



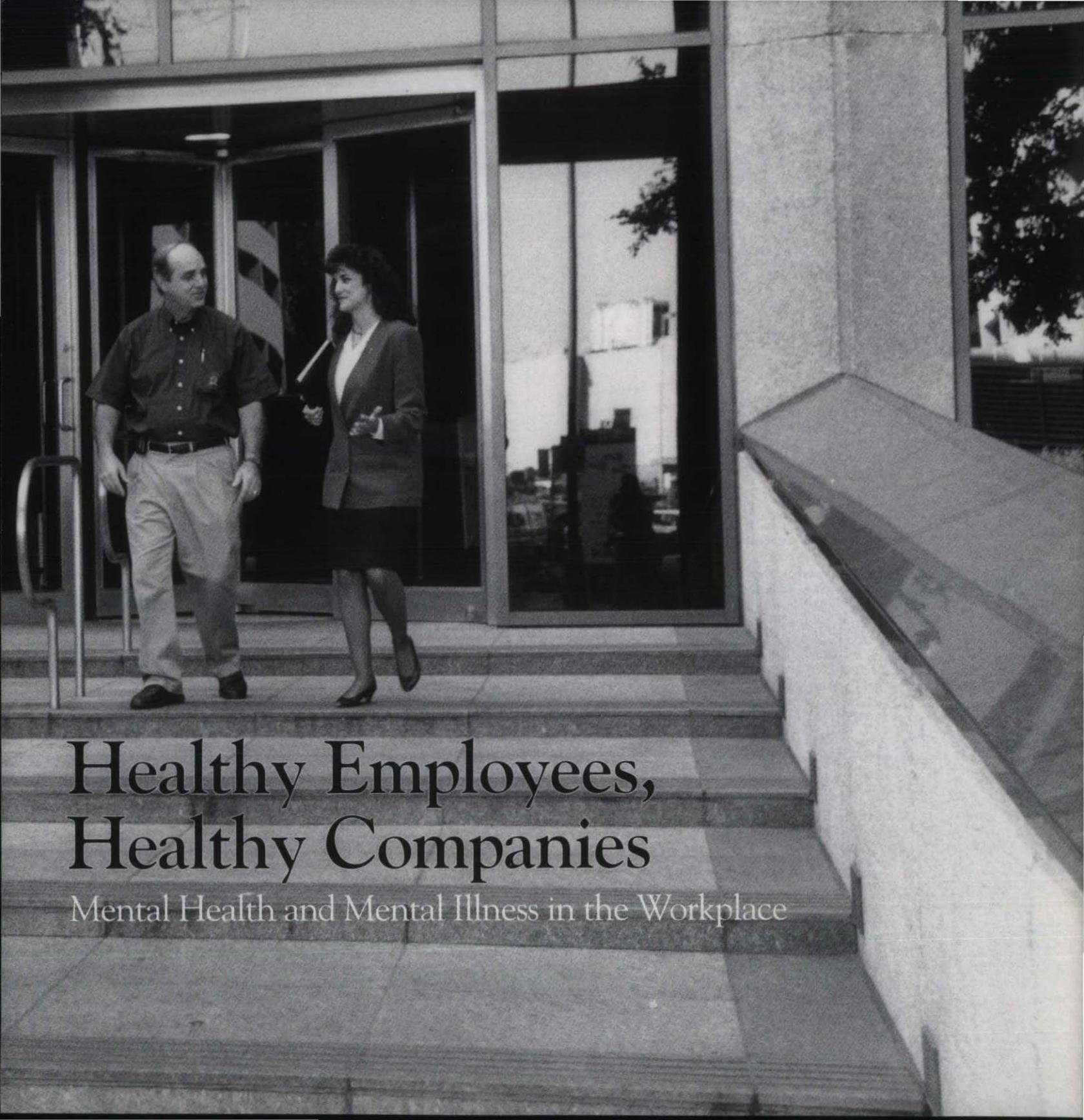
Healthy Employees, Healthy Companies

Mental Health and Mental Illness
In the Workplace



The Twelfth Annual Rosalynn Carter Symposium on Mental Health Policy
NOVEMBER 20 AND 21, 1996 • THE CARTER CENTER • ATLANTA, GEORGIA





Healthy Employees, Healthy Companies

Mental Health and Mental Illness in the Workplace

A Meeting of the Minds

Businesses and mental health professionals both want healthy employees

By Rosalynn Carter

Chair, The Carter Center Mental Health Task Force

To get anything on par with physical illness is a real accomplishment. Mental health has now become part of the national debate.

Our goal for this symposium is to create a forum in which we can address the concerns of the business community and the mental health community. These issues have been raised again and again over the past few years in the debate over national health care reform, health insurance reform, and parity for mental health coverage.

Legislation was passed in September 1996 that prohibits imposing caps on annual and lifetime mental health benefits. This seems like a small step.

We in the mental health community fought for, but didn't get, co-payments for mental health care. Nor did we get the requirement that insurance companies provide mental health benefits.

Still, the bill was a major plus. In the beginning, we were working hard just to include mental health in the health insurance debate. To get anything on par with physical illness was and is a real accomplishment. Mental health has now become part of the national debate.

Still there are also those who think the parity bill went too far. In our forum this year, we have the opportunity for the mental health and the business communities to talk about, and come to understand, each other's perspective. We can, I hope, reach some consensus about our common goal: healthy employees

and healthy businesses.

We in the mental health arena have to be realistic. We have to base our discussions on up-to-date information. We must realize that employers need cost-effective ways to treat mental health problems, and we should be prepared to show cost-effectiveness in our recommendations.

We need to give the business community information that shows how caring for employees' mental health improves productivity and work quality, and reduces absenteeism and turnover.

Also, we need to show that it can reduce violence in the workplace.

We should explore the impact of benefit plans on dependents of employees. We need to look at the environment of the workplace as well. Business people, too, have human as well as bottomline considerations—ranging from concerns about the mental health of employees to the value of preventive education for the workforce.

As we express our views, some suggestions and comments will be controversial. But overall, I think, we will find we have a lot in common. We all want the same things: a healthy workforce, a healthy community.

We must—and can—find ways to collaborate.

We need to be realistic.
We need to base our discussions
on up-to-date information.
We need to find cost-effective ways
to treat mental health
problems.

—Rosalynn Carter

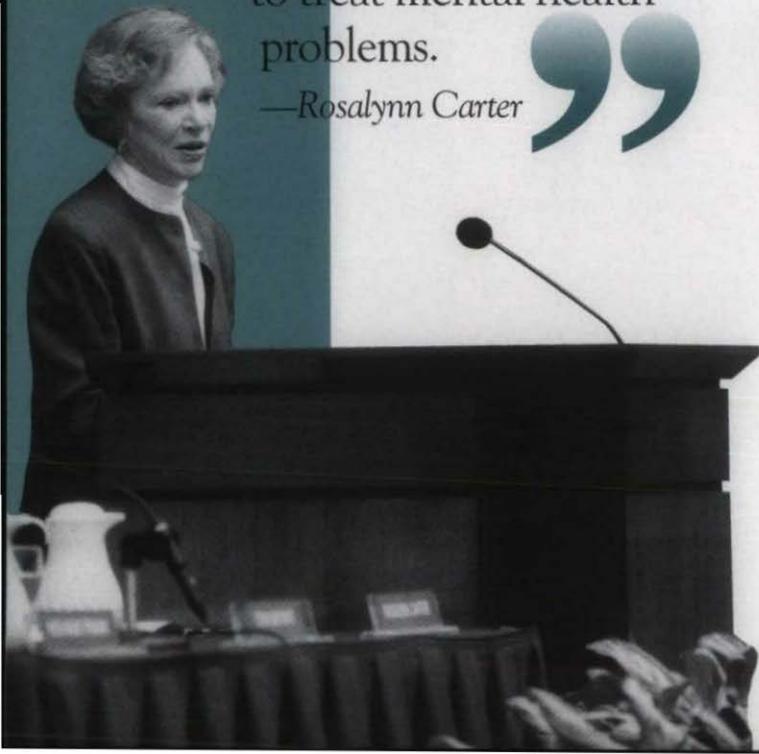


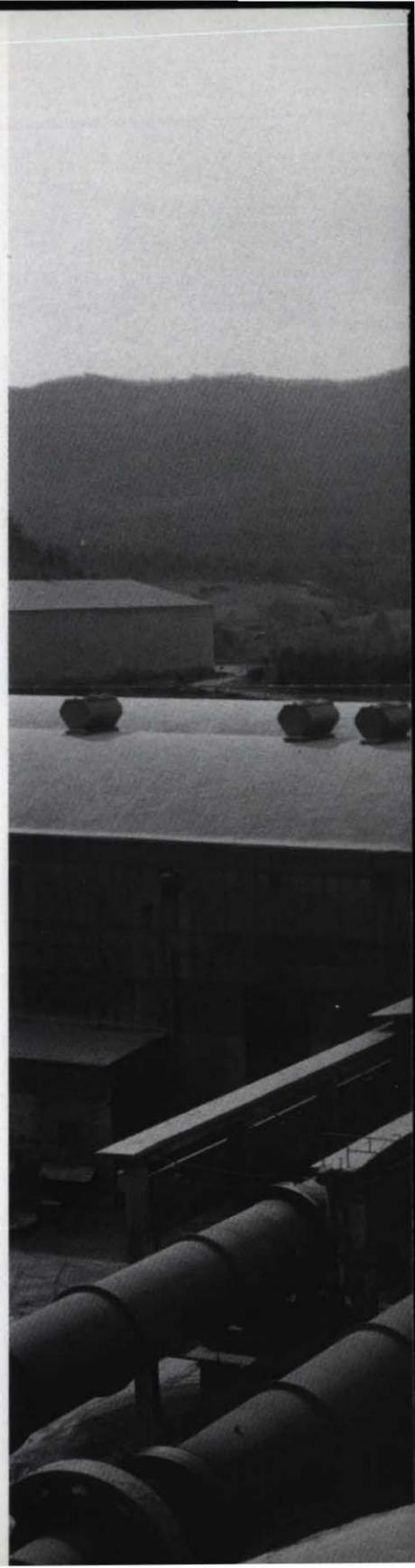
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The Twelfth Annual Rosalynn Carter Symposium on Mental Health Policy is made possible by funding from:

- Robert Wood Johnson Foundation, Princeton, New Jersey
- John D. and Catherine T. MacArthur Foundation, Chicago, Illinois
- BCI Corporation, Houston, Texas
- Pfizer Inc., U.S. Pharmaceuticals Group, New York, New York
- WXIA-TV, 11 Alive, Gannett Communities Fund, Atlanta, Georgia

Photographs of symposium participants by Kathryn Kolb; work place environmental photographs courtesy of NationsBank
Program Director: Dr. John Gates • Assistant Director: Judy Fitzgerald • Design: Everett Hullum and Nao Yamashita





Toward Win-Win Conclusions

First, acknowledge that markets matter—and that sometimes they don't work

By Richard G. Frank

Purchasers—large employers, state governments, and coalitions of employers—are restructuring markets for health insurance.

My assignment is to discuss the common ground between advocates for mental health care access and groups concerned with costs of health insurance plans. When I mentioned this opportunity to a friend, he said he hoped I'd been given just 10 minutes to fill.

But at the risk of being Pollyanna, I will advance the idea that there is significant common ground upon which mental health advocates and the business community can work. One reason that this common ground has been elusive is that participants in the debate have not owned up to the facts that:

- first, markets matter, and
- second, they don't always work right.

The new marketplace for health insurance is altering dramatically who makes health policies in this country. Purchasers—large employers, state governments, and coalitions of employers—are restructuring markets for health insurance. This phenomena offers a rare opportunity to experiment with solutions to long-standing and vexing problems—mental health foremost among them.

Richard Frank, Ph.D., is a professor of health economics in the Department of Health Care Policy at Harvard Medical School.

Common ground calls for win-win situations. Here's how we might make progress.

First, let's sketch a picture of the economics of mental health in the "good old days", the '70s and '80s. Mental health coverage was substantially more restricted than coverage for general medical care. Typical coverage consisted of 30 in-patient days per year, and 20 out-patient visits. Those 20 out-patient visits usually carried 50 percent co-payments rather than 20 percent co-payments. Commonly, lifetime limits accompanied this.

This was exactly the opposite of most people's conception of optimal insurance coverage. That is, the most valuable types of coverage protect individuals and their families against big losses. But in mental health, what emerged was the notion of optimal insurance stood on its head. Coverage for lower-cost, lower-intensity events was relatively good; it was only in the event of catastrophe that one was left to his or her own devices.

The reasons for this, in economic terms, are "moral hazard" and "adverse selection."

Moral hazard is an insurance term that has no moral content. It refers to the tendency for people to avail themselves of more services as the cost of those

services fall. Since insurance by its very nature drives a wedge between the total costs and the costs borne by an individual, extra use will almost inevitably result.

This is the dilemma of insurance: On one hand, we want to spread risk; on the other, we are concerned that the cost of doing so will be excessive.

The RAND Health Insurance Experiment provides the most convincing evidence that moral hazard was historically a greater problem in mental health care than in general medical care. The reported responses to reduced cost sharing in mental health were nearly twice as large as in general medical care. Specifically, when a plan that offered free care was compared to one that only had catastrophic coverage, the general medical costs doubled. In the area of mental health, they quadrupled.

Regardless of whether you interpret this as good or bad, it means costs of extra coverage are more responsive in the mental health area. The natural response by insurers is to increase cost-sharing. This is the nub of the debate on the cost of expanded health insurance: that parity in coverage will lead to disproportionate mental health costs.

Adverse selection occurs because enrollees know more about themselves than the insurer does. Individuals will choose the policies that look the best to them.

Since mental and addictive disorders can be more persistent than other mental illnesses, health plans have a strong incentive to reduce the likelihood that people with these illnesses will enroll in their plans. In other words, plans that are known as being good at mental health may be at risk of finan-

cial survival.

One way to achieve favorable selection during the good old days was to make sure that benefits were very limited. This happened most clearly under the federal employees' health benefit plans in the early '70s. Aetna offered a parity benefit; Blue Cross did not. Aetna quickly attracted a needier population of enrollees and began losing money. Competition in this situation was not to be efficient or to offer good service; it was to avoid bad risks.

This does not happen necessarily because of ill will towards the mentally ill. Plans that offered good coverage often went broke. In this case, competition led to an inefficient outcome—too little mental health coverage.

Consider a mid-size or small employer trying to select plans in the marketplace. Only limited coverage was available to them. Some argue that this was the efficient outcome of a well-functioning market. Not so. Because of the potentially ruinous consequences of attracting mentally ill people, plans had a strong incentive not to offer that benefit—even if everybody involved thought it was a good idea.

Now, advocates for mental health care and a growing number of researchers point out that mental illness creates significant losses of productivity.

Psychiatric illnesses account for six lost days and 31 days of reduced productivity or activity per 100 workers per month. These are big numbers.

It has been estimated that working people with mental problems on average earn 24% less than others of similar race, age, educational background, and job experience. These numbers show that in fact, mental disorders are extraordinarily disruptive



This is the nub of the debate: that parity in coverage will lead to disproportionate mental health costs.

There are health plan executives who boast that they can manage any premium. Surely, that claim cannot always be consistent with sensible care.

to productivity. Moreover, it has been reported that there is a \$3 return for every dollar spent on employee assistance programs. The implication drawn from all this is often the following:

Given the progress that has been made in treatment technologies, there is good economic incentive for an employer to make a good mental health plan and a state-of-the-art EAP plan available to employees.

Does this mean that employers who fail to adopt such policies are economically irrational? Possibly, but labor market dynamics need to be considered before reaching such a conclusion.

An employer with a highly skilled work force, dealing with intense competition to recruit and retain the most capable employees, faces a very different pay-off from offering a rich fringe benefit package and employee support program than a firm operating in a labor market where skill requirements are low and there is an abundance of potential workers who can be easily substituted for one another.

A small firm that employs a low-wage, low-skill labor pool that turns over frequently may not be able to shift compensation arrangements without either laying people off or raising prices, which could threaten their survival in a competitive industry. Moreover, they may not collect the benefits of such policies.

A large employer often faces a somewhat different situation. A large employer can design an insurance program and administrative arrangements that differ from what is available in the commercial marketplace. In addition, if the labor force is highly skilled and earns high wages, there is a lot more

flexibility to mix compensation between fringe benefit and wages. It is no accident that IBM, AT&T, and Xerox offer relatively rich benefits and most mid-size and small service industry firms offer a different set, usually more limited.

Here again, the market matters. One cannot make the leap from the fact that there are significant social benefits from treating mental illness to the conclusion that it is always in each employer's self-interest to offer that kind of coverage.

Finally, studies of EAPs show that they are very cost-effective. But it's not clear that when they are not implemented, it's because they're not cost-effective.

Enter managed care. The brave new world. Managed care changes, in fundamental ways, the key elements of the picture I have just painted. First, managed care appears to more successfully address the moral hazard problem. Managed care technology seems to be so good at controlling behavior health care cost that the abundant worry today is under-treatment, not over-treatment.

How does managed care achieve cost control? In some respects, this question engenders great passion. In other respects, it is a technical question. Managed care makes use of information systems, expert opinion, bargaining power, control of the intake and referral systems, and financial incentives to constrain utilization costs. Managed behavioral health care companies promise to remedy past excesses of fee-for-service by more appropriately matching patients and treatments.

In its best incarnations, managed behavioral health care appears able to save money by:

■ appropriately shifting treatment from hospital-based, in-patient alternatives to community-based care;

■ bargaining for better prices and getting better deals from providers; and

■ maintaining or expanding access, often in conjunction with an EAP, to treat illnesses earlier in their course.

However, there are health plan executives who boast that they can manage any premium. Surely, that claim cannot be consistent with sensible care, always. There is some premium that will be too low. Cost savings of zero to 80 percent have been claimed in the transition from fee-per-service and indemnity arrangements in managed behavioral health care.

There are several implications of relying on the complex administrative, clinical, and financial incentives that have been successful in the managed care arena.

First of all, having a generous insurance benefit no longer need imply runaway costs. Costs are controllable. It is the intensity of management and the degree to which service utilization is controlled that are key to determining the cost of covering a given population.

Increasingly, benefit design is taking a back seat to administrative arrangements and payment mechanisms as an essential element affecting spending on mental health care. Regardless of the benefit specified in the insurance contract, effective coverage depends on how one manages it. This means that there are many new mechanisms available for making a health plan either more or less attractive to

enrollees. For example, a plan can institute administrative procedures that will discourage enrollment by people with severe mental disorders by making a partial-care program very hard to access, or by locating residential programs in out-of-the-way places or undesirable neighborhoods. All serve these types of functions. All have been reported.

Thus, the adverse selection problem continues to be important even if we have learned how to solve the moral hazard problem. The policy significance of the greater reliance on administrative, clinical, and financial mechanisms to control costs is that the fixes to coverage limits resulting from adverse selection are much more complicated than they used to be.

In the good old days, states responded to concerns about too little coverage due to adverse selection by mandating benefits. They did so to limit the race to the bottom.

This is clearly more complicated when more mechanisms are being used to manage the way care is delivered. It is here that the complexity of the insurance contract becomes important. This, in part, spells bad news for the parity legislation.

Focusing on a single aspect of the insurance contracts leaves too many other areas that can be manipulated to get around the intent of the legislation. For example, when you remove a \$10,000 cap, you could define a policy where cost-sharing levels are defined to depend on the level of spending in the aggregate. If you hit \$10,000, you could specify a cost-sharing arrangement of 90 percent at that point.

In addition, management can be tailored to achieve premium goals. Economists call this the non-

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If managed care could achieve its cost savings in a way that is promised, and employers continue to be active in structuring markets for insurance, some savings from cost control can be re-invested in expanded coverage.

contractibility problem. That is, the service is so complex, that regulating little pieces of it becomes very difficult.

Now, parity legislation is important because it publicly states a desire to fix the problem in the market. Those market problems are real. I am however, pessimistic that the specific piece of parity legislation will have a significant impact on improving the performance of the insurance market.

What is notable about the managed care era is that the parties that make policy have changed dramatically with respect to the workings of the market and the availability of employee support programs. Employers are no longer passive players in the insurance market. In fact, they are structuring markets that best serve their objectives.

Those objectives typically relate to obtaining value for their health care outlays and sensitivity to the types of markets—labor and product—that they face.

It is this change that is the basis for optimism. For example, it has been employers at the forefront of adopting managed behavior health care. It is also they who have been extraordinarily cautious in using very aggressive financial incentives to pay for mental health care.

Self-insured plans are most likely to use so called “soft-capitation arrangements,” payments that share financial risks between managed care organizations and employers. It is also self-insured plans that attempt to limit incentives to under-treat.

Employers have also been key to introducing innovations in the structure of mental health and substance abuse benefits. Programs that carve out

mental health, and combine managed care and EAP services represent new approaches to organizing insurance for mental disorders. Such programs are sometimes accompanied by expanded coverage.

These approaches have been introduced by larger, self-insured employers and purchasing coalitions, which are growing markedly. Carve-out programs can attenuate adverse selection problems by requiring a managed care organization to take everybody.

Integrating EAP and insurance reduces duplication of services, expands the continuum of care, and opens new opportunities for early interventions.

Some of the skills and bargaining power of managed care are becoming available to mid-size, and even small, employers through purchasing alliances throughout the country. At last count, these were in about 20 states, and their success is leading to rapid expansion of these organizations.

Creating mental health care carve-out programs—where there is intense competition for the contract—means that one can win the adverse selection game without paying the price that we have faced in the past. This has a disadvantage of limiting employee choice, and this merits very careful consideration. Reports from private companies and several more systematic analyses suggest that these types of arrangements can be very successful in preserving or, in some cases, increasing benefits, controlling costs and doing so in a way that maintains quality and access.

This means, in both the public and private sector, that a number of practical approaches can deal with both the moral hazard and adverse selection

problems. Savings are achieved, incentives for plans to restrict access are limited, and quality of care becomes a goal.

Given all this change, where are the win-win situations?

If managed care could achieve its cost savings in a way that is often promised, and employers continue to be active in structuring markets for insurance, some savings from cost control can be re-invested in expanded coverage. This will only be successful if it is done in the context of new ways of organizing coverage—or adverse selection or other market dynamics will once again hurt the mental health coverage of our citizens.

This means that purchasers—through carve-outs, specific carve-in contracts, and other tools—can set up customized mar-

kets for behavioral health plans that produce value for their mental health dollar.

Here's a definition of a win-win situation. Consider four sets of players in a market: users of mental health care, employees and dependents who are not users of mental health care, providers, and employers. It is probably not possible to make all partici-

pants win in all dimensions.

The industry claims that managed care saves by reducing inappropriate care. In the fee-for-service world of the '70s and '80s, there was evidence of simultaneous under-use and over-use of mental health services. There was well documented over-hospitalization of children with mental health problems, but only 50 percent of people who were actively schizophrenic got treatment in any given year. This makes for a vexing dilemma that is not easily resolved through benefit design by itself. By simply expanding coverage, one is likely to see both appropriate and inappropriate use continue.

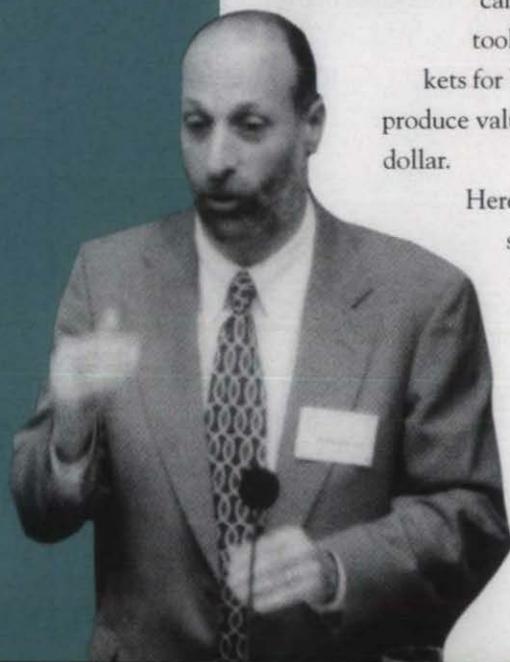
Managed care promises to save money without harming clinical care. Concern centers on the ability of managed care organizations to appropriately control costs. The care of individuals with severe mental disorders and severe addictive disorders is of particular concern because there is some evidence that these people have been hurt by under-capitated health plans. If managed care delivers on its promise, we have the makings of a win-win situation. If employers are willing to devote a portion of the savings from successful management to the expansion of coverage, then the users of mental health care can gain coverage and lower premiums by having their patterns of care altered. Non-users benefit from two things. They get lower premiums, but they also get expanded coverage in the event they become ill.

Similarly, employers gain flexibility in offering compensation packages. Providers potentially gain from patients with deeper and broader coverage.

Unfortunately, provider incomes are threatened to a yet unknown extent, as is their autonomy.

In mental health, what emerged was the notion of optimal insurance stood on its head. Coverage for lower-cost, lower-intensity events was relatively good; it was only in the event of catastrophe that one was left to his own devices.

—Richard Frank



The expansion of coverage also changes the division of labor between public and private sectors, giving the private sector more responsibility for the employed population and its dependents.

Making this a win-win situation requires several conditions:

- A willingness on the part of employers to share the savings with other participants in the mental health system.

- Having managed care firms live up to their promises. This calls for commitment to monitor access and quality of care.

To date, report cards have not been up to the task of tracking the performance of behavioral health care and managed care. The National Commission on Quality Assurance and the American Managed Behavioral Health Association are in the midst of serious efforts to rate health plans on the non-financial performance of behavioral health care. Until these things are ready for prime time, employers and other purchasers will have to continue a watch-dog role through their managed care contracts. IBM and Digital offer useful models for that.

- Employers and other purchasers will have to

structure markets for health insurance so that adverse selection is minimized. This means relying on behavior health care carve-outs, or specialized, well-designed, targeted carve-in programs. It means having intense competition for contracts.

This is hard work, and there are a variety of obstacles to overcome, including technical problems, continued mistrust of mental health benefits, and unwillingness to invest savings and expand coverage. It's ironic that the technology that creates so much suspicion in the behavioral health care community is creating opportunities to escape long-standing dilemmas related to insurance benefits for mental health care. Also, we fall victim to more serious market failures if we do not attend to the basic market forces in this industry.

Health care purchasers must serve a function similar to what many have wanted government to play: recognizing forces such as adverse selection and the availability and development of quality measures. Advocates will no doubt continue to advance the case for those who suffer from mental disorders, but they must recognize market forces in crafting solutions that can work.

Q&A with Richard Frank

Q Can you discuss expanded coverage? There are a large number of Americans with diagnosable disorders who are not treated, or who are very superficially treated.

The fundamental problem is that the sicker you are, the less effective coverage you have. The number one thing to fix is catastrophic

care. During the discussions over the recent parity legislation, the Congressional Budget Office estimated the cost of covering catastrophic care, and it was not expensive. This is a fix that comes at a relatively low cost.

Q Can you describe models where there would be incentives for investing in expanded coverage?

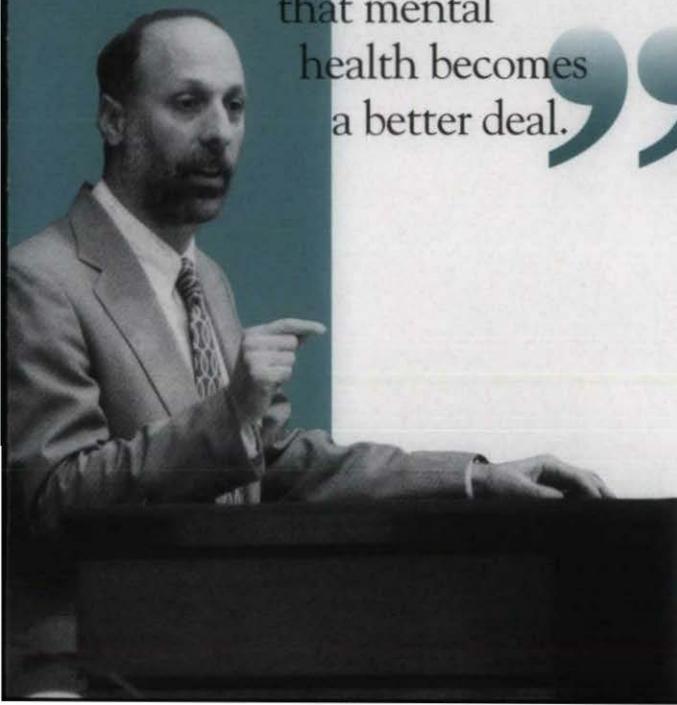
If you have a fairly stable work force, and you have to compete, there would be that incentive. I don't think employers like the idea of buying such limited coverage very often—very often, the market is set up so that they have very little choice. Competitive dynamics are potentially ruinous. We now have the opportunity to change some of that, meaning that mental health becomes a better deal. There are

also ways to restructure the market to get good coverage.

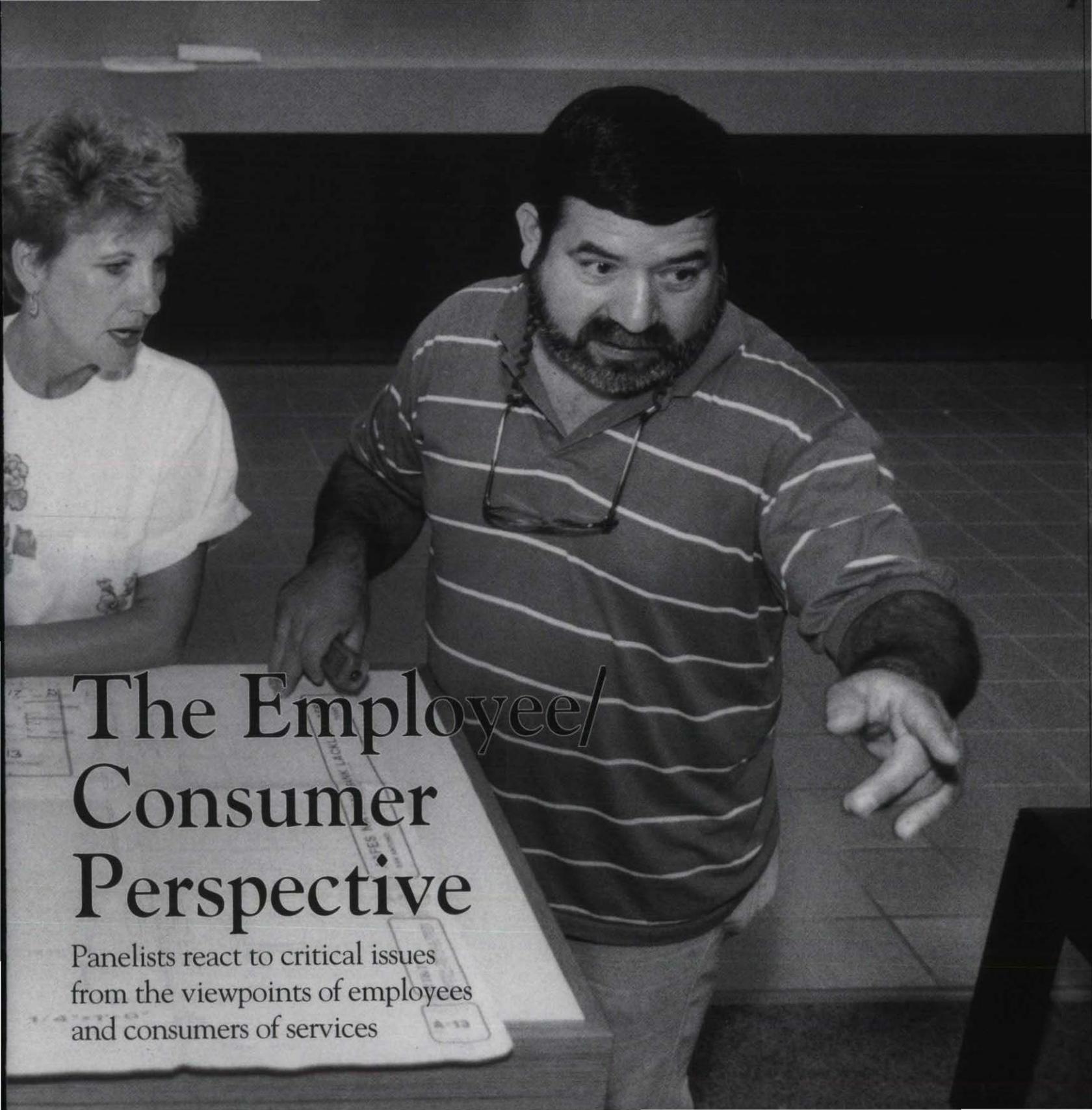
Q What would keep an employer from taking those profits home or to the shareholders, instead of reinvesting in expanded coverage?

Soft-capitation payment systems. If you believe there are lots of savings available in your insurance benefit, and you don't want someone to walk away with profits, don't write a contract that permits that. There are a couple of benefit-consulting firms who write contracts that cap the amount of profits that a vendor can make. They say, "Okay, a reasonable profit is 10 percent, to pull it out of the air. We will allow you to collect on 10 percent, but after that, any additional savings get returned to the employer."

Competitive dynamics are potentially ruinous. We now have the opportunity to change some of that, meaning that mental health becomes a better deal.







The Employee/ Consumer Perspective

Panelists react to critical issues
from the viewpoints of employees
and consumers of services

Alone in the Crowd

A social scientist with bipolar disorder reveals the effects of living with prejudice

By Jean Campbell

*My mental illness
is not who I am;
it does not define
my whole being.*

My training usually leads me into broad policy discussions, and when the topic is employment of people with serious mental illness, I usually talk about the Americans with Disabilities Act. However, since I have a bipolar disorder, my biography and that social history intersect.

In the long run, regardless of law, policy, and research, the problems one faces as a person with a psychiatric disability are often so sensitive and so subtle that they imperceptively grind away at your capacity to be a productive worker.

It is very hard for people to understand what a person with a psychiatric disorder really goes through at the work place. The most important element for all healthy workers is personhood. It's the attitudes of the people with whom you work, from administrators to co-workers, that are most critical in having productive workers.

Lost work days may be as much due to these attitudes as to the disorder itself. My mental illness is not who I am; it does not define my whole being. I have other interests, other concerns. In fact, I am all too human. However, there is a tendency, when your

psychiatric disorder is known, to conflate all of who you are under that category.

I did not go to school just to be a mental health consumer. Still, in the workplace if I am sad or happy or angry, some people think that it's due to my illness—not the life events that are going on around me. In fact, they may ask me if I am taking my medication instead of, "How's your family?"

This is also an easy way to dismiss you if you are aggressively advocating a particular issue. Not all people are alike. There is tremendous heterogeneity among all of us in this nation, and that is just as true with people with psychiatric disorders. You cannot make any assumptions.

Stereotyping of people with mental illnesses is ubiquitous and empirical evidence is equivocal about behaviors of people with a psychiatric disorder in the work environment. It is really important for productive workers who have a psychiatric disorder to take a hard look at the role that stigma and discrimination play.

It is really not surprising that many studies demonstrate that employers have strong negative perceptions. Most of those have to do with believing the common stereotypes of people with psychiatric disorders: violent, unpredictable, can't handle stress,

Jean Campbell, Ph.D., is a research assistant professor of psychiatry at the Missouri Institute for Mental Health.

lack social skills.

Even though the idea that people with psychiatric disorders are prone to violence is largely unwarranted, it is not totally groundless. Yet, the symptoms of mental illness are many times interpreted as voluntary defects of character. If you are depressed, you may be seen as lazy. I hide my depression under a shroud of physical illness: the flu, a cold. I don't talk openly, even though I have admitted that I am a person with a bipolar disorder. Then I too feel shame, that this is a moral defect.

When you don't talk about things, you don't get the support that you need from individuals and from your employer. Coming out of the closet was really difficult for me. When I was doing my Ph.D. thesis, I saw an ad in the newspaper for somebody to conduct a research project in California. The ad encouraged people with psychiatric disorders to apply. I had never seen that before. The job also offered a good salary; that was a real incentive. My experience would be valued, and I could do something of value.

However, as soon as I came out of the closet, people began to treat me differently. Once, I went with another mental health consumer to an agency to help supervise some interviews. The head of the agency was talking to both of us, but in the middle of her sentence she turned her back to talk to somebody else and totally ignored us. The person that I was with said, "They do that all the time." She said she didn't even notice.

More recent is a work experience in which a scholar from England came to do a presentation on the conditions in asylums in Scotland in the 18th

and 19th centuries.

The person started telling about some of the inmates in these places, invoking considerable humor. Making fun of people, story after story, showing pictures of inmates. My colleagues were all laughing. The more that went on, the more alienated I felt. It shows how you never quite feel one of the group. Our language reinforces difference. Common use of words like crazy, psycho, and whacko can really hurt.

Then, there is commonality of fate. We hear horrendous stories of serial killers, or somebody who has gotten up on a watchtower and shot people, and you find out that they had a history of mental disease. When you go to work, you wonder if people are regarding you differently.

So, in a sense, disclosure itself is disabling. Employers are encouraged to watch for symptoms of psychiatric disorders. While this has value, it also has a chilling effect in terms of disclosure. Nobody wants to be watched.

When I was the administrator of a nine-person unit, four of the people I supervised told me privately they had some psychiatric disorder and were getting medication or counseling. They wanted me to know, but they didn't want it known among the staff.

Such things make it very difficult to ask for reasonable accommodation in the work place. You have to define it individually, and negotiate, and that can be a real degradation ceremony in and of itself. Co-workers may be jealous of special privileges because many of the accommodations really deal with environmental conditions that all employees should have for quality of life in the workplace.



In the field of mental health, there may even be more stigma than in the general population. Professionals don't want to be called on the carpet when their language and behaviors are callous.

Since work is the passport to social and personal self-worth, and the key to recovery for people with mental illness, we must support social interventions in the work place itself.

Then, there is the shame of asking for reasonable accommodations, the internalized stigma. My most difficult experience came in my post-doctoral program, when I suffered severe depression.

I was very fearful to let people know what I was going through. First, I had been challenging them left and right about their attitudes and behavior. I thought I would lose a lot of ground if I asked for accommodations and acknowledged the depression. I feared I might be involuntarily hospitalized because many of them were psychiatrists and therapists, and they might have felt compelled to do that.

I was taking many classes, so I asked those professors for reasonable accommodations, for "incomplete" grades. But I never shared what I went through with the faculty in my program. I was afraid that there would be even more stigma than before.

Professionals do not want to be called on the carpet when their language and behaviors are callous. There is a certain denial and sense of safety in "them" and "us." I think it is very important that they take a leadership role in changing how we speak about people with mental illness.

You can get reasonable accommodations if you can do the essential functions of the job. But sometimes there is a patronizing concern that a mental health consumer cannot follow the rules, protocol, or expectations of other employees.

Once, someone left work for six months on medical leave because of a psychiatric disorder. The administrators were trying to make a special policy. I said, "What do we normally do?" It had not even occurred to them to check the normal policies, and

administrative remedies.

Last, but not least, there is the issue of parity. I am reminded of the problems with parity in medical prescriptions when I recently tried a medication called Paxil. When I got the prescription filled, the bill came to \$60—after insurance. It is very hard, particularly when you have multiple prescriptions, to stay on medications with those kind of out-of-pocket expenses. If you do not want others to know about your psychiatric disorder, you may even pay more expenses out-of-pocket, such as counseling.

In conclusion, the social awkwardness, demoralization, and unemployment induced by stigma cannot always be overcome by people with mental illness through individual coping mechanisms such as keeping one's history secret, or educating others about one's condition, or avoiding situations in which rejection occurs.

Quite the contrary. Research and my personal experience reaffirms that stigma is powerfully reinforced by culture and not easily overcome at the individual level. Since work is the passport to social and personal self-worth, and the key to recovery for people with mental illness, we must support social interventions in the workplace itself.

We need to consider the broad issues, the entire work environment. If we identify islands of excellence in healthy companies, we will be able to measure the outcomes of having a healthy work environment for people with psychiatric disorders. Finally, we must believe that people with mental illness can bring skills and scholarship to the workplace, and we should proactively seek their labor.

Considerations of Employees/Consumers

Five experts weigh stigma-busting against confidentiality

Dan Conti

Director of the Employee Assistance Program for First Chicago Corporation:

Not to sound coldhearted, but while a decrease in stigma is good for business as providers and good for humanity in general, how does it become a priority to a business leader? Also, there's the problem of decreasing stigma for employees while walking the fine line with their desire and need for confidentiality.

Frankly, I would have a difficult time walking into a CEO's office and telling him or her I'm here to help decrease stigma. I'm sure he would say that's good, but what else would we get? But if we look at it as a return on investment for our mental health dollars, then I've got their ear.

The next issue is to look at indirect costs, or see how productivity is directly affected by adding these benefits. Nothing will capture the ear of corporate America like being able to show the return on investment, that we really can produce great bangs for their bucks.

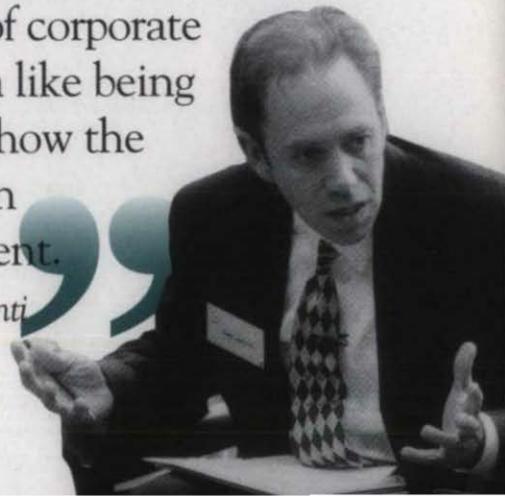
Robert McGarrah Jr.

Director of public policy for the American Federation of State, County, and Municipal Employees:

Can managed care deliver on its promise to provide better quality, more accessible, and lower-cost care? Does doing so require the employer and the managed care companies to essentially share the returns on the gains that they have mutually achieved in this process with the beneficia-

“Nothing will capture the ear of corporate America like being able to show the return on investment.”

—Dan Conti



Jeffrey Houpt, panel moderator, is a visiting professor in the Department of Social Medicine at Harvard Medical School and a member of The Carter Center Mental Health Task Force.

Walter Maher, panel facilitator, is director of public policy for Chrysler Corporation.

Where is the money being returned to the consumer?

ries, the workers and the people getting the services?

In the Carter Administration, when work was being done on the Mental Health Systems Act, one of the major issues was how to give workers in the public mental health care system an opportunity to participate in changes. This was dramatized by the Wyatt case in Alabama, in which employees of the state institutions sued Gov. George Wallace because the quality of care had deteriorated dramatically. The employees told Judge Frank Johnson that they simply wanted the respect and dignity they deserved to make changes in the delivery system. Judge Johnson realized that there were certain constitutional restrictions, considering both that there is no right to a job but there was a right to treatment.

This extends into the mental health of the work place at large. Do we respect one another, from the lowliest person who sweeps the floors to the nurses who work in the hospitals to the managed-care executives who reap incredible profits?

At the recent American Public Health Association meetings, a great deal of concern was expressed about the role of managed care and its potential conflict with public health. Of course, the poster person of the day is Leonard Abrahamson, formerly of US Health Care, who reaped approximately \$1 billion dollars and has a private jet for his commute.

Where is the money being returned to the consumer? Where is the system for workers with psychiatric disorders and union members I represented? These people need to come together and

At Chrysler and Ford, and some parts of General Motors, it has become a big issue to break down the paradigms of authority, the stigma between those who seem to know it all or have all the wealth and those who actually know the consumer and know the front-line work as it ought to be delivered. This is a fundamental issue that we need to address.

Maier: In collective bargaining, do many employers count on the savings associated with managed care to enable them to afford to offer a

“There are very few people in this country whose health care coverage—both for mental health and acute care—is not substantially subsidized by public resources.”

—David Manning



health plan? Or to free up money to increase other elements of compensation?

Exactly. I remember President Carter's attempts to pass hospital cost-containment legislation through because costs were going through the roof. We turned to managed care, a system created in a cooperative mode.

The early prepaid, group practice idea was non-commercial: Group Health, the Harvard committee. But it's becoming clear that state legislators now have thousands of bills on their desks and are passing them right and left, mandating various requirements for drive-thru deliveries, drive-thru mastectomies.

This is a half-baked way to deal with the problem. We need to destroy the stigma that comes from approaching a problem from the position that all power, all wealth, all knowledge is in the hands of those with the greatest educations and the greatest amounts of money.



David Manning

Vice president of Columbia HCA

We need to consider the financial incentives involved in the whole system, and whether, in fact, coverage is provided.

Carve-outs trouble me because there are relationships between acute health care plans and behavioral health care plans or mental health coverages. We create disincentives when we carve those things apart.

We spend a significant amount of money on

the acute care side that really involves behavioral health issues.

The notion that we will provide savings in order to provide additional coverage or better coverage troubles me, as well. While there are many fine employers represented in this meeting, most of the people in this country are not employed by those kinds of corporations. They are employed by very small companies, or in ways that barely give them access to any kind of coverage. The default, or catastrophic, coverage for which we are all eligible in one shape or another is publicly subsidized coverage. This includes Medicaid programs and those in which we fail to prevent very serious mental illness and states incur huge institutional costs.

We've got to look at the incentives, measuring things in the work place such as "days lost," things that are a substitute for real mental health coverages.

Last but not least, we need to closely examine tax equity and tax policy. There are very few people in this country whose health care coverage—both for mental health and acute care—is not substantially subsidized by public resources, either overt public resources that people fall into because we've created the wrong incentive for employers or tax incentives that we all have that lower the cost of our care enormously.

It is truly irrational to have a public policy in this country that creates and uses tax incentives, but fails to connect those tax incentives back to the real costs associated with this problem: lost productivity in the workplace, the cost of prisons, the cost of public institutions. The human costs of pain and suffering are even far greater.

Audits help us, as a company, to continue looking at the scientific literature, looking at levels of care as they evolve.

Ian Shaffer

Executive vice president and chief medical officer for Value Behavioral Health

In terms of carve-outs, it is critical for care providers to coordinate all components of the care that people need: medical care, behavioral health care, and disability management. We live in a fragmented world of health care delivery which predates carve outs. We need to refocus on thinking about people as total beings. It is a mistake to have a "fail first" mindset. From both a quality and a cost perspective, that is not good judgement.

The other component of this issue is formularies. Frequently, the managed behavioral health care companies do not control the formularies. The pharmacy benefit managers, or other components of medical assistance do. All groups need to share information about these drugs, to show the long-term gains so that we can say, "Yes, costs will be higher in the next quarter, but over the next several years, cost will be lowered, and more importantly, quality of life is going to improve."

Maher: *There is concern that some in the managed care industry may be trying to deter services. Tell us about the quality assurance programs at your company.*

We audit not only the providers, but also our own clinicians who are decision makers. These clinicians, who have the authority to certify, are licensed practitioners with at least three years' behavioral health experience. They are nurses with masters degrees. Those authorized to deny services are board-

certified and licensed psychologists, and board-certified psychiatrists.

Even though they are seasoned clinicians, we audit the decisions they make as a continuing way to improve quality. The audits also help us, as a company, to continue looking at the scientific literature, looking at levels of care as they evolve.

There is good and bad in every field. In 1987, Chrysler and the United Auto Workers union agreed in collective bargaining to a carve-out plan for mental health and substance abuse with us. There have been three collective bargaining sessions since then: in 1990, 1993 and 1996. UAW is not bashful about asking for something different or better, but each year has renewed that provision of our program. Quality assurance must ensure that quality benefits are delivered.

We need to direct our vision toward the work place, not just health care benefits and therapy and medical solutions. We have to look at what mental health consumers have identified as really helping their recovery: peer support programs. Research shows that they are cost effective and really do work.

We need to think about peer providers, self-help groups, peer-run clubhouses, peer-run employment services. We have to take bolder steps—in partnership with all the different stakeholders, particularly mental health consumers. What outcomes do they really want? What benefits work? What are the real problems?

I once did a well-being study in California, in which we found the most important thing in maintaining a person's mental health was therapeutic alliance. That is the relationship between the thera-

We have to look at what mental health consumers have identified as really helping their recovery: peer support programs. Research shows that they are cost effective and really do work.

pist and the recipient of services, relating to voice, validation, respect, and information. That doesn't cost a lot of money, but it does require a different mindset. We need to be able to grow, delivering services in ways that incorporate more of this reciprocal relationship and peer-run programs.



Sue Smith

Executive director of Georgia Parent Support Network and president of the Federation of Families for Children's Mental Health

I run a small business, employing between five and 12 people most of the time. I interviewed many, many insurance companies for our health coverage, including mental health care, and finally settled on one that was the very best I could find.

Then, one of our employees got sick. She came to me, and I called the company. The company said, "You have to call this special number." I called the special number. There, they said, "What we really want is to have the employee read this 'up-by-your-bootstraps' book."

I said, "You don't understand. This person has a history of mental illness, including needing medication." Their response: "There's a waiting period."

I found that even with the very best of intentions, I had not done a good job of choosing. We talk a lot about how coverage should work, but it is not translating into what is actually happening. Perhaps it is easier for larger industry.

Now, how do we translate all of this into "child

speak?" How do children live and where would their experiences be? They would be in schools, neighborhoods, and churches with friends. How do we make this a priority?

Whatever resources we direct to children, we will reap the benefit for a long time. An example: After spending four years in psychiatric institutions in Georgia, my daughter came home to attend a public school. I said, "We'll visit there, tell the counselors and get everything in place to support you." She is very smart, and said, "Please, don't do that. They won't allow me to have a normal failure, like any other teenager. If they know I'm ill, everything will relate to my illness."

We lose a great many children in the transition from childhood to adulthood. When we prepare normal children for this transition, we teach them how to drive, how to write a check, how to budget. We do the same for children with mental illness, but they need a variety of supports that we don't normally provide.

Industry could be a big part of this. Schools need to be a big part of it as do families, neighborhoods, and communities. What we do, or don't do, costs us.



Jean LeMasurier

Director of policy and program improvement for managed care for the federal Health Care Financing Authority

Thinking about the trend to privatizing the whole delivery system, and then thinking about stigma and discrimination led me to

The question is how to make managed care's integrated comprehensive systems work better for Medicare. Pay them better?

consider the most vulnerable populations, those depending on Medicare and Medicaid. It is a very big responsibility to consider the special needs that these populations might have, above and beyond what employers might require, as purchasers.

Then, there are the elderly. They do not identify their mental health needs routinely; they are not often used to the open culture of mental health and are afraid to get care. We need to rely on the physician or provider community to identify when a senior is depressed and when it is something very different than the grief of having lost a loved one. Doc-

tors and providers must distinguish between all the interrelating chronic care diseases, and must know what to do with an Alzheimers patient, versus what to do with a senior citizen who is depressed.

Providers must be able to serve a population, speak the language, be located conveniently for consumers. Many states have considered offering Med-

icaid mental health programs through public health care providers. Some community mental health centers may be a better source than private providers. What is important is to find out what is convenient and accessible for those who need the services.

The case management component of any delivery system is important. This is about more than getting medical help; it's about getting additional help, including social supports in your home. Purchasers are conducting focused consumer surveys to learn whether people are getting the care they need.

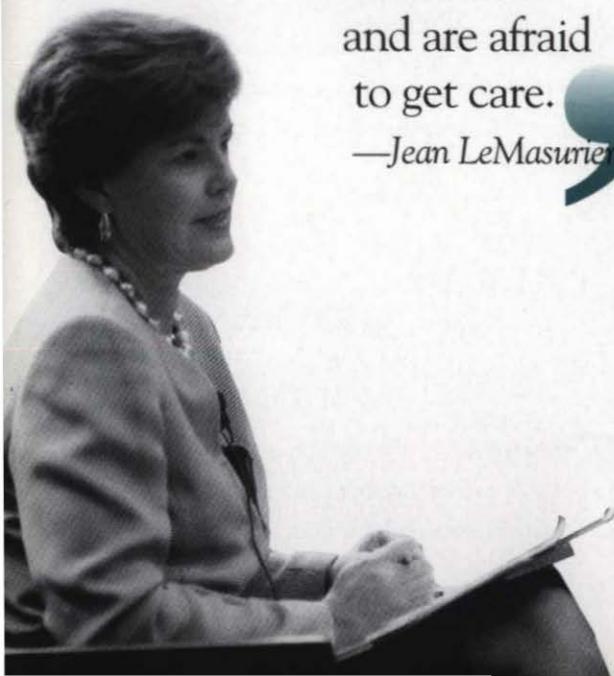
To move the agenda forward, purchasers need to look at how to measure outcomes. The key is to look at some very early measures—utilization, access standards, and readmissions after hospitalization. We are also starting to test some outcome measures for depression. We must continue our efforts to measure what we value.

Maher: *The salvation of Medicare was a major topic in the recent presidential campaign; it's a front-burner issue for federal budget discussions. Can carve-out programs that have worked well for managed care companies be incorporated into Medicare?*

Probably the Administration will not propose that. We'll be looking at a lot of new models for comprehensive managed care. The question is how to make managed care's integrated comprehensive systems work better. Pay them better? Make consumer information more accessible? The discussion really has not gotten to the level of the Medicare carve-out issue. There are a number of members of Congress who may, in fact, introduce legislation to that effect next year.

“The elderly do not identify their mental health needs routinely; they aren't used to the open culture of mental health and are afraid to get care.”

—Jean LeMasurier



Q&A with Panelists

The following questions were addressed to the panelists by Symposium participants

We're not listening yet to much about the working poor, those who work but have no coverage.

Q *To what extent are the mental health advocates trying to focus attention on developing affordable health care for people who would be cash customers?*

SUE SMITH: Catastrophic coverage would be unaffordable for many. We would have to expand the public system, to cover more of the needs of people who can't receive public assistance at this time.

We're not listening yet to much about the working poor, those who work but have no coverage. We do talk about the poorest of the poor, but we do not talk about the people who work but don't have good coverage. In my life experiences, I've been every one of these, and all of it because of a mental illness.

This last session of Congress and the presidential campaign show that we have the opportunity to place these demands on the table. Who would have thought that any, even remote, parity legislation would go through this last Congress? The president has made it a point to

say that he wants to have a program of care for children.

ROBERT MCGARRAH: Proposals are circulating now around Washington; they include some kind of a Medicare buy-in for children. The president talked about providing coverage for individuals who lose their jobs for up to six months. Mental health care coverage has to get parity treatment in those pieces of legislation.

We've got an opportunity now to build on gains we've made.

Q *You asked what families are doing, and what are their concerns. Many families are finding that managed care companies do not pay for new drugs, particularly anti-psychotic drugs that represent a major step toward recovery.*

IAN SHAFFER: It's a mistake to have a "fail-first" mindset. From both a quality and a cost perspective, that is not good judgment.

The other component of this issue is formularies. Frequently, the managed behavioral health care companies don't con-

trol the formularies. The pharmacy benefit managers, or other components of medical assistance programs, do. These areas need to share information about these drugs, to slow the long-term gains against the short-term expenses. We really need to quantify the gains, so that we can say, "Yes, costs will be higher in the next quarter, but over the next several years, costs will be lowered and, more importantly, quality of life is going to improve."

Q *Patients themselves have an enormous amount of self-hatred and stigma against mental illness. This affects treatment; they won't come, or, if they come, they don't stay on medication. We must pay attention to that as they return to the workplace.*

JEAN CAMPBELL: It causes problems to combine issues of non-compliance with stigma. Stigma does not cause people to refuse to take their medication. I just tried Paxil; the side effects that hit me included hypertension at a dangerous level. I will

Stigma does not cause people to refuse to take their medicine. I prefer depression to the side effects of Paxil.

probably have to go off Paxil—I prefer depression to those kinds of side effects.

It's difficult to be on the job, productive, when you cannot reach for a glass of water without your hand shaking, or when the medicine kept you from going to sleep the night before. We have to recognize that medication is not the best route for everybody.

There is tremendous coercion for people to follow medication regimens. Coercion may increase non-compliance. Both the treatment system and people receiving services have to be working for the same goals, and those goals have to be those of the recipient of the services.

Q *One of the triggers of my mental illness was my work place. We need to consider, "Is this mental health issue one of the individual, or a symptom of the health of the organization?"*

WALTER MAHER: I'm curious as to the reaction in the work place to the American With Disabilities Act. It's one thing to put in elevators and widen doors, but this type of accommodation takes a far greater level of sophistication.

Many people I know don't talk about the benefits the law brings to the individual, but about what it's brought to the business because of the teamwork and support that has been raised around the person with the disability.

Q *What is a healthy workplace, especially regarding the balance between confidentiality and accommodating special needs?*

AUDIENCE MEMBER: There are many situations within the work place related to mental illness: depression, sexual harassment, any kind of discrimination, the encouragement of workaholism. That's very difficult to address.

Neither have we addressed how these illnesses, particularly the non-catastrophic, affect family systems. For example, the last four patients I saw who were having major problems at work had not stopped working, but their productivity had nose-dived. Three were women who were depressed, in part because their husbands were alcoholic. The fourth case involved a couple who was running a small business and getting a divorce.

MAHER: You have to con-

sider the whole family as part of the services you offer. It is absolutely necessary that a company address these problems. Failing that, the employee goes on disability and the company must pay for a replacement. I once heard a congressman refer to a "fungible work force," that 100 percent turnover is meaningless because it takes 15 minutes to train replacements. There is no incentive to provide benefits.

Q *Where does quality fit in?*
CAMPBELL: It's important to involve consumers in a dialogue about quality because we do not share the same vision as mental health professionals.

Over the last 10 years, consumers have been getting together—in structured focus groups and informal self-help groups—to discuss what they do and do not want from services. Through national organizations, decision-makers have developed outcomes related to recovery and personhood and prevention.

Q *The state of Tennessee moved to managed care and expanded the covered population. Would any*

experiences there impact this discussion?

DAVID MANNING: TennCare's experience has enormous implications. We're unlikely to see vast sums of new money infused into health care, so we've got to find better ways to spend the dollars we do have. We have to very aggressively redirect dollars to the things that do work, that do im-

A scholar from England came to do a presentation on the conditions in asylums in Scotland in the 18th and 19th centuries. The person started telling about some of the inmates. Making fun of them, story after story, showing pictures. My colleagues were laughing. The more that went on, the more alienated I felt. You never quite feel like one of the group.

—Jean Campbell



prove quality of life.

Q *Even with the revolution of managed care, consumers still don't have power over their own lives and the ability to make changes in the system. When people feel they don't own their own lives, they don't go back for the next appointment, they don't comply with treatment. Can we focus on the groups that have no, or little, power?*

MANNING: That's true in public programs, and to some extent, in corporate programs because we create entitlement for institutions. We are more concerned with how changing the system will affect the institutions as employers, as part of the economy, than with how the changes will affect consumers. The only thing that has worked in any market-based economy is to empower the consumer, with information and resources, to move within the system to points that are responsive to them.

McGARRAH: The AFL-CIO is undertaking two new initiatives. One, that we join forces with the National Alliance for the Mentally Ill, Ralph Nader's organization, and the Citizens'

Coalition for Nursing Home Reform to bring together physicians, people who work throughout health care and consumers to demand accountability and quality from the organizations supposedly managing this new system.

Second, we now have a Center for Work Place Democracy to underscore respect and dignity for every individual in the work place. That's a critical ingredient in making the kinds of changes we're discussing here.

Moderator's Summary

HOUPT: I see a series of five balancing acts that are recurring themes:

- Reinvestment versus remaining globally competitive;
- Large employers versus small businesses;
- Quality assurance versus "fail first;"
- The perspective of a worker with a mental disorder versus the economic discounting of that worker; and
- Stigma versus rationality.

The Work Place of the Future

Look for more integrated services, less barriers between public and private sectors, and increasingly active consumers

By Mary Jane England

We are moving from just paying bills to buying value.

Although we come from different places and look at the world differently, those of us in the mental health profession are getting our act together, as evidenced with the recent passage of parity legislation. We have started the ball rolling.

Many of us were very disturbed that we were not able to pass President Clinton's legislation that would have finally allowed every American access to health care. I just returned from South Africa, which used to be the only other country that didn't offer its citizens health care. But a year ago, under its constitution, it joined the rest of the world in insuring that all its citizens have access to primary care.

We are becoming a global village. Our first lady has said it takes a village to raise a child. It takes a village to care for our loved ones with mental illnesses. We need to recognize the importance of caregivers, who have been the underpinning of many of the services provided to our children, our senior citizens, and our people with mental illness.

Mary Jane England, M.D., is president of the Washington Business Group on Health, a non-profit national health policy and research organization whose members include the nation's major employers. Dr. England provided the evening keynote speech for the Symposium.

Our large managed care companies are now selling to most of the European countries and in South Africa. Many of the items that we are discussing at this symposium are being sought after by many other countries.

What is the work place of the future going to look like? What opportunities do we have? We are struggling with some of the issues of diversity, with more women and minorities in the work place. We are seeing a different role for seniors. We are seeing the virtual work place, with its loneliness. We see tremendous stress with re-invention, down-sizing, right-sizing, and mergers.

In response, there has been a movement toward integration of services, allowing an employee to call one toll-free number and be directed to whatever services he or she needs. For too long, health care delivery systems have been fragmented: health benefits in one place, worker's compensation someplace else, disability management someplace else.

Now, they are adapting a more system-wide view of health and disability costs, and are interested in assessing the value of their benefit plans to improve health and work place productivity.

The companies in the forefront of the move to integration began by looking at health care costs.

They realize that integration can provide better services to employees and also save money.

Consumers and employees, are moving from passive to active participation. They want to be in control of the services they receive. They want to design them. They need information to make decisions. We also see more large employers providing better information about different health plans.

They want to empower employees and retirees to make choices that most effectively meet their needs and take greater responsibility for their personal health.

We are moving from just paying bills to buying value. Large employers no longer focus on cost. They are building very specific performance standards for health plans. Digital Equipment Corporations standards, set in 1995, have been a big step forward: no limit on benefits, direct access to mental health providers, and guidelines for triage, standards of care, and appeals.

We are seeing companies take responsibility, not shift it. General Motors is working with the United Auto Workers union in a wonderful experiment in Flint, Mich., to make not just a healthy company but a healthy community. That's the direction all of us should take. It isn't just the work site. Where are our kids? We need healthy schools, healthy communities.

But how do we measure the health of a community? First, we move from a sickness model to a health model. We get people on disability back to work, back to functioning, back to a productive life. We change the focus from the individual, to the community.

What will we see in the future? More employers will be involved in the management of their human capital, focusing on productivity rather than costs.

The question of how to measure productivity will be in the forefront. Five years ago, many in the mental health field thought the purchasers were intrusive. Now, some are saying, "Maybe the purchasers have assumed the role the federal government has not been doing. Like Digital, they have established some pretty thoughtful performance standards and are holding the health plans accountable."

Still, employers will move back from the micro-management of health plans, leaving them in the hands of professionals and consumers. Increasingly, consumers will play a major role in determining standards.

If I were in charge of the workplace of the future, I would want tremendous flexibility. Not just in schedule and hours, but in all benefits. Small businesses would form cooperatives to combine their purchasing clout and buy into some of the advantages available to large employers.

A lot of the opportunities involve common sense. Businesses have been working to make it easier for working mothers to breast feed by using pumps in the workplace. It has been an easy sell—because moms who breast feed take their children to the pediatrician less often. Breast milk provides babies immunity and they have fewer infections. We now even have a breast pump onsite at the American Psychiatric Association.

If I were in charge, there would be a 1-800-HELP line that people could call for child care re-

The three major health plans in Minnesota are terribly competitive for purchasers, but are cooperating at schools to reduce pediatric asthma.

Behavioral health professionals know a lot more about function than the rest of medicine.

sources and elder care resources, help for stressful times in people's lives. It would help employees pick colleges for their children, as well as provide health information.

We could provide on-site health clinics. Why not, for cholesterol screenings and mammograms and flu shots?

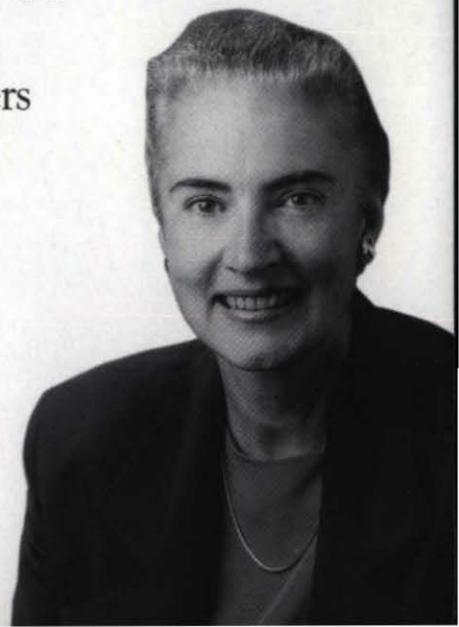
The same is true for school-based health clinics. There are now more than 1,000 in this country that include a mental health component. They should be everywhere, so that our children can be mainstreamed into the public schools and get the services they need. The three major health plans in Minnesota are terribly competitive for purchasers, but they are cooperating at school sites to reduce pediatric asthma. If not managed well, pediatric asthma takes children out of school and mom and dad also lose time from work. So, this is a win-win effort. And what's the big secret in pediatric asthma? Teaching the kids how to use their inhalers, managing their own condition.

Ninety percent of the management of chronic illnesses is not done by medical professionals. It is done by parents, children, and caregivers. We need to focus on the entire family, developing services in a continuum.

Services must also be

culturally appropriate. A meat-packing plant in Colorado employed a large number of Hispanics. Many were having babies born prematurely. The company discovered that moms were not seeking prenatal care, even though it was available. The men, who comprised most of the workers, did not want their wives going to white obstetricians. The women were more comfortable at the local public health clinic, where there were culturally competent nurse practitioners and obstetricians. So, the meat-packing firm bought services for their moms from the public sector. We need to eliminate the artificial barriers between public and private, learn-

“ We need to focus on the entire family, developing services in a continuum ... We need to eliminate the artificial barriers between public and private, learning from both sides. ”



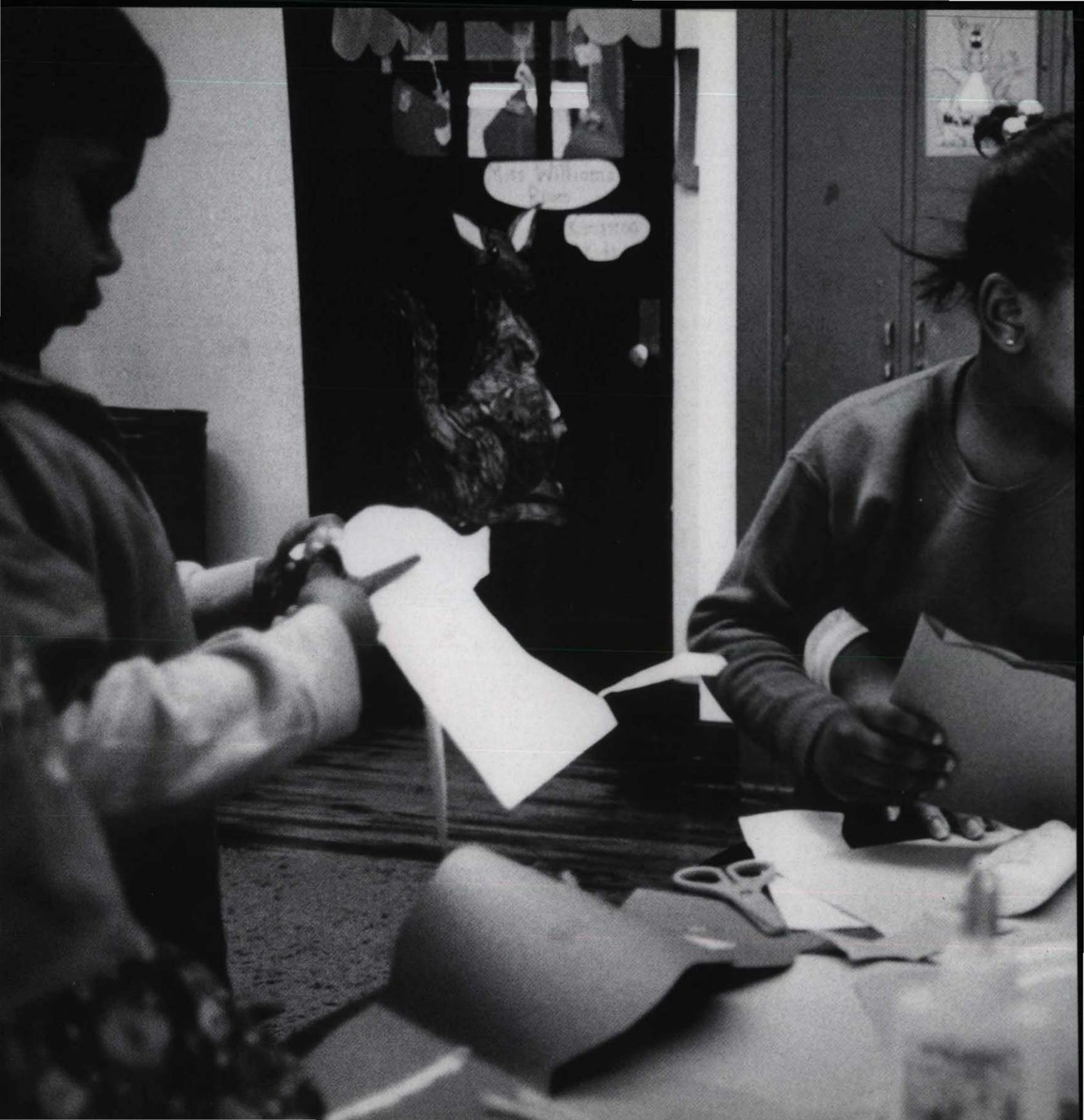
ing from both sides.

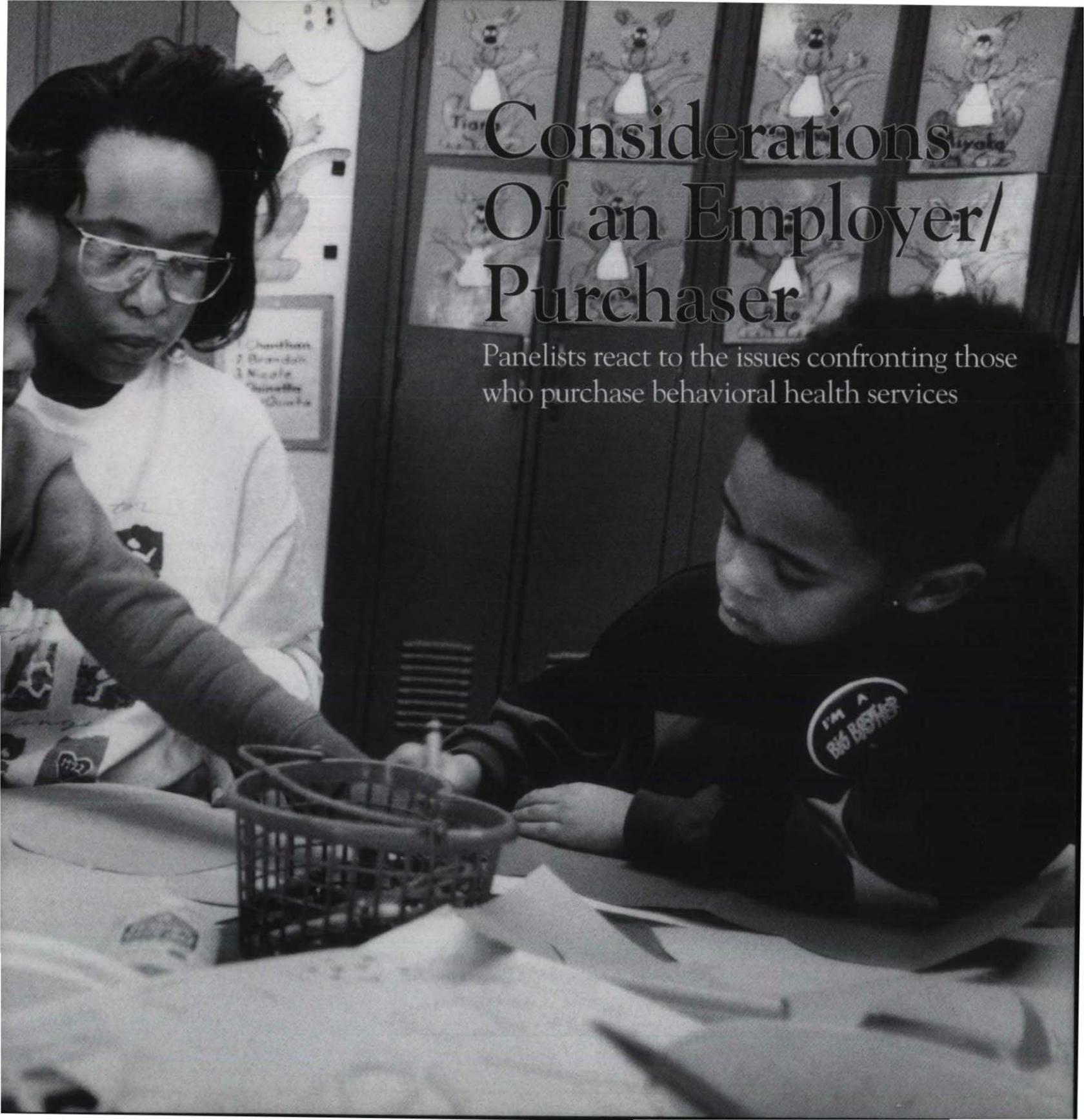
The fastest-growing area will be functional outcomes. Already, there are programs like FACCT, the Foundation for Accountability. This is the area where behavioral health professionals can really make a difference. We know a lot more about function than the rest of medicine. We need to build partnerships between purchasers, providers, and consumers to determine functional outcomes. Consumers and mental health professionals might say very different things about what is quality, what are good outcomes.

At the work place, at school, and in the community, we need the support of top management. We

desperately need leadership. Here, I must challenge my colleagues in other associations. Isn't it time we put aside our petty jealousies and competition and begin to cooperate? Don't we have a golden opportunity in the next session of Congress, knowing that when we work together we can really make a difference? In both the public and private sectors, we know that mental health services don't break the bank. They are cost-effective. They have value, improving direct and indirect costs.

We can move forward with very good data and a growing partnership between public and private, between purchasers and deliverers. We really can make a difference in the lives of our citizens.





Considerations Of an Employer/ Purchaser

Panelists react to the issues confronting those who purchase behavioral health services

The Business Tightrope

Companies must balance the needs of their employees with the needs of their investors

By Terrell Womack

Why are you picking on corporate America? We are the good guys. We are funding health care in America.

One of my responsibilities with BellSouth is the health care plan for some 270,000 people: BellSouth's employees, retirees, and their families. I'm also responsible to our one million shareholders, people who are counting on our ability to pay dividends and generate investment returns necessary to support their family savings or to pay for their retirement. Those one million shareholders are in addition to many other individuals represented by the one-third of our stock held by institutional investors.

My dilemma is balancing those needs. Why would you care about my dilemma? Because we have the same problem. If we are going to develop long-term solutions to mental health issues, we have to figure out how to fund them.

I have been asked to walk you through the thought process that business uses in considering whether to offer a benefits program, what type to offer, and how to pay for it.

Terrell Womack is assistant vice president for compensation, benefits and employee services at BellSouth Telecommunications.

We ask four questions:

- What is the cost?
- Will it help?
- What does the law make us do?
- How do we make it work?

On the question of cost: We are first and foremost an economic enterprise. That is our role in society.

Too often, and I've heard it here, a concern for cost is characterized as greed. We hear examples of takeovers, and investors on Wall Street, and CEOs who are making millions of dollars. Our charter as an economic enterprise is more fundamental than those examples, and more important than what has been articulated as greed. The issue facing BellSouth is whether we are going to prosper or become extinct.

Let me tell you a story that made this concept meaningful to me. Growing up in a small southern town, we would go downtown to go shopping. We would walk up and down the sidewalk, by this big glass window. Inside was one of the most wonderful sights a 10-year-old boy could ever see: a wall full of parakeets, hamsters, gerbils, and goldfish. That store was W.T. Grant, which went bankrupt some 20 years ago. Across the street was the Kressge 5 and 10 cent store. Kressge was able to adapt, and become Kmart,

arguably the most successful retail company in the United States, in the '60s and '70s. By the late '80s, it, too, had begun to experience difficulties as a new wave of retail enterprises began to take its place.

In 1996, BellSouth spent \$4 billion investing in new plants and equipment. Those investments help ensure our future. We are like any other company in America, trying to accumulate and invest the capital necessary to prosper.

If we don't make the earnings to generate that capital investment, or if we make bad investments, we die; we go out of business. That also means the death of the dreams of our employees, their families, and the retirees who are counting on us.

The second question, beginning the balancing act, is "What does it do for our people?"

"Our people" is a very interesting phrase, parental in nature. It runs counter to the way the society seems to be moving, but it is very real. We spend most of our time with our fellow employees, people we have known for many years. I read recently that an employee's average term of service with an employer is higher today than it was in the '50s.

There's also a very pragmatic point about why people are so important to us. A study by the Brookings Institute discussed how companies are valued. It asked the question, "When a company is purchased, what are the investors paying for?" In 1980, two-thirds of the purchase price was for things: plant, equipment, land, buildings, etc. One-third was its intrinsic value—its ability to generate income. By the '90s, that relationship had flip-flopped. One-third of the purchase price is for things; two-thirds was its intrinsic value—its value to generate income

and that means people.

At BellSouth we have spent about \$80 million this year training our employees. As a percentage, that is not atypical of other large organizations. This represents a significant investment, we cannot permit these employees and that investment, to be non-productive. And, not insignificantly, these employees are our primary link with our customers.

Then along comes the government, which wants to make sure that we are taking care of people. Hence the next question, "What do the regulators say?" "What does the law require?"

Philosophically, most business executives support progressive legislation. How can you argue with the Americans with Disabilities Act? However, problems sometimes arise from the interpretation of that legislation, the regulations that come out of the law, the court rulings, the unintended consequences.

There is a phrase I like: normal failure. You are not always successful in everything you try. We have employees who should not be in their jobs. They may be introverts, who, for some reason, when they were 18 chose a sales career. They are just not good at it, and they need to do something else. That's normal failure. However, from our perspective, normal failure results in us being hit with a rash of lawsuits stemming from all the regulations. If the lawsuits are grounded, shame on us. But most of them are not grounded. Most companies are actually trying to do the right thing, but what you see from the executive suite is this rash of lawsuits. So when we react negatively to additional regulation, it's because of our experiences.

We ask ourselves "Why are you picking on



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Most companies are trying to do the right thing, but what you see from the executive suite is this rash of lawsuits. So when we react negatively to additional regulation, it's because of our experiences.

corporate America?" We are the good guys. We are funding health care in America. We pay 60-70 percent of the health care bill directly, not counting what we pay through our corporate taxes and the personal income taxes of our employees and retirees.

There are 40 million people in America who are uninsured. It's fascinating that we want to lay mandates on employers who are paying the bill, while society in general is not willing to fully fund Medicaid. In fact, business subsidizes Medicaid every time it pays a hospital bill.

If a business does not offer benefits, it does not have to pay any attention to these mandates. The risk we run as a society is that over time, the people who are trying to generate returns on investments in a very competitive world are going to say, "Why am I doing this? I want out of this," particularly in areas that may not have consensus support by society in general, including mental health.

Business is somewhat cynical about the ability of legislation to actually resolve a problem. What we see is the downside; the negative reactions, unintended consequences, and the cost of trying to successfully implement regulations that legitimately help some but unfairly burden many others.

The final question confronting the benefits manager, no matter what the initiative, is "How do we make it work?"

People sitting in my chair have to control a

huge outflow of our company's resources and we are responsible for ensuring that those resources deliver high value to employees and the company. One challenge we face regarding mental health benefits is that the people providing the health services and the people receiving the services are disconnected from the people paying the bill. This lack of checks and balances in the system can open doors to abuse. I can tell you a story about a therapist conducting group sessions, but billing them as individual sessions. I know of another instance concerning an employee on long-term disability who periodically would get a psychiatrist to re-certify, if you will, that he was incapable of work due to the anxiety caused by decision-making. That employee's company happened to stumble across the information that this same person was an active city official in his hometown, and on the boards of several local institutions. A Board-certified psychiatrist had been telling them, "This person cannot function in any job."

Although many are helped through the system, stories like these really dampen my enthusiasm about asking senior management to put more money into the mental health system. Rather, our bias is to push for a more effective system of care through greater accountability and management—ensuring those that need care and appropriately served while eliminating waste in the system.

Considerations of Employers/Purchasers

Experts debate the compact between business and society

Consumers identify two issues as the most important: employment and housing. As a society, we fail those individuals, and ourselves, when we don't return individuals with illness to employment.

Joel Slack

Director of the Office of Consumer, Ex-Patient Relations, Alabama Department of Mental Health

The keynote speaker, an economist, stated the '70s and '80s were the "good old days." I believe he was referring to the economics of private psychiatric hospitals, psychiatrists, and psychologists. I do not believe he was referring to the patient experience. For example, my father worked for a major corporation back in 1976, when I became ill. He had an insurance policy of 100 percent coverage for two years of inpatient care. My parents researched the best hospitals in the country.

But after two years of private hospitalization and spending all of our assets, my attending psychiatrist said to me, "Joel, you are looking good these days. It is time for a community placement." I believe my psychiatrist compromised best practices and ethics to achieve a healthy bottom line for the private psychiatric hospital. There was such abuse of psychiatric insurance policies in the '70s and '80s—that is why we now find ourselves in such a dilemma.

Many of the speakers have presented from a business perspective. Their stories paint a beautiful picture of corporations and the assistance they provide to employees with mental illness. But the stories

I get from my consumer peers are not so beautiful. Many companies do not think twice about discharging a 20 or 25 year veteran. You can imagine what they do with someone suffering from a mental illness who is not performing at an optimum level. There are firms that provide training to companies on how to sidestep the Americans with Disabilities Act, and many consumers recount hiring methods and practices that prevent them from succeeding in the work place, or even sustaining their employment.

In trying to achieve commonality, we need to understand the economics of the consumers themselves—the challenges they face. We have talked about it from systemic and corporate perspectives; we need to talk about how it devastates a family.



Bernard Arons

Director of The Center for Mental Health Services

Do some of the issues we face have to do with the U.S. solution to the health of the nation, linking it to employment? What if our country had come up with a different solution, or if we were to change that solution? If we could attend to the health of all people, might not we have a

We need to be aware of the limits of the social compact. It is a permeable boundary, not strictly defined.

healthier workplace and healthier people?

We can't lose the focus on people in the context of their employment and what happens if they need services. Of the 5.5 million Americans who are working-age adults with severe mental illness, about 70-90 percent of them are not working.

Consumers, especially those with the more severe illnesses, identify two issues as the most important: employment and housing. As a society, we fail those individuals, and ourselves, when we don't return individuals with illness to employment. At the Center for Mental Health Services, we are sponsoring eight projects looking at the best ways to return individuals to employment. This is good for them, good for employers, and good for society, since we end up paying either way.

“Consumers, especially those with the more severe illnesses, identify two issues as the most important: employment and housing.”

—Bernard Arons

Mark Knight

Executive director of the American Association for Ambulatory Behavioral Healthcare

Like a lot of people here, I run a small business. Think about how we connect what we know about mental health to the way we interact in the work place. How can I, as a business manager, understand or see where interactions in the work place are going to show up as mental health costs in my organization?

Are we putting into practice some of the things we are talking about here—actively seeking to diversify our work force with people who have mental illness, practicing mentally healthy behaviors, cleaning-up toxic workplace environments?

We need to not just hector the business community about what to do, but act as models.

Sharon Miller

Owner of Temporary Health Care Provider, Inc.

I own a business, and am a board member of National Small Business United, which has 60,000 members representing six million employees and nine million people covered through its insurance programs. We are politically active, trying to institute change that is good for business. We feel that what is good for small business is ultimately good for large business.

I'm in small business because I wanted to direct, I wanted to have some control, I wanted to make a difference. Most of the small business owners I know have that same passion. Making a profit is not what drives most small business people; if it were, most small business people would close their doors and make more money working for someone else.

Small business cannot offer the same types of benefits as a large company, but they can offer some "soft assets." The average small business owner employs five to 10 people. That allows some flexibility, some accommodations unavailable in a larger company because of regulatory requirements. Those of us in businesses of less than 20 people fall under a lot of different rules, and for the most part, we have good places to work. I am not talking about professional associations; I mean gas stations, convenience stores, dry cleaners, florists.

A lot of small businesses accommodate people re-entering the work force, for a variety of reasons. Sometimes, they can't handle the pressures, the toxicity, of larger, more restricted environments.

Suzanne Gelber

President of SGR Health, Ltd.

In this country, we have designated that businesses be a leader in health care policy. That has its positive aspects and its negatives. Often, the mental health clinical community is not aware of the extent to which employers have innovated and provided some remarkable health care and human

services interventions.

For every story I hear from an employer about the excesses of greed among providers, there is a story about how that assistant vice president and/or his staff provided an extraordinary amount of health plan services and workplace-based services to an individual and his or her family. There is a humaneness in business that has been understated.

The workplace is a naturally occurring community, and it imports all of the excesses and problems of the community in which it is located. Most progressive businesses recognize this, and have developed a strong sense of social responsibility.

On the other hand, there clearly are good actors and bad actors to be found everywhere. There are ethical questions about the way mental health services have been delivered, there are questions about how businesses have welcomed or excluded people they may not see as desirable. But I have seen many businesses working with their local communities, welcoming vulnerable people into the organization.

Then, there is another sector of the business community that is trying to streamline itself to compete by outsourcing social service activities, turning them over to professional administrators who may or may not have the same values as the business.

As mental health professionals, we need to be aware of the limits of the social compact. It is a permeable boundary, not strictly defined, but I think that people of goodwill can work together to make that interaction a positive one.

I have seen many businesses working with their local communities, welcoming vulnerable people into the organization.

Q&A with Panelists

The following questions were addressed to the panelists by Symposium participants

Julius Richmond

panel moderator, is MacArthur professor emeritus of health policy at Harvard University, and a member of The Carter Center Mental Health Task Force.

Charles Ray

panel facilitator, is executive director of the National Community Mental Healthcare Council.

Q *Of the 40 million uninsured, approximately 80 percent work in small businesses. They are the working poor. Any thoughts, as we listened to people talk about being small business owners?*

TERRELL WOMACK: I don't accept that everybody who works for small businesses is part of the working poor. Some of them think they are making a pretty good living. There's not that

much difference between small business and large business. There's something of a myth: "It's easy for you guys, but we have our own peculiar problems." If you have 10 people, you can sit around one room and decide to do the right thing. When you have 100,000, it gets more difficult.

Nor are we myopic and greedy. We are just trying to make a return on our investment and get on with our lives.

simplify further? If on April 15th, when I send in my tax forms, I also check off what health plan I want, and pay the premium. That would save some of the legal maneuvers we go through to try to assure portability of health plans. For some of the unemployed, this would spread the risk.

But it does create other difficulties, and it does raise the question, "While employers complain about some of these issues, don't they want to maintain control over them?"

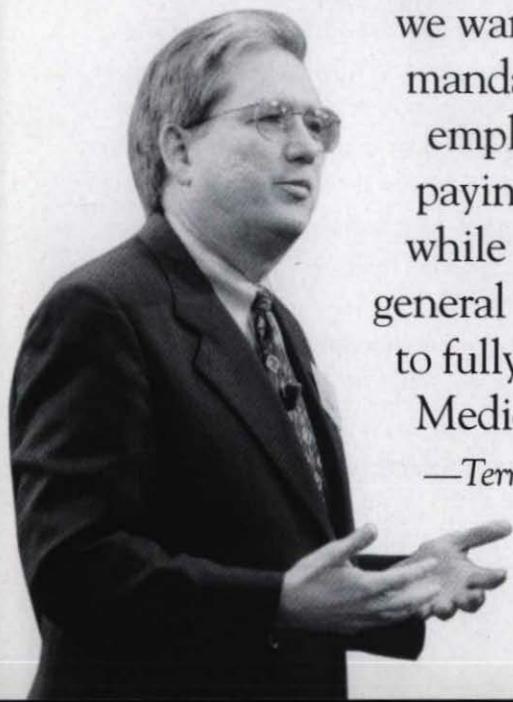
SHARON MILLER: One of the major issues of the 1995 White House Conference on Small Business was access to health care for small business, portability, and pre-existing problems not being excluded.

JOEL SLACK: Also, we keep going back to awareness. Our society doesn't know how to honor and value an unhealthy mind because it hasn't yet learned how to honor and value a healthy mind. It doesn't see the devastation that mental illness causes in a healthy mind. If we agree that

“It's fascinating that we want to lay mandates on employers who are paying the bill, while society in general is not willing to fully fund Medicaid.”
—Terrell Womack

Q *We are the only major industrialized nation that ties health care to employment. Does industry want this responsibility? Also, a majority of the uninsured in this country are children, and many employers offer insurance only to the employee, not his or her family. What are we doing for these children?*

BERNARD ARONS: De-linking health care and employment solves a lot of problems. There is a simplicity about it that is very appealing. But what if we could



mental illness is a common enemy, perhaps business, mental health care consumers, and the professionals can come together and deal with stigma.

Q I get a notice from my insurance company every year about getting a mammogram. If we did that for areas of mental health, could it help prevention? Second, not all mental illnesses are prevent-

able. When they are not, how do we think about the process of recovery instead of permanent disability or acute treatment?

MARK KNIGHT: I like the idea of an annual "mental gram." We need to define "prevention" in mental health. What is that annual mental gram? This past year, a colleague in a mental health advocacy organization was experiencing a substance abuse

problem. When I saw her in the work

place, surrounded by clinical specialists, she looked horrible. Obviously, something was wrong. Yet, no one in that organization was intervening. What prevented her colleagues from responding in a mental health organization? If she had walked into someone's office and presented herself as a client, she would have been diagnosed immediately.

Q How do you define prevention, when you balance the bottom line and what's good for your people?

MILLER: You start with very simple techniques: communication, in-services, EAP. The EAP provides confidentiality. It's also a way to come in the back door to get other services—most people with alcohol or substance abuse problems have underlying problems that cause the abuse.

WOMACK: The dilemma we face as employers is the issue of personal responsibility. I can do very little to prevent mental illness. I can make materials available, I can give employees access to services, but people must take responsibility. They have to depend on themselves to use the

“A lot of small businesses accommodate people re-entering the work force.

Sometimes, they can't handle the pressures, the toxicity, of larger, more restricted environments.”

—Sharon Miller



resources we provide.

SUZANNE GELBER: "Let she who is without sin cast the first stone" would be a useful principle. Given that so many of the health providers here are also small business owners, a pertinent question is, "How do you behave in your own personal life? Do you practice what you preach?"

Managed care organizations and behavioral health organizations often take too narrow a line

"A lot of companies let people go after they've worked there 20 or 25 years. You can imagine what they do with someone suffering from a mental illness."

—Joel Slack

in evaluating costs, especially for prescription drugs. Can businesses push them to see that it makes good business sense to look at the long term?

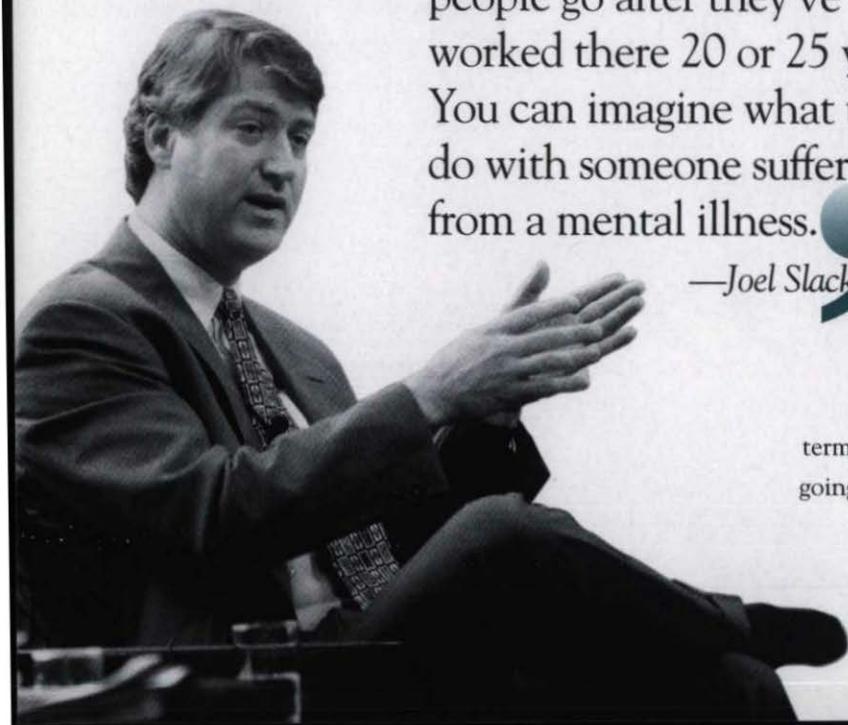
WOMACK: The answer is in the way we contract with the provider. We spend a lot of time talking about outcomes—a rudimentary science at this point. We talk about where we would like to be in two or three years. The key to managing the vendor is asking the right questions, and looking at how we reimburse that vendor.

There is a saying, "What interests my boss fascinates the hell out of me." The same thing applies with managed care providers. It depends on what you are specifying. If you are specifying cost reduction and short-term results, that is what you are going to get.

Q Is there a basic incompatibility between the efficiency and effectiveness that thrives in the business environment and the basic inefficiency and ineffectiveness associated with severe brain disease? Does this make business a fertile breeding ground for stigmatization and discrimination?

WOMACK: If you would permit me, I would like to address the issues of efficiency and the cost of mental illness. We love to talk about Wall Street, but it is basically society saying to business, "You need to return 15 to 20 percent on those assets we give you." That is the cost of staying in business. We live on capital. BellSouth has some \$40 billion dollars invested in all that equipment that makes us what the *Wall Street Journal* called "arguably the best telecommunications company in the world." What makes us work is capital. But the world is saying, "If you want it, you have to pay us 15 percent on it." That puts tremendous pressure on executives to spend their resources prudently.

Our executives are inundated with thousands of proposals, all of which on the surface are



good, particularly in an industry where the technologies are moving so fast. Where do you place your bets? These are critical decisions. There is a reluctance, from the arithmetic standpoint, to tackle something as is ill-defined and hard to measure as mental health. What makes it work is just pure leadership—people saying, “I can’t measure it, I can’t feel it, but I know it is there and we are going to do it.”

“Are we putting into practice some of the things we are talking about here?”

—Mark Knight



To some extent, the mental health community has been naive in trying to do financial analysis. They are not real good at it. They would increase their credibility more by just getting out there and doing some things. It is that ability to articulate your position—maybe without the numbers—that really makes you credible.

Remember when the whole idea of EAP caused a big debate in this country? Now, I don’t hear any business people even talking about it, other than to say, “This just makes sense. We are going to do it.” This is the same approach we need to take on the rest of mental health. As far as the issue you raised of stigma and discrimination, I think business reflects the behavior of society in general.

Q *A new survey shows that employees who kept their jobs were about as likely to contribute to an increase in disability claims during a restructuring period as workers who were being replaced. Your thoughts?*

WOMACK: We have not seen many really good public interventions in health care. As bad as businesses may be, I don’t

think there are many providers saying, “Please give me more Medicare-type programs.” To a large extent, they would rather deal with a private insurers.

I don’t believe that layoffs cause mental illness. I don’t think we are that powerful in people’s lives. If someone doesn’t have a certain “centeredness,” as life becomes increasingly unstable, things that they probably needed to deal with anyway come to the forefront.

It is incumbent on business to understand the carnage that downsizing causes for workers. It is incumbent on society to understand businesses, that we are trying to survive. But business helped create the illusion that working life will be stable. It is our role to help deal with with the carnage when it is not.

Q *Is it possible to integrate people with severe problems into the work force during a time when there is so much pressure on productivity?*

KNIGHT: It depends on the structure of the organization. In a hierarchy, where the pressure comes from the top, people with

mental illness will end up feeling like Dilbert, only they are more vulnerable than other workers.

It is going to take us re-inventing the way in which we work, and there is a great deal of thinking about this coming out of private sector management and innovation. I don't think we are operationalizing it as rapidly in the non-profit sector as seen by experiments and things going forward in the for profit sector.

“The work place imports all of the excesses and problems of the community in which it is located.”

—Suzanne Gelber



Q What creates a culture of change?

SLACK: In many cases, professional associations have taken the responsibility of educating the public. For example, the American Dental Association decided it was going to teach the general public prevention techniques. Because of this public awareness, insurance policies began to include one or two check-ups a year. The psychiatric associations must make similar mass media and educational efforts if they intend to create a change in culture and attitudes.

GELBER: There has been a

great deal of information distributed about the problems and dangers of mental illness, by business and federal, state and local governments—campaigns about depression awareness, drug abuse. Have they been heard?

Business clients who are most sensitive to mental health issues have either experienced illness themselves or with a family member. That covers a broad section of the population.

Are people ready to hear a message? There is a social ambivalence. If we don't hear the message, why not?

Moderator's Summary

RICHMOND: In a large sense, we are talking about generating the political will for society to really look at mental health issues as they affect individuals and families, and to provide appropriate services.

Political will is not directed only at the public sector. Uncoupling the financing of services from employment is an interesting proposition. It's part of our history, and we are not going to rub it out, but we need to recognize that there is some resistance to regulation.

In managed care, most of the regulation really comes in the private sector because that is the source of most of the funds for health services.

Reports from the Work Groups

The Work Place: Healthy or Harmful?

Attendees work in small groups to discuss how policies and practices in the work place contribute to the health of employees, their dependents, and the business itself

Joe Thompson

Group 1 reporter

Assistant vice president for collaborative research for the National Committee for Quality Assurance:

How do policies and practices in the work place contribute to the health of employees, their dependents, and the health of the business? These two groups have significant competing interests.

This group decided upon three criteria to determine an answer:

- Clear communication and a demonstrated exchange of values, mission, goals, and expectations. This means including representatives from all members of the organization in the design or review of policies, and recognition of what the company does for workers and what employees contribute to the company.
- Assessment of employee health and empowerment, including a high-morale and low-stigma environment, recognition of differences among individuals, educational opportunities, flexibility and progressive benefits.

- A continuously learning organization, which is financially stable, reliable and in which decisions and information are shared with the employees.

Here are specific areas which warrant more discussion:

- Eliminating the stigma associated with mental illness in the work place.
- Defining quality care, including outcomes, providers for specific services, and the integration of services.
- Establishing prevention, early detection, and recovery systems. This recognizes that in an era of downsizing, turnover, and rapid skill changes—as opposed to the physical exposures that were the problem in years past—the coming occupational hazard will be stress.
- Developing the best human resource practices, including reasonable accommodations for individuals with mental illness, proper concern for privacy, open information about benefits, and equal benefits for all members of an organization.

Leslie
Scalsett, J.D.

work group moderator, is vice president of The Lewin Group and a member of The Carter Center Mental Health Task Force.



Combine passion with data. Advocates always have had passion when approaching businesses to ask them to offer more mental health benefits; what we haven't done as well is give businesses numbers to see how this helps their overall productivity.

Cathy Climo

Group 2 reporter

Vice president of benefits for NationsBank South:

This group emphasized the following criteria:

- Importance of productivity in an organization that can evaluate the effectiveness of its policies

- A high level of participation from employees, and that provides quality output and value.
- Value is measured by the "bottom line," which is not limited to dollars. It includes stable employment opportunities. It includes healthy, satisfied employees, as measured by attendance, retention, ease of recruitment, and the level of grievances.

Recommendations include:

- Developing measures for clinical and productivity outcomes.
- Developing measures for the health of the work place.
- Finding role models to educate the public. Ted Turner, for example, has success, responsibility, money—and a mental health condition. We need more people to say that mental illnesses are no different than physical illnesses.
- Evaluating progress in diversity, understanding that the value someone receives from a job or organization has a great impact on his or her mental health.



George Cobbs

Group 3 reporter

Past president of Employee Assistance

Professionals Association:

Criteria for determining how work place policies and practices impact health include:

- Having standards of employment that are clearly defined and mutually agreed-upon.
- Having a mental health and wellness program that includes a clear description of benefits, promotions, education, and management training.
- Surveying employees, and using the information to ensure that programs are working.

Recommendations include:

- Combining passion with data. Advocates always have had passion when approaching businesses to ask them to offer more mental health benefits; what we haven't done is well is give businesses numbers to see how this helps their overall productivity.
- Defining communication needs, working toward the improvement of mental health benefits. Business and mental health advocates need to negotiate a shared vision.
- Acknowledging and rewarding role models, businesses that do a very good job of including comprehensive mental health plans. This is important so that other businesses will understand what we're asking them to do.
- Employing people with mental illnesses, so that businesses can learn that they can be very productive employees.



We need to increase the acceptance of mental and behavioral health differences in the work place, incorporating concerns about violence.

John Romeo

Group 4 reporter

*Director of the health care process team
for Bethlehem Steep Corporation:*

Creating a healthy workplace requires:

- collaboration, creating a partnership that favors trust in the workplace. Employees can feel confident telling their supervisors of a mental health or substance abuse problem, knowing they will get help instead of being fired.

- We want to collaborate to improve productivity through prevention, early detection, reduced incidents of serious illness, and reduced lost time. Everybody profits.

Recommendations include:

- Working together on focused educational efforts, including the presentation of role models for business and industry.

- Enhancing "reasonable accommodation" before someone is hired, during their employment, and after any incidents, as they return to work.

- Demonstrating the positive relationship of mutual benefit design and enhanced EAP roles. Mutual benefit means that employers seek the advice of employees; the EAP is the gateway to the behavioral health system.

- Enhancing return on investment by defining the value of a program as quality over cost.

- Identifying practical ways for small businesses to gain access to benefits.

◆

David Pruitt

Group 5 reporter

President-elect of the American Academy of Child and Adolescent Psychiatry

Criteria for a healthy work place include:

- Having policies and programs that prevent the abuse and harassment of employees. This would reduce stress.

- Measuring value—defined as costs plus quality.

- Promoting integration and prevention, so that mental health problems can be identified and treated early.

Recommendations include:

- Having equal access to care for chronic, as well as acute, conditions.

- Altering health care policies to encompass a broader range of mental health concerns.

- Improving attitudes toward mental illness and mental health.

- Finding better, faster ways to disseminate research; moving developments from the research bench to the bedside.

- Pairing government and communities with employers to implement the mental health objectives set by employers and employees.

◆

Employers and employees want to collaborate to improve productivity through prevention, early detection, reduced incidents of serious illness, and reduced lost time. Everybody profits.

Ruth Hughes

Group 6 reporter

Executive director of the International Association of Psychosocial Rehabilitation

Criteria for evaluating the success of interventions and benefits designed to keep employees productive include:

- Looking at costs, including days of work lost, disability, workman's compensation and accidents.
- Acknowledging variances in productivity measurements. At one place, it may indeed be the number of widgets produced. In another, it may focus on being able to get along with co-workers and supervisors.
- Satisfying employees by offering the benefits they want and need.

Recommendations include:

- Promoting dialogue between providers, users, and the people who make decisions on benefit packages about what impacts the mental well-being of employees.

- Expanding the number of decision-makers to include all stakeholders—users, non-users, providers, and managers. This provides constant feedback about the effectiveness and quality of services.

- Generating the public and political will to influence legislation and policy on health care, including who should pay for what.

- Collaborating on the development, integration, and dissemination of outcome measures, now still in the infant stage.

- Increasing the acceptance of mental and behavioral health differences in the work place, incorporating concerns about violence.

- Sharing the discussion of how to pay for health care between corporations and government.

A Healthier Work Force Through Managed Care

Linking mental health care and primary medical care remains a crucial concern

By Richard Surles

Managed care, if managed well, could overcome the myth that if a company offers a benefit, it will be used inappropriately and excessively, resulting in exorbitant costs. But warnings abound that managed care not managed well can block access to care, and to new procedures and medications, and that emphasis on cost containment makes the industry reluctant to cover certain practices. So where does the balance lie?

"Medical necessity" is one of the guiding principles of managed care. It requires a patient to prove that they have a health problem that needs treatment and that the suggested procedures will likely improve the problem. Clearly, in some situations, traditional medicine is necessary. But we are also learning that treating some medical conditions as isolated incidents, without providing environmental supports, can increase risks reduce efficacy and, in the long run, prove not cost-effective.

Managed behavioral healthcare is rapidly expanding into the marketplace, becoming even more

prevalent than managed medical healthcare. It is estimated that half of all employed Americans have their mental health benefits under managed care, while less than 30 percent have their medical benefits covered under this system. Managed care can help ensure a healthy work force, but we need to include new treatments for recovery and rehabilitation. We must be willing to flex the benefit.

The recent surge of managed behavioral care into employee benefit plans can be greatly attributed to the significant cost reductions in a very short time—typically, at least a 20 percent premium reduction from the previous-year premium.

So what should be done with those savings? Many critics voice concern that the savings result in unintended profits that the payer may not have recognized and may not have included in negotiations with the managed care entity.

The challenge is then how to create the proper incentive so that a benefit is not underused, or overused and doesn't allow for excess profits. This has led to the development of a "soft cap," a stipulation included in corporate contracts that allows managed care companies to exceed even the historic benefit up to a certain percentage. But if that level is surpassed, they are financially liable. Therefore, it encourages the managed care company to flex the

Richard Surles, Ph.D., is executive vice president of Merit Behavioral Care Corporation and a member of The Carter Center Mental Health Task Force.

Individuals fear using their benefits. They don't trust their employer's confidentiality vows. They're afraid of stigma, the side effects of medication, coercion to accept treatment.

Once a physician recognizes that a patient may suffer from mental illness, he or she must also recognize the physical symptoms of other possible medical problems.

benefit, and find creative alternatives.

One concern among employers contemplating whether to offer behavioral health is whether employees will use their benefit. Some people do not trust their employer's confidentiality vows, and/or are afraid of the stigma associated with treatment, the side effects of medication, or coercion to accept treatment.

Another issue is whether to "carve out" a mental health benefit or leave it within a larger health plan. Both ways have their merits and their pitfalls, but either way, the issue of linking mental health care and primary medical care is paramount. This is complicated: primary care physicians, especially those in managed care programs, are extremely

busy and not always able—or willing—to get involved in a patient's mental health care. In addition, many patients seeking behavioral health care do not want to involve anyone else in their care, including their primary care doctors. However, the importance of these physicians' involvement cannot be overstated.

Once a physician recognizes that a patient may suffer from mental illness, he or she must also recognize the physical symptoms of other possible medical problems. For example, there is a high mortality rate among people in their late 20s and 30s with major mental illnesses. Surprisingly, it is not usually the result of suicide; in fact, most people remain in active

“More must be done to ensure that the illness is being treated as effectively as possible ... Good mental health is both environmental and biological—we can not separate the two.”

—Richard Surles



treatment for their mental illnesses, but went undiagnosed or untreated for a major medical condition. For instance, men tended to go untreated for hypertension, and for women, for respiratory disease or obesity.

Recent articles in trade publications report that there is a new focus on people in the work force on long-term disability leave. It appears that a high percentage of these workers disabilities are related to mental illness. The decision whether to return to work also draws in issues of behavioral care. The current practice of simply requiring a note from your psychiatrist to return to work is not sufficient. More must be done to ensure that the illness is being treated as effectively as possible.

Many employers have been passive in the benefits offered to employees out on long-term disability, so we must creatively redesign a comprehensive strategy for disability assistance.

Good mental health is both environmental and biological—we can not separate the two.

Four themes consistently emerged at this Symposium to address this issue:

■ We must create a set of measures that allow us to identify a problem when it starts, to say,

“Wait a minute, there is something wrong in this work place.”

■ We need to focus on the health of individuals, to ensure that they have a high moral strength as evidenced by low violence, low racism, and low stigma.

■ Organizations must be open to change. They must examine their practices, see how that is affecting their employees, and determine how they are perceived by their customers.

■ We must combine early identification, easy access to confidential care, and a flexible benefit. We must move from the acute care model to one of recovery and rehabilitation.

Everything we do has to be perceived as adding value. For too long, we in the mental health movement have simply wanted to testify that what we did added value. While we await further scientific evidence, common sense and experience are teaching us how to add value to a managed mental health benefit. Future opportunities to demonstrate effectiveness through data which relates health and mental health status to productivity and satisfaction should be a common goal between employees and benefit managers.

A very high portion of the decisions to leave the workplace are related to mental illness and disabilities. We need to creatively redesign benefits to employees out on long-term disability.

In Closing

Can we not do more to end the stigma of mental illness?

By Rosalynn Carter

*Almost every
person with
a mental illness
can be helped.
Can we afford
not to act on that
knowledge?*

Our goal was to create a forum for open dialogue on critical issues regarding mental health and mental illness in the work place. We did that, perhaps for the first time deeply involving people from fields other than the mental health community.

I hope we can continue to talk, to collaborate.

The issue of stigma was raised again and again.

Here at The Carter Center, we just made a video with Kathy Cronkite and Rod Steiger talking about their depression. Pastors show our video in church as a way to bring up the issue of stigma. Families have used it. Public television stations have aired it. The Carter Center also has an anti-stigma fellowship program for journalists, and we are seeking funding for a blue-ribbon commission of educators, business people, and representatives of the criminal justice system to address stigma.

Almost every person with a mental illness can be helped.

Most can lead normal, contributing lives.

Can we afford not to act on that knowledge? Can we not do more, today, tomorrow, in the weeks and years ahead, to end the stigma of mental illness—and to bring wholeness and the opportunity for meaningful employment—into the lives of so many people and families in this country?

Post-Script

Common Ground for Business and Mental Health

By John Gates & Judy Fitzgerald

The Carter Center Mental Health Task Force decided in January of 1996 that the topic of the Twelfth Annual Rosalynn Carter Symposium on Mental Health Policy would be "*Mental Health and Mental Illness in the Workplace: Healthy Employees / Healthy Companies.*"

That decision stemmed from the recognition that, throughout the preceding two and a half years of effort to increase access to healthcare for people with mental illness, and especially in those efforts focused upon changing certain health insurance practices, the source of much of the opposition to change was organizations representing large and small businesses. While supportive of continuing efforts on the part of the mental health community to impact legislation at both national and state levels, the Task Force felt there would be value to provide a forum for discussion and potential collaboration between leaders in the mental health community and those in the business community.

The fact that a bill with some parity provisions was passed by Congress in September, 1996, did not negate the wisdom of that original decision. Indeed, by that time, adverse positions had rigidified and the line in the sand was clearer than ever before.

While the parity debate was unfolding, prepa-

rations were being made for the Symposium. Panelists and speakers were asked to participate with the understanding that the purpose of the Symposium was to foster better mutual understanding of the different perspectives of those in the mental health community and the business community. In addition, all parties were asked to identify potential common ground between the two groups that might foster the health of employees and the companies for which they work.

The various keynote speakers, panelists, and participants exceeded expectations. The concerns of the mental health community were clearly heard by business leaders (*e.g.*, *a priori* limitations on visits, high co-insurance payments, lifetime limitations far below those for physical illness, and the absence of psycho-social supports for those with serious mental illness). Stories were told of people feeling devalued, of individuals suffering in secret, fearing job loss due to a mental illness, and families devastated by the lack of comprehensive coverage.

Similarly, business leaders described their concerns about greatly increased costs, indefinite numbers of therapy sessions, whether treatment was effective, and frustration over historic utilization review procedures. Stories were told of past practices involving the unnecessary hospitalization of children, professional certifications of individual's

The purpose of the Symposium was to foster better mutual understanding of the different perspectives of those in the mental health community and the business community.

It is incumbent upon both the mental health community and the business community to foster an environment of learning and cooperation and to seek venues to achieve the goals encouraged by the Symposium.

inability to function despite clear-cut evidence that such individuals were functioning, and occasional instances of malingering.

Business leaders also emphasized that they had responsibilities not just to active employees and their families, but to retirees and their families, to shareholders, and to many others, and to stay competitive in order to remain in business. They rejected the idea that their concerns about cost were reflections of excessive greed.

Following the exchange of viewpoints, all participants were asked to identify common ground (i.e., issues of mutual interest) where collaborative work might result in healthier employees and companies. The following suggested actions emerged as common ground for future work:

Enhancing Communications

- **To confront the myths and stereotypes** which foster stigma and to improve attitudes toward mental illness and addictive disorders.
- **To articulate company values, goals, and expectations** regarding well-being and productivity, thus linking the health and development of employees and the company in which they work.
- **To define the meaning of behavioral health** and to provide information about practical ways in which behavioral health can be promoted by employees and the company.
- **To share up-to-date facts** about mental illnesses, their causes, treatments and the effectiveness of treatments.

- **To educate regarding the early signs and symptoms** of problems, and to ensure that all understand company policies regarding early detection and intervention.

- **To make clear the manner in which employee and company well-being will be evaluated**, and to publish periodically aggregate data regarding the results of the evaluation.

- **To report on the changes in health care costs and delivery** resulting from managed care practices and ways in which such practices may be improved to the betterment of employees and their companies.

Collecting Data

- **To establish a data set** that is feasible and economical to implement which links the well-being of employees and the well-being of companies.
- **To analyze company investments and returns on investments** in health promotion, illness prevention, early detection, employee assistance, and health benefit plans.
- **To list indicators of health** and sound methods for measuring and analyzing them.
- **To explore how costs analyses and cost-offset analyses** can be calculated and applied to policy making.
- **To describe the needs and resources of small and large employers** and recognize the implications for systems of data collection and analysis for each.
- **To determine how information might be used to change individual or organizational practices**, and decide how this information will be shared with all concerned on a periodic basis.

Making Accommodations

- To review company practices with regard to the hiring, training, and supervision of persons with mental illness and to assure that policies provide for reasonable accommodations.
- To hire individuals who are or have been consumers of services.
- To provide information regarding best practices in providing accommodation.
- To sensitize employees and management about devaluing and stigmatizing behaviors or practices, and similarly to inform regarding behaviors and practices which value and support all persons.

These recommendations by the work groups reflect an awareness that it is in the best interests of individuals from the mental health and business communities to continue to identify areas of mutual interest and to create opportunities for ongoing, constructive dialogue.

Members of both groups have different experiences, resources, and wisdom to offer in the areas of enhancing communication, collecting data, and making accommodations. It is incumbent upon each side to foster an environment of learning and cooperation and to seek venues to achieve these goals.

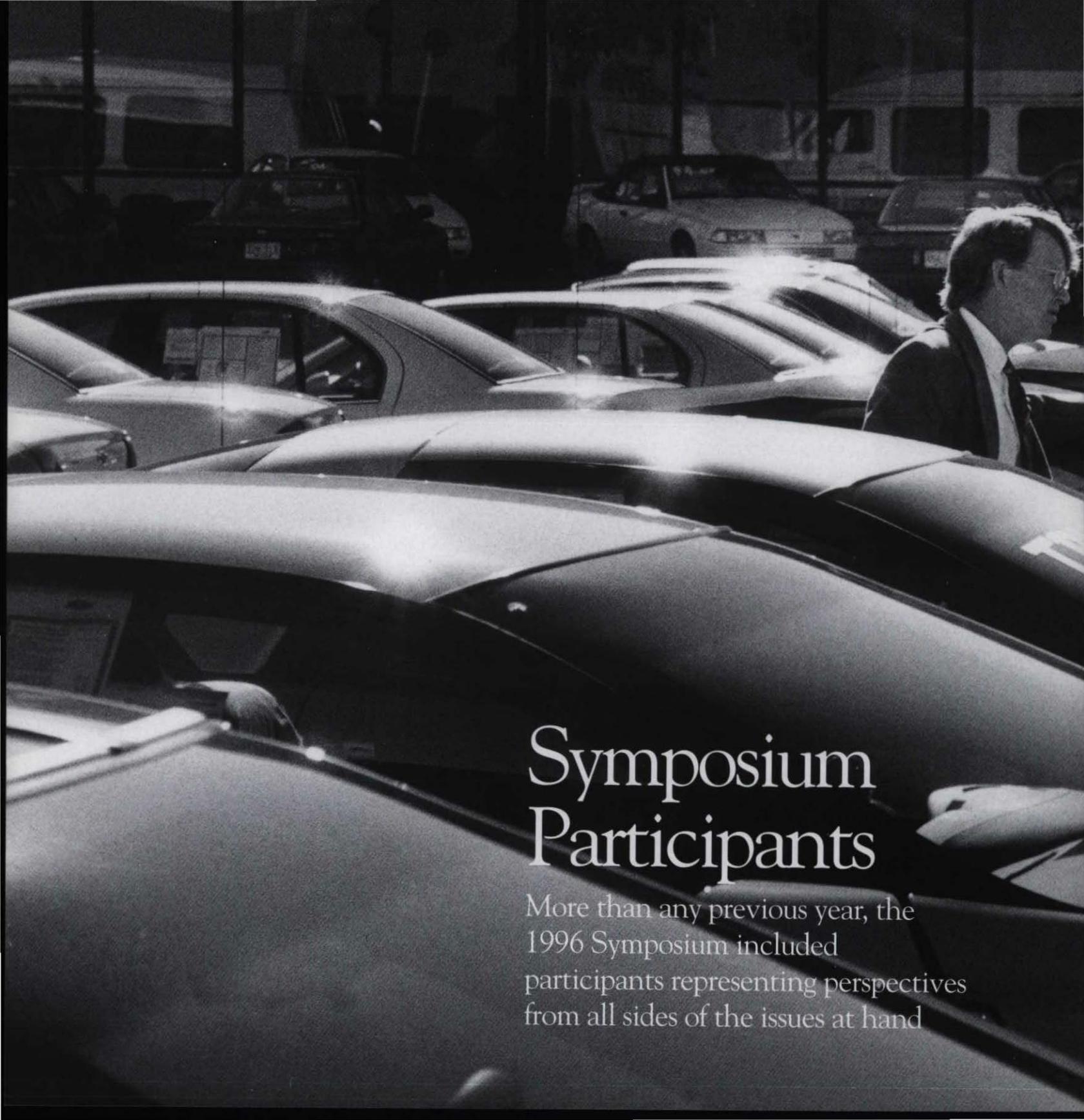
What Is To Be Gained?

Progress in reducing stigma; clearer articulation of company values, missions and goals, particularly those related to health and well-being; a focus on prevention, early detection, and wellness in the workplace; data which captures the full impact of healthcare decisions by employers; policies and procedures in the workplace which support productivity for a diverse workforce; and the identification of specific activities which require collaboration between individuals with business and mental health expertise.

A certain amount of tension will likely remain. This healthy tension can help push toward a balance between well-being and productivity, between individual health and corporate health, between preserving confidentiality and removing stigma, and between costs and returns on investments. Such balance cannot be achieved without active participation from the mental health and business communities alike.

Rosalynn Carter's 1996 Symposium has provided a glimpse of what can be accomplished when both groups come together with an intention to cooperate.

Healthy tension can help push toward a balance between well-being and productivity, between individual health and corporate health, between costs and returns on investments.



Symposium Participants

More than any previous year, the 1996 Symposium included participants representing perspectives from all sides of the issues at hand



Special Guests and Agency Representatives

The following individuals are the official representatives of their organizations to the Twelfth Annual Rosalynn Carter Symposium on Mental Health Policy

American Academy of Child & Adolescent Psychiatry
Virginia Q. Anthony, *Executive Director*
David Pruitt, M.D., *President-Elect, Board of Directors*

American Aging Concern
Barry Risenberg, *President*

American Association of Children's Residential Centers
Claudia Waller, B.S., R.N., *Executive Director*

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Marcia Lasswell, M.A., *President, Board of Directors*
Michael Bowers, M.A., *Executive Director*

American Association of Pastoral Counselors
Gerald J. DeSobe, Ph.D., *President, Board of Directors*
C. Roy Woodruff, Ph.D., *Executive Director*

American Association of Private Practice Psychiatrists
Lawrence Sack, M.D., *President, Board of Directors*

American Association of Psychiatric Services for Children
Sydney Koret, Ph.D. *Executive Director*

American Association of Retired Persons
Carol Cober, M.S., *Manager*

American College of Neuropsychopharmacology
Roger Meyer, Ph.D., *Past President, Board of Directors*

American Counseling Association
Gail Robinson, Ph.D., N.C.C., C.C.M.H.C., L.P.C., *President, Board of Directors*
Courtland C. Lee, Ph.D., *President-Elect, Board of Directors*

American Family Therapy Academy
Ellen Berman, M.D., *Member, Board of Directors*

American Group Psychotherapy Association
Marsha S. Block, C.A.E., *Chief Executive Officer*

American Hospital Association
Merry Beth Kraus, *Director, Section for Psychiatric and Substance Abuse Services*

American Managed Behavioral Healthcare Association
E. Clarke Ross, D.P.A., *Executive Director*

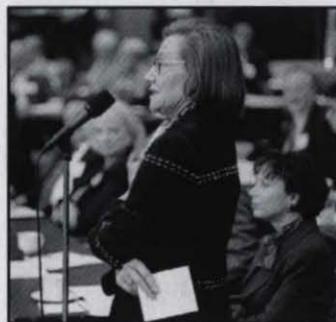
American Nurses Association
Beverly Malone, Ph.D., R.N., *President, Board of Directors*
Faye Gary, Ed.D., R.N., *Representative*

American Psychiatric Association
Melvin Sabshin, M.D., *Medical Director*

American Psychiatric Nurses Association
Tim Gordon, *Executive Director*
Nancy Valentine, Ph.D., R.N., M.P.H., C.N.A.A., F.A.A.N., *President, Board of Directors*

American Psychoanalytic Association
Glenn E. Good, Ph.D., *President, Board of Directors*
Lawrence B. Inderbitzin, M.D., *Fellow, Member, Board of Directors*
Ellen Fertig, *Administrative Director*

American Psychological Association
Raymond D. Fowler, Ph.D., *CEO, Executive Vice President*
Henry Tomes, Ph.D., *Executive Director for Public Interest*
Russell Newman, Ph.D., J.D., *Executive Director for Professional Practice*



- Cindy Yeast, *Assistant Executive Director of Public Relations/Communications*
- American Society of Adolescent Psychiatry**
Glen T. Pearson, M.D., *President, Board of Directors*
- Anxiety Disorders Association of America**
Jerilyn Ross, M.A., L.I.C.S.W., *President*
- Association for Ambulatory Behavioral Health Care**
Mark Knight, M.S.W., *Executive Director*
- Association of Child/Adolescent Psychiatric Nurses**
Beth Bonham, *President, Board of Directors*
- Association of Mental Health Clergy**
Chaplain David Carl, *President*
Mary Kendrick Moore, *Chaplain*
- Bazelon Center for Mental Health Law**
Chris Koyanagi, *Acting Director*
- Compeer, Inc.**
Bernice Skirboll, M.S., *Executive Director*
- Employee Assistance Professional Association, Inc.**
George Cobbs, *President, Board of Directors*
- Families First**
Jill Wilson, L.P.C., C.A.C., *Employee Assistance Services*
- Federation of Families for Children's Mental Health**
Sue L. Smith, M.P.H., *President*
- Institute for Behavioral Health Care**
Nancy Knoble, *Manager of Employer Initiatives*
- Institute of Medicine**
Lynne de Grande, A.C.S.W., C.E.A.P., *Senior Consultant*
Constance Pechura, Ph.D., *Director for Division of Neuroscience and Behavioral Health*
- International Association of Psychosocial Rehabilitation Services**
Scott Graham, *President-Elect*
Ruth A. Hughes, Ph.D., *Executive Director*
- The Policy Resource Center, Inc.**
Anne Drissel, *Executive Director*
- National Alliance for the Mentally Ill**
Melissa Saunders-Katz, *Campaign Project's Manager*
Claire Griffin-Francell, *Past Vice President & Director of Curriculum and Training*
- National Association of County Behavioral Health Directors**
Robert Egnew, M.S.W., M.P.H., *President*
- National Association of Protection and Advocacy Systems, Inc.**
James Jackson, *President, Board of Directors*
- National Association of Psychiatric Health Systems**
Mark Covall, *Executive Director*
- National Association of Psychiatric Treatment Centers for Children**
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Robert W. Glover, Ph.D., *Executive Director*
Colette Croze, *Health Care Reform Project Manager*
- National Committee for Quality Assurance**
Joe Thompson, M.D., M.P.H., *Assistant Vice President of Collaborative Resources*
- National Community Mental Healthcare Council**
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Anne F. Kilguss, *Vice President*
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- National Foundation for Depressive Illness, Inc.**
Peter Ross, *Executive Director*
- National Institute of Mental Health**
Rex W. Cowdry, M.D., *Deputy Director*
Marsha Corbett, *Director, Office of Scientific Information*
- National Mental Health Association**
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Al Guida, *Vice President of Government Affairs*
- National Mental Health Consumer Clearinghouse**
Thomas Leibfried, *Consumer Advocate*
- National Parkinson Foundation**
Mary Willis, *Patient Services Coordinator*



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Pathways to Promise
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Representative

President's Committee on Employment of People With Disabilities
John Lancaster, *Executive Director*

Society for Education and Research in Mental Health Psychiatric Nursing
Lorna Mill-Barrell, *President*

Substance Abuse and Mental Health Services Administration
Bernard S. Arons, M.D., *Director Center for Mental Health Services*
Ron Manderscheid, Ph.D.,
Chief, Survey and Analysis Branch
Carlotte A. Mehuron,
Director, Office of External Liaison

Washington Business Group on Health
Mary Jane England, M.D., *President*

World Federation for Mental Health
Beverly Benson Long, M.S., M.P.H.,
President, Board of Directors
Nancy Wallace, *Special Representative to the United Nations*

Jean Campbell, Ph.D.
Research Assistant Professor
Missouri Institute for Mental Health

J. Benedict Centifanti, Esq.
Director
Forensic Advocacy Coalition

Arthur A. Cheokas
Rosalynn Carter Institute for Human Development

Cathy Climo
Vice President of Benefits
NationsBank South

Fred Cloud
Volunteer Advocacy Coordinator
Public Policy Council of the Mental Health Associations of Tennessee

Daniel J. Conti, Ph.D.
Director
Employee Assistance Program
First Chicago Corporation

Bruce Davison
Employee Assistance Program Manager
Digital Equipment Corporation

James T. Evans
Vice Chairman and General Counsel
Brittan Communications International Corporation

Ronald A. Finch, E.Ed.
Mental Health Association of Metro Atlanta
Coopers and Lybrand, CPA

Paul Jay Fink, M.D.,
Associate Vice President
Belmont Center for Comprehensive Treatment

Stan N. Finkelstein
Executive Director
Pharmaceutical Industry
MIT, Sloan School of Management

Richard G. Frank, Ph.D.
Professor
Health Economics Department of Health Care Policy
Harvard Medical School

Laurie Garduque, Ph.D.
Program Officer
The John D. and Catherine T. MacArthur Foundation

Reverend William C. Gaventa
Coordinator
Community and Congregational Supports
University Affiliate Program of New Jersey

Suzanne Gelber, Ph.D., M.S.W.
President
SGR Health, Ltd.

Geri Sheller-Gilkey, Ph.D., L.C.S.W.
Assistant Professor
Emory University School of Medicine

Sherryl H. Goodman, Ph.D.
Associate Professor
School of Psychology
Emory University

The Carter Center is honored to have the following special guests in attendance:

James Astuto
Regional Manager
Managed Care
GTE Corporation

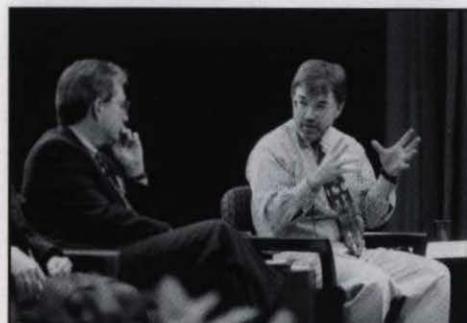
Thomas E. Backer
President
Human Interaction Research Institute

John C. Bartlett, M.D., M.P.H.
Executive Vice President
Quality Improvement
Magellan Health Services

Ray Bemis
Manager, Personnel Assistance Programs
Delta Airlines, Inc.

Wayne N. Burton, M.D.
Vice President
Corporate Medical Director
First Chicago Corporation

Sabrina Callahan
Coordinator
Human Resources
The Carter Center



Paul E. Greenberg
Principal
Analysis Group Economics

Claudia Griffiths
Manager
Occupational Health
Zeneca Pharmaceuticals

Sheryl Gripper
Vice President
Gannett Communities Fund
WXIA-11 Alive

Ivor D. Groves, Ph.D.
Director
Human Systems and Outcomes

Gary Gunderson, M.Div.
Program Director
Interfaith Health Program
The Carter Center

David H. Haigler, Ed.D.
Associate Director
Rosalynn Carter Institute for
Human Development

William Hale, M.D.
Executive Vice President and CEO
CPC Managed Care Operations

Kay Hamner
Associate Director
Operations
The Carter Center

George T. Harding, M.D.
Medical Director, Chairman
Harding Hospital

Mark S. Herak
Chief Executive Officer
Southeastern Network for Addic-
tion and Psychiatric Services

Jan Holcomb, R.N.
Executive Director
Mental Health Association of
Illinois

Iris Hyman
Consumer Affairs Specialist
Center for Mental Health Services

W. Thomas Johnson
Director, Healthcare
Healthcare Marketing Alliances

Lasa Y. Joiner
Vice Chair
Georgia Department of Human
Resources

Stanley S. Jones, Jr.
Georgia 811 Commission

Leonard Kirschner, M.D.
Vice President
Health Care Initiatives
Electronic Data Systems

Peggy Kirschner
Chair
Counseling Department
Dysart High School

Carol Koplan, M.D.
Faculty Member
Rollins School of Public Health
Emory University

Steve Lambert
Manager
Communications & Association
Relations
Zeneca Pharmaceuticals

Jean LeMasurier
Director
Policy & Program Improvement
Office of Managed Care
Health Care Financing Authority

Don R. Lipsitt, M.D.
Professor of Psychiatry
Harvard Medical School

Nancy Loving
Vice President
Burson Marsteller

Walter B. Maher
Director, Federal Relations
Chrysler Corporation

David L. Manning
Vice President
Columbia/HCA Healthcare Corpo-
ration

Donald W. Manthei, Ph.D.
DWM Consulting
American Mental Health Alliance-
National

Annette Maxey
Director
Behavioral Health Planning Unit

Robert McGarrath, Jr., J.D.
Director of Public Affairs
American Federation of State,
County and Municipal Employees

Matthew E. McGowan
Program Director
Erasing the Stigma

Frank McGuirk
Director
Western Interstate Commission for
Higher Education

Vera Mellen, M.A.
Executive Director
The Social Center for Psychiatric
Rehabilitation

Marjorie Mudrick
Executive Director
Mental Health Association in
Delaware

Bill Mulcahy
Member, Board of Directors
Community Friendship

J. Robert Newbrough, Ph.D.
Professor
Vanderbilt University
Member, Board of Directors
Rosalynn Carter Institute for
Human Development

Jack Nottingham, Ph.D.
Executive Director
Rosalynn Carter Institute for Hu-
man Development



John Orr
Co-Owner, Administrator
Mountainview Psychiatric Hospital

Sunday June Pickens, M.D.
Vice President
Physicians Services
Green Spring Health Services, Inc.

Beth Pollard
Director
Human Resources
Scientific Atlanta, Inc.

Carl Eddie Roland
Director
Division of Mental Health, Mental
Retardation and Substance
Abuse
Georgia Department of Human
Resources

John A. Romeo
Director
Health Care Processing Team
Bethlehem Steel Corporation

Louise M. Rosenburgh
Associate Executive Director
Resource Development
The Social Center for Psychiatric
Rehabilitation

George D. Roth
Executive Director
Champaign County Mental Health
Board

Susan Salasin
Director
Mental Health and Criminal Justice
Program
Center for Mental Health Services

Tracy Secallus
CNS Marketing
Pfizer, Inc.

**Francis S. Selgrath, M.H.S.,
C.E.A.P., C.A.A.P.**
Chairman, Board of Directors
Mustard Seed, Inc.

Ian Shaffer, M.D.
Chief Medical Officer and
Executive Vice President
Value Behavioral Corporation

Edward R. Shapiro, M.D.
Medical Director/CEO
Austen Riggs Center

Steven S. Sharfstein, M.D.
President, Medical Director and CEO
The Sheppard and Enoch Pratt
Hospital

Crystal Hayman Simms
Worksite Trainer/Consultant
Mental Health Association in
Delaware

W. Douglas Skelton, M.D.
Dean
Mercer University, School of
Medicine

Joel Slack
Director
Alabama Department of Mental
Health
Office of Consumer Ex-Patient
Relations

Fred Smith, M.Div.
Assistant Director
Substance/Violence Abuse
Interfaith Health Program
The Carter Center

Marjorie P. Smith
Commissioner
Georgia Department of Medical
Assistance

Patricia Still
Executive Director
Well Spouse Foundation

Henry J. Steadman, Ph.D.
President
Policy Research Associates, Inc.

Otto Wahl, Ph.D.
Associate Professor
George Mason University
Department of Psychiatry

Elaine Walker, Ph.D.
Professor
Emory University Psychology
Department

W. Evelyn Walker
Vice President
Human Resources
Intelligent Electronics, Inc.

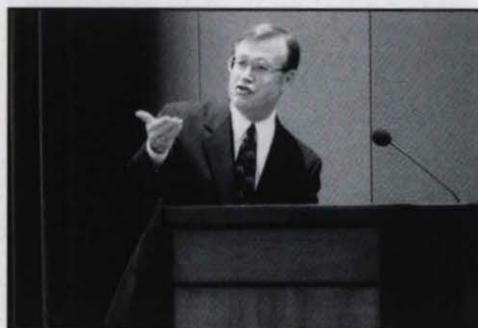
Danny Wedding
Director
Missouri Institute of Mental Health

Arlene Wildstein, Ph.D.
Director
Mental Health Solutions

Terrell G. Womack
Assistant Vice President
Total Compensation, Benefits and
Employee Services
BellSouth Telecommunications

Tara Wooldrige, L.C.S.W.
Manager, Personnel Assistance
Delta Air Lines, Inc.

Ellen Yancey
Director of Development
Department of Psychiatry
Morehouse School of Medicine



Task Force Members

Rosalynn Carter, *Chairperson*

Jane Delgado, Ph.D., *President and CEO, National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)*

Nancy Domenici, *Past Member, Board of Directors of the National Alliance for the Mentally Ill; Member, National Advisory Mental Health Council, 1985-1988*

Leon Eisenberg, M.D., *Pressley Professor of Social Medicine & Professor of Psychiatry, Emeritus, Harvard Medical School, Department of Social Medicine*

Jack Gordon, *President, Hospice Foundation of America*

Leslie Scallet, J.D., *Vice President, Lewin Group*

B. Franklin Skinner, *Former Chairman and CEO, BellSouth*

Richard Surles, Ph.D., *Executive Vice President, Merit Behavioral Care Corporation*

Ex-Officio Members

Thomas Bryant, M.D., J.D., *Chairman, President's Commission on Mental Health, 1977-78; Chairman, Non-Profit Management Associates, Inc.*

Kathryn Cade, *White House Projects Director for First Lady Rosalynn Carter; Managing Director, Global Asset/Liability Analysis, Bank of Boston*

Jeffrey Houpt, M.D., *Visiting Professor, Department of Social Medicine, Harvard Medical School*

Fellows

William Foege, M.D., *Director, Centers for Disease Control, 1977-83; Health Policy Fellow, The Carter Center*

Julius Richmond, M.D., *Surgeon General of the United States & Assistant Secretary of Health and Human Services, 1977-81; John D. MacArthur Professor of Health Policy, Emeritus, Harvard University*

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Joanne Woodward, *Actress; Director*

Staff

John Hardman, M.D., *Executive Director, The Carter Center*

John Gates, Ph.D., *Director, Mental Health Program*

Judy Fitzgerald, M.S.W., *Assistant Director, Mental Health Program*

Lynne Randolph, *Administrative Assistant, Mental Health Program*

Theresa Sheets, *Secretary, Mental Health Program*

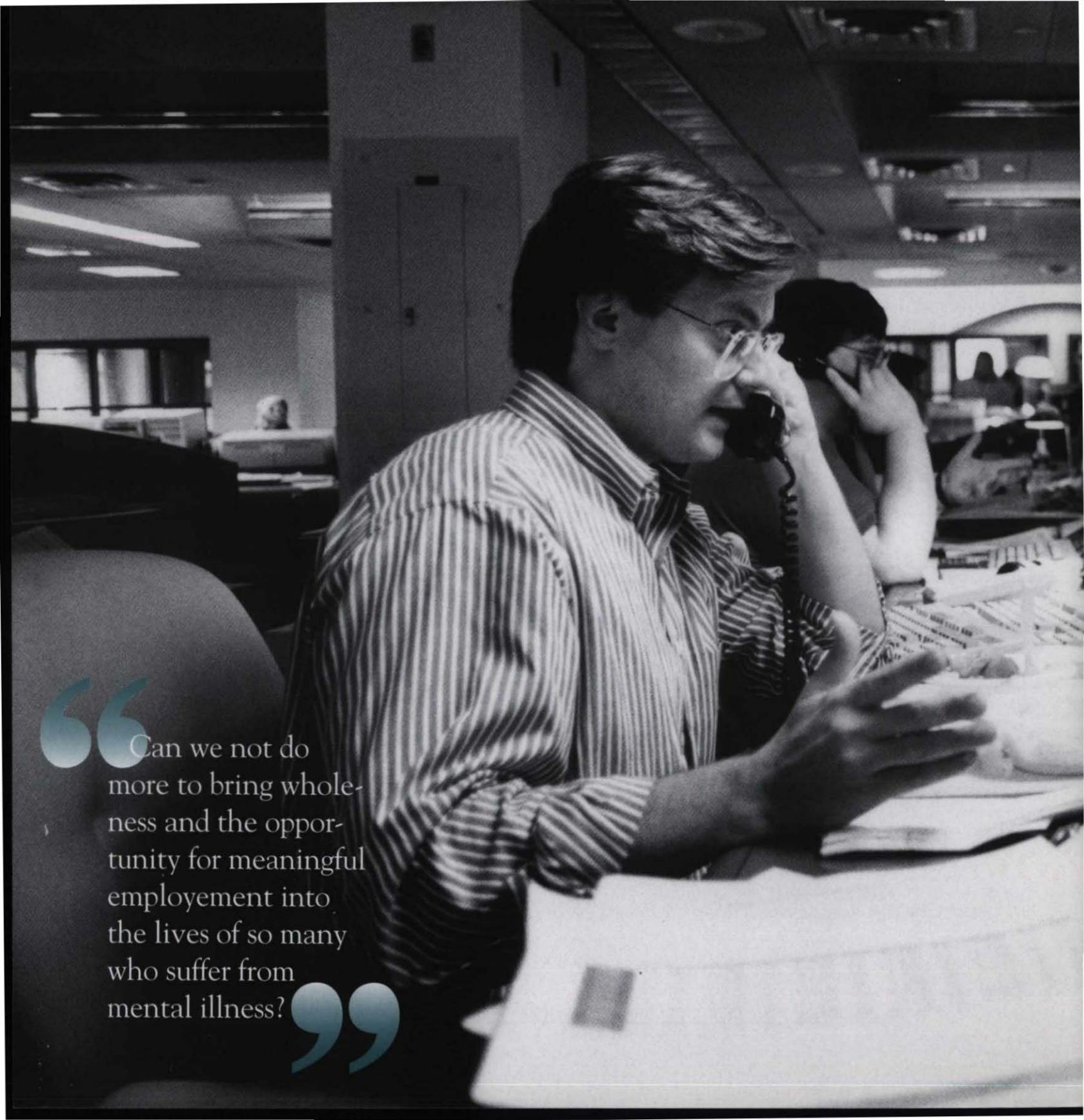
The Carter Center Mental Health Program

One Copenhill

Atlanta, GA 30307

404/420-5165

ccmph@emory.edu



“ Can we not do more to bring wholeness and the opportunity for meaningful employment into the lives of so many who suffer from mental illness? ”



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Almost every person with a mental illness can be helped. Most can lead normal, contributing lives. Can we afford not to act on that knowledge? Can we not do more—today, tomorrow, in the weeks and years ahead—to bring wholeness into the lives of so many individuals and families in this country?

—Rosalynn Carter”

