notion that mental health is fundamental health.

Foreword

Since the turn of this century, thanks in large measure to research-based public health innovations, the lifespan of the average American has nearly doubled. Today, our Nation's physical health—as a whole—has never been better. Moreover, illnesses of the body once shrouded in fear—such as cancer, epilepsy, and HIV/AIDS to name just a few—increasingly are seen as treatable, survivable, even curable ailments. Yet, despite unprecedented knowledge gained in just the past three decades about the brain and human behavior, mental health is often an afterthought and illnesses of the mind remain shrouded in fear and misunderstanding.

This Report of the Surgeon General on Mental Health is the product of an invigorating collaboration between two Federal agencies. The Substance Abuse and Mental Health Services Administration (SAMHSA), which provides national leadership and funding to the states and many professional and citizen organizations that are striving to improve the availability, accessibility, and quality of mental health services, was assigned lead responsibility for coordinating the development of the report. The National Institutes of Health (NIH), which supports and conducts research on mental illness and mental health through its National Institute of Mental Health (NIMH), was pleased to be a partner in this effort. The agencies we respectively head were able to rely on the enthusiastic participation of hundreds of people who played a role in researching, writing, reviewing, and disseminating this report. We wish to express our appreciation and that of a mental health constituency, millions of Americans strong, to Surgeon General David Satcher, M.D., Ph.D., for inviting us to participate in this landmark report.

The year 1999 witnessed the first White House Conference on Mental Health and the first Secretarial Initiative on Mental Health prepared under the aegis of the Department of Health and Human Services. These activities set an optimistic tone for progress that will be realized in the years ahead. Looking ahead, we take special pride in the remarkable record of accomplishment, in the spheres of both science and services, to which our agencies have contributed over past decades. With the impetus that the Surgeon General's report provides, we intend to expand that record of accomplishment. This report recognizes the inextricably intertwined relationship between our mental health and our physical health and well-being. The report emphasizes that mental health and mental illnesses are important concerns at all ages. Accordingly, we will continue to attend to needs that occur across the life span, from the youngest child to the oldest among us.

The report lays down a challenge to the Nation—to our communities, our health and social service agencies, our policymakers, employers, and citizens—to take action. SAMHSA and NIH look forward to continuing our collaboration to generate needed knowledge about the brain and behavior and to translate that knowledge to the service systems, providers, and citizens.

Nelba Chavez, Ph.D.
Administrator
Substance Abuse and Mental Health
Services Administration

Steven E. Hyman, M.D.
Director
National Institute of Mental Health
for The National Institutes of Health

Bernard S. Arons, M.D.
Director
Center for Mental Health Services

Preface

from the Surgeon General
U.S. Public Health Service

The past century has witnessed extraordinary progress in our improvement of the public health through medical science and ambitious, often innovative, approaches to health care services. Previous Surgeons General reports have saluted our gains while continuing to set ever higher benchmarks for the public health. Through much of this era of great challenge and greater achievement, however, concerns regarding mental illness and mental health too often were relegated to the rear of our national consciousness. Tragic and devastating disorders such as schizophrenia, depression and bipolar disorder, Alzheimer's disease, the mental and behavioral disorders suffered by children, and a range of other mental disorders affect nearly one in five Americans in any year, yet continue too frequently to be spoken of in whispers and shame. Fortunately, leaders in the mental health field—fiercely dedicated advocates, scientists, government officials, and consumers—have been insistent that mental health flow in the mainstream of health. I agree and issue this report in that spirit.

This report makes evident that the neuroscience of mental health—a term that encompasses studies extending from molecular events to psychological, behavioral, and societal phenomena—has emerged as one of the most exciting arenas of scientific activity and human inquiry. We recognize that the brain is the integrator of thought, emotion, behavior, and health. Indeed, one of the foremost contributions of contemporary mental health research is the extent to which it has mended the destructive split between "mental" and "physical" health.

We know more today about how to treat mental illness effectively and appropriately than we know with certainty about how to prevent mental illness and promote mental health. Common sense and respect for our fellow humans tells us that a focus on the positive aspects of mental health demands our immediate attention.

Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender. A key disparity often hinges on a person's financial status; formidable financial barriers block off needed mental health care from too many people regardless of whether one has health insurance with inadequate mental health benefits, or is one of the 44 million Americans who lack any insurance. We have allowed stigma and a now unwarranted sense of hopelessness about the opportunities for recovery from mental illness to erect these barriers. It is time to take them down.

Promoting mental health for all Americans will require scientific know-how but, even more importantly, a societal resolve that we will make the needed investment. The investment does not call for massive budgets; rather, it calls for the willingness of each of us to educate ourselves and others about mental health and mental illness, and thus to confront the attitudes, fear, and misunderstanding that remain as barriers before us. It is my intent that this report will usher in a healthy era of mind and body for the Nation.

David Satcher, M.D., Ph.D.
Surgeon General

EXECUTIVE SUMMARY

A REPORT OF THE SURGEON GENERAL ON MENTAL HEALTH

Mental health—*the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.*

Mental illness—*the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.*

This is the first Surgeon General's report ever issued on the topic of mental health and mental illness. The science-based report conveys several messages. One is that **mental health is fundamental to health**. The qualities of mental health are essential to leading a healthy life. Americans assign high priority to preventing disease and promoting personal well-being and public health; so too must we assign priority to the task of promoting mental health and preventing mental disorders. Nonetheless, mental disorders occur and, thus, treatment and mental health services are critical to the Nation's health. These emphases, combined with research to increase the knowledge needed to treat and prevent mental and behavioral disorders, constitute a broad public health approach to an urgent health concern.

A second message of the report is that **mental disorders are real health conditions** that have an immense impact on individuals and families throughout this Nation and the world. Appreciation of the clinically and economically devastating nature of mental disorders is part of a quiet scientific revolution that not only has documented the extent of the problem, but in recent years has generated many real solutions. The decision to publish the report at this time was based, in part, on the tremendous growth of the science base that is enriching our understanding of the awe-inspiring complexity of the brain and behavior. This understanding increasingly supports mental health practices.

The body of this report is a summary of an extensive review of the scientific literature and of consultations with mental health care providers and consumers. Contributors guided by the Office of the Surgeon General examined more than 3,000 research articles and other materials, including first-person accounts from individuals who have experienced mental disorders. Today, a strong consensus among Americans in all walks of life holds that our society no longer can afford to view mental health as separate and unequal to general health. This consensus resonates with the Surgeon General's conviction that mental health should be part of the mainstream of health.

The review of research supports two main findings:

- **The efficacy of mental health treatments is well documented, and**
- **A range of treatments exists for most mental disorders.**

On the strength of these findings, the single, explicit recommendation of the report is to ***seek help if you have a mental health problem or think you have symptoms of a mental disorder.***

the "burden of disability" associated with the whole range of diseases and health conditions suffered by peoples throughout the world. Possibly the most striking finding of the landmark Global Burden of Disease study is that the impact of mental illness on overall health and productivity in the United States and throughout the world is profoundly underrecognized. Today, in established market economies such as the United States, mental illness is the second leading cause of disability and premature mortality. Mental disorders collectively account for more than 15 percent of the overall burden of disease from *all* causes and slightly more than the burden associated with all forms of cancer (Table 1). These data underscore the importance and urgency of treating and preventing mental disorders and of promoting mental health in our society.

Table 1. Disease burden by selected illness categories in established market economies, 1990

	Percent of Total DALYs*
All cardiovascular conditions	18.6
All mental illness**	15.4
All malignant disease (cancer)	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious and parasitic disease	2.8
All drug use	1.5

*Disability-adjusted life year (DALY) is a measure that expresses years of life lost to premature death and years lived with a disability of specified severity and duration (Murray & Lopez, 1996).

**Disease burden associated with "mental illness" includes suicide.

Mental Health and Mental Illness: Points on a Continuum

As will be evident in the pages that follow, "mental health" and "mental illness" may be thought of as points on a continuum. *Mental health* refers to the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society. It is easy to overlook the value of mental health until problems surface. Yet from early childhood until death, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem. These are the ingredients of each individual's successful contribution to community and society. Americans are inundated with messages about *success*—in school, in a profession, in parenting, in relationships—without appreciating that successful performance rests on a foundation of mental health.

Many ingredients of mental health may be identifiable, but mental health is not easy to define. In the words of a distinguished leader in the field of mental health prevention, ". . . built into any definition of wellness . . . are overt and covert expressions of values. Because values differ across cultures as well as among subgroups (and indeed individuals) within a culture, the ideal of a uniformly acceptable definition of the construct is illusory. . ." (Cowen, 1994). In other words, what it means to be mentally healthy is subject to many different interpretations that are rooted in value judgments that may vary across cultures. The challenge of defining mental health has stalled the development of programs to foster mental health (Secker, 1998), although some strides have been made—for example, wellness programs for older people.

Mental illness refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alterations in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior spawn a host of problems—patient distress, impaired functioning, or

term refers to research that is examining the workings of the brain at the most fundamental levels. Studies focus, for example, on the complex neurochemical activity that occurs within individual nerve cells, or neurons, to process information; on the properties and roles of proteins that are expressed, or produced, by a person's genes; and on the interaction of genes with diverse environmental influences. All of these activities now are understood, with increasing clarity, to underlie learning, memory, the experience of emotion, and, when these processes go awry, the occurrence of mental illness or a mental health problem.

Equally important to the mental health field is "top-down" research; here, as the term suggests, the aim is to understand the broader behavioral context of the brain's cellular and molecular activity and to learn how individual neurons work together in well-delineated neural circuits to perform mental functions.

Effective Treatments. As information accumulates about the basic workings of the brain, it is the task of translational research to transfer new knowledge into clinically relevant questions and targets of research opportunity—to discover, for example, what specific properties of a neural circuit might make it receptive to safer, more effective medications. To elaborate on this example, theories derived from knowledge about basic brain mechanisms are being wedded more closely to brain imaging tools such as functional Magnetic Resonance Imaging (MRI) that can observe actual brain activity. Such a collaboration would permit investigators to monitor the specific protein molecules intended as the "targets" of a new medication to treat a mental illness or, indeed, to determine how to optimize the effect on the brain of the learning achieved through psychotherapy.

In its entirety, the new "integrative neuroscience" of mental health offers a way to circumvent the antiquated split between the mind and the body that historically has hampered mental health research. It also makes it possible to examine scientifically many of the important psychological and behavioral theories regarding normal development and mental illness that have been developed in years past. The unswerving goal of mental health research is to develop and refine clinical treatments as well as preventive interventions that are based on an understanding of specific mechanisms that can contribute to or lead to illness but also can protect and enhance mental health.

Mental health clinical research encompasses studies that involve human participants, conducted, for example, to test the efficacy of a new treatment. A noteworthy feature of contemporary clinical research is the new emphasis being placed on studying the effectiveness of interventions in actual practice settings. Information obtained from such studies increasingly provides the foundation for services research concerned with the cost, cost-effectiveness, and "deliverability" of interventions and the design—including economic considerations—of service delivery systems.

Organization and Financing of Mental Health Care. Another of the defining trends has been the transformation of the mental illness treatment and mental health services landscapes, including increased reliance on primary health care and other human service providers. Today, the U.S. mental health system is multifaceted and complex, comprising the public and private sectors, general health and specialty mental health providers, and social services, housing, criminal justice, and educational agencies. These agencies do not always function in a coordinated manner. The configuration of the system reflects necessary responses to a broad array of factors including reform movements, financial incentives based on who pays for what kind of services, and advances in care and treatment technology. Although the hybrid system that exists today serves diverse functions well for many people, individuals with the most complex needs and the fewest financial resources often find the system fragmented and difficult to use. A challenge for the Nation in the near-term future is to speed the transfer of new evidence-based treatments and prevention interventions into diverse service delivery settings and systems, while ensuring greater coordination among these settings and systems.

Consumer and Family Movements. The emergence of vital consumer and family movements promises to shape the direction and complexion of mental health

efforts, and the opportunities open to persons with mental illness to participate to the full extent of their interests in the community of their choice.

Mental Health and Mental Illness Across the Lifespan

The Surgeon General's report takes a lifespan approach to its consideration of mental health and mental illness. Three chapters that address, respectively, the periods of childhood and adolescence, adulthood, and later adult life beginning somewhere between ages 55 and 65, capture the contributions of research to the breadth, depth, and vibrancy that characterize all facets of the contemporary mental health field.

The disorders featured in depth in Chapters 3, 4, and 5 were selected on the basis of the frequency with which they occur in our society, and the clinical, societal, and economic burden associated with each. To the extent that data permit, the report takes note of how gender and culture, in addition to age, influence the diagnosis, course, and treatment of mental illness. The chapters also note the changing role of consumers and families, with attention to informal support services (i.e., unpaid services), with which many consumers are comfortable and upon which they depend for information. Persons with mental illness and, often, their families welcome a proliferating array of support services—such as self-help programs, family self-help, crisis services, and advocacy—that help them cope with the isolation, family disruption, and possible loss of employment and housing that may accompany mental disorders. Support services can help to dissipate stigma and to guide patients into formal care as well.

Mental health and mental illness are dynamic, ever-changing phenomena. At any given moment, a person's mental status reflects the sum total of that individual's genetic inheritance and life experiences. The brain interacts with and responds—both in its function and in its very structure—to multiple influences continuously, across every stage of life. At different stages, variability in expression of mental health and mental illness can be very subtle or very pronounced. As an example, the symptoms of separation anxiety are normal in early childhood but are signs of distress in later childhood and beyond. It is all too common for people to appreciate the impact of developmental processes in children, yet not to extend that conceptual understanding to older people. In fact, people continue to develop and change throughout life. Different stages of life are associated with vulnerability to distinct forms of mental and behavioral disorders but also with distinctive capacities for mental health.

Even more than is true for adults, children must be seen in the context of their social environments—that is, family and peer group, as well as that of their larger physical and cultural surroundings. Childhood mental health is expressed in this context, as children proceed along the arc of development. A great deal of contemporary research focuses on developmental processes, with the aim of understanding and predicting the forces that will keep children and adolescents mentally healthy and maintain them on course to become mentally healthy adults. Research also focuses on identifying what factors place some at risk for mental illness and, yet again, what protects some children but not others despite exposure to the *same* risk factors. In addition to studies of normal development and of risk factors, much research focuses on mental disorders in childhood and adolescence and what can be done to prevent or treat these conditions and on the design and operation of service settings best suited to the needs of children.

For about one in five Americans, adulthood—a time for achieving productive vocations and for sustaining close relationships at home and in the community—is interrupted by mental illness. Understanding why and how mental disorders occur in adulthood, often with no apparent portents of illness in earlier years, draws heavily on the full panoply of research conducted under the aegis of the mental health field. In years past, the onset, or occurrence, of mental illness in the adult years was attributed principally to observable phenomena—for example, the burden of stresses associated with career or family, or the inheritance of a disease viewed to run in a particular family. Such explanations now may appear naive at best. Contemporary studies of the brain and behavior are racing to fill in the picture by elucidating specific

mental disorders that are more severe than the "ups and downs" in the usual course of development.

- Approximately one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year, but only about 5 percent of all children experience what professionals term "extreme functional impairment."
- Mental disorders and mental health problems appear in families of all social classes and of all backgrounds. No one is immune. Yet there are children who are at greatest risk by virtue of a broad array of factors. These include physical problems; intellectual disabilities (retardation); low birth weight; family history of mental and addictive disorders; multigenerational poverty; and caregiver separation or abuse and neglect.
- Preventive interventions have been shown to be effective in reducing the impact of risk factors for mental disorders and improving social and emotional development by providing, for example, educational programs for young children, parent-education programs, and nurse home visits.
- A range of efficacious psychosocial and pharmacologic treatments exists for many mental disorders in children, including attention-deficit/hyperactive disorder, depression, and the disruptive disorders.
- Research is under way to demonstrate the effectiveness of most treatments for children in actual practice settings (as opposed to evidence of "efficacy" in controlled research settings), and significant barriers exist to receipt of treatment.
- Primary care and the schools are major settings for the potential recognition of mental disorders in children and adolescents, yet trained staff are limited, as are options for referral to specialty care.
- The multiple problems associated with "serious emotional disturbance" in children and adolescents are best addressed with a "systems" approach in which multiple service sectors work in an organized, collaborative way. Research on the effectiveness of systems of care shows positive results for system outcomes and functional outcomes for children; however, the relationship between changes at the system level and clinical outcomes is still unclear.
- Families have become essential partners in the delivery of mental health services for children and adolescents.
- Cultural differences exacerbate the general problems of access to appropriate mental health services. Culturally appropriate services have been designed but are not widely available.

Chapter 4: Adults and Mental Health

- As individuals move into adulthood, developmental goals focus on productivity and intimacy including pursuit of education, work, leisure, creativity, and personal relationships. Good mental health enables individuals to cope with adversity while pursuing these goals.
- Untreated, mental disorders can lead to lost productivity, unsuccessful relationships, and significant distress and dysfunction. Mental illness in adults can have a significant and continuing effect on children in their care.
- Stressful life events or the manifestation of mental illness can disrupt the balance adults seek in life and result in distress and dysfunction. Severe or life-threatening trauma experienced either in childhood or adulthood can further provoke emotional and behavioral reactions that jeopardize mental health.
- Research has improved our understanding of mental disorders in the adult stage of the life cycle. Anxiety, depression, and schizophrenia, particularly, present special problems in this age group. Anxiety and depression contribute to the high rates of suicide in this population. Schizophrenia is the most persistently disabling condition, especially for young adults, in spite of recovery of function by some individuals in mid to late life.
- Research has contributed to our ability to recognize, diagnose, and treat each of these conditions effectively in terms of symptom control and behavior management. Medication and other therapies can be independent, combined, or sequenced

stances, prevent mental disorders are outpacing the capacities of the existing service system to deliver mental health care to all who would benefit from it. Approximately 10 percent of children and adults receive mental health services from mental health specialists or general medical providers in a given year. Approximately one in six adults, and one in five children, obtain mental health services either from health care providers, the clergy, social service agencies, or schools in a given year.

Chapter 6 discusses the organization and financing of mental health services. The chapter provides an overview of the current system of mental health services, describing where people get care and how they use services. The chapter then presents information on the costs of care and trends in spending. Only within recent decades, in the face of concerns about discriminatory policies in mental health financing, have the dynamics of insurance financing become a significant issue in the mental health field. In particular, policies that have emphasized cost containment have ushered in managed care. Intensive research currently is addressing both positive and adverse effects of managed care on access and quality, generating information that will guard against untoward consequences of aggressive cost-containment policies. Inequities in insurance coverage for mental health and general medical care—the product of decades of stigma and discrimination—have prompted efforts to correct them through legislation designed to produce financing changes and create parity. Parity calls for equality between mental health and other health coverage.

- Epidemiologic surveys indicate that one in five Americans has a mental disorder in any one year.
- Fifteen percent of the adult population use some form of mental health service during the year. Eight percent have a mental disorder; 7 percent have a mental health problem.
- Twenty-one percent of children ages 9 to 17 receive mental health services in a year.
- The U.S. mental health service system is complex and connects many sectors (public–private, specialty–general health, health–social welfare, housing, criminal justice, and education). As a result, care may become organizationally fragmented, creating barriers to access. The system is also financed from many funding streams, adding to the complexity, given sometimes competing incentives between funding sources.
- In 1996, the direct treatment of mental disorders, substance abuse, and Alzheimer's disease cost the Nation $99 billion; direct costs for mental disorders alone totaled $69 billion. In 1990, indirect costs for mental disorders alone totaled $79 billion.
- Historically, financial barriers to mental health services have been attributable to a variety of economic forces and concerns (e.g., market failure, adverse selection, moral hazard, and public provision). This has accounted for differential resource allocation rules for financing mental health services.
  - — "Parity" legislation has been a partial solution to this set of problems.
  - — Implementing parity has resulted in negligible cost increases where the care has been managed.
- In recent years, managed care has begun to introduce dramatic changes into the organization and financing of health and mental health services.
- Trends indicate that in some segments of the private sector per capita mental health expenditures have declined much faster than they have for other conditions.
- There is little direct evidence of problems with quality in well-implemented managed care programs. The risk for more impaired populations and children remains a serious concern.
- An array of quality monitoring and quality improvement mechanisms has been developed, although incentives for their full implementation have yet to emerge. In addition, competition on the basis of quality is only beginning in the managed care industry.
- There is increasing concern about consumer satisfaction and consumers' rights. A Consumers Bill of Rights has been developed and implemented in Federal Employee Health Benefit Plans, with

tunities but also challenge the scientific community to develop new approaches to clinical and health services interventions research. Because the vitality and feasibility of clinical research hinges on the willing participation of clinical research volunteers, it is important for society to ensure that concerns about protections for vulnerable research subjects are addressed. Responding to the calls of managed mental and behavioral health care systems for evidence-based interventions will have a much needed and discernible impact on practice. Special effort is required to address pronounced gaps in the mental health knowledge base. Key among these are the urgent need for evidence which supports strategies for mental health promotion and illness prevention. Additionally, research that explores approaches for reducing risk factors and strengthening protective factors for the prevention of mental illness should be encouraged. As noted throughout the report, high-quality research and the effective services it promotes are a potent weapon against stigma.

- ***Overcome Stigma***: Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others. For our Nation to reduce the burden of mental illness, to improve access to care, and to achieve urgently needed knowledge about the brain, mind, and behavior, stigma must no longer be tolerated. Research on brain and behavior that continues to generate ever more effective treatments for mental illnesses is a potent antidote to stigma. The issuance of this Surgeon General's Report on Mental Health seeks to help reduce stigma by dispelling myths about mental illness, by providing accurate knowledge to ensure more informed consumers, and by encouraging help seeking by individuals experiencing mental health problems.
- ***Improve Public Awareness of Effective Treatment***: Americans are often unaware of the choices they have for effective mental health treatments. In fact, there exists a constellation of several treatments of documented efficacy for most mental disorders. Treatments fall mainly under several broad categories—counseling, psychotherapy, medication therapy, rehabilitation—yet within each category are many more choices. All human services professionals, not just health professionals, have an obligation to be better informed about mental health treatment resources in their communities and should encourage individuals to seek help from any source in which they have confidence.
- ***Ensure the Supply of Mental Health Services and Providers***: The fundamental components of effective service delivery, which include integrated community-based services, continuity of providers and treatments, family support services (including psychoeducation), and culturally sensitive services, are broadly agreed upon, yet certain of these and other mental health services are in consistently short supply, both regionally and, in some instances, nationally. Because the service system as a whole, as opposed to treatment services considered in isolation, dictates the outcome of recovery-oriented mental health care, it is imperative to expand the supply of effective, evidence-based services throughout the Nation. Key personnel shortages include mental health professionals serving children/adolescents and older people with serious mental disorders and specialists with expertise in cognitive-behavioral therapy and interpersonal therapy, two forms of psychotherapy that research has shown to be effective for several severe mental disorders. For adults and children with less severe conditions, primary health care, the schools, and other human services must be prepared to assess and, at times, to treat individuals who come seeking help.
- ***Ensure Delivery of State-of-the-Art Treatments***: A wide variety of effective, community-based services, carefully refined through years of research, exist for even the most severe mental illnesses yet are not being translated into community settings. Numerous explanations for the gap between what is known from research and what is practiced beg for innovative strategies to bridge it.
- ***Tailor Treatment to Age, Gender, Race, and Culture***: Mental illness, no less than mental health,

their co-occurrence with other mental disorders as well as the treatment of co-occurring conditions. Brief sections on substance abuse in adolescence and late life also are included in the report.

Preparation of the Report

In September 1997, the Office of the Surgeon General, with the approval of the Secretary of the Department of Health and Human Services, authorized the Substance Abuse and Mental Health Services Administration (SAMHSA) to serve as lead operating division for preparing the Surgeon General's Report on Mental Health. SAMHSA's Center for Mental Health Services worked in partnership with the National Institute of Mental Health, National Institutes of Health, to develop this report under the guidance of Surgeon General David Satcher, M.D., Ph.D. The Federal partners established a Planning Board comprising individuals who represent a broad range of expertise in mental health: university-based researchers and educators, practicing mental health professionals, self-identified consumers of mental health services, and many knowledgeable advocates in diverse areas of the mental health field. Also included on the Planning Board were individuals representing Federal Operating Divisions, Offices, Centers, and Institutes and private nonprofit foundations with interests in the area of mental health.

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Surgeon General's Report on Mental Health
U.S. Department of Health and Human Services

Report Summary and "Courses of Action"

Main finding and key recommendation

- The main finding of the report is that ***mental health treatments are effective.***
- The single, explicit recommendation of the report is to ***seek help if you experience symptoms of mental illness.***

Overview

- The complexity of the brain is fully consistent with the fact that it supports all behavior and mental life. Proceeding from an acknowledgment that all psychological inputs are ultimately recorded in the brain and that all psychological outputs reflect biological processes, the modern neuroscience of mental health offers an enriched understanding of the inseparability of human experience, brain, and mind.
- Mental functions, which are disturbed in mental disorders, are mediated by the brain. In the process of transforming human experience into physical events, the brain undergoes changes in its cellular structure and function.
- Few lesions or physiologic abnormalities define the mental disorders, and for the most part their causes remain unknown. Mental disorders, instead, are defined by signs and symptoms.
- Diagnoses of mental disorders made using specific criteria are as reliable as those for general medical disorders.
- About one in five Americans experiences a mental disorder in the course of a year. Almost half of all adults who have a mental disorder in their lifetime also experiences a co-occurring substance (alcohol or other drug) use disorder, which complicates treatment.
- A range of treatments proven effective exists for nearly all mental disorders. Two broad types of intervention include psychopharmacologic and psychosocial treatments—for example, psychotherapy or counseling; these often are most effective when combined.

- In the mental health field, progress in developing preventive interventions has been slow because for most major mental disorders, there is insufficient understanding about etiology (or causes of illness) and/or there is an inability to alter the *known* etiology of a particular disorder. Still, some successful strategies have emerged in the absence of a full understanding of etiology.
- About 15 percent of the U.S. adult population uses mental health services in any year. Yet critical gaps exist between those who need service and those who received service. Gaps also exist between optimally effective treatment and what many individuals receive in actual practice settings.
- Mental illness must be understood in a social and cultural context and mental health services must be designed and delivered in a manner that is sensitive to the perspectives and needs of racial and ethnic minorities.
- "Consumerism" has increased the involvement of individuals with mental disorders

and their families in mutual support services, consumer-run services, and advocacy. They are powerful agents for changes in service programs and policy.

- A "recovery" movement reflects renewed optimism about the outcomes of mental illness due to improved treatment and rehabilitation as well as increased involvement of individuals in the management of their own lives and conditions.

Children and Mental Health

- Childhood is characterized by periods of transition and reorganization, making it critical to assess the mental health of children and adolescents in the context of familial, social, and cultural expectations about age-appropriate thoughts, emotions, and behavior.
- The range of what is considered "normal" is wide; still, children and adolescents can and do develop mental disorders that are more severe than the "ups and downs" in the usual course of development.
- Approximately one in five children and adolescents experience the signs and symptoms of a DSM-IV disorder during the course of a year, but only about 5 percent of all children experience "extreme functional impairment."
- Psychiatric disorders appear in all types of families, of all social classes, and of all backgrounds. No one is immune. Yet there are children who are at greatest risk by virtue of a broad array of factors. These include physical problems; intellectual disabilities (retardation); low birth weight; family history of psychiatric, substance abuse, and other disorders; multigenerational poverty; and caregiver separation or abuse and neglect.
- Preventive interventions have been shown to be effective in reducing the impact of risk factors for mental disorders and improving social and emotional development.
- A range of efficacious psychosocial and pharmacologic treatments exists for many mental disorders in children, including attention-deficit/hyperactive disorder, depression, and the disruptive disorders.
- The effectiveness of most treatments for children in actual practice settings has yet to be well-established, and significant barriers exist to receipt of treatment.
- Primary care and the schools are major settings for the recognition of mental disorders in children and adolescents, yet trained staff are limited, as are options for referral to specialty care.
- The multiple problems associated with "serious emotional disturbance" in children and adolescents are best addressed with a "systems" approach; that is, drawing on multiple service sectors. The effectiveness of systems approaches designed to overcome fragmentation is mixed and is the subject of ongoing research. The face-valid approach is favored by advocates and governmental initiatives.
- Families have become essential partners in the delivery of mental health services for children and adolescents.
- Cultural barriers to appropriate care exacerbate the general problems of access to mental health services. Culturally appropriate services have been designed but are not widely available.

Adults and Mental Health

- As individuals move into adulthood, developmental goals focus on productivity and intimacy including pursuit of education, work, leisure, creativity and personal relationships.

Good mental health enables individuals to cope with adversity while pursuing these goals.

- Untreated, mental disorders can lead to lost productivity, unsuccessful relationships and significant distress and dysfunction. Mental illness in adults can have a significant and continuing effect on children in their care.
- Science has improved our understanding of mental disorders in the adult stage of the life cycle. Anxiety, depression, and schizophrenia, particularly, present special problems in this age group. Anxiety and depression contribute to the high rates of suicide in this population. Schizophrenia is the most persistently disabling condition, especially for young adults, in spite of higher than expected rates of recovery of function in mid-to-late life.
- Science has contributed to our ability to recognize, diagnose, and treat each of these conditions effectively in terms of symptom control and behavior management. Medication and other therapies can be independent, combined, or sequenced depending on the individual's diagnosis and personal preference.
- A new recovery perspective is supported by evidence on rehabilitation and treatment.
- Certain expected events of mid-life (e.g. divorce or other stressful life events) create mental health problems (not necessarily disorders) that may be addressed through a range of interventions.
- Care and treatment in the real world of practice does not conform to what science tells us is best. At times care is poor.
- Substance abuse is a major co-occurring problem for adults with mental disorders. Evidence supports integrated treatment, although there are substantial gaps between what research recommends and what typically is available.
- Several special problems in care and treatment of adults have been recognized, beyond traditional mainstream mental health concerns, including racial and ethnic differences, consumer involvement, and the consequences of disability and poverty.
- Barriers of access exist in the organization and financing of services for adults. There are specific problems with Medicare, Medicaid, income supports, housing and managed care.
- Stressful life events or the manifestation of mental illness can disrupt the balance adults seek in life and result in distress and dysfunction. Severe or life threatening trauma experienced either in childhood or adulthood can further provoke emotional and behavioral reactions that jeopardize mental health.

Older Adults and Mental Health

- Important life tasks remain for individuals as they age. Elderly individuals continue to learn and contribute to the society, in spite of physiologic changes due to aging and increasing health problems.
- Continued intellectual, social and physical activity throughout the life cycle are important for the maintenance of mental health in late life.
- Stressful life events, such as declining health and/or the loss of mates, family members or friends often increase with age. However, persistent bereavement or serious depression is not normal and should be treated.

- Normal aging is not characterized by mental or cognitive disorders. Mental or substance use disorders that present alone or which co-occur should be recognized

and treated as illnesses.

- Disability due to mental illness in individuals over 65 years old will become a major public health problem in the near future because of demographic changes. In particular dementia, depression, and schizophrenia, among other conditions, will all present special problems in this age group:
- Dementia produces significant dependency and is a leading contributor to the need for costly long-term care in the last years of life.
- Depression contributes to the high rates of suicide in this population; and
- Schizophrenia continues to be disabling in spite of higher than expected rates of recovery of function late in life.
- There are effective interventions for most mental disorders and many mental health problems experienced by the elderly, such as persistent bereavement, depression, and anxiety disorders.
- Older individuals can benefit from the advances in psychotherapy, medication, and other treatment interventions for mental disorders enjoyed by younger adults with appropriate age and health status modification.
- Treating older adults with mental disorders includes other benefits to overall health by improving the interest and ability of individuals to care for themselves and follow their primary care provider's directions and advice, particularly about taking medications.
- Primary care practitioners are a critical link in identifying and addressing mental disorders in older adults. Opportunities are missed to improve mental health and general medical outcomes when mental illness is under-recognized and under-treated in primary care settings.
- Barriers to access exist in the organization and financing of services for aging citizens. There are specific problems with Medicare, Medicaid, nursing homes, and managed care.

Organizational and Financial Barriers to Care

- Epidemiologic surveys indicate that a substantial proportion of the U.S. population has evidence of a mental disorder in any one year (one in five) and at some time in a lifetime (about one-half).
- Significant proportions (15 percent) of the population use some form of mental health service during the year and during their lifetimes. Almost half of the users do not meet strict diagnostic criteria for a disorder (but have some evidence of impairment) and more than half of those with severe disorders do not use services.
- The de facto mental health service system is complex and connects many sectors (public–private, specialty–general health, health–social welfare, housing, criminal justice and education). As a result, care may become organizationally fragmented, creating barriers to access. The system is also financed from many funding streams, adding to the complexity, given sometimes competing incentives.
- In 1996, the direct treatment of mental disorders, substance abuse, and Alzheimer's disease cost the Nation $99 billion; direct costs for mental disorders alone totaled $69 billion. In 1990, indirect costs for mental disorders alone totaled $79 billion
- Historically there have been financial barriers to care attributable to a variety of economic forces and concerns (e.g., market failure, adverse selection, moral hazard, and public provision). This has accounted for differential resource allocation rules for financing

mental health services.

- "Parity" legislation has been a partial solution to this set of problems.
- Implementing parity has resulted in negligible cost increases where the care has been managed.
- In recent years, managed care has begun to introduce dramatic changes into the organization and financing of health and mental health services.
- Trends indicate that per capita mental health expenditures have declined much faster in some segments of the private sector than they have for other conditions.
- Although there is little direct evidence of problems with quality where it has been measured, the evidence is biased in favor of better implemented programs. The risk for more impaired populations and children remains a serious concern.
- An array of quality monitoring and quality improvement mechanisms have been developed.
- There is increasing concern about consumer satisfaction and consumers' rights. A Consumers Bill of Rights has been developed and implemented in Federal Employee Health Benefit Plans with broader legislation currently pending in the Congress.

Confidentiality

- People's willingness to seek help is contingent on their confidence that personal revelations of mental distress will not be disclosed without their consent.
- The U.S. Supreme Court recently has upheld the right to the privacy of these records and the therapist-client relationship.
- Although these issues are common to health care in general, there are special concerns for mental health care and mental health care records because of the extremely personal nature of the material shared in treatment.
- State and federal laws protect the confidentiality of health care information but are often incomplete because of numerous exceptions, which often vary from State to State. Several States have implemented or proposed models for protecting privacy that may serve as a guide to others.
- States, consumers, and family advocates take differing positions on disclosure of mental health information without consent to family caregivers. In States, which allow such disclosure, information provided is usually limited to diagnosis, prognosis and information regarding treatment, specifically medication.
- When conducting mental health research it is in the interest of both the researcher and the individual participant to address informed consent and to obtain certificates of confidentiality before proceeding. Federal regulations require informed consent for research being conducted with Federal funds.
- New approaches to managing care and information technology threaten to further erode the confidentiality and trust deemed so essential between the direct provider of mental health services and the individual receiving those services. It is important to monitor advances so that confidentiality of records is enhanced instead of impinged upon by technology.
- Until the stigma associated with mental illnesses is addressed, confidentiality of mental health information will continue to be a critical point of concern for payers, providers and consumers.

Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

June 7, 1999

Dear State Medicaid Director:

Mental illness affects millions of Americans, many of whom rely on Medicaid to cover their health and mental health care needs. In recognition of the White House Conference on Mental Health, I am writing to provide information about several issues related to mental health services.

Developments in Mental Health Treatment

Assertive Community Treatment (ACT) programs have been used to serve persons with serious and persistent mental illness for a number of years. Programs based on ACT principles employ interdisciplinary treatment teams, shared caseloads, 24-hour mobile crisis teams, assertive outreach for treatment in clients' own environments, individualized treatment, medication, rehabilitation and supportive services. Assertive Case Management (ACM) programs which incorporate shared caseloads also provide this array of individualized, community-based services.

The evidence base for a variety of treatment and service interventions for persons with schizophrenia, including ACT and ACM, has recently been reviewed by the Schizophrenia Patient Outcomes Research Team (PORT), with support from the Agency for Health Care Policy and Research and the National Institute of Mental Health. With respect to persons with schizophrenia who are at high risk for discontinuation of treatment or for repeated crises, the PORT team concluded that:

> "Randomized trials have demonstrated consistently the effectiveness of these programs [ACT and ACM] in reducing inpatient use among such high-risk patients. Several studies also support improvements in clinical and social outcomes. These studies suggest that both ACT and ACM are superior to conventional case management for high-risk cases (Schizophrenia Bulletin, 1998)."

States should consider this recommendation in their plans for comprehensive approaches to community-based mental health services. Programs based on ACT principles can be supported under existing Medicaid policies, and a number of States currently include ACT services as a component of their mental health service package. Consumer participation in program design and the development of operational policies is especially key in the successful implementation of ACT programs.

Consumer Directed Care

Advance directives are becoming an increasingly important tool for consumers of mental health services to articulate their decisions about treatment, and to guide treatment when they can not

make these decisions themselves. Current Medicaid rules (42CFR 431.20, 434.20, and 489.100) require that States develop and provide current information about State laws that deal with advance directives. We urge all State Medicaid programs to work with their State mental health authorities to ensure appropriate attention to mental health issues in their advance directives policies, and to consider how these policies are operationalized in Medicaid program services.

Pharmacy

Finally, I would like to underscore that Federal statutory requirements noted in my February 12, 1998 letter about new medications for schizophrenia apply to services that States carry out via contract. When there are prior authorization requirements for prescription medicines, including the new generation of drugs for schizophrenia, prescription requests must be responded to in 24 hours. In emergency situations, there must be provisions for dispensing at least a 72 hour supply of the requested drug.

I appreciate your attention to these important mental health updates. If you have questions or would like further information, please contact Peggy Clark (410-786-5321). If you are interested in finding out more about ACT programs, the mental health authority in your state would be a good resource. Additionally, consultation and technical assistance are available from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (Michael English, 301-443-3606).

Sincerely,

Sally K. Richardson
Director

cc:
All HCFA Regional Administrators

All HCFA Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
American Public Health Services Association

Robert Glover
National Association of State Mental Health Program Directors

Joy Wilson
National Conference of State Legislatures

Matt Salo
National Governors' Association

Development of FEHB Mental Health and Substance Abuse Policy

Over the past years, the FEHB Program has not accepted reductions in the value of mental health benefits offered by carriers, has encouraged judicious utilization management to help compensate for modest improvements in benefits, and allowed benefit improvements to be an exception to cost-neutral benefit change requirements.

In1990 we advised carriers to consider managing care rather than reducing benefit levels if experiencing high utilization in mental health and substance abuse benefits.

In 1991, in support of the President's initiative to combat substance abuse, we required all fee-for-service plans to have a stand-alone inpatient substance abuse benefit and to increase the maximum payment by $500. We also required a mandatory case management proposal from all fee-for-service plans.

In 1992, we set the minimum lifetime maximum for mental health benefits at $50,000 and encouraged higher maximums.

In 1993, we instituted a maximum annual out-of-pocket limit on fee-for-service plans of $4,000 per person under a High Option plan and $8,000 per person under a Standard Option plan for mental health and substance abuse benefits.

In 1994, we required minimum coverage for mental health benefits of 50% of the cost of 30 inpatient days and 20 outpatient visits per calendar year. Inpatient days were permitted to be exchanged for outpatient day treatment at a rate of two day treatments per inpatient day. Health maintenance organizations that had combined mental health and substance abuse benefits were directed to offer benefits that covered 30 inpatient days and 20 outpatient visits for each category.

In 1995, prior to the Mental Heatlh Parity Act, we eliminated lifetime maximums for mental health benefits.

In 1998, OPM implemented the remaining requirements of the Mental Health Parity Act, by prohibiting annual maximums on mental health benefits. We encouraged health benefit carriers to move away from contractual day and visit limitations and high deductibles and encouraged judicious utilization management. We also encouraged the use of PPOs so that increased benefit levels could be achieved on a cost neutral basis.

For 1999, we directed that pharmacotherapy, medical visits, and testing to monitor drug treatment for mental conditions be covered as pharmaceutical disease management.

FEHB Program Carrier Letter
All Carriers

U.S. Office of Personnel Management
Office of Insurance Programs

Letter No. 1999-0XX **Date:** June 7, 1999

Fee-for-service [XX] Experience-rated HMO [XX] Community-rated HMO [XX]

SUBJECT: Mental Health and Substance Abuse Parity

Introduction

At the recent White House Conference on Mental Health Parity, the President directed the Office of Personnel Management to achieve mental health and substance abuse parity in the Federal Employees Health Benefits (FEHB) Program. Our work with health plans and others has demonstrated conclusively that this goal can be reached effectively. In its simplest form, we want to enlist your support to make plan coverage for mental health and substance abuse identical with regard to traditional medical care deductibles, coinsurance, copays, and day and visit limitations. We recognize that there are a variety of benefit design approaches that can achieve this goal. We are excited about this initiative and look forward to a cooperative introduction in the 2001 contract year.

Background

Over the past several years, the FEHB Program has been moving toward mental health and substance abuse parity. We eliminated lifetime and annual maximums in the FEHB Program. We negotiated with health plans to move away from contractual day and visit limitations and high deductibles, copayments, and coinsurance for mental health coverage. For 1999, pharmacotherapy, medical visits and testing to monitor drug treatment for mental conditions were covered as pharmaceutical disease management. We encouraged the use of Preferred Provider Organizations and utilization management to improve mental health benefits, and we allowed some mental health improvements as an exception to our normal policy of only accepting cost-neutral benefit changes. Finally, we have not accepted proposed reductions in the value of mental health benefits. While we had good success, more work is needed.

We reviewed research by the National Advisory Mental Health Council, the National Alliance for the Mentally Ill, the Substance Abuse and Mental Health Services Administration, and others. We also considered recommendations of the National Institutes of Mental Health. These sources indicated a growing consensus on key issues of the effectiveness of treatment and the efficiency of managed delivery systems in providing care.

At our 1998 carrier conference, we hosted a panel of experts on mental health and substance abuse services. Their presentations stimulated a lively discussion on how managing behavioral health care can affect the cost, comprehensiveness, and quality of mental health and substance

abuse services in an employer-sponsored health benefits program. Many of you expressed an interest in using the information provided to enhance programs within your plans. These activities coincided with other factors such as legislative action at the State level, insurance industry trends, recent advances in treatment, and the proven ability of managed behavioral health care organizations to control costs.

Action

We are convinced that mental health and substance abuse parity can be introduced, using appropriate care management, in a way that expands the range of benefits offered and holds costs to a minimum. We believe that parity can be delivered in a fully coordinated managed behavioral health environment that incorporates techniques such as case management, authorized treatment plans, gatekeepers and referral mechanisms, contracted networks, pre-certification of inpatient services, concurrent review, discharge planning, retrospective review, and disease management. We hope to partner with you in creating options that will work best for your plan.

We encourage you to start planning your implementation strategy now, since contractual arrangements take time to put into place. By working together, we can ensure a smooth transition to parity in 2001.

If you have any questions regarding this letter, please contact your contract representative.

Sincerely,

Frank D. Titus
Assistant Director
for Insurance Programs

MENTAL HEALTH AND SUBSTANCE ABUSE PARITY

Q. What is OPM's goal in increasing mental health and substance abuse benefits in the Federal Employees Health Benefits Program?

A. Our goal is to eliminate disparities in insurance coverage for mental health and substance abuse treatment and treatment of physical illnesses of federal employees by providing better access to services at a reasonable cost.

Q. What type of mental illness do we expect carriers to cover?

A. We expect coverage for the treatment of conditions such as schizophrenia (including schizoaffective disorder), bipolar (manic-depressive) disorder, obsessive-compulsive disorders, panic disorders, attention deficit (hyperactivity disorder), Tourette's syndrome, and major depression.

Q. What specific benefits will the FEHB carriers be required to offer?

A. We will require that carriers cover mental health and substance abuse treatment subject to the same benefit levels and limitations that they apply to physical illness or disease. Carriers will not be able to set more stringent limits on the number of outpatient visits or days in the hospital for treatment of mental disorders or substance abuse than for the treatment of physical illnesses like heart disease or cancer. OPM will also bar higher coinsurance, copayments, or deductibles for mental health and substance abuse care than for the treatment of physical illnesses.

Q. How would you counter critics who say extending mental health benefits would create abuse by people seeking endless "talk therapy"

A. That's another myth to bust. Most people with mental illness are not out to rip off the system. A number of companies are already providing parity, and it's costing about 25 cents a day, at the most. That's much less than the people who have been afraid to provide mental health coverage were predicting. Twenty-five cents a day represents an increase of $91 a year, or 3 percent of the $3,000 spent by a typical employer on health benefits for an employee.

Q. Would you elaborate on the seemingly small effect on premiums?

A. Specifically, a study by the Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that new actuarial estimates of full parity implementation across all product types project an average 3.6 percent premium increase, and that parity with certain limits on "cost-sharing" or "service limits" could range between .4-1.2 percent respectively. A National Advisory Mental Health Council (NAMHC) study indicates that actual industry experience has shown a 30-50 percent cost savings on mental health benefits when introduced with managed care techniques in markets with little prior managed care experience. In markets already utilizing managed care techniques prior to the introduction of parity, total health plan premiums increased by less than 1 percent.

These and other studies have convinced us that parity coverage for mental health and substance abuse treatment provided through a managed behavioral health care system is both affordable and desirable for Federal members.

Q. What are some delivery system changes that would help contribute to manageable costs?

A. Many employers, insurers, and health maintenance organizations have hired specialized managed behavioral health care companies to manage care by authorizing only appropriate and effective treatment. We believe that parity should be delivered in a fully coordinated managed behavioral health environment that incorporates managed care techniques such as case management, authorized treatment plans, gatekeepers and referral mechanisms, contracted networks, pre-certification of inpatient services, concurrent review, discharge planning, retrospective review, and disease management.

Q. What has OPM done to promote mental health coverage in the past?

A. Over the past several years, the FEHB Program has been moving toward mental health and substance abuse parity. We eliminated lifetime and annual maximums in the FEHB Program. We negotiated with health plans to move away from contractual day and visit limitations and high deductibles, copayments, and coinsurance for mental health coverage. For 1999, pharmacotherapy, medical visits and testing to monitor drug treatment for mental conditions were covered as pharmaceutical disease management. We encouraged the use of preferred provider organizations and utilization management to improve mental health benefits, and we allowed some mental health improvements as an exception to our normal policy of only accepting cost-neutral benefit changes. Finally, we have not accepted proposed reductions in the value of mental health benefits. While we had good success, more work is needed.

Q. How will OPM's efforts compare with similar efforts nationwide?

A. We are building on a major push in the States to enact parity legislation. Since 1990, 22 States have passed laws that require the same or similar levels of coverage for mental and physical illnesses, five in 1999 alone. A study by the Substance Abuse and Mental Health Services Administration found that State parity laws had a small effect on premiums. Also, parity bills are currently pending in nine additional States, including California and New York.

Q. How will OPM's efforts compare with the current Mental Health Parity Act?

A. The Mental Health Parity Act of 1996 is an example of "limited parity" legislation. It was an important first step. Since it only affects annual and lifetime dollar limits, day and visit limits and higher copayments, coinsurance, and deductibles may still be applied to mental health services. It also only addressed mental health and did not address substance abuse coverage. Although the current Mental Health Parity Act will sunset in October 2001, we anticipate broad support for comprehensive parity coverage in future federal legislation.

CONFERENCE AGENDA

7:30 AM **Breakfast at the White House (State Floor)**
HRC and MEG in attendance
Director Janice Lachance, Secretaries Riley and Shalala, Chairman Kennard, and Representative Rivers in attendance

10:30 – 11:30 AM **Breakout Sessions at Howard University**

Advances in Science and Research

Clinton Administration Chair:	Dr. Steven E. Hyman (NIMH)
Congressional Members:	Representative Brian Baird (D-WA)
	Senator John Chafee (R-RI)
Facilitator:	Steve Galloway, Consultant, ADL

Mental Health and the Criminal Justice System

Clinton Administration Chair:	Attorney General Janet Reno (DOJ)
Congressional Member:	Rep. Ted Strickland (D-OH)
Facilitator:	Dr. John Monahan, University of Virginia School of Law

Mental Health as a Public Health Issue

Clinton Administration Chair:	Secretary Donna E. Shalala (HHS)
Congressional Members:	Rep. Rosa DeLauro (D-CT)
	Rep. Sherrod Brown (D-OH)
Facilitator:	Dr. Howard Goldman, University of MD School of Medicine

Access to Employment, Housing, Transportation, and Community Supports

Clinton Administration Chair:	Secretary Alexis M. Herman (DOL)
Congressional Member:	Rep. Marcy Kaptur (D-OH)
Facilitator:	Caryl Stern-LaRosa, Director of ADL

Children's Mental Health

Administration Chair:	Secretary Richard W. Riley (ED)
Congressional Members:	Rep. Sheila Jackson Lee (D-TX), Rep. George Miller (D-CA)
Facilitator:	Dr. Laurie Garduque, John D. & Catherine T. MacArthur Foundation

Education and Training for Health Care Providers

Clinton Administration Co-Chairs:	Secretary Togo D. West, Jr. (VA)
Congressional Members:	Representative Lois Capps (D-CA)
	Rep. Nancy Johnson (R-CT)
Facilitator:	Dr.Ellen Frank, University of Pittsburgh

Barriers to Effective Mental Health Services

Clinton Administration Co-Chairs:	Director Janice R. Lachance (OPM)
	Comm. Kenneth S. Apfel (SSA)
Congressional Members:	Senator Paul Wellstone (D-MN)
	Rep. Marge Roukema (R-NJ)
Facilitator:	Dr. Richard G. Frank, Harvard Medical School

Ethnic and Cultural Issues in Mental Health Service Delivery

Clinton Administration Co-Chairs:	Secretary Dan Glickman (USDA)
	Nelba Chavez, SAMHSA
	Dr. Michael Trujillo, IHS
Congressional Member:	Rep Ciro Rodriguez (D-TX)
Facilitator:	Dr. Ivan C.A. Walks, ValueOptions

Meeting the Mental Health Needs of People with Multiple Disabilities

Clinton Administration Co-Chairs:	Gen Barry R. McCaffrey (ONDCP)
	Dr. Kenneth W. Kizer (VA)
	Dr. Wesley Clark, SAMHSA/CSAT
Congressional Members:	Representative Jim McDermott(WA)
Facilitator:	Sandra Thurman, AIDS Policy

Primary Care, Prevention, and the Lifecycle

Clinton Administration Co-Chairs:	Dr. Sue Bailey (DOD)
	Dr. Margaret A. Hamburg (HHS)
Congressional Members:	Rep. Donna Christian-Christensen
	Rep. Patrick J. Kennedy (D-RI)
Facilitator:	Dr. Don Vereen (ONDCP)

Individual Rights: Promoting Fairness and Respecting Privacy

Clinton Administration Co-Chairs:	Bill Lann Lee, Department of Justice
Congressional Members:	Senator Joseph Lieberman (D-CT)
Facilitator:	Jonathan Young

Peer Support, Consumer Advocacy, and Recovery

Clinton Administration Co-Chairs:	Dr. Bernie Arons (SAMHSA) Judith E. Heumann, (ED)
Congressional Members:	Representative Lynn Rivers (D-MI) Senator Harry Reid (D-NV)
Facilitator:	Deborah Batiste, ADL

Community Responses to Youth At Risk

Clinton Administration Co-Chairs:	Bruce Reed (DPC)
Congressional Members:	Representative Jesse Jackson Jr. (IL) Senator Arlen Specter (R-PA)
Facilitator:	Richard Socarides

Mental Health Online

Clinton Administration Co-Chairs:	Chairman William Kennard (FCC) Dr. John M. Eisenberg (AHCPR)
Congressional Members:	Representative Sam Farr (D-CA)
Facilitator:	Ellen Hofheimer Bettmann (ADL)

12:30 – 2:00 PM

Plenary Sessions at Howard

POTUS, VPOTUS, MEG and HRC in attendance
Commissioner Apfel, Director McCaffrey, Sec. Riley, Director Lachance, Dr. Sue Bailey, Defense, Sec. West, Dr. Steven E. Hyman (NIMH), Dr. Margaret Hamburg (HHS), Sec. Glickman, Dr. Nelba Chavez (SAMHSA) Secretary Alexis Herman, Chairman William Kennard, Dr. Bernie Arons (SAMHSA), Dr. H. Westley Clark, (SAMHSA/CSAT), Dr. John M. Eisenberg (HHS) in attendance

There are over a thousand downlinks to the plenary session. The two largest sites are in Portland, Oregon, and Flint, Michigan.

Mrs. Gore, together with Mike Wallace, will be leading a session where people with mental illness discuss their personal experiences.

The VP will be leading a session to discuss the community's response to people with mental illness.

Dr. Satcher will satellite in from Atlanta to lead a session on the response of employers to employees with mental illness and the associated insurance issues.

HRC, together with Congresswoman Lynn Rivers, will lead a session on the importance of research and scientific investment in this issue.

3:30 – 5:00 PM	Town Hall Meeting VPOTUS and MEG in attendance
5:30 – 7:00 PM	Reception at VP Residence VPOTUS and MEG in attendance Commissioner Apfel, Director McCaffrey, Director Lachance, Dr. Sue Bailey, Defense and Dr. John M. Eisenberg (HHS)

CLINTON/GORE ADMINISTRATION TAKES UNPRECEDENTED STEPS TO ADDRESS MENTAL ILLNESS AT THE FIRST-EVER WHITE HOUSE CONFERENCE ON MENTAL HEALTH

Today, at the first-ever White House Conference on Mental Health, the Clinton/Gore Administration is unveiling a comprehensive range of initiatives to improve mental health. The Administration's proposals address a variety of key mental health issues including improving parity, dispelling myths about mental illness, improving community responses to encourage people with mental illnesses to get help, taking new strides in research, and challenging Congress to pass a series of bills that will help people with mental illness. Today the Administration is:

PARITY

Assuring that the Federal Employees Health Benefits Plan (FEHBP) -- the nation's largest private insurer – implements full mental health and substance abuse parity. Today the Office of Personnel Management is sending a letter to the 285 participating health plans informing them that starting next year they will have to offer full mental health and substance abuse parity to participate in the program. OPM will work with these plans throughout the year to evaluate to what extent they need to make modifications to come into compliance. This step will provide full parity for nine million beneficiaries and assure the federal government leads the way to providing parity. **(POTUS)**

Educating Americans about current mental health parity laws. Many Americans with mental illnesses are not aware that the Mental Health Parity Act of 1996 required health plans that cover mental health benefits to guarantee equal lifetime and annual benefits for mental and physical treatments. To help assure that consumers and employers are fully aware of the current protections under the law, the Department of Labor will launch a new outreach campaign to educate Americans about their existing parity rights. This campaign will include: (1) new public service announcements on local radio stations nationwide as well as columns to promote awareness; (2) an outreach campaign to inform consumers they can call the Department's 1-800 number to understand these protections; and (3) working with consumer advocates to assure awareness about the law. **(POTUS- *one sentence*)**

IMPROVING COMMUNITY RESPONSES TO MENTAL HEALTH NEEDS

Helping teachers and parents identify and assist kids at risk. The Administration also announced it's plan to host a series of meetings this Fall in every state where teachers and faculty from schools could come together for training on spotting troubled youth and guidance on how to help them. Participating organizations include NEA, American Psychological Association, PTA, HHS, DOJ, and the Department of Education. (HHS will also work with the AFT to place 200,000 posters in every school around the nation to foster community awareness about mental illness. This outreach campaign will reach an estimated 4.8 million children.) **(POTUS)**

Implementing new strategies to the mental health needs of crime victims. Communities that are victims of terrorism or mass violence have enhanced needs for mental health services following these types of emergencies. To assure that part of any comprehensive response to these crises includes a strong mental health component, the Administration is announcing a new interagency partnership between the Department of Justice's Office for Victims of Crime and the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration (SAMSHA). Part of this effort includes appointing someone within the Emergency Disaster Relief Branch of SAMHSA to work with the Office for Victims of Violence to assure that there is a strategy in place to address the mental health needs of victims of federal crime. This new partnership will assure that the response to these crises include mental health training, technical assistance, and consultation services to communities for assisting victims of crime. **(VP)**

Implementing a new comprehensive approach to address combat stress in the military. Combat stress reactions are common, as those in combat are in foreign environments and many times under extreme conditions. At least 30 percent of those who have spent time in war zones experience post traumatic stress disorder. The importance of addressing combat stress reduction is timely given the deployments around the world. Today the President directed the Department of Defense to report back within 180 days on an implementation plan for a comprehensive combat stress program throughout the military (leadership, morale, and unit cohesion are key factors in primary prevention). DOD will also hold a conference this fall to develop strategies and educate military leaders and medical personnel about the need to enhance current practices to assure that prevention strategies are strengthened. **(VP)**

Reaching out to the vulnerable homeless Americans with mental illnesses. The Department of Housing and Urban Development is proposing a new initiative to encourage communities to create safe havens—places for homeless mentally ill Americans can get treatment and care, including a new satellite conference for communities to learn strategies and develop ways to create these safe havens. The Administration will also launch a 2-year, $4.8 million grant program to study the treatment, housing, education/training and support services needed by homeless women and their children. This program will impact as many as 2,000 homeless mothers and their 4,000 children, many of whom suffer from mental illnesses. Finally, the Department of Veteran Affairs will double the number of "stand downs" events to reach out to homeless Americans with mental illness to help them get the treatment and services they need. **(Mrs. Gore)**

Launching a National Mental Health and Medical/Surgical Care integration strategy. The Department of Veteran's Affairs will provide mental health assessment and care to veterans served by medical primary care teams and that medical assessment and care is available to veterans served by mental health primary care teams. Clinicians will be trained in the issues and methods involved in integration of mental health and medical services. VA will evaluate and monitor quality and outcomes of integrated medical/surgical and mental health services. **(No Principal)**

REDUCING STIGMA AND PROMOTING AWARENESS

Announcing a new nationwide anti-stigma campaign to dispel the myths and promote awareness about mental illness. At a radio address with the President, Mrs. Gore announced that this fall she will launch a major anti-stigma campaign to dispel the myths and promote awareness about mental health and how to access treatment. This campaign will be chaired by Mrs. Gore and will include a whole range of private sector partners including the Ad Council, community organizations, the media and others. **(POTUS-*radio address;* Mrs. Gore *highlight at the conference*)**

Launching the expansion of the "Caring For Every Child" mental health campaign. At least one in ten American children and adolescents may have behavioral, emotional or mental health problems. To take steps right away to reduce stigma, the Administration will launch a five year five million dollar campaign to help reduce stigma in targeted communities by highlighting the special mental health needs of children. This public/private campaign will assist states and communities in developing culturally competent education programs about the mental health needs of children, for parents, primary care providers, educators and social services workers. **(Mrs. Gore)**

Educating older Americans and their health professionals about the risks for depression. The National Institutes of Mental Health (NIMH) estimates that five million Americans over the age of 65 suffer from some form of depression. However, many of these Americans do not recognize their symptoms as depression and do not receive the treatment they need. NIMH and the Administration on Aging (AoA) will launch an outreach initiative to educate the elderly and their healthcare professionals that they may be at risk for or suffer from a mental illness. AoA will work to get this information throughout the aging network, including through the AoA website, the AoA newsletter (that goes to 600 older adult agencies), and the State Units on Aging, that run a range of programs serving millions of older Americans including meals on wheels and adult day care centers. **(Mrs. Gore)**

Launching six new study sites to help older adults with mental illness get quality treatment in primary care settings. Research indicates that three-fourths of older adults who commit suicide had visited a primary care physician within the month before their suicide and 20 percent had visited their primary care physician on that very day. Usually older adults do not seek services for these disorders due to the lack of awareness that their symptoms are a treatable mental illness, rather than normal signs of aging. The Department of Veteran Affairs will collaborate with the Substance Abuse and Mental Health Services Administration in HHS by providing $17 million to expand an existing SAMHSA program to test two models of primary care service delivery for aging persons with mental health and/or substance abuse disorders in these six sites for a total of thirteen. **(Mrs. Gore)**

IMPROVING TREATMENT FOR AMERICANS WITH MENTAL ILLNESS

Encouraging states to offer more coordinated Medicaid services for people with mental illness. Millions of Americans with severe mental illness rely on Medicaid to pay for their physical health and mental health care. To encourage states to make the most effective services available to treat mental health needs, the Health Care Financing Administration (HCFA) will advise all state Medicaid directors that: (1) Medicaid will reimburse for services provided in Assertive Community Treatment (ACT) programs targeting people with people with the most severe and persistent mental illness; (2) Medicaid recipients all have access to medications that have been approved by FDA for the treatment of serious mental illnesses; and (3) states should educate Medicaid providers and beneficiaries about the existence of advance planning directives for individuals who may be incapacitated in the future and unable to control their care. **(POTUS)**

Launching a pilot program to help people with mental illness get the quality treatment they need to return to work. Of the 4.7 million Americans that receive Social Security Disability Insurance (SSDI), the Social Security Administration estimates that approximately one in nine (about 500,000) has an affective disorder (such as depression or a bipolar disorder). Research suggests that many of these affective disorders cases could be effectively treated and perhaps could return to work. The Administration will launch a new five-year, $10 million demonstration to provide treatment for SSDI beneficiaries with affective disorders. Up to 1,000 SSDI beneficiaries with affective disorders will participate in this pilot, and SSA will monitor this study to determine if it enables these beneficiaries to return to work and determine to the extent this can be launched on a broader scale. This complements the Roth-Moynihan-Jeffords-Kennedy legislation that allows people to buy into the Medicaid or Medicare program when they return to work. **(VP)**

PROMOTING FAIR TREATMENT AND REDUCING DISCRIMINATION

Developing and implementing new strategies to address mental illness in the criminal justice system. The Bureau of Justice Statistics estimates that the prevalence of mental illness in prisons and jails is about 10 to 15 percent. The Substance Abuse and Mental Health Services Administration within HHS and DOJ are hosting a conference later this summer to focus on how all aspects of the criminal justice system can better address the needs of mentally ill offenders. The conference will bring together mental health experts, leaders in the juvenile justice system and law enforcement officials from around the country to focus on a range of topics including, model prevention strategies; treatment and support needs of juvenile offenders, how institutional and community corrections can better treat those with mental illnesses. Following up on promising strategies learned at this conference as well as other community practices that have proven effective, DOJ will launch an outreach efforts to educate the criminal justice community on how to better serve people with mental health needs. These efforts include a new guide that discusses community-based strategies as well as a partnership with the National GAINS center so communities interested in pursuing these approaches can get technical assistance and ideas about how to implement successful strategies. **(VP)**

Reducing discrimination and stigma in housing. The Department of Housing and Urban Development (HUD) will hold three training and awareness sessions led by Secretary Cuomo and facilitated by community partners in HUD's 81 offices to reduce stigma and discrimination in housing and to help assure that housing facilities address the needs of consumers with mental illness. HUD will require that all their employees and its thousands of grantees participate in one of these sessions by satellite. **(No Principal)**

Eliminating stricter standards currently applied to federal hiring practices for adults with psychiatric disabilities. Currently, there are excepted appointment authorities that are explicitly designed to encourage the federal government to hire individuals with disabilities by exempting them from the competitive appointment process. However, these appointments have traditionally held stricter standards when applied to adults with psychiatric disabilities. In January, Mrs. Gore announced that the President was asking OPM to look into this disparity. Today, the President is issuing an Executive Order to direct OPM to change their policy to assure that Americans with mental disabilities are afforded the same hiring opportunities currently available to individuals with mental retardation and severe physical disabilities. The Administration also called upon all employers to reexamine their hiring practices. **(POTUS)**

Releasing a new regulation to prevent inappropriate use of seclusion and restraint in hospital settings and supporting legislative efforts on this issue. A series of highly publicized cases in Connecticut in 1998 highlighted several mentally ill children residing in psychiatric institutions who died after being restrained by facility staff. The Harvard Center for Risk Analysis estimates that between 50 and 150 such deaths occur annually across the country. There are indications that frequently the restraining holds are not used as a last resort, but rather as a routine method of discipline. To address this problem, HCFA will issue an interim final regulation with public comment to assure that, as a condition for participating in Medicare, seclusion or restraints are used only in accordance with a patient's plan of care and only as a last resort. In addition, HCFA will announce their intent to examine extending regulatory requirements on seclusion and restraint use to other provider settings where HCFA funds services. The Administration also endorsed legislation in this area, co-sponsored by Senators Lieberman and Dodd, that assures further protections. **(Announce after conference with Mrs. Gore and Senators)**

IMPROVING PROGRESS IN RESEARCH

Launching landmark study to determine nature of mental illness and treatment nationwide to help guide strategies and policy for the next century. In July, The National Institute of Mental Health (NIMH) will launch a $7.3 million major new study to collect the first data collected in over a decade on mental illness, including the prevalence and duration of mental illness, and the types of treatment that are most commonly used. This study of 10,000 Americans will provide information that will help guide how the nation allocates resources and designs policies for the 21st century. **(HRC)**

Developing two new clinical trials to improve mental health treatment. The National Institute of Mental Health is announcing that this fall they will launch two new five-year clinical trials to build on effective treatments for those affected by mental illness including: a new $36 million trial to test new antipsychotic medications that have fewer side effects for the treatment of severe mental illnesses and a $25 million trial to test intervention strategies for the treatment of patients who have depression, but are resistant to available treatments including older adults who have less than optimal responses to initial treatment of their depression. Unlike other studies, these new effectiveness trials will be set in a wide range of "real world" environments allowing for a stronger understanding of how interventions translate in everyday life. **(HRC)**

CHALLENGE FOR CONGRESS TO PASS LEGISLATION TO IMPROVE CARE AND SERVICES FOR PEOPLE WITH MENTAL ILLNESS.

Fund an historic increase in the mental health block grant. The White House called on the Congress to pass the President's FY 2000 budget proposal for a $70 million increase in the mental health block grant. In an era of surpluses, the Administration also called on states to expand their coverage in this area. **(Mrs. Gore)**

Pass a strong enforceable patients' bill of rights. The Administration also challenged the Congress to pass a strong enforceable patients' bill of rights that assures that consumers, including those with mental health needs, receive critical protections such as access to specialists, the continuity of care protections, and an independent appeals process to address grievances with their health plans. **(POTUS)**

Pass strong comprehensive privacy protections and legislation to eliminate genetic discrimination. The President and Vice President also urged Congress to pass comprehensive legislation to assure medical records privacy, so that information, including sensitive information about mental illness, is protected. In addition, as researchers continue to unlock the genetic code, which enhances the potential to expand treatment options, the Administration urged the Congress to pass legislation that prevents employers and health care plans discriminating against Americans based on their genetic information. **(POTUS or VP)**

Pass Roth-Moynihan-Jeffords-Kennedy legislation to enable people with disabilities return to work. Access to affordable health insurance is the biggest barrier preventing people with disabilities from returning to work. Congress was encouraged to pass this legislation which would help people with disabilities, including mental illnesses, buy into Medicare and Medicaid so they can return to work. **(POTUS)**

Challenge Congress to hold hearings on mental health parity legislation and to review the strengths and weaknesses of the current law. The Administration urged the Congress to hold hearings right away on the strengths and weaknesses of the current mental health parity law and to determine the feasibility of congressional legislation that would expand these proposals for private health plans. **(POTUS)**