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COMMENTS:

Exec. Summary of S.G. report on mental health

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Executive Summary

Mental Health

A Report of the Surgeon General

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

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 has 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 our personal well-being and public health; so too must we assign priority to the task of promoting mental health and preventing mental disorders. Treatment and mental health services are also critical to the Nation's health. These emphases, combined with expanding the knowledge base needed to treat and prevent mental and behavioral disorders, constitute a broad public health approach to a health concern of pressing urgency.

A second message of the report is to emphasize that **mental disorders are "real" medical 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 comes on the heels of—indeed, 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 reflects the tremendous growth of the science base that is enriching our understanding of the awe-inspiring complexity of the brain and behavior—an understanding that, in turn, increasingly supports mental health practices.

The body of this report was developed on the basis of an extensive review of the scientific literature and 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.

Based on an exhaustive review of research, the report arrives at two main findings:

- **Mental health treatments are effective,** and
- **A range of effective 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.***

Once a person has made the decision to seek help for a mental health problem, he or she can choose from a broad variety of helping sources, treatment approaches, and service settings. There is no "one size fits all" treatment for mental disorders. Personal preference may influence, for example, the choice of psychotherapeutic, or "talk" therapy over the use of medications; in another case, an individual may feel most comfortable raising questions about symptoms of mental distress with a family doctor, with a trusted member of the clergy, or if a child's health is the subject of concern, with a teacher or a school counselor. There are many individuals who are familiar with questions about mental health care and who, as a first point of contact, can provide invaluable assistance in obtaining appropriate and effective care.

Despite the effectiveness of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment. Most often, reluctance to seek care is an unfortunate outcome of very real barriers to help seeking. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness.

Stigma erodes confidence that mental disorders are valid, treatable health conditions. It leads people to avoid socializing, employing or working with, or renting to or living near persons who have a mental disorder, especially a severe disorder like schizophrenia. Stigma deters the public from wanting to pay for care and, thus, reduces consumers' access to resources and opportunities for treatment and social services. A consequent inability or failure to obtain treatment reinforces destructive patterns of low self-esteem, isolation, and hopelessness. Stigma tragically deprives people of their dignity and interferes with their full participation in society. It must be overcome.

Increasingly effective treatments for mental disorders promise to be the most effective antidote to stigma. Effective interventions help people to understand that mental disorders are not character flaws but are legitimate illnesses that respond to specific treatments, just as other health conditions respond to medical interventions. Fresh approaches to disseminating research information are needed urgently.

While they are being developed, this report provides information that organizations, experts, and many other individuals can use to educate all Americans about mental health and mental illness.

Overarching Themes of the Surgeon General's Report

Key themes, summarized here, run throughout the report. The importance of information, policies, and actions that will reduce and eventually eliminate the cruel and unfair stigma attached to mental illness is one. The importance of a solid research base for every mental health and mental illness intervention is another. As our Nation has seen in the past, establishing mental health policy on the basis of good intentions alone can make bad situations worse; evaluating the practicality and effectiveness of new approaches is efficient and, more critically, is accountable to those for whom an intervention is intended. Additional, overarching notions or themes in the report include the following.

Public Health Perspective

In the United States, mental health programs, like general health programs, are rooted in a *population-based public health model.* Broader in focus than medical models that concentrate on diagnosis and treatment, public health attends, in addition, to the health of a population in its entirety; that is, it encourages a focus on epidemiologic surveillance, health promotion, disease prevention, and access to services. Although much more is known through research about mental illness than about mental health, the report attaches high importance to public health practices that seek to identify risk factors for mental health problems; to mount preventive interventions that may block the emergence of severe illnesses; and to actively promote good mental health.

Mental Disorders Are Disabling

The World Health Organization, in collaboration with the World Bank and Harvard University, mounted an ambitious research effort in the mid-1990s to determine 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 years (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, 1966).
**Disease burden associated with "mental illness" includes suicide.

Mental Health and Mental Illness

As will be evident in the pages that follow, "mental health" and "mental illness" are not polar opposites but 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 heightened risk of death, pain, disability, or loss of freedom (DSM-IV, 1994).

This report uses the term "mental health problems" for signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder. Almost everyone has experienced mental health problems in which the distress one feels matches some of the signs and symptoms of mental disorders. Mental health problems may warrant active efforts in health promotion, prevention, and treatment. Bereavement symptoms in older adults offer a case in point. Bereavement symptoms of less than 2 months' duration do not qualify as a mental disorder, according to professional manuals for diagnosis (DSM-IV, 1994). Nevertheless, bereavement symptoms can be debilitating if they are left unattended. They place older people at risk for depression, which, in turn, is linked to death from suicide, heart attack, or other causes (Zisook & Shuchter, 1991, 1993; Frasure-Smith et al., 1993, 1995; Conwell, 1996). Much can be done—through formal treatment or through support group participation—to ameliorate the symptoms and to avert the consequences of bereavement. In this case, early intervention is needed to address a mental health problem before it becomes a disorder.

Mind and Body

As it examines mental health and illness in the United States, the report confronts a profound obstacle to public understanding, one that stems from an artificial, centuries-old separation of mind and body.

Even today, everyday language encourages a misperception that mental health or mental illness is unrelated to physical health or physical illness. In fact, the two are inseparable. In keeping with modern scientific thinking, this report uses mind to refer to all mental functions related to thinking, mood, and purposive behavior. The mind is generally seen as deriving from activities within the brain. Research reviewed for this report makes it clear that mental functions are carried out by a particular organ, the brain. Indeed, new and emerging technologies are making it increasingly possible for researchers to demonstrate the extent to which mental disorders and their treatment—both with medication and with psychotherapy—are reflected in physical changes in the brain.

Scope of the Report and General Conclusions

Chapter 1: Introduction and Main Messages

Chapter 1 of the report elaborates on the overarching themes highlighted above, and describes the criteria applied to the scientific evidence that is cited throughout the report. The chapter also lists the key conclusions drawn from each succeeding chapter. These conclusions are provided, as well, in the following pages of this Executive Summary.

Chapter 2: The Fundamentals of Mental Health and Mental Illness

The past 25 years have been marked by several discrete, defining trends in the mental health field. These have included:

- The extraordinary pace and productivity of scientific research on the brain and behavior;
- The introduction of a range of effective treatments for most mental disorders;
- A dramatic transformation of our society's approaches to the organization and financing of mental health care; and
- The emergence of a powerful consumer and family movement.

The brain has emerged as the central focus for studies of mental health and mental illness. New scientific disciplines, technologies, and insights have begun to weave a seamless picture of the way in which the brain mediates the influence of biological, psychological, and social factors on human thought,

behavior, and emotion in health and in illness. Molecular and cellular biology, along with molecular genetics, complemented by sophisticated cognitive and behavioral science are preeminent research disciplines in the contemporary neuroscience of mental health. These disciplines are affording unprecedented opportunities for "bottom-up" explorations of brain mechanisms; this 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 peoples' abilities to learn, to remember, to experience emotion, and, when these processes go awry, to experience 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 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.

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 a safer, more effective medication that could be developed to minimize or eliminate adverse side effects. 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—both somatic and psychosocial—as well as preventive interventions that are based on an understanding of specific mechanisms that lead to illness and that 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.

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. Its configuration reflects necessary responses to a broad array of factors including reform movements, financial incentives based on who would pay 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.

The third key trend listed above—the emergence of a vital consumer and family movement—also promises to shape the direction and complexion of mental health programs for many years to come. Although divergent in their historical origins and philosophy, organizations representing consumers and family members have promoted important, often overlapping goals and have invigorated the fields of research as well as treatment and service delivery design. Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability, as well as by age or gender or by the racial and cultural identity of those who have mental illness.

Chapter 2 of the report was written to provide background information that would help persons from outside the mental health field better understand topics addressed in subsequent chapters of the report. Although the chapter is meant to serve as a mental health primer, its depth of discussion supports a range of conclusions:

- The multifaceted 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, symptoms, and functional impairments.
- 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. Approximately 15 percent of all adults who have a mental disorder in one year also experiences a co-occurring substance (alcohol or other drug) use disorder, which complicates treatment.
- A range of effective treatments exists for nearly all mental disorders. Two broad types of intervention include psychosocial treatments—for example, psychotherapy or counseling—and psychopharmacologic treatments; 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 10 percent of the U.S. adult population uses mental health services in the health sector in any year, with another 5 percent seeking such services from social service agencies, schools, religious, or self-help groups. 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 and less severe mental health problems 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.

Mental Health and Mental Illness Across the Lifespan

The Surgeon General's report takes a life span 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 experienced by 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 neurobiological and genetic mechanisms that are the platform upon which a person's life experiences can either strengthen mental health or lead to mental illness. It now is recognized that factors that influence brain development prenatally may set the stage for a vulnerability to illness that may lie dormant throughout childhood and adolescence. Similarly, no single gene has been found to be responsible for any specific mental disorder; rather, variations in multiple genes contribute to a disruption in healthy brain function that, under certain environmental conditions, results in a mental illness. Moreover, it is now recognized that socioeconomic factors affect individuals' vulnerability to mental illness and mental health problems. Certain demographic and economic groups, such as women, low-income individuals, and racial and ethnic minorities are more likely than others to experience mental health problems and some mental disorders. Vulnerability alone may not be sufficient to cause a mental

disorder; rather, the causes of most mental disorders lie in some combination of genetic and environmental factors, which may be biological or psychosocial.

The fact that many, if not most, people have experienced mental health problems that mimic or even match some of the symptoms of a diagnosable mental disorder tends, ironically, to prompt many people to underestimate the painful, disabling nature of severe mental illness. In fact, schizophrenia, mood disorders such as major depression and bipolar illness, and anxiety often are devastating conditions. Yet relatively few mental illnesses have an unremitting course marked by the most acute manifestations of illness; rather, for reasons that are not yet understood, the symptoms associated with mental illness tend to wax and wane. Not only do such patterns of illness tend to reinforce stigmatizing views about persons with mental illness, but they pose special challenges to the implementation of treatment plans and the design of service systems that are optimally responsive to an individual's needs during every phase of illness. As this report concludes, enormous strides are being made in diagnosis, treatment, and service delivery, placing the productive and creative possibilities of adulthood within the reach of persons who are encumbered by mental disorders.

Late adulthood is when changes in health status may become more noticeable and the ability to compensate for decrements may become limited. As the brain ages, a person's capacity for certain mental tasks tends to diminish, even as changes in other mental activities prove to be positive and rewarding. Well into late life, the ability to solve novel problems can be enhanced through training in cognitive skills and problem-solving strategies.

The promise of research on mental health promotion notwithstanding, a substantial minority of older people are disabled, often severely, by mental disorders including Alzheimer's disease, major depression, substance abuse, anxiety, and other conditions. In the United States today, the highest rate of suicide—an all-too-common consequence of unrecognized or inappropriately treated depression—is found in older males. This fact underscores the urgency of ensuring that health care provider training properly emphasizes skills required to differentiate accurately the causes of cognitive, emotional, and behavioral symptoms that may, in some instances, rise to the level of mental disorders, and in other instances be expressions of unmet general medical needs.

As the life expectancy of Americans continues to extend, the sheer number—although not necessarily the proportion—of persons experiencing mental disorders of late life will expand, confronting our society with unprecedented challenges in organizing, financing, and delivering effective mental health services for this population. An essential part of the needed societal response will include recognizing and devising innovative ways of supporting the increasingly more prominent role that families are assuming in caring for older, mentally impaired and mentally ill family members.

Chapter 3: 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 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 "extreme functional impairment."
- Mental disorders and mental health problems 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 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 has yet 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; that is, drawing on multiple service sectors. The effectiveness of systems approaches designed to overcome

fragmentation is the subject of ongoing research. The face-valid, or "common sense," 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.

Chapter 4: Adults and Mental Health

1. 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.
2. 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.
3. 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.
4. 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.
5. 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 depending on the individual's diagnosis and personal preference.
6. A new recovery perspective is supported by evidence on rehabilitation and treatment as well as by the personal experiences of consumers.

7. Certain common events of midlife (e.g., divorce or other stressful life events) create mental health problems (not necessarily disorders) that may be addressed through a range of interventions.
8. Care and treatment in the real world of practice do not conform to what research tells us is best. At times care is inadequate, but there are models for improving treatment.
9. Substance abuse is a major co-occurring problem for adults with mental disorders. Evidence supports combined treatment, although there are substantial gaps between what research recommends and what typically is available.
10. Several special problems in care and treatment of adults have been recognized, beyond traditional mainstream mental health concerns, including racial and ethnic differences, lack of consumer involvement, and the consequences of disability and poverty.
11. 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.

Chapter 5: 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 among males in this population; and
- — Schizophrenia continues to be disabling in spite of recovery of function by some individuals in mid to late life.

- There are effective interventions for most mental disorders experienced by the elderly (for example, depression and anxiety), and many mental health problems, such as persistent bereavement.
- Older individuals can benefit from the advances in psychotherapy, medication, and other treatment interventions for mental disorders enjoyed by younger adults, when these interventions are modified for age and health status.
- Treating older adults with mental disorders accrues 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 underrecognized and undertreated 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.

Chapter 6: Organization and Financing of Mental Health Services

In the United States in the late 20th century, research-based capabilities to identify, treat, and, in some instances, prevent mental disorders is outpacing the capacities of the service system the Nation has in place 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—that is, nondiscriminatory coverage.

1. Epidemiologic surveys indicate that one in five Americans have a mental disorder in any one year.
2. 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.
3. Twenty-one percent of children ages 9 to 17 receive mental health services in a year.
4. 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.
5. 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.
6. 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.
7. In recent years, managed care has begun to introduce dramatic changes into the organization and financing of health and mental health services.
8. 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.
9. 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.

10. An array of quality monitoring and quality improvement mechanisms has been developed although incentives for their full implementation and competition on the basis of quality have yet to emerge in the managed care industry.

11. 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.

Chapter 7: Confidentiality of Mental Health Information: Ethical, Legal, and Policy Issues

In an era in which the confidentiality of all health care information, its accessibility, and its uses are of concern to all Americans, privacy issues are particularly keenly felt in the mental health field. An assurance of confidentiality is understandably critical in individual decisions to seek mental health treatment. Although an extensive legal framework governs confidentiality of consumer-provider interactions, potential problems exist and loom ever larger.

- 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 confidentiality 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 that 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.

Chapter 8: A Vision for the Future—
Actions for Mental Health in the New Millennium

The extensive literature that the Surgeon General's report reviews and summarizes leads to the conclusion that ***a range of effective treatments exists for most mental disorders.*** Moreover, a person may choose a particular approach to suit his or her needs and preferences. Based on this finding, the report's principal recommendation to the American people is to ***seek help if you have a mental health problem or think you have a symptom of a mental disorder.*** As noted earlier, stigma interferes with the willingness of many people—even those who have a serious mental illness—to seek help. And, as documented in this report, those who do seek help will all too frequently learn that there are substantial gaps in the availability of state-of-the-art mental health services and barriers to their accessibility. Accordingly, the final chapter of the report goes on to explore opportunities to overcome barriers to implementing the recommendation and to have seeking help lead to effective treatment.

The final chapter identifies the following courses of action.

- ***Continue to Build the Science Base***: Today, integrative neuroscience and molecular genetics present some of the most exciting basic research opportunities in medical science. A plethora of new pharmacologic agents and psychotherapies for mental disorders afford new treatment opportunities 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 subjects are addressed in such a way that research continues to flourish. 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 effective treatments for virtually every mental disorder. 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, is influenced by age, gender, race, and culture. To be optimally effective, approaches to the diagnosis and treatment of mental illness must be attentive to those same factors. "Culturally competent" services incorporate understanding of racial and ethnic groups, their histories, traditions, beliefs, and value systems. The preference of many members of ethnic and racial minority groups to be treated by mental health professionals of similar background underscores the need to redress the current insufficient supply of mental health professionals of color.
- ***Facilitate Entry Into Treatment***: Public and private agencies have an obligation to facilitate entry into mental health care and treatment through the multiple "portals of entry" that exist: primary health care, schools, and the child welfare system. To enhance adherence to treatment, agencies should offer services that are responsive to the needs and preferences of service users and their families. At the same time, some agencies receive inappropriate referrals. For example, an alarming number of children and adults with mental illness are in the criminal justice system inappropriately. Importantly, assuring the small number of individuals with severe mental disorders who pose a threat of danger to themselves or others ready access to adequate and appropriate services promises to reduce significantly the *need* for coercion in the form of involuntary commitment to a hospital and/or certain outpatient treatment requirements that have been legislated in most states and territories. Coercion should not be a substitute for effective care that is sought voluntarily; consensus on this point testifies to the need for research designed to enhance compliance with treatment.

- *Reduce Financial Barriers to Treatment*: Concerns about the cost of care—concerns made worse by the disparity in insurance coverage for mental disorders in contrast to other illnesses—are among the foremost reasons why people do not seek needed mental health care. While both access to and use of mental health services increase when benefits for those services are enhanced, preliminary data show that the effectiveness—and, thus, the value—of mental health care also has increased in recent years, while expenditures for services, under managed care, have fallen. Equality between mental health coverage and other health coverage—a concept known as parity—is an affordable and effective objective.

Scope of Coverage of the Report

This report considers some conditions which are not always associated with the mental disorders and does not consider others which can be found in classifications of mental disorders such as DSM-IV. The report includes, for example, a discussion of autism in Chapter 3 and provides an extensive section on Alzheimer's disease in Chapter 5. Although both of these conditions are listed with specific criteria in DSM-IV, they often are viewed as being outside the scope of the mental health field. In both cases, mental health professionals are involved in the diagnosis and treatment of these conditions, often characterized by cognitive and behavioral impairments. The developmental disabilities and mental retardation are not discussed except in passing in this report. These conditions were considered to be beyond its scope with a care system all their own and very special needs. The same is generally true for the addictive disorders, such as alcohol and other drug use disorders. The latter, however, co-occur with such frequency with the other mental disorders, which are the focus of this report, that the co-occurrence is discussed throughout. The report addresses the epidemiology of addictive disorders and 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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Zisook & Shuchter, 1991.

Zisook & Shuchter, 1993.

SYLVIA / JACK - THIS WAS RELEASED WITHOUT CLEARANCE. IT PUTS US @ HHS IN A VERY AWKWARD POSITION VIS-A-VIS THE WELLSTONE BILL. I THINK YOU SHOULD RAISE THIS AT THE PODESTA MEETING

THANKS, DON.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

FOR IMMEDIATE RELEASE
Tuesday, July 27, 1999

Contact: Steve Panton
(202) 395-6618

National Drug Control Policy Director Barry R. McCaffrey Issues Statement on Substance Abuse Parity in Health Insurance Coverage

(Washington, D.C.) National Drug Control Policy Director Barry R. McCaffrey today made the following statement about national policy on substance abuse parity. "Substance abuse parity in health insurance coverage is both good drug control policy and good health policy. The President's June 7, 1999 decision to require substance abuse parity for 9 million federal employees underscores the administration's commitment to parity for all Americans." President Clinton's decision was influenced by the following:

- **Parity is an important element of drug control policy.** The National Drug Control Strategy's goal of reducing drug use by 50 percent in the next ten years can only be accomplished with a significant expansion of capacity to treat the nation's drug users.

- **Parity can help close the treatment capacity gap.** Seventy percent of drug users are employed and most have private health insurance. Yet 20 percent of public treatment funds were spent on people with private health insurance in 1993, due to limitations on their policies.

- **Adolescents will benefit most.** Adolescents, many of whom are covered by parents' insurance plans and policies, will benefit significantly from parity. While about half of adults in immediate need of drug treatment receive it, HHS estimates that treatment capacity is sufficient for only about 20 percent of adolescents with the same immediate need. Parity will facilitate access to appropriate care for adolescents.

- **Parity is affordable.** According to a 1998 study by the Substance Abuse and Mental Health Services Administration, of both actuarial models and case studies of states that have adopted parity, the average premium increase for full parity of substance abuse treatment is 0.2 percent, about one dollar per month for most families.

  - A March 1999 SAMHSA report, Effects of the Mental Health Parity Act of 1996, found that among employers who made changes as a result of the Act, 86 percent made no compensatory changes to their benefits, primarily because expected cost increases were judged minimal or nonexistent. A May 1999 study by RAND found a cost to managed care health plans of just over $5 per person each year to give employees of large companies unlimited substance abuse benefits.

  - The alternative is to continue paying the high cost of medical care by waiting to treat the physical effects of substance abuse: long-term effects like liver and other organ damage and acute effects like heart attack and stroke.

(more)

- **Parity will reduce the overall burden of substance abuse to society.** Illegal drugs cost our society approximately $110 billion each year in avoidable costs. Drug treatment results in decreased drug use and crime, better social functioning, and reduced transmission of disease.

"Parity is an important element of the National Drug Control Strategy," said McCaffrey. "Parity will improve public understanding of addiction, increase access to care, bring drug treatment into the mainstream of health care, and reduce suffering for millions of Americans."

-30-

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. email	Betsey Parker to John Glaser re: personal medical (1 page)	05/28/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20146

FOLDER TITLE:
Mental Health

2012-0463-S
rc797

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

names given by Pat Brady
re: NH long term care

1) John Poirier (603)226-4900
-NH Health care assoc.

2) Eileen Meehan (603)226-4900
-alzheimers assoc.

3) Dennis Hett (603)626-3479
-ass. for homes + services for the aging

4) Rebecca Farver (603) 225-1996
-NH long term care inst.

5) Ellen Sheridan
-State comm. on aging (603) 224-7612

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. memo	Judy Riggs to Barbara Wooley re: Caregivers for June 3 Event (partial) (1 page)	05/28/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20146

FOLDER TITLE:
Mental Health

2012-0463-S
rc797

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b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

MEMORANDUM

TO: Barbara Wooley
FROM: Judy Riggs
RE: Caregivers for June 3 Event
DATE: May 28, 1999

I have two contacts for you:

Eileen Meehan, executive director of the Alzheimer's Association in New Hampshire and a long distance caregiver for her parents in Connecticut. Work phone: 603/226-5868; home phone: P6/(b)(6)

P6/(b)(6) [0016]

Also, the New Hampshire chapter just got $15,000 from the state attorney general (result of a settlement with an HMO) which they will use to begin a small respite program. This is only a drop in the bucket in terms of need, however, and the Caregiver Support Program would bring the state the real money they need to meet the needs of Alzheimer caregivers and other caregivers. She would be prepared to talk about that as well.

I strongly recommend that you call Eileen. She is a very effective spokesperson. She can also link you to other caregivers (including Helen Zarnowski.)

Helen Zarnowski is 77 years old and was full-time caregiver for her husband, who had Alzheimer's, until he died about 3 years ago. She chairs the NH chapter Public Policy Committee and is liaison to the 40 support groups the chapter runs in NH. You need to reach her through Eileen.

Both Eileen and Helen live right outside of Manchester. They would come to the meeting together.

OPPENHEIMER WOLFF DONNELLY & BAYH LLP

FAX COVER LETTER

1350 Eye Street N.W.
Suite 200
Washington, D.C. 20005-3324

(202) 312-8000
FAX (202) 312-8100

May 28, 1999

TO: **Chris Jennings**
COMPANY: **The White House**
PHONE: **456-1414**
FAX: **456-5557**

FROM: **Birch Bayh**
DIRECT DIAL:
E-MAIL:
RE:

COMMENTS: Hi Chris —
Great to be able to chat. It's been too long. Thanks for giving a close look at the LVRS issue. I honestly think this is our kind of issue. Thanks again. We'll check when I get back from Mexico.
Birch

Originals: ☒ **Not being sent** **Sent by:** ☐ **Post Office** ☐ **Messenger** ☐ **Air Courier**

Completed by : /

You should receive 13 **page(s) including this page.**
If the transmission is incomplete, please call (202) 312-8000 as soon as possible.

LUNG VOLUME REDUCTION SURGERY:
A TREATMENT FOR END STAGE EMPHYSEMA THAT WORKS

Background

There is no cure for emphysema or for the nearly 2 million Americans who suffer with it every day of their lives. The principal cause of this disease is smoking. Less than 5%, or about 90,000 of serious emphysema sufferers are qualified candidates for lung volume reduction surgery (LVRS). By definition, these people, ***many of whom are Medicare dependent***, have only two to five years to live. As the very act of breathing is labored and difficult, they rely heavily on supplemental oxygen and are often confined to their homes, unable to perform many tasks associated with daily living.

With improved technology to prevent air leaks, LVRS was reinvigorated in the early 1990s. LVRS permits qualified emphysema patients, who literally cannot breathe normally with their distended lungs, to improve the mechanics of their remaining lungs after sections of the most severely affected lungs are removed. ***LVRS is not for everyone and it must be limited to qualified patients at qualified medical centers.***

There is consensus within the physician community, both among pulmonologists and thoracic surgeons, that qualified patients can be identified prior to surgery through the application of patient selection criteria, and that these patients should be able to receive the surgery at qualified centers and have Medicare cover and pay for it now. Please see the attached Consensus Statement and Patient Selection Criteria endorsed by 65 of the most renowned physicians around the country. This consensus is based upon all of the available scientifically valid data demonstrating that short of a lung transplant, ***LVRS significantly improves lung function and quality of life for emphysema patients not achievable through any other means***. Regarding lung transplants, it is important to note that not every LVRS candidate is a lung transplant candidate, that lung transplants are very rare due to the limited number of available lungs, and that lung transplants are very expensive (and paid for by HCFA). Each lung transplant costs about $200,000 plus the cost of all the drugs needed to prevent rejection of the transplant for the rest of the patient's life. LVRS costs about $35,000 per procedure. The attached June 29, 1998 *Wall Street Journal* article provides good overall background information and speaks directly to the quality of life issue.

HCFA's Non-Coverage Decision

Over three years ago, on January 1, 1996, HCFA implemented a national non-coverage decision for LVRS on the grounds that not enough data existed to support coverage. In an effort to collect data on LVRS in a controlled setting, HCFA linked with NIH to establish a prospective randomized clinical trial, known as the National Emphysema Treatment Trial (NETT). Eighteen centers were selected, one of which dropped out of the study due to ***ethical concerns*** regarding the randomization element of the protocol, i.e., randomizing between LVRS and pulmonary rehabilitation. The ethical concern is grounded in the fact that there are enough data to (a)

support the surgery for a well-defined patient population whose health is significantly impaired, and (b) conclude that pulmonary rehabilitation does not improve lung function. Randomization is only appropriate when one doesn't know which of the two treatments produces the better results. Today, the results are in: ***LVRS is the only ethical option.***

The NETT was originally designed as a seven year trial. HCFA and NIH now say that it will take 4 1/2 years from the February 1998 start of randomizing patients (until August 2002) to collect all of the data necessary to make a coverage decision. Patient recruitment is so slow, however, that at the current one-quarter speed of recruitment, ***the NETT would take 18 years to collect all of the data HCFA claims it needs*** to make a coverage decision.

The Data

As the Consensus Statement reflects, the experts believe there are enough data to support a modification of HCFA's coverage policy, currently limited to paying for the surgery when performed within the context of the NETT. ***More than 130 peer reviewed articles have been published since HCFA non-coverage decision, all of which support LVRS***. In its June 1998 Report to Congress (mandated by the FY97 Appropriations Act to be submitted no later than January 1, 1997) ***HCFA cited less than 25% of the available studies to support its position.*** Previously, in April 1997, then-HCFA Administrator Bruce Vladeck testified before the House Ways and Means Health Subcommittee that if the data demonstrated that certain patients would likely benefit from LVRS, then HCFA would change its coverage policy to provide the surgery for those people immediately. HCFA has not taken this step despite the available data.

The Discrimination

Further, regardless of HCFA's non-coverage decision, ***many of the best known insurance companies and HMOs like Aetna, Blue Cross Blue Shield, State Farm, Kaiser Permanente, Harvard Pilgrim Health Care, and even the Veterans Administration cover and pay for LVRS***. Many of these organizations made this decision based upon their own technology assessment. Please see the attached list of more than 40 such companies. The result of HCFA's non-coverage policy, therefore, is to discriminate against Medicare-dependent beneficiaries who do not have the means to pay for the surgery through private insurance or from their personal resources.

The Solution

HCFA has the authority and the ability, based upon all of the available data, to modify its coverage policy to extend coverage and payment to a well-defined patient population when these patients have LVRS at qualified medical centers. The Patient Selection Criteria attached to the Consensus Statement define that patient population. As a prerequisite to coverage and payment, HCFA can require that all data generated be channeled to a national registry for ongoing analysis.

DECEMBER 1998 CONSENSUS STATEMENT ON LUNG VOLUME REDUCTION SURGERY

As the physicians in the field with years of education and experience, we know that lung volume reduction surgery (LVRS) provides clear benefit to a known segment of the late-stage emphysema population.[1] These benefits include (1) an objectively measurable improvement in lung function, not otherwise attainable through pulmonary rehabilitation or any other treatment, and (2) a quantifiable improvement in quality of life and, therefore, a significant reduction of daily suffering. These outcomes are highly comparable to those achieved for the elderly who receive Medicare-supported surgery for other diseases such as lung and esophageal cancer. Given our experience in treating late-stage emphysema sufferers who qualify for LVRS, we believe those who are Medicare beneficiaries should have the opportunity to receive Medicare-supported LVRS at appropriately qualified medical centers that are more broadly and geographically accessible than at present.

WILLIAM H. WARREN, M.D., FRCSC, FCCP
PROFESSOR OF CARDIOVASCULAR-THORACIC SURGERY, RUSH PRESBYTERIAN-ST. LUKES MEDICAL CENTER, DIRECTOR, THORACIC SURGERY, COOK COUNTY HOSPITAL
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[1] The patient selection criteria that define this patient population are attached to this Consensus Statement. It is important to note that the sound medical judgment of skilled, qualified physicians is needed to assess whether a particular LVRS candidate satisfies these selection criteria, which must be treated as guidelines, not absolutes. Each person has a unique medical history and disease morphology which requires that physician judgment be an essential element of any treatment plan. It is recommended that HCFA cover and pay for LVRS when it is performed on patients satisfying these selection criteria, with any judgment-based deviations documented, as determined by surgeons based at qualified medical centers. These criteria reflect the accumulation of peer reviewed published, and unpublished, but available data, and the shared view of the physicians who have signed on to this Consensus Statement.

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As of March 8, 1999

LUNG VOLUME REDUCTION SURGERY
PATIENT SELECTION CRITERIA

There is consensus within the medical community that the available medical data regarding lung volume reduction surgery support immediate Medicare coverage and payment for late stage emphysema sufferers who meet the following selection criteria:[2]

- Emphysema with hyperinflation and defined target areas, e.g., areas of poorly perfused, overinflated lung, limited to the apices of the lung
- Marked physiologic impairment
    - forced expiratory volume in one second less than 35% of predicted
    - residual volume greater than 200% of predicted and total lung capacity greater than 125% of normal resulting from the diseased lung being hyperinflated
- Marked restriction in activity despite maximal medical therapy, including ambulatory oxygen
    - activities contemplated include daily routines such as walking up and down stairs, talking on the telephone, bathing, and getting dressed
- Age: less than 75 years old (with exceptions based upon evaluation of other criteria)
- Body weight: between 70% and 120% of ideal
- Ability to participate in vigorous pulmonary rehabilitation program for 8 continuous weeks prior to surgery
    - vigorous pulmonary rehabilitation involves use of treadmill (or stationary bicycle where indicated) and upper body exercises
- No coexisting major medical problems such as angina, pulmonary hypertension (mean pulmonary artery pressure greater than 35 millimeters of mercury), stroke, and absence of malignancy with life expectancy of less than two years
- Willingness to undertake risk of morbidity and mortality of surgery
- Abstinence from cigarette smoking for 6 continuous months prior to surgery

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[2] It is important to note that the sound medical judgment of skilled, qualified physicians is needed to assess whether a particular LVRS candidate satisfies these selection criteria, which must be treated as guidelines, not absolutes. Each person has a unique medical history and disease morphology which requires that physician judgment be an essential element of any treatment plan. It is recommended that HCFA cover and pay for LVRS when it is performed on patients satisfying these selection criteria, with any judgment-based deviations documented, as determined by surgeons based at qualified medical centers. These criteria reflect the accumulation of peer reviewed published, and unpublished, but available data, and the shared view of the physicians who have signed on to the attached Consensus Statement.

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Second Opinion

Why Medicare Covers A New Lung Surgery For Just a Few Patients

Emphysema Victims Are Told To Wait up to 5 Years As Clinical Trials Proceed

Mr. Farris Empties His IRAs

By CAROL GENTRY
Staff Reporter of THE WALL STREET JOURNAL

Not so long ago, Medicare would cover just about any new procedure a surgeon wanted to try out – as long as the doctor came up with a way to bill for it properly. Then the government tightened the rules, requiring that certain new surgeries undergo much the same scrutiny that applies to new drugs.

In the process, Medicare set off a bitter dispute over ethics, standards and health-care costs. And in the middle of the controversy are thousands of emphysema sufferers anxiously waiting for a procedure called lung-volume reduction.

To many of the country's leading thoracic surgeons, the procedure is a tremendously effective way to improve or extend the lives of patients who are, literally, gasping for air. Those doctors, however, are pitted against some of their own colleagues, along with the Health Care Financing Administration, the federal agency that runs Medicare. The government wants to test the procedure by providing it to some patients, denying it to others, and then over several years determining whether it is safe and effective.

The stakes are big. The operation costs at least $30,000, and doctors estimate that at least 10% of the nation's two million emphysema sufferers could benefit. Do the math, and that works out to a tab of more than $6 billion.

But the stakes are big in another way as well. Many emphysema victims are clamoring for the operation and are angry that the government won't pay for it outside of a small clinical trial. They feel betrayed by a system that may make them wait five years for the surgery, if they get it at all. And they have found an unlikely ally – some big health-maintenance organizations that have concluded the government is denying treatment to people who will die by the time the trials are finished.

Emphysema patients are driven by desperation. The disease, linked to cigarette smoking, leaves patients with thin, oversized lungs that lack the elasticity to expel air after each breath. As lung function decreases, patients become exhausted at the slightest activity, such as taking a shower, and often must be hooked to an oxygen tank. Drugs and exercise regimens buy patients some time, but the treatment usually fails. Indeed, the average life expectancy for patients with advanced emphysema is about three years.

That has led surgeons to experiment in ways that have been "aggressive, creative and occasionally rash," says James E. Sabin, a Harvard University medical ethicist.

Over the years, doctors have tried taking out patients' ribs, injecting helium into their abdomens, or removing a nerve bundle in the neck in a procedure called glomectomy. One surgeon in the early 1960s performed almost 4,000 glomectomies and claimed a high cure rate, Dr. Sabin says, before researchers demonstrated that it offered no benefit.

About 30 years ago, surgeon Otto Brantigan came up with the idea of cutting patients' lungs back to a more normal size. But the death toll was high, and he abandoned the procedure. Then, Joel Cooper, a St. Louis surgeon who had achieved great success in lung transplantation, revived it in January 1993.

Joel Cooper

At a professional meeting the next year, he told stories of early success to fellow thoracic surgeons. They were amazed, and many of them began cutting, lasering and stapling lungs without fully understanding what they were doing. They used a variety of lung-surgery codes to bill the procedure to Medicare, but in December 1995, after the government found out what was going on, it cut off payments. Later, officials released a study showing that among 700 Medicare patients who underwent lung-reduction surgery in late 1995, the one-year mortality rate was 26%. Many others suffered complications requiring further hospitalization.

Shortly thereafter, Medicare announced it would cover the surgery only for 2,200 patients in a study co-sponsored by the National Institutes of Health. A similar number of patients will be in a control group that continues with nonsurgical remedies. The rest of Medicare's emphysema sufferers – who aren't part of the study – will be covered just for nonsurgical treatment.

Doctors are split over the ethics of the trials. The most experienced lung-reduction team in the country, at Barnes Jewish Hospital in St. Louis, withdrew from the study in April after Dr. Cooper, citing "reams of evidence" that the operation works, said he couldn't withhold the surgery from patients who would almost certainly benefit. Richard Fischel, a surgeon who was assisting the principal investigator in Los Angeles, says he has also

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Lung Surgery Raises Ethical Issues

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resigned on ethical grounds.

An alternative trial is being organized by Blue Cross & Blue Shield of Massachusetts and other insurers and medical centers in that state. It will have a control group, too, but patients will be able to cross over and get surgery after just six months, rather than five years. The principal investigator for that study, cardiac surgeon Robert L. Berger of Harvard Medical School, says it won't be as complete as NIH's but is the right thing to do. "Somebody struggling for breath—that demands compassion," he says.

Lining up behind NIH and Medicare are many nonsurgical lung specialists and their professional organization, the American Thoracic Society. They say there are too many questions about lung reduction to justify making it a mass-market procedure, as it probably would become if Medicare paid for it. "The conduct of clinical trials, preferably in a controlled, randomized fashion, is urgently needed," the group said in a 1996 report.

"There's a belief out there that this is a life-saving operation," says John Reilly, a pulmonologist and co-leader of the NIH study at Brigham and Women's Hospital in Boston. "There's no data to say that it is."

Barry Make, a pulmonologist who is principal investigator for the study at the National Jewish Medical and Research Center in Denver, says that if the five-year clinical trial weren't conducted, "the important questions would never be answered."

Setting up the trial has proved to be cumbersome. It took two years to plan the study, which officially began last October, and as of June 19, only 41 patients had been sent to surgery or the control group. The pace seems glacial to patients, because most of them have a limited window before becoming too weak to qualify.

James Farris of Overland Park, Kan., disabled from emphysema since 1989, had been waiting for the Medicare trial for a year and a half when, in May, he decided he could risk no further delay. Mr. Farris, 62 years old, cashed in his IRAs and paid for the surgery himself, with the blessing of his wife, Linda.

"The government was dillydallying," she says. "At some point, you draw a line in the sand and say, 'OK, we've got to do it.' "

Many Medicare patients are questioning whether it is fair for some to serve as study subjects while insurance covers it for others. David Blake, for example, received the surgery through Tennessee's program for the uninsured, Tenn-Care. It made him "a new man," he says, able to play tennis and run his three-state exterminating company. While his brother John was also judged a good candidate for surgery, he was covered only by Medicare, which won't pay. John has gradually gone downhill and spent the past couple of months on a ventilator. "The only thing we can do now is pray to the Big Boss," David Blake says.

Ethicists see the issue as a flashpoint in the debate over how to balance the seemingly limitless potential for technological advancements in health care against limited money to pay for them. But this much is already clear: Clinical trials for surgery present unforeseen dilemmas.

While patients enrolled in drug studies don't know whether they are getting the real pill or a placebo, the control-group patients in a surgical trial know exactly who they are, since they aren't going under the knife.

Walter J. Hildebrand of Naples, Fla., and his wife Marsha made extraordinary sacrifices so he could participate in the NIH trial. She quit her job, and they shuttered their home and moved to Columbus, Ohio, as there was no study site nearby. So when he received a call saying he had been assigned to the nonsurgical group, he slumped to the floor. "It's really devastating," he says, adding that Medicare is treating him "like a lab animal."

Another problem: While new drugs must first be approved by the Food and Drug Administration before they can be sold, surgeons don't need government approval to perform new operations. Several top medical centers around the country, including Barnes Jewish, offer lung-reduction surgery for those who can pay for it—a fact not lost on Medicare patients.

Mr. Hildebrand, for example, remains in the control group but is negotiating with Barnes Jewish to have the surgery there and to pay for it himself. (Medicare would pay bills stemming from postoperative complications.)

NIH assumed from the start that as many as 30% of patients assigned to standard medical care would bail out or find a way to pay for the surgery on their own, says Gail Weinmann, program officer for the study. But no one is sure how high the numbers will be. "There was no precedent for this," she says.

Success rates for those getting lung reduction appear to have solidified. In 1996, two private, nonprofit evaluation agencies delivered upbeat reports on the procedure. ECRI of Plymouth Meeting, Pa., noted that while the surgery isn't appropriate for all patients, the improvement is real and measurable on pulmonary tests for all but about 15% of patients. The mortality rate for experienced teams, according to the report, is about 5% within one to three months after surgery—considered good for such frail patients. ECRI also noted that patients who undergo standard treatment, without surgery, show no improvement and predicted that the "damage done to the control group could be substantial." Meanwhile, Blue Cross & Blue Shield Association in Chicago also reviewed the research and concluded that the operation was effective enough to qualify for coverage.

The sums at stake are considerable, and many of the players have a financial interest. Hospitals that take part in the NIH trials receive Medicare payment for the patients they treat and support for research, while hospitals that drop out can make money on private patients.

Several companies that make instruments and supplies for the procedure also have an interest. Meanwhile, Dr. Cooper notes that he receives royalties on a reinforcing strip he developed to seal the lung incision, but says that doesn't compromise his stance. "I'm working for my patients," he says—something that his fiercest critics agree with.

Dr. Cooper says Medicare officials should just acknowledge that the procedure works and engage in an honest cost-benefit debate. Instead, he says, they "are hiding behind a scientific study to ration the procedure."

Bruce Vladeck, ex-chief of HCFA who now is a professor at Mount Sinai School of Medicine in New York, says the agency didn't calculate the cost of lung reduction in deciding whether to cover it. The only issue, he says, was: "Does this produce a clinical benefit or not?"

However, Dr. Kang, Medicare's current clinical director, says the government must determine whether new procedures are worth the money, compared to alternatives. "There are limited Medicare dollars, and you need to ask the question," he says.

The surgery has placed some HMOs in the unfamiliar position of having a more liberal coverage policy than Medicare. And it has caused "tremendous angst" among doctors who are accustomed to supporting clinical trials because they believe in science, says Mitchell Sugarman, director of medical technology assessment for the Permanente Federation, the medical affiliate for Kaiser Foundation Health Plan of Oakland, Calif.

When the NIH/Medicare trial began, Kaiser Permanente had to decide what to do if its own Medicare patients asked for the surgery. Mr. Sugarman says the doctors decided that if patients didn't want to enter the trial, they didn't have to, and they would remain eligible for the surgery just as other Kaiser patients are.

Harvard Pilgrim Health Care of Brookline, Mass., which says it has been covering the surgery with good results since 1996, went through similar turmoil when the NIH trial began, says Roberta Herman, an internist who chairs the HMO's technology committee. The decision came down to this: Did the plan owe its allegiance to science or to its patients?

Ultimately, Harvard Pilgrim threw its weight behind the Blue Cross alternative trial, with the six-month maximum delay. Dr. Herman says, "We couldn't live with the notion of telling members they might have to wait five years."

INSURANCE COMPANIES WHO CURRENTLY COVER LVRS

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Battelle
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Blue Cross and Blue Shield-Alabama
Blue Cross and Blue Shield-California
Blue Cross and Blue Shield-Federal-MO
Blue Cross and Blue Shield-Illinois
Blue Cross and Blue Shield-Indiana
Blue Cross and Blue Shield-Iowa
Blue Cross and Blue Shield-Kansas
Blue Cross and Blue Shield-Maine
Blue Cross and Blue Shield-Michigan
Blue Cross and Blue Shield-Missouri-Alliance
Blue Cross and Blue Shield-New Jersey-Empire
Blue Cross and Blue Shield-New York-Empire
Blue Cross and Blue Shield-Tennessee-Tenn Care
California Medicaid
Central States
CNA Health Partners
Connecticut General -- Cigna -- HMO, PPO, Indemnity
Coresource-Health & Welfare Local
Genelco
Golden Rule
Goodyear
Government Employees Health Plan-GEHA
Great West Life
Group Health Plan
Harvard Pilgrim
Healthlink-Local Pipefitters, Local Carpenters Unions
Illinois Medicaid
John Deere Health Care
Kaiser Permanente (at Brigham & Womens)
Mega Life and Health Insurance
Metra Health
Metropolitan Life
PAI Associates
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P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[002]

DOB: [redacted]
SS#: P6/(b)(6)

Lived in Bedford for 50 yrs

Helen Zarnowski P6/(b)(6)

- Was a FT Caregiver 7-8 yrs
- Husband had Alz.
- Died 3 years ago @ 81
- Got Treatment @ VA But also had ~~Bost~~. Priv. Phys. + Neurologist.
- Pro Support Group / Community Awareness
- Chairs NH chapter Public Policy Committee
- Liason to 40 Support Groups the chapter runs in NH.
- Volunteer @ Alz Assoc.
- Very kind, positive, enthusiastic about her work
- Sees progress being made.

May 28, 1999

PLEASE DELIVER IMMEDIATELY.

TO: Ms. Sarah Bianchi
FROM: John Glaser
National Committee to Preserve Social Security and Medicare
SUBJECT: Suggested individuals for Gore visit
FAX: (202) 456-~~5557~~ 6218
NUMBER OF PAGES: Two pages, Including this one.

The New Hampshire Citizen's Alliance at our request has provided the attached list.

We will be working closely with them during the primary season in New Hampshire.

Please give them or me a call if you have any questions.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. email	Barbara Woolley to Sarah Bianchi re: phone numbers (partial) (2 pages)	05/27/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20146

FOLDER TITLE:
Mental Health

2012-0463-S
rc797

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Barbara D. Woolley@EOP
05/27/99 06:25:49 PM

Record Type: Record

To: Sarah A. Bianchi/OVP@OVP

cc:
Subject: new hampshire

The following are names of folks who need to be called for their story. Do you want to have your intern call them?

---------- Forwarded by Barbara D. Woolley/WHO/EOP on 05/27/99 06:25 PM ----------

Moya.Thompson@AoA.gov
05/27/99 06:13:00 PM

Record Type: Record

To: Barbara D. Woolley@eop

cc:
Subject: names I faxed

My computer is working but only for email:

here are the names I hand wrote: (of caregivers)
(and faxed to you)

Florence Cimon
P6/(b)(6)
Rose Wrizek
P6/(b)(6)
Eileen Yanko
P6/(b)(6)
Patricia LeClerc
P6/(b)(6)
~~Roxanne Gosselin~~
P6/(b)(6)

P6/(b)(6) C003

Angela Custer
P6/(b)(6)
Teresa Pouliot
P6/(b)(6)
~~Ron Desha~~
P6/(b)(6)

Marjorie Rice
P6/(b)(6)
June Lake
P6/(b)(6)

P6/(b)(6)

They have all been contacted in advance and have given permission to be called about their story/family member/challenges

These all came from a very helpful person Arlene Kerschner, Easter Seals Society -- Home number P6/(b)(6) or work 603-623-8863, ext 413

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. note	re: personal medical (2 pages)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20146

FOLDER TITLE:
Mental Health

2012-0463-S
rc797

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DRAFT

Draft HCFA Fact Sheet

ENSURING ACCESS TO STATE-OF-THE-ART THERAPIES

Background: HCFA is encouraging state Medicaid agencies to make use, when appropriate, of new types of drugs that can better help persons with schizophrenia and reduce hospital stays.

In February 1998, HCFA informed state Medicaid directors about recent advances in the treatment of schizophrenia including the availability of new medications called atypical antipsychotic drugs. This letter provided specific guidance on how new drugs are to be incorporated into states' reimbursement and coverage policies. This letter also contained information from the National Institute of Mental Health summarizing data that demonstrates the clinical advantages of the newly available treatments.

The pharmacologic profiles of newer atypical antipsychotic medications are effective for a broad range of symptoms of schizophrenia with substantial reductions in side effects. These new drugs reduce the number of psychiatric readmissions because patients on these drugs are more compliant with this therapy because of fewer side effects. Inappropriate rehospitalization has obvious implications for the patient's employment, school and social functioning. In addition, costs of rehospitalization are avoided, reducing the "revolving door" of repeated patient readmissions.

HCFA will reissue and update its guidance to ensure that states revise their drug formularies, including those provided through managed care plans, to reflect recent advances in pharmacological treatment of schizophrenia. HCFA will also work with ~~the National Alliance of the Mentally Ill (NAMI)~~ to determine if there are specific problems in individual states and respond accordingly.

There should be no additional costs associated with this initiative since use of these drugs reduces the number and length of hospital stays.

This should not lead us what you did before but rather highlight a range of mental health or [illegible] than

issuing new letter

needs definition of problem of mental illness & medicaid & this drug

why is this letter important

can we make this sound better Americans more like press release

DRAFT

Draft HCFA Fact Sheet

SERVING ~~PERSONS~~ WITH SERIOUS MENTAL ILLNESS w/ MORE EFFECTIVE COMMUNITY TREATMENTS

Background: Assertive Community Treatment (ACT) programs for a number of years have successfully supported people with severe mental illness, especially those who are at risk for hospitalization. ACT programs use a number of treatment approaches to meet the complex needs of the severely mentally ill, including multi-disciplinary treatment teams, shared caseloads, 24-hour mobile crisis teams, assertive outreach for treatment for clients in their own community, individualized treatment, medication, rehabilitation and supportive services.

first time endorsing

Interest in ACT has been heightened by research performed by the Schizophrenia Patient Outcomes Research Team (PORT), a research team supported by HHS's Agency for Health Care Policy and Research and the National Institute of Mental Health. This research concluded that ACT represents an improved approach to conventional case management for high-risk patients.

~~The National Alliance for the Mentally Ill has launched an initiative to promote these programs which have been adopted in whole or part in 25 states~~. HCFA is currently reviewing the experience of these states, and will use this information to develop additional technical assistance and guidance.

to states who want to develop innovations in this area

Because ACT programs offer additional ways to assist people with serious mental illness, HCFA is distributing additional information about ACT to the states. HCFA is issuing a letter to state Medicaid Directors describing the ACT programs as a comprehensive approach to community-based mental health services.

when

The Bazelon Center for Mental Health Law proposed the development of a new optional Medicaid service permitting states to cover an array of intensive community based services through a state plan amendment. However, since these services are already available under Medicaid, HCFA believes that a regulation is not necessary and proposes instead to promote the ACT model as guidance to States.

CUT THIS

HCFA will assess the information gathered from its study of current state experience and incorporate the concerns of the patients' rights groups into the state medical directors and any future guidance.

Don't highlight what we are doing

Individual states may incur additional costs if this treatment model is fully implemented; however, this does not represent a programmatic expansion since these services can be made available under Medicaid under current law. In addition, the treatment model is designed to reduce more costly hospital utilization.

Please don't highlight one mental health group

Also, need today a WH conference on mental health

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Need reference to NIH conference on mental health

EMBARGOED for release: June 7, 1999

"Real world" trials to target psychosis, refractory depression

have $ in headline

Contact: Jules Asher
301-443-4536
jasher@nih.gov

Two large-scale clinical trials were announced today by the National Institute of Mental Health (NIMH) to test the effectiveness of mental health treatments under "real world" conditions. One set of trials will identify which of several new generation antipsychotic medications -- used to treat psychosis in schizophrenia, severe depression, and Azheimer's disease -- are best for which patients. A second set of trials will investigate the best ways to help people who have not responded adequately to existing drug and talk therapies for depression.

"These new trials will be based on a broader public health model -- on actual treatment outcome in a naturalistic context -- including cost-effectiveness and patient compliance," said NIMH Director Steven E. Hyman, M.D.

For example, the trials of anti-psychotic medications will actively recruit participants who also have drug and alcohol problems, because such co-morbidity is common in the real world. The new trials will also strive for demographic and geographic diversity in multiple clinical settings, so that the findings will have broader applicability.

NIMH will award contracts for the new trials in early Fall 1999, with patient recruitment to begin in Spring 2000. The Institute will invest a total of more than $100 million in four such new large-scale trials; contracts for two others were recently awarded on treatment of adolescent depression and manic depressive illness. For more information, contact NIMH Public Inquiries, 301-443-4513.

The National Institute of Mental Health (NIMH) is part of the National Institutes of Health (NIH), the Federal Government's primary agency for biomedical and behavioral research. NIH is a component of the U.S. Department of Health and Human Services.

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DRAFT

JUNE xx, 1999

Contact: SAMHSA Press Office
(800)487-4890

Should say effect of poster, purpose

ANTI-STIGMA POSTER: "IT'S ELEMENTARY: UNDERSTANDING PEOPLE WITH MENTAL ILLNESS"

Today at the first - ever WH conf on mental health

The Clinton-Gore administration has made a commitment to reducing the stigma associated with mental illness. In order to further this goal, HHS will distribute a new anti-stigma poster to more than 200,000 elementary schools nationwide. This partnerhip between HHS' Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services and the American Federation of Teachers (AFT) will reach an estimated 4.8 million children.

to be posted in classrooms, etc.

Individuals with mental illnesses constantly battle misunderstandings and misconceptions regarding their disorders. It is estimated that in any given year 50 million Americans experience a mental health disorder, yet only one-fourth of them actually receive mental health services. This is often the result of the pervasive stigma and accompanying discrimination surrounding mental illness. → cite reason why so impt to have this in the schools

The poster, which depicts children, young people, elderly people, people of different races, contains a message that counters the flood of pejorative images about people with mental illnesses that constantly bombard children. It's script says quite simply: "Know me as a person, not by my mental illness. We are your friends, neighbors, and family. We improve and recover. We are major contributors to American life. We deserve dignity and respect."

SAMHSA, an agency of the U.S. Department of Health and Human Services, is the lead Federal agency for improving the quality and availability of substance abuse prevention, addiction treatment, and mental health services in the United States. News media requests for information on SAMHSA's substance abuse and mental health programs should be directed to Media Services at 1-800-487-4890. This release may be obtained on the Internet at ***www.samhsa.gov****.*

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We should have stat about children if we have it.

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EMBARGOED for release: June 7, 1999

Contact: Constance Burr
301-443-4536

National Institute of Mental Health Launches Landmark Study of Mental Health in the U.S.

first sentence

~~HHS~~ is launching a landmark 5-year study of mental health in America, beginning July 1, 1999. The new study, announced at the first-ever White House Conference on Mental Health, will make fundamental contributions to understanding mental illness and to allocating resources for diagnosing, treating, and rehabilitating people with mental disorders. Supported by the National Institute of Mental Health (NIMH), the $7.3 million research project will examine the prevalence of mental health problems in a representative sample of 10,000 Americans age 15 and older. The survey will address issues of vital importance to public health, providing information on the duration of various mental disorders, the kinds of disability they produce, the links between socioeconomic status and mental health, and the relationship between types of mental illness and use of services.

Could this is first time this data have been

The study is funded through an NIMH grant to Harvard University, led by epidemiologist Dr. Ronald Kessler. In part, the survey will make it possible to identify s trends, a vital tool for planning and assessing public and private mental health services, as well as insurance coverage. The research project will contribute to the World Mental Health 2000 initiative of the World Health Organization (WHO). WHO, in turn, will use this information to increase health policy makers' recognition of mental disorders as a priority in public health prevention and intervention efforts worldwide.

Meeting the mental health needs of Americans requires solid information on the national scope and distribution of mental disorders in the U.S., the impairments they cause, and how people use or fail to use the mental health resources available to them. This information is a vital tool for planning and assessing public and private mental health services, as well as insurance coverage. Earlier surveys conducted in the early 1980s and early 1990s have provided the foundations for myriad public health and policy decisions. But now, especially with the U.S. health care system undergoing enormous change, updated findings in a new national statistical portrait of the nation's mental health is essential.

The beneficiaries of this research include Americans currently or potentially affected by mental disorders, as well as citizens of other countries where mental health epidemiologic data provide a cornerstone for public health.

~~With funding from an NIMH research grant to Harvard University, the survey will be conducted on contract by the University of Michigan's Survey Research Center. The cost for the 5-year study is $7.3 million, of which $3 million will be spent in the first year.~~

The National Institute of Mental Health is a component of the National Institutes of Health, an agency of the U.S. Department of Health and Human Services. The Office

of Communications and Public Liaison carries out educational activities and publishes and distributes research reports, press releases, fact sheets, and publications intended for researchers, health care providers, and the general public. For more information contact:

Office of Communications and Public Liaison, NIMH
Information Resources and Inquiries Branch
6001 Executive Blvd., Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: 301-443-4513
Fax: 301-443-4279
Mental Health FAX 4U: 301-443-5158
E-mail: nimhinfo@nih.gov
NIMH home page address:
www.nimh.nih.gov

DRAFT

What is about Depression

EMBARGOED for release: June 7, 1999

Contact: Constance Burr
301-443-4536

to unveil new outreach efforts including new PSA

National Institute of Mental Health and Administration on Aging
~~Offer Fact Sheet on~~ Older Adults and Depression
unveil new campaign

The ~~Administration~~ on Aging (AoA) is joining the National Institute of mental Health (NIMH) in ~~a saturation dissemination of its new fact sheet,~~ "Older Adults—Depression and Suicide Facts," on recognizing signs of depression, reducing suicide risk in older adults, and promoting treatment. In cooperation with AoA, NIMH will make information available nationwide on this widely underrecognized and undertreated illness. The ~~fact sheet~~ brochure was unveiled at the first-ever White House Conference on Mental Health on June 7, 1999.

Nearly 5 million of the 34 million Americans ages 65 and older suffer from depression, but doctors and patients may have trouble recognizing its signs. To help identify and promote discussion of depression during medical visits, the fact sheet includes a cue card of symptoms for older adults entitled, "Before You Say, 'I'm Fine.'" It presents questions for older adults to ask themselves, such as if they feel nervous or empty, guilty or worthless, or whether life seems worth living. If their answers indicate that they are depressed, the card suggests talking to a doctor. The fact sheet also cites the role of modern brain imaging technologies, studies of genetics and brain chemistry, and a variety of effective medications and psychotherapies regarding the clinical course and treatment of late-life depression.

"Older Adults—Depression and Suicide Facts" will be on the NIMH Website at www.nimh.nih.gov and on the AoA Website at www.aoa.gov. In addition, AoA, together with its regional offices throughout the country, will promote and disseminate the important information through its national aging network of 57 State Offices on Aging, 655 Area Agencies on Aging, 225 tribal organizations, consumer organizations, and volunteers who work on the front lines with older Americans and their families throughout the country.

The National Institute of Mental Health is a component of the National Institutes of Health, an agency of the U. S. Department of Health and Human Services. The Office of Communications and Public Liaison carries out educational activities and publishes and distributes research reports, press releases, fact sheets, and publications intended for researchers, health care providers, and the general public. A publications list may be obtained by contacting:

DRAFT

JUNE xx, 1999

Contact: SAMHSA Press Office
(800) 487-4890

TOUCHING MORE LIVES EVERY DAY: CARING FOR EVERY CHILD'S MENTAL HEALTH EDUCATION CAMPAIGN, II

HHS will launch a five-year $6.5 million campaign to reduce stigma in targeted communities by highlighting the special mental health needs of children. The "Caring for Every Child's Mental Health: Communities Together" education campaign has been designed to educate families, schools and communities about the facts of mental illness with the goal of improving mental health care for children.

Of the nation's more than 68 million children and adolescents under the age of 17, at least one in five may have a diagnosable mental health problem at any point in time. Among those middle and high school age adolescents (ages 9-17), one in 10 may experience an emotional disturbance of such severity that it disrupts the activities of daily life, such as school, family and community activities. Untreated, these problems can stand between children or adolescents and educational attainment, compromising their futures.

The Center for Mental Health Services, Substance Abuse and Mental Health Services Administration will conduct the campaign, linking it to 34 current grant sites of the successful and innovative Comprehensive Community Mental Health Services for Children and their Families Program. The campaign is mobilizing a national partnership between the public and private sectors -- CMHS, joined with health care providers, provider organizations, children and their families, intermediaries, to enhance and expand the public education initiative. The goals:

- To increase the access of children and adolescents with serious emotional disturbances and other mental health needs (and their families) to comprehensive systems of community-based mental health care;

- To highlight the costs of mental illnesses among children and adolescents;

- To spotlight the benefits of community-based, family-focused interventions for children and adolescents with these health problems; and

- To dispel the fear and misunderstanding of mental illnesses in general and, in particular, the feelings of failure and embarrassment that can stand between families and the mental health care their child or adolescent needs.

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Office of Communications and Public Liaison, NIMH
Information Resources and Inquiries Branch
6001 Executive Blvd., Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: 301-443-4513
Fax: 301-443-4279
Mental Health FAX 4U: 301-443-5158
E-mail: nimhinfo@nih.gov
NIMH home page address:
www.nimh.nih.gov

The Administration on Aging, an agency of the U. S. Department of Health and Human Services, is the only Federal agency dedicated exclusively to policy development, planning, and the delivery of home and community-based support services to older persons and their caregivers through the national network of state and local agencies on aging, tribal organizations, and service providers and volunteers. For more information contact:

Administration on Aging
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

Telephone: (202) 619-0724
TDD: (202) 401-7575
Fax: (202) 260-1012
E-Mail: aoainfo@aoa.gov
Internet Web Site: http://www.aoa.gov

DRAFT

JUNE 1999

Contact: SAMHSA Press Office
(800) 487-4890

MULTI-MILLION GRANT PROGRAM TARGETS HOMELESS WOMEN AND THEIR CHILDREN

Overview: *Families, particularly single female-headed families with dependent children, are the most rapidly growing segment of the homeless population in the 1990s . On any given night, approximately 100,000 children nationwide sleep in emergency shelters, abandoned buildings, or on the street. One-half of these children are age 6 or younger. Additionally, many of these families exhibit a degree of dysfunction in the areas of mental health, substance use, or co-occurring disorders that significantly impairs their ability to break their homeless cycle or provide adequate parenting, and is sufficient in magnitude to be of concern to treatment programs. According to recent research, up to 600,000 individuals are homeless on any given night and as many as 7 million Americans had at least one episode of homelessness during the last half of the 1980's. In the past decade studies indicate that up to one-third of single, homeless adults have a serious and persistent mental illness and as many as half of these individuals have co-occurring alcohol and/or other substance use disorders. Though there are no easy solutions to the persistent national problem of homelessness, effective interventions have been identified and implemented and help bridge gaps in service systems.*

Today, the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services will invest approximately $4.8 million into a grant program designed to help homeless women and their children. This program will help reduce stigma, advance our understanding of the most effective interventions to assist homeless women and their children and show us the best ways to address their treatment, housing, education/training, and support service needs.

The grant program will include {# TBD} sites, that can reach as many as 2,000 homeless mothers and 4,000 homeless children. The program is targeted to the unique circumstances of homeless mothers with psychiatric and/or substance use disorders who are caring for their dependent children, and will focus on the goals of mental health and substance abuse treatment, trauma recovery, movement out of homelessness, family preservation and social and life skill development.

The {# TBD} sites, and a coordinating center will collaborate in : (1) conducting an epidemiological study of the homeless mothers and children in order to fully articulate their treatment and service needs; (2) document treatment and service models currently being used to move homeless families out of homelessness, stabilize housing placement, decrease substance abuse and improve mental health and social functioning; and (3) design evaluation plans to systematically study the effectiveness of the interventions on an individual and cross-site basis.

# # #

DRAFT

Draft press release

FOR IMMEDIATE RELEASE
May XX, 1999

Contact: HCFA Press Office
(202) 690-6145

HCFA ANNOUNCES NEW PROTECTIONS FOR PATIENTS IN PSYCHIATRIC HOSPITALS

HCFA Administrator Nancy-Ann DeParle today announced new protections to curtail the improper use of restraints and seclusion on psychiatric patients in hospitals.

The interim final regulations, which will be effective in 60 days, were published in today's *Federal Register.*

"These protections underscore the Administration's determination to protect all patients from harm associated with the inappropriate use of restraints. They will help ~~will~~ prevent the dangerous use of restraints and protect children and other vulnerable patients who deserve safe, quality care," DeParle said.

The new patients' rights protections build on HCFA's improved enforcement of quality of care in hospitals, added DeParle. She called on Congress to enact patient protection legislation proposed by President Clinton in his fiscal year 2000 budget.

The proposed patients' rights protections will apply to all participating hospitals, including acute, psychiatric, rehabilitation, long-term, children's, and alcohol-drug hospitals.

Medicare regulations have helped decrease the improper use of restraints and seclusion in nursing homes and intermediate care facilities for people with mental retardation. The patients' rights regulations extend federal protections against inappropriate use of restraints and seclusion to psychiatric patients who are hospitalized.

The new regulations require that a hospital provide a patient or family member at the time of admission with a formal notice of their rights. These rights include the right to be free from restraints and seclusion in any form when used as a means of coercion, discipline, convenience or retaliation. Other rights include the right to privacy and to make decisions about the patient's care.

If patients and their families have any concerns about the quality of care provided at a psychiatric hospital or community hospital operating a psychiatric service, they may contact the state survey agency or HCFA regional office to find out whether the hospital had been cited for a violation of the patient safety requirements.

The new patient protections also make consistent standards used by HCFA and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) to ensure only appropriate use of restraints and seclusion. HCFA adopted the same approach and time frames

DRAFT

for monitoring the use of restraints and seclusion developed and enforced by the Joint Commission when it accredits hospitals and behavioral health facilities.

HCFA's regulations also contain new requirements on staff training so that health care workers who have direct patient contact will learn the appropriate and safe use of seclusion and restraints.

In addition to HCFA's efforts, a number of federal agencies are increasing attention to inappropriate seclusion and restraint practices. Most notably, the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services provides funds to state protection and advocacy systems. These systems, present in each state, have a strong record of addressing and resolving consumer complaints related to the misuse of seclusion and restraint. Moreover, HCFA staff are actively participating with CMHS in the development and implementation of an action plan that will continue to address problems with the misuse of seclusion and restraints in our nation's health care facilities.

"Children and other vulnerable patients must be able to count on quality care that's safe and free of improper seclusion and restraints. Working together with Congress and health care providers, we can ensure that these Americans get those protections," DeParle stated.

###

DEPARTMENT OF HEALTH & HUMAN SERVICES

Lynnette Williams

Deputy Assistant Secretary for Public Affairs

Phone: (202)690-7850 Fax: (202)690-5673

To: Sarah Bianchi

Fax: 456-5557 Phone: _____

Date: 5/27/99 Total number of pages sent: 3

Comments:

Sarah —

final pieces

1) HCFA ACT program

2) HCFA Drug Therapies

Advance directive on mental health services to come 5/28/99 am.

200 Independence Avenue, S.W., Bldg. HHH, Room 647-D, Washington, D.C. 20201

Draft HCFA Fact Sheet

SERVING PERSONS WITH SERIOUS MENTAL ILLNESS

Background: Assertive Community Treatment (ACT) programs for a number of years have successfully supported people with severe mental illness, especially those who are at risk for hospitalization. ACT programs use a number of treatment approaches to meet the complex needs of the severely mentally ill, including multi-disciplinary treatment teams, shared caseloads, 24-hour mobile crisis teams, assertive outreach for treatment for clients in their own community, individualized treatment, medication, rehabilitation and supportive services.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Lynnette Williams

Deputy Assistant Secretary for Public Affairs

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Date: 5/27/99 Total number of pages sent: 3

Comments:

Sarah –

Final pieces

1) HCFA ACT program

2) HCFA Drug Therapies

Advance directive on mental health services to come 5/28/99 am.

200 Independence Avenue, S.W., Bldg. HHH, Room 647-D, Washington, D.C. 20201

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Draft HCFA Fact Sheet

ENSURING ACCESS TO STATE-OF-THE-ART THERAPIES

Background: HCFA is encouraging state Medicaid agencies to make use, when appropriate, of new types of drugs that can better help persons with schizophrenia and reduce hospital stays.

In February 1998, HCFA informed state Medicaid directors about recent advances in the treatment of schizophrenia including the availability of new medications called atypical antipsychotic drugs. This letter provided specific guidance on how new drugs are to be incorporated into states' reimbursement and coverage policies. This letter also contained information from the National Institute of Mental Health summarizing data that demonstrates the clinical advantages of the newly available treatments.

The pharmacologic profiles of newer atypical antipsychotic medications are effective for a broad range of symptoms of schizophrenia with substantial reductions in side effects. These new drugs reduce the number of psychiatric readmissions because patients on these drugs are more compliant with this therapy because of fewer side effects. Inappropriate rehospitalization has obvious implications for the patient's employment, school and social functioning. In addition, costs of rehospitalization are avoided, reducing the "revolving door" of repeated patient readmissions.

HCFA will reissue and update its guidance to ensure that states revise their drug formularies, including those provided through managed care plans, to reflect recent advances in pharmacological treatment of schizophrenia. HCFA will also work with the National Alliance of the Mentally Ill (NAMI) to determine if there are specific problems in individual states and respond accordingly.

There should be no additional costs associated with this initiative since use of these drugs reduces the number and length of hospital stays.

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Draft HCFA Fact Sheet

SERVING PERSONS WITH SERIOUS MENTAL ILLNESS

Background: Assertive Community Treatment (ACT) programs for a number of years have successfully supported people with severe mental illness, especially those who are at risk for hospitalization. ACT programs use a number of treatment approaches to meet the complex needs of the severely mentally ill, including multi-disciplinary treatment teams, shared caseloads, 24-hour mobile crisis teams, assertive outreach for treatment for clients in their own community, individualized treatment, medication, rehabilitation and supportive services.

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Draft press paper

1) Anti-Stigma Poster (SAMSHA)
2) Clinical Trials (NIMH)
3) Landmark study (NIMH)
4) Older adults & depression (NIMH)
5) Children's Campaign (SAMSHA)
6) Homeless Grants (SAMSHA)
7) Restraint Reg (HCFA)

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JUNE xx, 1999

Contact: SAMHSA Press Office
(800)487-4890

ANTI-STIGMA POSTER: "IT'S ELEMENTARY: UNDERSTANDING PEOPLE WITH MENTAL ILLNESS"

The Clinton-Gore administration has made a commitment to reducing the stigma associated with mental illness. In order to further this goal, HHS will distribute a new anti-stigma poster to more than 200,000 elementary schools nationwide. This partnerhip between HHS' Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services and the American Federation of Teachers (AFT) will reach an estimated 4.8 million children.

Individuals with mental illnesses constantly battle misunderstandings and misconceptions regarding their disorders. It is estimated that in any given year 50 million Americans experience a mental health disorder, yet only one-fourth of them actually receive mental health services. This is often the result of the pervasive stigma and accompanying discrimination surrounding mental illness.

The poster, which depicts children, young people, elderly people, people of different races, contains a message that counters the flood of pejorative images about people with mental illnesses that constantly bombard children. It's script says quite simply: "Know me as a person, not by my mental illness. We are your friends, neighbors, and family. We improve and recover. We are major contributors to American life. We deserve dignity and respect."

SAMHSA, an agency of the U.S. Department of Health and Human Services, is the lead Federal agency for improving the quality and availability of substance abuse prevention, addiction treatment, and mental health services in the United States. News media requests for information on SAMHSA's substance abuse and mental health programs should be directed to Media Services at 1-800-487-4890. This release may be obtained on the Internet at ***www.samhsa.gov****.*

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EMBARGOED for release: June 7, 1999

"Real world" trials to target psychosis, refractory depression

Contact: Jules Asher
301-443-4536
jasher@nih.gov

Two large-scale clinical trials were announced today by the National Institute of Mental Health (NIMH) to test the effectiveness of mental health treatments under "real world" conditions. One set of trials will identify which of several new generation antipsychotic medications -- used to treat psychosis in schizophrenia, severe depression, and Azheimer's disease -- are best for which patients. A second set of trials will investigate the best ways to help people who have not responded adequately to existing drug and talk therapies for depression.

"These new trials will be based on a broader public health model -- on actual treatment outcome in a naturalistic context -- including cost-effectiveness and patient compliance," said NIMH Director Steven E. Hyman, M.D.

For example, the trials of anti-psychotic medications will actively recruit participants who also have drug and alcohol problems, because such co-morbidity is common in the real world. The new trials will also strive for demographic and geographic diversity in multiple clinical settings, so that the findings will have broader applicability.

NIMH will award contracts for the new trials in early Fall 1999, with patient recruitment to begin in Spring 2000. The Institute will invest a total of more than $100 million in four such new large-scale trials; contracts for two others were recently awarded on treatment of adolescent depression and manic depressive illness. For more information, contact NIMH Public Inquiries, 301-443-4513.

The National Institute of Mental Health (NIMH) is part of the National Institutes of Health (NIH), the Federal Government's primary agency for biomedical and behavioral research. NIH is a component of the U.S. Department of Health and Human Services.

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EMBARGOED for release: June 7, 1999

Contact: Constance Burr
301-443-4536

National Institute of Mental Health Launches Landmark Study of Mental Health in the U.S.

HHS is launching a landmark 5-year study of mental health in America, beginning July 1, 1999. The new study, announced at the first-ever White House Conference on Mental Health, will make fundamental contributions to understanding mental illness and to allocating resources for diagnosing, treating, and rehabilitating people with mental disorders. Supported by the National Institute of Mental Health (NIMH), the $7.3 million research project will examine the prevalence of mental health problems in a representative sample of 10,000 Americans age 15 and older. The survey will address issues of vital importance to public health, providing information on the duration of various mental disorders, the kinds of disability they produce, the links between socioeconomic status and mental health, and the relationship between types of mental illness and use of services.

The study is funded through an NIMH grant to Harvard University, led by epidemiologist Dr. Ronald Kessler. In part, the survey will make it possible to identify s trends, a vital tool for planning and assessing public and private mental health services, as well as insurance coverage. The research project will contribute to the World Mental Health 2000 initiative of the World Health Organization (WHO). WHO, in turn, will use this information to increase health policy makers' recognition of mental disorders as a priority in public health prevention and intervention efforts worldwide.

Meeting the mental health needs of Americans requires solid information on the national scope and distribution of mental disorders in the U.S., the impairments they cause, and how people use or fail to use the mental health resources available to them. This information is a vital tool for planning and assessing public and private mental health services, as well as insurance coverage. Earlier surveys conducted in the early 1980s and early 1990s have provided the foundations for myriad public health and policy decisions. But now, especially with the U.S. health care system undergoing enormous change, updated findings in a new national statistical portrait of the nation's mental health is essential.

The beneficiaries of this research include Americans currently or potentially affected by mental disorders, as well as citizens of other countries where mental health epidemiologic data provide a cornerstone for public health.

With funding from an NIMH research grant to Harvard University, the survey will be conducted on contract by the University of Michigan's Survey Research Center. The cost for the 5-year study is $7.3 million, of which $3 million will be spent in the first year.

The National Institute of Mental Health is a component of the National Institutes of Health, an agency of the U.S. Department of Health and Human Services. The Office

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of Communications and Public Liaison carries out educational activities and publishes and distributes research reports, press releases, fact sheets, and publications intended for researchers, health care providers, and the general public. For more information contact:

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Phone: 301-443-4513
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NIMH home page address:
www.nimh.nih.gov

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EMBARGOED for release: June 7, 1999

Contact: Constance Burr
301-443-4536

National Institute of Mental Health and Administration on Aging Offer Fact Sheet on Older Adults and Depression

The Administration on Aging (AoA) is joining the National Institute of mental Health (NIMH) in a saturation dissemination of its new fact sheet, "Older Adults—Depression and Suicide Facts," on recognizing signs of depression, reducing suicide risk in older adults, and promoting treatment. In cooperation with AoA, NIMH will make information available nationwide on this widely underrecognized and undertreated illness. The fact sheet was unveiled at the first-ever White House Conference on Mental Health on June 7, 1999.

Nearly 5 million of the 34 million Americans ages 65 and older suffer from depression, but doctors and patients may have trouble recognizing its signs. To help identify and promote discussion of depression during medical visits, the fact sheet includes a cue card of symptoms for older adults entitled, "Before You Say, 'I'm Fine.'" It presents questions for older adults to ask themselves, such as if they feel nervous or empty, guilty or worthless, or whether life seems worth living. If their answers indicate that they are depressed, the card suggests talking to a doctor. The fact sheet also cites the role of modern brain imaging technologies, studies of genetics and brain chemistry, and a variety of effective medications and psychotherapies regarding the clinical course and treatment of late-life depression.

"Older Adults—Depression and Suicide Facts" will be on the NIMH Website at www.nimh.nih.gov and on the AoA Website at www.aoa.gov. In addition, AoA, together with its regional offices throughout the country, will promote and disseminate the important information through its national aging network of 57 State Offices on Aging, 655 Area Agencies on Aging, 225 tribal organizations, consumer organizations, and volunteers who work on the front lines with older Americans and their families throughout the country.

The National Institute of Mental Health is a component of the National Institutes of Health, an agency of the U. S. Department of Health and Human Services. The Office of Communications and Public Liaison carries out educational activities and publishes and distributes research reports, press releases, fact sheets, and publications intended for researchers, health care providers, and the general public. A publications list may be obtained by contacting:

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JUNE xx, 1999

Contact: SAMHSA Press Office
(800) 487-4890

TOUCHING MORE LIVES EVERY DAY: CARING FOR EVERY CHILD'S MENTAL HEALTH EDUCATION CAMPAIGN, II

HHS will launch a five-year $6.5 million campaign to reduce stigma in targeted communities by highlighting the special mental health needs of children. The "Caring for Every Child's Mental Health: Communities Together" education campaign has been designed to educate families, schools and communities about the facts of mental illness with the goal of improving mental health care for children.

Of the nation's more than 68 million children and adolescents under the age of 17, at least one in five may have a diagnosable mental health problem at any point in time. Among those middle and high school age adolescents (ages 9-17), one in 10 may experience an emotional disturbance of such severity that it disrupts the activities of daily life, such as school, family and community activities. Untreated, these problems can stand between children or adolescents and educational attainment, compromising their futures.

The Center for Mental Health Services, Substance Abuse and Mental Health Services Administration will conduct the campaign, linking it to 34 current grant sites of the successful and innovative Comprehensive Community Mental Health Services for Children and their Families Program. The campaign is mobilizing a national partnership between the public and private sectors -- CMHS, joined with health care providers, provider organizations, children and their families, intermediaries, to enhance and expand the public education initiative. The goals:

- To increase the access of children and adolescents with serious emotional disturbances and other mental health needs (and their families) to comprehensive systems of community-based mental health care;

- To highlight the costs of mental illnesses among children and adolescents;

- To spotlight the benefits of community-based, family-focused interventions for children and adolescents with these health problems; and

- To dispel the fear and misunderstanding of mental illnesses in general and, in particular, the feelings of failure and embarrassment that can stand between families and the mental health care their child or adolescent needs.

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www.nimh.nih.gov

The Administration on Aging, an agency of the U. S. Department of Health and Human Services, is the only Federal agency dedicated exclusively to policy development, planning, and the delivery of home and community-based support services to older persons and their caregivers through the national network of state and local agencies on aging, tribal organizations, and service providers and volunteers. For more information contact:
Administration on Aging
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

Telephone: (202) 619-0724
TDD: (202) 401-7575
Fax: (202) 260-1012
E-Mail: aoainfo@aoa.gov
Internet Web Site: http://www.aoa.gov

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JUNE 1999

Contact: SAMHSA Press Office
(800) 487-4890

MULTI-MILLION GRANT PROGRAM TARGETS HOMELESS WOMEN AND THEIR CHILDREN

Overview: *Families, particularly single female-headed families with dependent children, are the most rapidly growing segment of the homeless population in the 1990s . On any given night, approximately 100,000 children nationwide sleep in emergency shelters, abandoned buildings, or on the street. One-half of these children are age 6 or younger. Additionally, many of these families exhibit a degree of dysfunction in the areas of mental health, substance use, or co-occurring disorders that significantly impairs their ability to break their homeless cycle or provide adequate parenting, and is sufficient in magnitude to be of concern to treatment programs. According to recent research, up to 600,000 individuals are homeless on any given night and as many as 7 million Americans had at least one episode of homelessness during the last half of the 1980's. In the past decade studies indicate that up to one-third of single, homeless adults have a serious and persistent mental illness and as many as half of these individuals have co-occurring alcohol and/or other substance use disorders. Though there are no easy solutions to the persistent national problem of homelessness, effective interventions have been identified and implemented and help bridge gaps in service systems.*

(illegible), the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services will invest approximately $4.8 million into a grant program designed to help homeless women and their children. This program will help reduce stigma, advance our understanding of the most effective interventions to assist homeless women and their children and show us the best ways to address their treatment, housing, education/training, and support service needs.

The grant program will include {# TBD} sites, that can reach as many as 2,000 homeless mothers and 4,000 homeless children. The program is targeted to the unique circumstances of homeless mothers with psychiatric and/or substance use disorders who are caring for their dependent children, and will focus on the goals of mental health and substance abuse treatment, trauma recovery, movement out of homelessness, family preservation and social and life skill development.

The {# TBD} sites, and a coordinating center will collaborate in : (1) conducting an epidemiological study of the homeless mothers and children in order to fully articulate their treatment and service needs; (2) document treatment and service models currently being used to move homeless families out of homelessness, stabilize housing placement, decrease substance abuse and improve mental health and social functioning; and (3) design evaluation plans to systematically study the effectiveness of the interventions on an individual and cross-site basis.

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Draft press release

FOR IMMEDIATE RELEASE
May XX, 1999

Contact: HCFA Press Office
(202) 690-6145

HCFA ANNOUNCES NEW PROTECTIONS FOR PATIENTS IN PSYCHIATRIC HOSPITALS

HCFA Administrator Nancy-Ann DeParle today announced new protections to curtail the improper use of restraints and seclusion on psychiatric patients in hospitals.

The interim final regulations, which will be effective in 60 days, were published in today's *Federal Register.*

"These protections underscore the Administration's determination to protect all patients from harm associated with the inappropriate use of restraints. They will help ~~will~~ prevent the dangerous use of restraints and protect children and other vulnerable patients who deserve safe, quality care," DeParle said.

The new patients' rights protections build on HCFA's improved enforcement of quality of care in hospitals, added DeParle. She called on Congress to enact patient protection legislation proposed by President Clinton in his fiscal year 2000 budget.

The proposed patients' rights protections will apply to all participating hospitals, including acute, psychiatric, rehabilitation, long-term, children's, and alcohol-drug hospitals.

Medicare regulations have helped decrease the improper use of restraints and seclusion in nursing homes and intermediate care facilities for people with mental retardation. The patients' rights regulations extend federal protections against inappropriate use of restraints and seclusion to psychiatric patients who are hospitalized.

The new regulations require that a hospital provide a patient or family member at the time of admission with a formal notice of their rights. These rights include the right to be free from restraints and seclusion in any form when used as a means of coercion, discipline, convenience or retaliation. Other rights include the right to privacy and to make decisions about the patient's care.

If patients and their families have any concerns about the quality of care provided at a psychiatric hospital or community hospital operating a psychiatric service, they may contact the state survey agency or HCFA regional office to find out whether the hospital had been cited for a violation of the patient safety requirements.

The new patient protections also make consistent standards used by HCFA and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) to ensure only appropriate use of restraints and seclusion. HCFA adopted the same approach and time frames

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for monitoring the use of restraints and seclusion developed and enforced by the Joint Commission when it accredits hospitals and behavioral health facilities.

HCFA's regulations also contain new requirements on staff training so that health care workers who have direct patient contact will learn the appropriate and safe use of seclusion and restraints.

In addition to HCFA's efforts, a number of federal agencies are increasing attention to inappropriate seclusion and restraint practices. Most notably, the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services provides funds to state protection and advocacy systems. These systems, present in each state, have a strong record of addressing and resolving consumer complaints related to the misuse of seclusion and restraint. Moreover, HCFA staff are actively participating with CMHS in the development and implementation of an action plan that will continue to address problems with the misuse of seclusion and restraints in our nation's health care facilities.

"Children and other vulnerable patients must be able to count on quality care that's safe and free of improper seclusion and restraints. Working together with Congress and health care providers, we can ensure that these Americans get those protections," DeParle stated.

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