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Applying Science to Public Policy:

The Context of the

Surgeon General's Report

on Mental Health

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When David Satcher, M.D., Ph.D., issued *Mental Health: A Report of the Surgeon General* on December 13, 1999, some commentators remembered earlier surgeon generals' reports and their effect on public policy, particularly the first report which launched the nation's campaign against smoking in 1964. In a front page article the next day, Robert Pear of the *New York Times* commented: "The report is significant because it meticulously analyzes huge amounts of data and puts the imprimatur of the government on the findings, just as the surgeon general's report on smoking and health did in 1964."[1] The latest report was the 50th since the report on smoking but the first to deal with issues in the area of mental health. (Twenty-eight of the earlier Surgeon Generals' reports had addressed tobacco issues.) In many ways, it is not surprising that it has taken so long to turn to this area of health policy, since it has not been unusual for health policymakers to give mental health wide berth. To many health policy experts, the area of mental health has seemed alien, dealing as it does with separate systems of services, including psychology, social services, housing, and income support.

Yet, among the key findings of the report issued by Satcher is one he highlighted at the press conference on December 13: "There's no scientific reason to differentiate between mental health and other kinds of health. Mental illnesses are physical illnesses." The report is the result of a review of more than 3,000 research monographs and thus rests on a solid foundation of state-of-the-art science in the area of mental health. The *Washington Post* reported on December 14: "[Satcher] said he hoped the report would have the lasting impact of the initial report on smoking, but that it would 'be more effective than the smoking report in terms of actually changing how people lived.'"

The purpose of this background paper is to review the report in terms of the political, historical, economic, and attitudinal forces which have shaped mental health policy in the United States while highlighting the findings of the report that have the most salience from a federal policy perspective. While the report itself and its executive summary are clear, informative documents, they are written for a broad audience, and the overall length of the report—almost 500 pages—may inhibit some policymakers from reviewing the entire document.

KEY FINDINGS, DEFINITIONS, AND SCOPE OF THE REPORT

The report makes a number of key findings, which might be summarized as follows:

- Mental illnesses are devastatingly real and affect roughly one in five Americans in the course of a year.

- The diagnosis and treatment of mental illness are grounded on a scientific basis that is as strong as that for the diagnosis and treatment of nonmental or physical illness.

- The stigma associated with mental illness is irrational but a major factor in impeding the needed treatment of Americans with mental illness.

- Especially in a period of managed care ascendancy, there is no rationale for a lack of parity in insurance coverage between mental health and physical health.

- Americans do not have equal access to mental health care. Income, race, and ethnicity are significant factors inhibiting equal access.

The report also offers several basic definitions:

- *Mental illness* refers 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.[2]

- *Mental health problems* [are] signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder. . . . Bereavement symptoms in older adults [of short duration—less than two months] offer a case in point.

In terms of scope, the report explicitly omits discussion of developmental disabilities (such as mental retardation, cerebral palsy, and autism) and addictive disorders (such as alcoholism and drug abuse), with the exception of dual diagnoses of mental illness and chemical dependency.

CONTEXT

To fully appreciate the potential impact of the report, it is helpful to consider its political, historical, economic, and attitudinal context. Economists Richard Frank and Thomas McGuire succinctly capsulize some of the basic contextual differences between mental health and general health:

> In terms of public and private policy in the U.S., mental illness and substance abuse are not treated the same as other illnesses. In comparison to physical illness, government pays for more of mental health and substance abuse care, and private insurance pays for less. . . . The public system in mental health has a role as protector of

public safety. When efforts have been made to reform the health sector in the U.S., mental health and substance abuse are usually handled separately.[3]

Widespread Skepticism about Intervention

A major reason that mental health policymaking is often segregated from health policymaking is a basic skepticism about whether mental health interventions have any effect—or, if they have an effect, whether it is positive and cost-efficient. In his book on the history of the treatment of people with mental illness in America, Gerald Grob points out: "The prevailing image was that psychiatric therapies were distinctly inferior to those employed in general practice. That therapeutics in general medical practice were no different from those in psychiatry was all but ignored."[4] Popular caricatures of people with mental illness and the treatment they receive, typified by Woody Allen's ridicule of his lengthy time in psychotherapy, only reinforce this attitude.

At least part of the reason for the skepticism about how wisely funds are invested in various mental health therapies is a sense that some portion of those receiving such therapies do not in fact need them but are, at worst, what is popularly characterized as "the worried well," people coping with the "normal" stresses of everyday life.

Insurance Practices

The report itself comments on the way this skepticism affects insurance coverage of mental illness:

> Private health insurance is generally more restrictive in coverage of mental illness than in coverage for somatic illness. This was motivated by several concerns. Insurers feared that coverage of mental health services would result in high costs associated with long-term and intensive psychotherapy and extended hospital stays. They were also reluctant to pay for long-term, often custodial, hospital stays that were guaranteed by the public mental health system, the provider of "catastrophic care."

Two terms—*moral hazard* and *adverse selection*—are frequently applied to describe the special fears of insurers about covering mental illnesses. Moral hazard describes a situation in which consumers' demand for a good is highly sensitive to the price they confront; in other words, in health coverage, the lower the consumer's out-of-pocket cost, the more of the good will be consumed. It is generally accepted that demand for mental health services—especially outpatient mental health services—is more price-sensitive than demand for other health services.

Adverse selection describes the apprehension of insurers that if they offer generous, high-quality mental health coverage, they will draw a group of enrollees with a disproportionate amount of high-risk consumers—people with mental illness will naturally gravitate to the health plans that cover it best, it is theorized. Commenting on the probability of adverse selection, Frank and McGuire observe:

> There is both direct and indirect evidence suggesting that the mentally ill and substance abuse users [sic] are associated with higher levels of health care spending and that they systematically select health plans that offer more generous coverage for behavioral health treatment.[5]

In some ways, the very use of such negative terminology—moral hazard and adverse selection—gives a negative overtone to policy discussions in this area. Bruce Vladeck and his former HCFA colleagues make this point when they comment:

> Even the language in which policymakers characterize the effects of coverage betray a fundamental bias against the population for whom aid is provided. . . . Offer a benefit, and a moral hazard exists that some unworthy will advance to claim it. When the political culture accepts a disability paradigm grounded in a false conception of benefits users as unworthy or immoral, it is difficult to see how the problem can be impartially studied, let alone resolved.[6]

The point they make also seems applicable to the term "adverse selection."

Historically, especially in a fee-for-service context, insurers have pursued a number of strategies to protect themselves from what they see as the threat of potentially open-ended mental health expenditures. For one thing, they have applied a number of seemingly arbitrary limits to mental health benefits, such as number of days of inpatient treatment, number of outpatient visits, aggregate yearly and lifetime limits on insurance outlays, and high deductibles and copayments. Removing such limits, which are seldom applied to coverage for non–mental health benefits, has been the prime rationale for the parity legislation which has now been enacted in nearly 30 states as well as at the federal level through the Mental Health Parity Act of 1996 (P.L. 104-204).[7]

There is growing evidence that such limits, which have always been seen as a rather "blunt instrument," are increasingly outmoded, as more and more Americans receive their mental health coverage through managed care arrangements. As the report points out: "In 1999, almost 177 million Americans with health insurance (72 percent) were enrolled in managed behavioral health organizations [MBHOs]." The MBHOs offer specialized

coverage only for mental health and substance abuse, allowing them to manage benefits in these areas very rigorously. The 72 percent figure excludes other Americans who may be enrolled in managed care arrangements in which behavioral health was still managed by a general-purpose health maintenance organization (HMO) or preferred provider organization (PPO).

Under any managed care arrangement, the need for such limits on visits, days, and expenditures is obviated by the opportunity to make individual, case-by-case decisions on medical necessity, including whether coverage of a benefit is appropriate for an individual and, if so, what type and quantity of the benefit are covered. While the apparent need for limits on benefits in managed care contracts seems to have disappeared, they persist, especially in states without parity laws.[8] Where they do, they reflect in part a continued mind-set that mental health benefits warrant restrictions that other benefits do not.

Third-Party Reimbursement for Mental Health: Public versus Private

Private insurance plays a smaller role in reimbursing behavioral health care costs than in all of health care reimbursement—funding about 26 percent of mental health and substance abuse costs in comparison to 31 percent of total health costs.[9] Ohio Mental Health Director Michael Hogan recently observed:

> Behavioral disorders remain essentially the only set of health problems for which state and local governments finance and manage a specialty treatment system. . . . The public mental health system is the only substantial, disease-specific treatment system in existence today. . . . States remain the largest single payer for mental health care, if states' contributions to Medicaid are considered. Public spending covered 53 percent of all mental health treatment costs. Private insurance payments . . . covered only about a quarter of costs.[10]

It is widely believed that the very existence of this separate public system provides both employers and insurers a ready excuse for offering people with private insurance only limited coverage for mental health benefits. The report concludes:

> Existence of the public sector as a guarantor of "catastrophic care" for the uninsured and underinsured allowed the private sector to avoid financial risk and focus on acute care of less impaired individuals, most of whom received health insurance benefits through their employer.

Table 1 presents a comparison of the sources of payment for services provided by the mental health/substance abuse sector with those provided by the health system as a whole in the United States in 1996. As the report indicates, the public system plays a residual or safety net role in covering mental health expenses: "The public sector serves particularly those individuals who have no health insurance, those who have insurance but no mental health coverage, and those who exhaust limited mental health benefits in their health insurance."

TABLE 1
Comparison of U.S. Spending on Mental Health and Substance Abuse Services with Spending on All Health Care, by Source of Payment, 1996
(in percent)

	Mental Health/ Substance Abuse	All Health
Private Payers		
Private insurance	25.8	31.0
Out-of-pocket	15.1	18.2
Other private	2.8	3.4
Total private	43.7	52.5
Public Payers		
Medicaid*	18.9	14.8
Medicare	14.0	21.0
Other federal**	4.0	4.4
Other state/local	19.4	7.3
Total public	56.3	47.5
TOTAL	100.0	100.0

Note: Percentages may not total 100 due to rounding.

*Includes both federal and state Medicaid expenditures.

**Includes Veterans Administration, Department of Defense, federal block grants.

Source: David McKusick, Tami L. Mark, Edward King, Rick Harwood, Jeffrey A. Buck, Joan Dilonardo, and James S. Genuardi, "Spending for Mental Health and Substance Abuse Treatment 1996," Health Affairs, *17, no. 5 (September/ October1998): 147-157.*

Federalism and Mental Health Policy

While the role of the federal government in mental health policy throughout American history has been subordinate to that of the states, federal participation

changed dramatically with the enactment of the Community Mental Health Centers Acts in 1963 and 1965 and the amendments to the Social Security Act of 1965, which created Medicaid and Medicare. The report points out:

> Since the mid-1960s . . . the role of the Federal government has increased. In addition to Medicare and Medicaid, the Federal government funds special programs for adults with serious mental illness and children with serious emotional disability. Although small in relation to state and local funding, these federal programs provide additional resources. They include the Community Mental Health Block Grant, Community Support programs, the PATH program for people with mental illness who are homeless, the Knowledge Development and Application Program, and the Comprehensive Community Mental Health Services for Children and Their Families Program.

As shown in Table 1, however, Medicare and Medicaid are the dominant forces in federal behavioral health spending, accounting for about eight times the share provided by the federal programs which are more targeted to behavioral health problems. (Medicaid expenditures include state matching funds, which account for about 43 percent of total Medicaid spending.)

From the outset, both Medicaid and Medicare included provisions that were designed to prevent the states from utilizing either program as a means of subsidizing what had previously been exclusively state-local fiscal responsibilities for mental health services, particularly in state mental hospitals (where reimbursement was governed by what these federal entitlement programs called exclusions for "institutions for mental disease" [IMDs]). But both programs were far less restrictive in terms of coverage outside of institutional boundaries. As Vladeck and his colleagues point out:

> State mental hospitals were the mainstay of mental health care in the years before the enactment of the Medicare and Medicaid programs, and both programs had features designed to avoid paying for care in these settings. . . . However, a gradual shift in the location of mental health care from the states to the federal government began in the 1960s and 1970s with deinstitutionalization. Consequently, federal programs have become increasingly important for chronically mentally ill populations, first by default, as deinstitutionalization proceeded, and then with the expansion of entitlements to include SSI [Supplemental Security Income] and Medicaid benefits. This "Medicaidization" of mental health, and the perception of a need to level the playing field by expanding mental health services, is forcing consideration of how policy should respond to mental illness.[11]

Medicaid coverage in the community offered a special stimulus to deinstitutionalization insofar as Title XIX offered coverage for the following services:

- Nursing home care for elderly and chronically ill patients, regardless of their diagnosis. (This led to the transfer of large numbers of elderly mental hospital patients to nursing homes.)

- Inpatient psychiatric services in general community hospitals. (Especially for patients with acute mental illness, this led to a shift of locale of treatment from state mental hospitals, as more and more general hospitals created psychiatric units. By 1983, two-thirds of episodes of mental illness were treated in general hospitals.)

- Rehabilitative services provided outside special psychiatric settings.

While Medicaid reimbursed many of the medical expenses of former mental patients living in the community, the Federal Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs paid for their essential living expenses such as room and board. States have no financial obligation for sharing in the costs of SSDI payments, although they have the option of supplementing SSI grants.

Cost-Shifting among Payers

With all of these separate funding streams and payers, it is not surprising that there is considerable effort to shift costs across the mental health system. Frank and McGuire describe mental health policy as a "cascading cost-shifting game" in which each of "the players across levels and within levels of the game makes choices subject to rules set at a higher level."[12] In a recent article in *Health Affairs*, David Mechanic and Donna McAlpine of Rutgers University suggest the implications of this cost-shifting for public mental health policy: "Behavioral health care is an area in which it is relatively easy to shift costs and responsibilities to other sectors, so boundaries have to be made clear and transparent to monitoring efforts."[13]

Obstacles to Access

In his preface to the report, Satcher makes a striking statement: "Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services." This is a telling observation in the context of 44 million Americans who lack any health insurance and countless

others who are underinsured. As pointed out above, the report notes that nearly half of Americans with a severe mental illness do not seek treatment and that almost two-thirds of those with a diagnosable mental disorder fail to seek treatment.

The report goes on to identify a number of major obstacles to needed mental health services, including the following:

- Concerns about cost—obviously linked to inadequate third-party coverage.

- Worry about stigma and public attitudes toward mental illness.

- Minimization of the mental illness or disorder, sometimes linked to a belief that the problem will resolve itself.

- Lack of sensitivity to racial, ethnic, and other minorities on the part of a mental health delivery system which is dominated by white, Anglo providers offering care based almost exclusively on a model of their own racial group's needs.

Stigma and Popular Attitudes toward Mental Illness

The increase of knowledge about mental illness might have been expected to dispel the stigma associated with it in recent years, but the report notes that stigma has actually increased over the past 40 years: "Why is stigma so strong despite better public understanding of mental illness? The answer appears to be fear of violence; people with mental illness, especially those with psychosis, are perceived to be more violent than in the past." The report indicates that a series of surveys found that "selective media reporting reinforced the public's stereotypes linking violence and mental illness and encouraged people to distance themselves from those with mental disorders." The cases of Andrew Goldstein, who pushed Kendra Webdale under the wheels of an oncoming New York subway train; Russell Weston, Jr., who shot and killed two U.S. Capitol policemen; and the two teenaged boys who shot members of the Columbine High School community in Colorado before taking their own lives are recent examples of such intense media attention.

The forces of deinstitutionalization, which have reduced mental hospital populations and increased the number of people who might formerly have been institutionalized but are either receiving community treatment or are homeless, have obviously increased public awareness of people with mental illness. The

examples the public sees sometimes engage in bizarre or threatening behavior, increasing both public discomfort and stigma. Stigmatization of mental illness prohibits all but a few public figures from disclosing their mental illness in an attempt to educate the public— reporter Mike Wallace, author William Styron, and actress Patty Duke are among the few who have disclosed their conditions. It is perhaps noteworthy that none is a politician and that the politicians who are leaders in fighting for the rights of people with mental illness are typically those with relatives with mental illness—not consumers themselves.

The report responds to public fears of violence from people with mental illness as follows:

The greatest risk of violence is from those who have dual diagnoses, i.e., individuals who have a mental disorder as well as a substance abuse disorder. There is a small elevation in risk of violence from individuals with severe mental disorder (e.g., psychosis), especially if they are noncompliant with their medication. Yet the risk of violence is much less for a stranger than a family member or person who is known to the person with mental illness. *In fact, there is very little risk of violence or harm from casual contact with an individual who has a mental disorder. . . .* To put this all in perspective, the overall contribution of mental disorders to the total level of violence in society is exceptionally small.

Nonetheless, the report underscores the adverse effects of stigma on individual consumers: "Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others."

Deinstitutionalization and the Shift to Community-Based Services

The world of mental health treatment has changed dramatically in the last half century. In the mid-1950s, state mental hospital populations peaked at over 500,000 patients and a relatively small percentage of people were being treated for mental illness in community-based settings. The succeeding decades brought remarkable advances in psychopharmacology, community-based services, and—perhaps most importantly—federal funding, especially through the Medicaid program, all of which contributed to a shift towards community-based placements and the reduction in state mental hospital censuses—and, in many cases, the outright closure of such hospitals. The work of advocates as well as numerous court rulings have also added to the pressures in favor of deinstitutionalization.

The changes were rapid and dramatic. In 1955, 77.4 percent of all patient care episodes were attended to in inpatient settings and 22.6 percent on an outpatient basis. In 1968, following a substantial expansion of outpatient services, the percentages had shifted to 47.3 inpatient and 52.7 outpatient. From 1955 to 1970, the census of public mental hospitals dropped from 558,922 to 337,619, while admissions rose from 178,003 to 384,511 annually. (Obviously, length of stay declined sharply over the period.)[14] The report notes that the current inpatient population has dropped to less than 100,000.

The report puts these developments in an important historical and social welfare policy context:

> The dual policies of community care and deinstitutionalization . . . were implemented without evidence of effectiveness of treatments and without a social welfare system attuned to the needs of hundreds of thousands of individuals with disabling mental illness. . . . Many discharged mental patients found themselves in welfare and criminal justice institutions, as had their predecessors in earlier eras; some became homeless or lived in regimented residential (e.g., board and care) settings in the community.

One of the primary problems encountered in deinstitutionalizing the massive number of people who left the state hospitals, while at the same time preventing the institutionalization of many who would have been hospitalized under prior policies, was that generic social welfare programs were ill-prepared to respond to this new demand. Many social services agencies had limited experience or expertise in assisting people with mental illness—and few had large enough budgets to accommodate a new population needing services.

As public mental health policy moved toward community treatment, basic differences between mental health and other health care became apparent. Mental health programs for people with severe and persistent illness necessarily had to encompass an array of services typically thought extraneous to health care, including housing, income support, protective services, and, where appropriate, vocational rehabilitation and other employment services.

Mental Health's Shrinking Portion of the National Health Care Accounts

In recent years, the fraction of national health expenditures going to mental health has been declining. The report indicates that between 1986 and 1996, when health care spending was growing by more than 8 percent, mental health spending grew by about by 1 percent less. This decline is not in itself reason for concern. No one claims to have established any normative figures for how much health care spending ought to go for mental health.

Yet there is evidence that mental health expenditures have been brought under rigorous managed care controls to an extent which has not been true of other health expenditures. This development has raised some concerns about quality. As Mechanic and McAlpine observe:

> There are indications that reductions in the intensity of care may have gone too far. . . . For every day of reduced [inpatient] stay, the odds of readmission within sixty days increased by 3.1 percent. . . . For those with large reductions (ten or more days), the risk of readmission within sixty days was 37 percent higher than for patients whose days of care were not reduced.

Viewed from the context of a single employer, this policy may indeed be "penny wise and pound foolish," in that the savings generated from mental health expenditure reductions may be leading to increases in other health care spending. From their recent study of a large corporation that reduced mental health service use as a result of cost containment efforts, Robert Rosenheck of the Yale University School of Medicine and his colleagues conclude:

> Savings in mental health services were fully offset by increased use of other services and lost workdays. . . . Perhaps the most important implication of this study is that reductions in use of mental health services can be associated with compensatory increases in use of medical services and may adversely affect the functional and health status of patients, with no savings to payers . . . .If reducing mental health care is associated with increased medical service use and cost, it may be inferred that use of mental health services prior to these reductions was restraining such costs.[15]

These findings only seem to underscore the validity of the report's repeated message that mental health and physical health are inextricably linked.

PURPOSES SERVED BY THE REPORT

Translating Science into Laypeople's Language

Certainly, the basic purpose of the report is educating the public and the policymaking process about the realities of mental health and mental illness. It accomplishes this mission primarily by conveying the findings of a large number of scientific and social scientific studies in language that is understandable by the lay public.

To take but a single example, the report addresses the lack of public understanding of the incapacitating nature of serious mental illness. It does this first by confirming that serious mental illnesses are indeed debilitating:

> The fact that many, if not most, people have experienced mental health problems that mimic or even match some of the symptoms of 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.

The report goes on to call attention to a study which compares several psychiatric diagnoses to more familiar physical diagnoses, using the framework of Disability Adjusted Life Years (DALYs):

> The measure of disease burden used in [the Global Burden of Disease study], called Disability Adjusted Life Years (DALYs), allows comparison of the burden of disease across many different disease conditions. DALYs account for lost years of healthy life regardless of whether the years were lost to premature death or disability. For example, major depression is equivalent in burden to blindness or paraplegia, whereas active psychosis seen in schizophrenia is equal in disability burden to quadriplegia.

The report also cites findings with immediate policy relevance. For example, it reports on a study that found that 51 percent of older people who committed suicide saw their physician within a period 30 days prior to taking their own life. Given the disproportionately high suicide rate among the elderly—especially older men—the implication seems obvious: if nonpsychiatric physicians were trained to identify suicidal indications among older patients, they might intervene to prevent a significant number of suicides.

Eradicating Stigma and Popular Biases

At the press conference at which the report was released, Tipper Gore called mental illness "the last great stigma of the twentieth century." The same evening, in a televised interview with Gwen Ifill of public television's "NewsHour with Jim Lehrer," Satcher elaborated:

> That's our first charge . . . to really see if we can change the environment so that people feel comfortable. . . . If a person has a cardiovascular disease or diabetes, they're not embarrassed to seek care, but so often in this country if people have mental illness, they're embarrassed. Families are embarrassed. You can't change that unless you change the level of awareness . . . and change the attitudes of the American people.
>
> I think one of the reasons there's so much stigma surrounding mental illness is . . . there are a lot of

people who just don't believe that mental illnesses are real. . . . This report shows the science that says that the bases of mental illness are chemical changes in the brain and, therefore, physical changes, changes in the basic cells of the brain.

Satcher's observations call to mind a controversial comment about suicide made by Minnesota Governor Jessie Ventura in an interview published in the November 1999 issue of *Playboy*:

> I've seen too many people fight for their lives. I have no respect for anyone who would kill himself. If you're a feeble, weak-minded person to begin with, I don't have time for you. . . . I don't have sympathy is what my feelings are on suicide. . . . To me it's something that doesn't have to happen if people take a positive attitude on life like I do.

Ventura was apparently unaware when he made this comment that 90 to 95 percent of suicides are associated with one of several major mental illnesses—depression, manic-depressive disorder, schizophrenia, drug and alcohol abuse, and personality disorders. The report is full of scientific evidence to counter such attitudes.

Affirming the Efficacy of Treatment

In the executive summary, the report points out: "Increasingly effective treatments for mental disorders promise to be the most effective antidote to stigma." It then goes on to state two major conclusions:

- The efficacy of mental health treatments is well documented.

- A range of treatments exists for most mental disorders.

It would appear that at least some of the reason for skepticism about the effectiveness of mental health interventions is attributable to unrealistic attitudes towards the results produced by somatic—that is, non-psychiatric—medicine. National Institute of Mental Health Director Steven Hyman and his associate Grayson Norquist commented in a recent *Health Affairs* article:

> From a policy perspective, the decision to provide services often comes down to perceived use of limited resources to provide care for those illnesses that have the greatest impact on public health. Yet it is interesting to note that in general medicine there is no lack of coverage for illnesses that have only temporary and mild disability and no effective treatments (such as viral upper respiratory tract infections) or for which treatments have low efficacy (such as pancreatic cancer). In many cases, diagnosable, highly disabling, and highly treatable mental disorders have received far fewer resources.[16]

In a similar vein, the report comments:

> The thresholds of mental illness have . . . been set by convention, but the fact is that this gray zone is no different from any other area of medicine. Ten years ago, a serum cholesterol of 200 was considered normal. Today, the same number alarms some physicians and may lead to treatment. Perhaps every adult in the United States has some atherosclerosis [arterial occlusion, popularly called "hardening of the arteries"], but at what point does this move along a continuum from normal into the realm of illness? Ultimately, the dividing line has to do with severity of symptoms, duration, and functional impairment.

When it comes to diagnostic categories as opposed to thresholds, however, the report is even less ambiguous: "Diagnoses of mental disorders made using specific criteria are as reliable as those for general medical disorders." It describes the DSM-IV (the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition), published by the American Psychiatric Association and used across the country as the diagnostic system for mental illness, as "a unique approach to diagnosis by a professional field" and goes on to point out: "No other sphere of health care has created such an extensive compendium of all of its disorders with explicit diagnostic criteria."

At least part of the misunderstanding here may be linked to a conflation or confusion of acute and chronic conditions. Even with chronic somatic conditions, there is generally little hope for *cure*; often, the best that can be hoped for is *maintenance*—that is, preventing further deterioration. As noted above, many serious mental disorders are chronic. The report injects a note of realism in this regard:

> Although psychiatric therapies can alleviate symptoms and permit individuals to live in the community, there is no "magic bullet" that will cure all cases of serious mental illness. Like cardiovascular, renal, and other chronic degenerative disorders, serious mental disorders require both therapy and management.

Just as medical science gives us little guidance on how to prevent chronic physical disease, it also sheds little light on how to prevent mental illness—especially chronic mental illness. Part of the reason is that we have been able to learn remarkably little about the etiology or origins of chronic illness in either the physical or mental health arenas. The report frankly concedes this limitation:

> 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 . . . and/or there is an inability to alter the *known* etiology of a particular disorder.

Emphasizing the Importance of Culturally Competent Services

The failure of mental health interventions to take into consideration the unique features of all major ethnic and racial minorities, including African Americans, Hispanics, Asian Americans, and American Indians, is one of the major findings of the report: "The U.S. mental health system is not well equipped to meet the needs of racial and ethnic minority populations. Racial and ethnic minority groups are generally considered to be underserved by the mental health services system."

To remedy this, the report recommends a goal of "cultural competence," which it defines as follows:

> To be culturally competent is to deliver treatment that is equally effective to all sociocultural groups. The treatments provided must not only be efficacious (based on clinical research), but also effective in community delivery. The delivery of effective treatments is complicated because most research on efficacy has been conducted on predominantly white populations.

Cultural competence is of special importance in mental health for a number of reasons, but one stands out. A disproportionate number of minority group members have household incomes below the federal poverty threshold. This means that they are at special risk both in terms of developing a mental disorder—people in the lowest socioeconomic strata are about two and one-half times more likely than those in the highest strata to have such a disorder—and in terms of experiencing difficulty in getting access to any treatment for that disorder.

To cite but a few examples, the report notes the following special characteristics of minority groups that need to be considered:

- One of the common idioms of distress is somatization, the expression of mental distress in terms of physical suffering. . . . Epidemiological studies have confirmed that there are relatively high rates of somatization among African Americans.

- Among Mexican-Americans and Asian Americans, relatively high rates of marriage and low rates of divorce, along with a greater tendency to live in extended family households, indicate an orientation toward family.

- Immigrant families with relatives who may be undocumented . . . are less likely to trust authorities for fear of being reported and having the family member deported.

The report also draws attention to the emerging body of research on ethnopsychopharmacology, a field which

investigates genetic and psychosocial differences which influence the effectiveness of courses of mental health pharmaceutical therapies among different racial and ethnic groups. With regard to psychosocial differences, the report points out that language barriers and other communications problems may hinder proper compliance with prescribed dosing. With respect to genetic differences, it notes:

> There is wide racial and ethnic variation in drug metabolism . . . due to genetic variations in drug-metabolizing enzymes (which are responsible for breaking down drugs in the liver). . . . Since most of the ethnic variation comes in the form of inactivation or reduction in activity in the enzymes, the result is higher amounts of medication in the blood, triggering untoward side effects. For example, 33 percent of African Americans and 37 percent of Asians are slow metabolizers of several antipsychotic medications and antidepressants.

Establishing an Agenda for Future Action

In addition to addressing the areas of public education, stigma, communicating about effective treatments, and cultural competence just discussed, the report establishes five more agenda items for future action:

- *Continue to build the science base*—The report emphasizes the importance of "research that explores approaches for reducing risk factors and strengthening protective factors for the prevention of mental illness," important areas where the knowledge base is limited.
- *Ensure the supply of mental health services and providers*—Among the critical areas experiencing professional personnel shortages are services to children and adolescents as well as older people with serious mental illnesses. In addition, more specialists with expertise in cognitive-behavioral therapy and interpersonal therapy—two forms of psychotherapy of proven effectiveness for severe mental disorders—are urgently needed.
- *Ensure delivery of state-of-the-art treatments*—Despite the established knowledge base about effective, community-based services, the report indicates that there is a pronounced gap between research and practice in many communities.
- *Facilitate entry into treatment*—The report speaks of the obligation of public and private agencies to facilitate entry into mental health care and treatment through the multiple "portals of entry," including primary health care, schools, and the child welfare system. It also voices concern about the "alarming number of children and adults with mental illness [who] are in the criminal justice system inappropriately."
- *Reduce financial barriers to treatment*—While expressing general concern about the degree to which financial barriers impede access to needed treatment for mental illness, the report also declares without qualification: "Equality between mental health coverage and other health coverage—a concept known as parity—is an affordable and effective objective."

USING THE REPORT IN A PUBLIC POLICY CONTEXT

In essence, the report offers policymakers a compendium of policy-relevant research to guide their decision making about coverage of mental health services. For the most part, it assiduously avoids making explicit policy recommendations, although many of the research findings it features all but seem to point in certain directions. As many observed when the report was released, its effects on policy will depend very much on the uses of which policymakers and advocates choose to make it.

ENDNOTES

1. Robert Pear, "Mental Disorders Common, U.S. Says; Many Not Treated," *The New York Times*, December 13, 1999, 1.

2. The report distinguishes between *disorders* and *diseases* as follows:

> Most mental health conditions are referred to as disorders, rather than diseases, because diagnosis rests on clinical criteria. The term "disease" is generally reserved for conditions with known pathology (detectable physical change). The term "disorder," on the other hand, is reserved for clusters of symptoms and signs associated with distress and disability (i.e., impairment of functioning), yet whose pathology and etiology are unknown.

3. Richard G. Frank and Thomas G. McGuire, *Economics and Mental Health*, NBER Working Paper Series: Working Paper 7052, National Bureau of Economic Research, Cambridge, Massachusetts, March 1999, 1.

4. Gerald N. Grob, *The Mad among Us: A History of the Care of America's Mentally Ill* (Cambridge, Mass.: Harvard University Press, 1994), 179.

5. Frank and McGuire, *Economics and Mental Health*, 49.

6.   Bruce Vladeck, Ellen O'Brien, Thomas Hoyer, and Steven Clauser, "Challenges in Medicare and Medicaid for Persons with Disabilities," in *Disability: Challenges for Social Insurance, Health Care Financing, and Labor Market Policy*, ed. Virginia P. Reno, Jerry L. Mashaw, and Bill Gradison (Washington, D.C.: National Academy of Social Insurance, 1997), 87-88.

7.   For discussions of parity issues, see Karl Polzer, "Mental Health Coverage Parity: Separating Wheat from Chaff," National Health Policy Forum Issue Brief No. 745, July 20,1999, and Richard E. Hegner, "Mental Health Parity: Unresolved Issues Affecting Employers, Consumers, and Insurance Coverage," National Health Policy Forum Issue Brief No. 709, November 13, 1997.

8.   Parity laws themselves may be obsolescent in the face of the growing dominance of managed care, which offers insurers the opportunity to "game" such statutes by adhering to them in contractual language but violating the spirit of the laws in their utilization review and medical necessity decisions.

9.   Frank and McGuire, *Economics and Mental Health*, 12.

10. Michael F. Hogan, "Public-Sector Mental Health Care: New Challenges," *Health Affairs*, 18, no.5 (September/ October 1999): 106.

11. Vladeck, O'Brien, Hoyer, and Clauser, "Challenges in Medicare and Medicaid," 96-97.

12. Frank and McGuire, *Economics and Mental Health*, 72.

13. David Mechanic and Donna D. McAlpine, "Mission Unfulfilled: Potholes on the Road to Mental Health Parity," *Health Affairs*, 18, no. 5 (September/October 1999): 18.

14. All these statistics are from Grob, *The Mad among Us,* 266-267.

15. Robert A. Rosenheck, Benjamin Druss, Marilyn Stolar, Douglas Leslie, and William Sledge, "Effect of Declining Mental Health Services on Employees of a Large Corporation," *Health Affairs*, 18, no. 5 (September/October 1999): 193, 201, 202.

16. Grayson Norquist and Steven E. Hyman, "Advances in Understanding and Treating Mental Illness: Implications for Policy," *Health Affairs*, 18, no. 5 (September/October 1999): 38.