



TCC00010013

*Proceedings  
of*

*The Seventh Annual Rosalynn Carter Symposium  
on Mental Health Policy*

**“PHYSICAL AND MENTAL HEALTH:  
CLOSING THE GAPS”**

**Rosalynn Carter, Chairperson**

November 21, 1991

THE  
CARTER CENTER  
OF EMORY UNIVERSITY



*The Seventh Annual Rosalynn Carter Symposium  
on Mental Health Policy*

**“PHYSICAL AND MENTAL HEALTH:  
CLOSING THE GAPS”**

**Rosalynn Carter, Chairperson**

November 21, 1991

The Carter Center  
Atlanta, Georgia

The Seventh Annual Rosalynn Carter Symposium on Mental Health Policy was made possible by funding from the John D. and Catherine T. MacArthur Foundation, Chicago, Illinois, Gannett Corporation, Arlington, Virginia, and the van Ameringen Foundation, New York, New York.

*The Seventh Annual Rosalynn Carter Symposium on Mental Health Policy*

**PHYSICAL AND MENTAL HEALTH:  
CLOSING THE GAPS**

**Rosalynn Carter, Chairperson**

November 21, 1991

**PROGRAM**

- 8:00 - 8:45 a.m.      Registration  
                            Coffee and Bagels
- 8:45 - 9:00 a.m.      Welcome and Introductions:  
  
                            Thomas E. Bryant, M.D., J.D.  
                                    *Chairman, Non-Profit Management Associates, Inc.*  
  
                            Rosalynn Carter  
                                    *Chairperson*  
  
                            John Hardman, M.D.  
                                    *Director, The Carter Center Mental Health Program*
- 9:00 a.m.              Program Chaired by:  
                            Julius Richmond, M.D.  
                                    *Director, Harvard University Division of Health Policy; Visiting Fellow,  
                                    Mental Health Program, The Carter Center of Emory University*
- 9:00 - 9:40 a.m.      CLOSING THE GAP BETWEEN KNOWLEDGE AND PRACTICE:  
                            THE TREATMENT OF DEPRESSION IN PRIMARY CARE  
  
                            Leon Eisenberg, M.D.  
                                    *Professor of Social Medicine, and Professor of Psychiatry,  
                                    Harvard University Medical School*
- 9:40 - 10:20 a.m.    EDUCATING PRIMARY HEALTH PROFESSIONALS FOR MENTAL HEALTH CARE  
  
                            Robert Michels, M.D.  
                                    *Dean, Cornell University Medical College*
- 10:20 a.m.            Coffee Break
- 10:40 - 11:30 a.m.   Panel of Discussants  
  
                            Moderator:  
                            Roy Menninger, M.D.  
                                    *President, The Menninger Foundation*  
  
                            Panel:  
                            Beverly Long, M.S., M.S.P.H.  
                                    *Honorary Secretary, World Federation for Mental Health*  
  
                            Joseph A. Rogers  
                                    *President, Project SHARE*  
  
                            Raymond D. Fowler, Ph.D.  
                                    *Chief Executive Officer, The American Psychological Association*

11:30 - 12:15 p.m.

Overview And Update On The Carter Center Task Force On Mental Health

William Foege, M.D.  
*Executive Director, The Carter Center*

Introductions:  
Rosalynn Carter  
*Chairperson*

Panel - Task Force Members:

Moderator:  
Julius Richmond, M.D.  
*Director, Division of Health Policy, Harvard University; Visiting Fellow,  
The Carter Center of Emory University Mental Health Program*

The Carter Center Task Force on Mental Health:

Rosalynn Carter  
*Chairperson*

Johnnetta B. Cole, Ph.D.  
*President, Spelman College*

Jane L. Delgado, Ph.D.  
*President and Chief Executive Office, The National Coalition of Hispanic Health  
and Human Services Organizations*

Leon Eisenberg, M.D.  
*Professor of Social Medicine and Psychiatry, Harvard University Medical School*

Robert D. Ray  
*President and Chief Executive Office, Blue Cross And Blue Shield of Iowa;  
Former Governor of Iowa 1969-83*

Leslie J. Scallet, J.D.  
*Executive Director, Mental Health Policy Resource Center*

William S. Woodside  
*Chairman, Sky Chefs, Inc.*

Joanne Woodward  
*Actress, Director*

Ex Officio Members:  
Thomas E. Bryant, M.D., J.D.  
*Chairman, Non-Profit Management Associates, Inc.*

Kathryn Cade  
*Vice President, Public Finance, Bank of Boston*

Jeffrey L. Houpt, M.D.  
*Dean, School of Medicine, Emory University*

Antonia Novello, M.D.  
*Surgeon General of the United States*

12:15 - 12:45 p.m.

Concluding Remarks:

Jeffrey Houpt, M.D.  
*Dean, Emory University School of Medicine*

Rosalynn Carter  
*Chairperson*

*The Seventh Annual Rosalynn Carter Symposium*  
**"PHYSICAL AND MENTAL HEALTH:  
CLOSING THE GAPS"**

**Rosalynn Carter, Chairperson**

November 21, 1991

**AFTERNOON PROGRAM**

The afternoon session is open to symposium speakers, representatives from national organizations, the Mental Health Task Force and special guests.

- 12:45 - 1:45 p.m. Luncheon in Rotunda B
- 2:00 - 4:00 p.m. Participants will be assigned to one of four groups. The discussions will include a focus on quality of life, prevention and general well being.
- Facilitator:  
J. Michael McGinnis, M.D.  
*Deputy Assistant Secretary for Health Director, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services*
1. "THE RELATIONSHIP BETWEEN PHYSICAL AND MENTAL HEALTH:  
CLOSING THE GAPS"
- Group Leader:  
David Pruitt, M.D.  
*Director, Division of Child Psychiatry, University of Tennessee College of Medicine*
2. "MENTAL HEALTH OBJECTIVES FOR THE YEAR 2000"
- Group Leader:  
Paul J. Fink, M.D.  
*Chairman, Department of Psychiatry, Albert Einstein Medical Center*
3. "THE CHRONICALLY MENTALLY ILL: PROGRAMMATIC NEEDS FOR  
OPTIMAL FUNCTIONING AND WELL-BEING"
- Group Leader:  
Charles B. Nemeroff, M.D.  
*Professor and Chairman, Department of Psychiatry, Emory University School of Medicine*
4. "MENTAL HEALTH AND THE MEDIA: OVERCOMING STIGMA AND  
PROMOTING THE CONCEPTS OF WELLNESS, PREVENTION, AND IMPROVED  
QUALITY OF LIFE"
- Group Leader:  
Carole Szpak  
*Director of Communications, National Association of Private Psychiatric Hospitals*
- 4:00 - 4:30 p.m. Closing Remarks:  
Julius Richmond, M.D.  
*Director, Division of Health Policy, Harvard University; Visiting Fellow,  
The Carter Center of Emory University Mental Health Program*
- Rosalynn Carter  
Chairperson
- 4:30 - 5:00 p.m. Reception in Rotunda B

The Following Individuals are the Official Representatives of their Organizations to the  
Seventh Annual Rosalynn Carter Symposium on Mental Health Policy:

*Academy of Psychosomatic Medicine*

Troy L. Thompson II, M.D., President

*American Academy of Child and Adolescent Psychiatry*

David B. Pruitt, M.D., Chairman Work Group on Consumer Issues

*American Association of Retired Persons*

Gwendolyn Bedford, Vice Chairman, Board of Directors

*American Association for Marriage and Family Therapy*

Ray Bardill, Ph.D., President

*American College of Neuropsychopharmacology*

Oakley Ray, Ph.D., Secretary

*American Hospital Association*

Rebecca Chickey, Senior Staff Specialist

*American Medical Association*

Robert C. Rinaldi, Ph.D., Director, Division of Health Sciences

*American Nurses Association, Inc.*

Hattie Bessent, Ed.D., R.N., Deputy Executive Director

*American Psychiatric Association*

Paul J. Fink, M.D., Director

*American Psychoanalytic Association*

Lawrence Inderbitzen, M.D., Director

*American Psychological Association*

Raymond D. Fowler, Ph.D., Chief Executive Officer

*Anxiety Disorders of America*

Jerilyn Ross, M.A., L.I.C.S.W., President

*Black Psychiatrists of America*

Isaac Slaughter, M.D., President

*Compeer, Inc.*

Bernice W. Skirboll, M.S., President, Executive Director

*Mental Health Law Project*

Leonard S. Rubenstein, J.D., Director

*National Alliance for Research on Schizophrenia and Depression*

Connie Lieber, President

*National Alliance for the Mentally Ill*

Catherine A. Vath, President, Board of Directors

*National Association of Social Workers*

Josephine A.V. Allen, Ph.D., A.C.S.W., First Vice President

*National Association of Private Psychiatric Hospitals*

Frederick D. Raine, President

*National Council of Community Mental Health Centers*

Steven J. Solomon, Ph.D., Immediate Past President

*National Depressive and Manic Depressive Association*

Betty Hamilton, Member of the Board of Directors

*National Federation Societies for Clinical Social Work*

Marty Wakeland, President, Georgia Chapter

*National Foundation for Depressive Illness*

Peter Ross, Executive Director

*National Mental Health Association*

Elisabeth Rukeyser, Chief Executive Officer

*National Mental Health Consumers' Association*

Paul Dorfner, President

*Project SHARE*

Joseph A. Rogers, President

*World Federation for Mental Health*

Richard Mollica, M.D., Chairman, International Committee on Refugees and Migrants

## TABLE OF CONTENTS

### WELCOME AND INTRODUCTIONS

|   |   |
|---|---|
| Thomas E. Bryant, M.D., J.D.....          | 1 |
| Rosalynn Carter, Chairperson.....         | 2 |
| John B. Hardman, M.D.....                 | 4 |
| Julius Richmond, M.D., Program Chair..... | 6 |

### KEYNOTE ADDRESSES:

|  |    |
|--|----|
| "Closing the Gap Between Knowledge and Practice:<br>the Treatment of Depression in Primary Care"<br>Leon Eisenberg, M.D..... | 8  |
| "Educating Primary Health Professionals for<br>Mental Health Care"<br>Robert Michels, M.D.....                               | 18 |

### PANEL OF DISCUSSANTS:

|                                     |    |
|-------------------------------------|----|
| Roy Menninger, M.D., Moderator..... | 23 |
| Raymond Fowler, Ph.D.....           | 24 |
| Beverly Long, M.S., M.S.P.H.....    | 27 |
| Joseph Rogers.....                  | 28 |

### INTRODUCTION OF MENTAL HEALTH TASK FORCE:

|                                   |    |
|-----------------------------------|----|
| William Foege, M.D.....           | 35 |
| Rosalynn Carter, Chairperson..... | 37 |

### MORNING SESSION CLOSING REMARKS:

|                         |    |
|-------------------------|----|
| Jeffrey Houpt, M.D..... | 43 |
|-------------------------|----|

### AFTERNOON SESSION SUMMARIES:

|  |    |
|--|----|
| J. Michael McGinnis, M.D., Facilitator.....  | 46 |
| 1. "The Relationship Between Physical and Mental Health:<br>Closing the Gaps"<br>Group Leader:<br>David Pruitt, M.D..... | 52 |

2. "Mental Health Objectives for the Year 2000"  
 Group Leader:  
 Paul J. Fink, M.D.....53

3. "The Chronically Mentally Ill: Programmatic Needs for Optimal  
 Functioning and Well-Being"  
 Group Leader:  
 Charles B. Nemeroff, M.D.....56

4. "Mental Health and the Media: Overcoming Stigma and Promoting  
 the Concepts of Wellness, Prevention, and Improved Quality  
 of Life"  
 Group Leader:  
 Carole Szpak.....57

**CLOSING REMARKS**

Julius B. Richmond, M.D.....59

Rosalynn Carter, Chairperson.....60

APPENDIX A Bibliography - Dr. Eisenberg's Address.....61

APPENDIX B Figure 1.....66

          Figure2.....67

          Figure3.....68

**Acknowledgements:**

Symposium coordinators - Thomas Bryant, M.D., Geri Scheller-Gilkey, Ph.D., John Hardman, M.D., Jeffrey Houpt, M.D., Julius Richmond, M.D., Maryann Roper, M.D.

Margaret Cornett - as Symposium Administrative Assistant and for transcription and editing of the manuscript.

Carter Center staff for editing - John Hardman, M.D., Carol Koplan, M.D., Ruth McAdams, Bunny Meyer, Maryann Roper, M.D., Laine Thomas, and Laura Turner.

**The Seventh Annual Rosalynn Carter Symposium  
on Mental Health Policy**

**Mental Health and Physical Health: Closing the Gaps  
Rosalynn Carter, Chairperson**

**Morning Session  
Chaired by Julius Richmond, M.D.**

**Welcome and Introductions**

**Thomas Bryant, M.D., J.D.  
Rosalynn Carter, Chairperson  
John Hardman, M.D.**

**Thomas Bryant, M.D., J.D.**

I would like to be the first to welcome you to the Seventh Annual Rosalynn Carter Symposium. You have a right to know why I have that particular pleasure and honor. My name is Tom Bryant, and I am presently from Washington, D.C., but I am originally from the South. I went to school at Emory, and when I left Emory, I went to Washington. In a way, the move did prepare me for the Carters to come - which they did ten years after I got there. When they came, as most of you know, one of the first things that President Carter did was create the President's Commission on Mental Health in 1977. I was doing my math and that was just 14 years ago. I worked with Mrs. Carter at that time, and was the Director of the President's Commission on Mental Health, and have been involved with her, and in her work in the mental health field since then. There is a little bit of an aberration in that - I am a physician and an attorney, and I'm not a psychiatrist. When I was named as the Chairman of the President's Commission on Mental Health, there were a lot of raised eyebrows, particularly in certain professional circles. It was an interesting learning experience for me, and one of the most wonderful things about coming to the annual Rosalynn Carter Symposium is that I get to see a lot of the friends that I made and worked with during that period of time, and those friendships have held up. It's been quite a wonderful thing for me. I'm speaking on behalf of a lot of us that you will meet during the course of this Symposium.

My particular assignment (in addition to welcoming you and talking two minutes longer than I intended to) is to introduce the person that is the center of all of this, Mrs. Carter. I just look back, (and you'll probably do it in the course of the day too), and see what I said at this time last year, and I've probably said more or less the same thing the year before, and the year before that, which is - the focus of all this activity is Rosalynn Carter, and has been since Mrs. Carter got interested in mental health. She tells that story better than anyone else. I have been a part of that, and most of us have been a part of the energy level that she has brought to the field of mental health. There has been no single person in this country, in any of our lifetimes, who has

caused more attention to be devoted to and paid to the subject of mental health and to the mental illnesses that we live with. She has been the number one advocate for better care and for better services for the mentally ill. She has spoken out around the world, she has spoken here in this country, she has served on boards, she has had commissions. Still, even though they are as busy as they are here at the Carter Center and it never ceases to amaze me the things they're doing here; she continues to work devotedly and just extraordinarily hard in the field of mental health. Would you join me in welcoming our Chairperson, Mrs. Rosalynn Carter.

**Rosalynn Carter, Chairperson**

Thank you. Tom's a good friend, and he couldn't get out of the mental health field if he wanted to because I call on him for everything. I do want to welcome all of you here today: old friends, and some new people. We invite the presidents of the different organizations, and the presidents change, so we get to have some new people along. It's wonderful to be with old friends and people that I have worked with in the mental health field for a long time.

I always look forward to this day. I want to thank the John D. and Catherine T. MacArthur Foundation, the Gannett Corporation and the van Ameringen Foundation for making this Symposium possible. I couldn't do the things that I am able to do without the help of these foundations and corporations.

We have had some exciting developments since we met together last year. The main thing is a major grant that we received from the MacArthur Foundation, and we now have a Carter Center Mental Health Secretariat. We have named a Task Force that is going to be working. I think that I will wait to tell you about the Task Force, because later in the program we will introduce the members of the Task Force and tell you a little bit about what we are doing. It is exciting and it is a dream come true because we have these symposia every year, this is the seventh one, and we have such great ideas and I have never been able to follow up on them.

The one thing that I have followed up on is the media initiative. The media initiative is a program that we started here to try to educate the media about mental illnesses and about words and phrases to use in describing them, and to have the media portray people suffering from mental illnesses as they are. As you know and I know, rather than being violent, people who suffer from mental illnesses are most often shy and withdrawn. They are not pictured that way in the media. Earlier this year, we invited the media coordinators from the different mental health organizations to come here to the Carter Center. We will meet again this afternoon, and we hope that we can coordinate our efforts so that we can have a larger impact on the media.

I did go to California to meet with writers of television programs and movie scripts, and we have some ongoing correspondence with the "creative community," as they call it in California. We are going to be working with the print press in the immediate future to try to inform them and educate them more about mental illnesses.

The third thing that I wanted to talk to you about is a program that I am involved with at the Rosalynn Carter Institute at my local college in Americus, Georgia. Dr. Capitan, the President of Georgia Southwestern, is here this morning, and some of the Board members of that Institute. If you are here, would you stand? This is an interesting program, and it involves a mental health component. I thought you might be interested in it.

We are working with caregivers, trying to help caregivers across the spectrum of human services. We have in our community searched out the lay caregivers, those people who are in their homes tied down with someone they have to take care of all the time. The first conference we had was so exciting. These lay caregivers were meeting others who were in their own situation. They were really able to share with one another. We saw how important that was to them. We have now formed a "CareNet," we call it. We have the heads of the different government agencies, professional caregivers, advocates and lay caregivers all working together. We are really developing some good coalitions. One of the things that we are working on is a "needs assessment" to determine what the needs of the caregivers are. We have finished phase one. We had students paired with lay caregivers, interviewing professionals. We used the students from the college. It worked so well, particularly when we had a young student with an elderly caregiver talk to the professionals.

The next phase, which we will be doing this winter, will be to have the students and the professionals interviewing the lay caregivers. When we get this needs assessment done, the CareNet will, of course, assess what we have learned and develop some priorities. It is an interesting program and I think that what we are going to be able (what we hope) to do is to form a model in South Georgia that can be replicated across the country. I am excited about that.

The other program that you've probably heard about is our Atlanta Project. We don't take on small things at the Carter Center! We are taking a look at the city of Atlanta, and with the help of many volunteers we are going to solve all the human problems. We may not succeed, but Jimmy says "In order to succeed, you have to be willing to try." So we are going to try.

Yesterday with the Mental Health Task Force, one of the things we discussed was what kind of action program we could develop in the Atlanta area to prevent mental illnesses. We were thinking about working with children. I'll be excited next year to tell you what

we are doing.

One of the first conferences we had at the Carter Center was called "Closing the Gap." We looked at the Gap between what we know how to do and what we actually do in treating diseases and illnesses. We had about 130 scientists, mostly from the Centers for Disease Control, that studied the range of diseases. And we came up with the major causes of unnecessary sickness and death that have the greatest potential of being overcome. There were six of them. Violence, mental illness and substance abuse were some. We learned that 60 to 70% of premature sickness and death can be prevented (premature is before age 65). We also learned that an equivalent percentage had a mental illness component.

And so our topic today is "Physical and Mental Health, Closing the Gap." It has been demonstrated that people with depression are just as unable to carry out their daily routine as people with other chronic and severe health conditions. But depression often goes undetected and untreated. Primary health care practitioners see about half of all people suffering from mental illnesses. Although medical knowledge for treatment of mental illnesses is available, frequently it is not used. This morning we are going to hear more about this from Dr. Eisenberg and Dr. Michels. I am looking forward to that.

And now, to get on with the program today, it is my privilege to introduce the Director of the Carter Center Mental Health Program, Dr. John Hardman. I'll tell you a little about him before he comes to the podium. John is a child, adolescent and adult psychiatrist. That's the range, John. His major work has been in education and child development. He has served as medical director of Peachford Hospital, a 225-bed psychiatric facility, prior to joining the Carter Center. His experience includes clinical psychiatry and administration of international public health. He just spent the last year in Geneva on a joint Carter Center/World Health Organization program educating the developing world about tobacco and what tobacco can do to people. He is still working on that at times but he's here, the Director of the Carter Center Mental Health Program. I ask you to come to the podium, John Hardman.

**John Hardman, M.D.**

Thank you, Mrs. Carter. You can see why we are very excited here at the Carter Center about not only the mental health program, but what this means in terms of our other programs here. Certainly, the mental health component of The Atlanta Project will be extremely important.

The idea for the annual mental health symposium started with Dr. Bryant and Dr. Houpt, and the Emory Department of Psychiatry. As was mentioned, this is the seventh symposium that we have had, but only since 1987 have we held the symposium here at the Carter

Center. The Carter Center was completed in the fall of 1986. Our '87 program was the first one here. Last year the administration of the program shifted from the Department of Psychiatry to the Carter Center. The relationship with Emory University has continued and is a very strong one.

As you know, Dr. Jeffrey Houpt is now the Dean of the Emory University Medical School. He is on our Task Force here at the Center and will be speaking to you later this morning, giving the concluding remarks.

This year we would like to welcome the new Chair of the Department of Psychiatry, Dr. Charles Nemeroff. In addition to his M.D. degree, Dr. Nemeroff also has a Ph.D. in neurobiology and was professor of psychiatry and pharmacology, chief of the division of biological psychiatry at Duke before coming to Emory. Dr. Nemeroff, would you stand up so that we can welcome you? We look forward to the symposium tradition continuing with the support from Dr. Nemeroff.

Each year Dr. Geri Scheller-Gilkey of the Emory University Department of Psychiatry has coordinated this Symposium, even after its physical move to the Carter Center last year while I was in Geneva. Geri has continued with the same dedication and energy to this year's symposium. Dr. Maryann Roper of the Carter Center staff and Margaret Cornett also have spent many hours working on this year's Symposium. Would the three of you stand so that we can recognize you: Geri, Maryann, Margaret.

The mental health program at the Carter Center had its genesis in these symposia. It now provides the capability to broaden, strengthen, and take action on the ideas and thoughts discussed by you in these sessions.

It is truly a great pleasure to introduce our visiting fellow to the mental health program this year who will chair our sessions for today. Dr. Julius Richmond is the John D. MacArthur professor of Health Policy Emeritus at Harvard University. He was Surgeon General and Assistant Secretary of Health and Human Services from 1977 to 1981, the Carter presidential years. During his term as Surgeon General, he issued the report Healthy People, National Health Promotion and Disease Prevention Objectives which has been institutionalized by the Public Health Service. Since 1987 Dr. Richmond has served as Chairperson of the Steering Committee of the Forum of the Future of Children and Families of the National Academy of Sciences. His collaborative work with Dr. Bettye Caldwell on the development of young children growing up in poverty led to his appointment as the first Director of the National Head Start program. Dr. Richmond...

**Julius Richmond, M.D.**

Thank you very much, John. It's a real privilege to have been asked to serve as a Visiting Fellow in the development of the Mental Health Program which Mrs. Carter has initiated here at the Carter Center. It continues the long tradition that she has established in furthering programs in mental health, emphasizing prevention, as well as the care of the mentally ill.

I want to take just a moment, because it's important in terms of the symbolism in relationship to health promotion and disease prevention, to come back to Mrs. Carter's mentioning of John Hardman's activities last year in Geneva in dealing in concerns about smoking - in particular young people and smoking throughout the world. It is fortuitous that we are meeting today on the day of the Great American Smoke-out when the nation renews its commitment to the anti-smoking effort. I think it's important to note that the work of the Public Health Service and the work of Mrs. Carter in fostering better education for health, and particularly in mental health, has bore some fruit.

We have had a consistent decline over a number of years in smoking in the United States, but as John Hardman could tell you, the numbers of people smoking in the developing world is increasing so we do have a task before us.

I would like to mention that we do have with us, Dr. Michael McGinnis, who was my Deputy Assistant Secretary for Health Promotion and Disease Prevention in the Public Health Service. Today he has continued in that post, and I think we are all indebted to him and all of his colleagues in the Public Health Service by what he has continued to do to foster health promotion and disease prevention in the United States and throughout the world.

As you have heard, these annual symposia have highlighted major issues in our concerns about health broadly, but particularly mental health. In these annual symposia, Mrs. Carter has taken the opportunity to bring together representatives of various organizations in the field of mental health to share concerns, share ideas, and share the sense of commitment to prevention as well as the improvement in the care of the mentally ill. This year's Symposium is no exception. The matter of physical and mental health, and picking up on our earlier theme of the Carter Center as Mrs. Carter has indicated, "Closing the Gaps, Physical and Mental Health," is a very important issues for us to be attending to.

I wondered why it was suggested that I chair this part of the program, and I thought at first it was just because of my seniority. I think I can make pretty good claims for seniority. And then I thought, "Well, perhaps it's because I'm a pediatrician, and pediatricians are integrationists in the sense of bringing

physical and mental health issues together, because one cannot think of development without thinking of physical and mental health as integrated processes."

As you've already heard, we have a very exciting program before us. I'd like to introduce our first speaker, who is a very close colleague who has been trained in child psychiatry at the Johns Hopkins Medical School and then became Director of that Program. His mentor was Dr. Leo Kanner, who for a long time studied the dynamic development of autism in children and did some of the first studies in the follow-up of autistic children, that is, what happens to them over time. After his distinguished career in the child psychiatry program at Johns Hopkins, (as the Chinese are inclined to say), "His wisdom opened up, and he came to Boston to be with us at Harvard" where he assumed the Directorship not just of child psychiatry, but the entire department of psychiatry at the Massachusetts General Hospital and demonstrated for us what his high intellect and managerial skill could do in developing a very exciting program.

After a number of years, he joined us at the Children's Hospital and the Judge Baker Children's Center in Boston where he carried on what has been the enduring theme of his career, that is, scholarly activities in psychiatry, mental health and more broadly in medicine. As one of the great scholars in the field of medicine at Harvard University, and the medical school in particular, recognizing the importance of social issues in health and mental health he established a Department of Social Medicine to bring to the attention of medical students and others in the field, the importance of social issues. He brought into the medical school environment a dynamic program of teaching and research, bringing together social scientists from the various backgrounds of psychology, sociology, and anthropology. I think it is fair to say that currently at the Harvard Medical School, these are so closely interwoven with the medical students' educational background that they are inseparable from the biomedical considerations which have, of course, historically dominated medical education.

And so this morning, he brings to us his scholarly view of the issues around closing the gap, and what he is going to be talking about is "Closing the Gap Between Knowledge and Practice, the Treatment of Depression in Primary Care." So it is a great pleasure for me to introduce to you, Dr. Leon Eisenberg.

**CLOSING THE GAP BETWEEN KNOWLEDGE AND PRACTICE:  
THE TREATMENT OF DEPRESSION IN PRIMARY CARE**

**Leon Eisenberg, M.D.**

There is a very considerable gap between the knowledge gained from clinical psychiatric research and the application of that knowledge in the everyday world of general medical practice.

Although what we do not know in psychiatry and medicine far exceeds what we do know, there have been very considerable advances in our understanding of the psychobiology of mental disorders and of the way to treat those disorders. The new treatments in psychiatry have powerful effects in reducing symptoms and restoring personal effectiveness -- not for all patients, but for many, not always, but often, not forever, but for substantial periods of time. What should concern us is the fact that these treatments are not being delivered to many patients who can benefit from them. Why? What can be done about it?

Obviously, neither psychiatric nor general medical care is available to patients who lack access to doctors, that is, to those 38 million Americans without public or private insurance and with limited personal funds. The nation's failure to correct this inequity shames all of us. But that problem is not specific to mental health, though it is worse for psychiatric patients. All citizens have a responsibility to change national priorities in health care. Our concern here is with patients who do have access, who do consult physicians, but who still miss out on care for their mental symptoms.

The gap is found in doctors' offices all over the United States. Psychiatric disorders cause extensive suffering and functional impairment among the patients seen in general medical care. All too often, the source of the patient's complaints is not recognized by the primary care provider. When it is, and when treatment is recommended, such care as the patient is likely to receive is provided by that primary physician. Yet, despite the fact that depression and anxiety are the most common problems physicians encounter in the outpatient setting, they are poorly trained to diagnose and treat these disorders. Further, the way doctors are reimbursed by third party payers penalizes the conscientious practitioner who does take the time needed for appropriate clinical management. The result is predictable: underrecognition and ineffective care persists despite rigorous research showing that depression and anxiety can be treated effectively by drugs and psychotherapy.

What is the evidence for these claims?

Studies of the psychosocial problems of patients who attend primary care medical practices abound. They all find a substantial amount of psychiatric morbidity among patients who consult their family doctors; some patients present frank psychiatric symptoms; others present complaints for which no identifiable biological cause can be found; still others have symptoms which are out of proportion to their medical conditions. The percentage of diagnosable psychiatric disorder found in studies of general practice varies considerably. Some investigators cite rates as low as 11%, others as high as 36%; most reports fall somewhere in between (Schulberg and Burns 1988). The reason for such wide variance is an interesting methodological question in itself but not germane to this discussion.

Let us be conservative and work with the minimum estimate: 11%, even though it fails to include many patients with manifest psychiatric distress, patients whose symptoms do not fit the categories of the A.P.A. Diagnostic and Statistical Manual: DSM IIIR (Barrett et al. 1988). According to the U.S. National Center for Health Statistics (1991), there were 692 million visits to physicians' offices in 1989. If as few as 11% of those visits were for psychological difficulties, that would produce more than 75 million physician encounters! If the correct percentage is 36, then the number rises to 250 million visits.

Clearly then, psychiatric disorders in general medical practice account for an enormous number of medical consultations. Nonetheless, skeptics may ask: how many are "legitimate" visits to the doctor: that is, should these patients be dismissed as "the worried well," folks who should be encouraged to stay at home? That belief is widespread among the general public and among all too many physicians as well. Let us look at the facts. Depression among patients in primary care practice will serve as the index condition.

Kenneth Wells and his colleagues (1989) at the Rand Corporation evaluated some 11,000 outpatients enrolled in one of three health care systems: a health maintenance organization, a large multi-specialty group practice, or a small group practice at three different research sites: Boston, Chicago and Los Angeles. At intake, patients completed screening questionnaires designed to identify depressive disorders. Those whose response exceeded a cutoff value on the symptom scale were given a structured diagnostic interview by telephone, one designed to identify depression by DSM III criteria.

The characteristics of patients with current depressive disorder were contrasted with those of patients with one of eight other chronic conditions: hypertension, diabetes, advanced coronary artery disease, angina pectoris, arthritis, back problems, lung problems, or GI disorder. On comparisons of physical, social and role function and days in bed, the depressed patients were worse

off than the medical patients on 17 out of 24 pair-wise comparisons. Thus, the illness burden resulting from depression was comparable with, or worse than, that uniquely associated with other chronic medical conditions.

Although patients who met the rigorous official criteria for major depression were more disabled than those with depressive symptoms not severe enough to meet cut off scores, the symptomatic patients themselves had serious impairment in physical, social and role function, more so than most of the chronically ill patients except those with heart disease. Patients suffering from chronic medical conditions plus depressive showed additive effects.

Let us shift focus from patients attending their doctors to individuals in the community. The relation between depression and disability was examined by a research team from Duke which studied a representative community sample. Broadhead and his colleagues (1990) carried out a one year follow-up of 3,000 people who had been diagnosed as having either major or minor depressive disorder in their epidemiologic catchment area study. At follow-up, persons with major depression had a four and a half times greater risk of disability, and those with minor depression had a one and a half times greater risk, than did asymptomatic individuals in the community. Because of its greater prevalence, minor depression resulted in 50% more disability days than did major depression. The North Carolina study also noted the high frequency of co-morbidity between anxiety disorders and depression.

Time permits but one more example of the medical significance of the diagnosis of depression. Rovner et al (1991) examined 450 consecutive admissions to a nursing home. In the judgement of research psychiatrists, one in eight suffered from major depressive disorder; few were recognized, and still fewer treated by staff physicians. Within 12 months of admission, depressed patients were one and one half times as likely to have died as non-depressed patients carefully matched for the severity of other medical indicators.

So far, I have provided evidence for two points: first, that psychiatric problems are common, and generate tens, if not hundreds, of millions of outpatient visits; and second, that depression, often associated with anxiety, is a major source of suffering, of inability to function and of days lost to work.

Psychiatric disorder is common. It generates substantial morbidity. Is it recognized by primary care providers? This question has been addressed in a number of investigations. Estimates vary among studies because of the differences in criterion measures; rates for failure of detection have ranged from 45% to 90% (Schulberg and Burns 1988; Ormel et al. 1990). Precise estimates need not concern us. What is clear is the evidence that the diagnostic skills of many generalists are inadequate to the

task. Yet, general medical care is, de facto, the only operative mental health system for the majority of patients (Regier et al. 1978).

Reasons for non-recognition are not far to seek. One is the inadequate preparation provided by current medical education for the clinical practice of general medicine. The problem, however, is more than simply want of appropriate attention to psychosocial issues in the classroom. The formal content of the medical curriculum has less impact on the kind of physicians students become than the "hidden" curriculum, that is, the values implicitly embodied by what is not taught, as well as by what is, by the behaviors modelled by the faculty, and by the rewards and admonishments given to the students (Eisenberg 1980; 1988). Because medical education will be discussed by Bob Michels, I will say no more on the topic.

Patients themselves may have been socialized into becoming part of the problem by what is becoming normative for office practice. Patients consistently under-report personal distress to their physicians. In a primary care study in rural counties of California, Good and her colleagues (1987) found that only 20% to 30% of patients who had experienced emotional distress, family problems, behavior problems or sexual dysfunction reported those experiences to their primary care providers. It is as if doctors and patients have agreed that physical complaints are the only legitimate tickets of admissions to a doctor's office. Patients who are ready to say more, if encouraged to do so, often find their comments cut short by a doctor who is asking where the pain is and whether it is sharp or dull rather than being interested in the circumstances, personal and social, under which it occurs (Mishler 1984).

The reasons for under-recognition go beyond an inadequate medical curriculum and the etiquette of being a proper patient. Many primary care patients somatize their distress; that is, they experience physical discomfort rather than overt psychological symptoms. However, if their concerns are probed in a sensitive fashion, most patients will offer psychosocial attributions; that is, they will acknowledge that personal and family difficulties may have contributed to their medical complaints.

Unfortunately, some physicians unwittingly collude with patients in ignoring psychiatric problems. They harbor doubts that psychiatric disorders are "real" because there are no diagnostic laboratory tests and because the findings are not "objective" in the sense that an abnormal x-ray or an EKG is thought to be (Eisenberg 1988). For such physicians, a psychiatric diagnosis carries a stigma. They limit its use to chronic complainers who refuse to get better. Physicians with negative attitudes towards psychiatry are less likely to recognize depression and anxiety in their patients (Robbins and Kirmayer 1991). Some doctors are reluctant to discuss

a psychiatric diagnosis directly with somatizing patients lest those patients take umbrage and seek medical care elsewhere. Such patients do exist; they are used to rationalize the doctor's failure to be up front about psychiatric matters. However, it is as often the doctor as the patient who is unwilling to face the issues. Both doctor and patient are uncomfortable in discussing sensitive personal matters; exploring them takes time; time is at a premium. To be blunt about it, some doctors are themselves "somatizers"; to them, illness is "real" only when it is associated with verifiable organic pathology (Kirmayer 1988).

When the need for care is recognized, such treatment as the patient receives is most often supplied by primary care physicians rather than by mental health specialists (Regier et al 1978). What is the quality of that care?

Judged against established standards for the treatment of major depressive disorder (Potter et al 1991), the performance of generalists is woefully inadequate. Patients with recurrent unipolar depression are in need of long term treatment; they require relatively high doses of anti-depressants and show additional benefit when interpersonal psychotherapy is combined with drugs (Frank et al. 1990). In general medical practice, antidepressant drugs are often prescribed in homeopathic doses; courses of treatment are usually far too brief; problem-centered psychotherapy is rarely provided despite strong evidence that it is effective (Elkin et al 1989). Changing prevailing practice patterns is difficult (Shapiro et al 1987). Katon and his colleagues (1991) evaluated depressed medical patients under care in a well-regarded West Coast health maintenance organization; less than a third of the patients received adequate antidepressant treatment from their internists. Prescribing practices were not improved by providing psychiatric consultation to the physicians.

To summarize, psychiatric disorders are common and lead to significant morbidity; yet, they are under-recognized and they are under-treated in primary care practice.

Does the problem lie in the personal characteristics of primary care physicians or in the social characteristics of primary care practice? It is far more the latter than the former. Indeed, family physicians themselves lament the barriers to adequate care (Orleans et al 1985). What is it about primary care practice that brings this situation about, above and beyond the variation in competence of individual practitioners?

One problem is the unsuitability of the DSM IIIR categories for use with patients seen in general medical practice. Those categories were developed to describe patients who had passed through a series of screens before arriving at the psychiatric clinic. Goldberg and Gater (1991) have illustrated just how skewed that population sample is. They estimate that one in four of the patients

attending a British GP suffer from one of the common mental disorders: "becoming anxious, distressed or depressed." The GP recognizes only about 40% of that group; that is, he identifies 1 in 10 of his patients having psychosocial problems. Of that number, only 20%; that is, 2 out of 100 GP attenders are treated by mental health workers. Yet it is on that un-representative subsample that our classification scheme has been based.

Studies of psychiatric problems among primary patients before have a long tradition in the United Kingdom, where they were begun by Michael Shepherd (Shepherd et al 1959, Shepherd et al 1986); the findings from U.S. studies are remarkably similar. Barrett et al (1988) examined patients seen in general office practice and found that many of them simply do not fit into the specialist's nomenclature. Mixed states of depression and anxiety are common. He and his colleagues believed that there is a need of a "purpose-built" nosology so that general medical patients can be sorted out in a fashion useful for making treatment decisions.

A second quandary lies in evaluating the efficiency of the customary psychopharmacological treatments when they are applied to the primary care context. It is not at all clear that antidepressant drugs work as well for mild as they do for major depressions; Paykel and his colleagues (1988a, 1988b) found little additional benefit above that produced by placebo from the use of tricyclics for patients with mild depression. Surely, however major depression should be as responsive in the generalist's as in the specialist's patients. Think again. Antidepressant drugs usually take several weeks before they work; side effects may become prominent well before relief is obtained. Unless the patient is strongly motivated, she or he may become discouraged and discontinue taking medication before a full therapeutic dose has been applied.

The psychiatrist provides care to a small subset of patients who have remained after drop-outs during the referral process have weeded out poorly motivated patients. The psychiatrist's patients have accepted the diagnosis of depression and are eager for help. Unmotivated patients remain with the primary care physician; their poor compliance may contribute to his unsatisfactory prescribing record. That this may well be the case is suggested by Katon's (1991) study. Patients who had been given "first generation" antidepressants which have more side effects filled fewer renewal prescriptions than did patients given newer drugs reported to have more favorable side effect profiles.

This cannot, however, be the whole story. Using medication effectively, whether for diabetes or for depression, is based on much more than simply filling in a prescription blank. Explaining to the patient the nature of the problem, the pros and cons of the treatment options, the risks and relative significance of the several side effects, and the importance of active participation in

decision-making and follow-through are keys to the success of drug prescribing, a process for which psychiatrists are likely to have more skills than most generalists.

A third problem, and the one most difficult to remedy, lies in what might be called the "ecology" of primary care practice. Its economics are based on maximizing patient throughput because the payment per visit is relatively small, and certainly so in comparison to specialist fees. Physician/patient encounters last from 3 to 20 minutes at most and average 6 or 7 minutes. Office design and space management emphasize relatively rapid processing of patients.

Management strategies for patients with depression and anxiety are time and labor intensive. There are no short cuts in assessing psychiatric status. Adherence to antidepressive medications is bound to be poor unless there is a close working alliance between doctor and patient to monitor side effects and to provide reassurance when it is needed. Useful as antidepressants are, counseling methods such as interpersonal psychotherapy (Klerman & Weissman 1984) and cognitive behavior therapy (Beck et al 1979) are essential to enhance social function and to minimize recurrence. Psychological interventions are even more essential for the treatment of anxiety. Benzodiazepines are at best palliative; undue reliance on drugs for treating anxiety is associated with dependency and iatrogenic morbidity; these complications are particularly worrisome among elderly patients.

What is to be done in order to improve the care medical patients with psychosocial distress receive?

The answer does not lie in referral to mental health specialists; they are too few of us; we are clustered in cities; we are expensive. Any realistic hope of change must rest on improving the quality of care in the general medical sector. For this, no single solution will suffice (Schulberg and McClelland 1987). We will need to increase the knowledge of, and change attitudes toward, psychiatric disorders, to help generalists to improve their interviewing skills, to develop a range of practical therapeutic options, and reshape reimbursement schedules. We cannot assume that training schemes will work simply because they are intuitively sensible; rather, each potential intervention must be tightly coupled to an evaluation. What matters is whether the care delivered in day to day medical practice is better after the intervention, not whether or not the doctor can pass an examination at the completion of the training module.

With respect to knowledge acquisition, the NIMH has committed itself to a D/ART (Depression/Awareness Recognition and Treatment) campaign (Regier et al 1988). It employs educational programs to provide current information to those likely to encounter depressed people (teachers, ministers, case workers, concerned citizens) as

well as to primary care providers. This approach, valuable as it is for other purposes, is too broad to meet the needs of practitioners. Continuing medical education programs must be targeted to physicians in office practice; they must be scheduled so as to permit hands-on learning and periodic upgrading of diagnostic and therapeutic skills. Such programs should be evaluated by patient outcomes.

Attitude change is a major challenge. Knowledge, to the extent that it supplants ignorance, does modify attitudes; however, the student must be willing to listen. Doctors who sign up of their own volition for courses will be those who are most receptive. I suggest we postpone worrying about others until our educational programs have accommodated the volunteers. Their numbers will exceed our capacity for mounting training programs for some years to come. More than attitudes are at stake; aptitudes and dispositions matter as well. Not every physician is equipped to be, or is interested in becoming a psychotherapist. If he or she is to be competent, skills in diagnosis and case management are indispensable. More intensive patient counseling can be carried out by health workers attached to the practice: psychologists, social workers, and psychiatric nurses (Klerman et al 1987).

I have left for last the toughest conundrum of all: redesigning reimbursement schedules so that they reward rather than punish those physicians who take the time to provide psychosocially sensitive care, care as necessary for medical as it is for psychiatric patients. If I stress that depression produces as much suffering and disability as heart disease or diabetes, the same data argue with equal force for the severity of the distress and demoralization that accompany chronic medical diseases (Kleinman 1988). Measures to enable primary care physicians to apply psychosocial skills in daily practice will enhance care for all patients with chronic illnesses.

None of this will happen unless primary care practitioners are paid adequately for time devoted to counseling their patients. Obviously, logging time in provides no assurance that the time is well used. Mechanisms to assess the quality of psychosocial care provided will be essential. The challenge of quality assurance, may I remind you, applies throughout medical and surgical practice; it is not limited to psychological interventions. Reimbursing adequately for time will raise charges in the primary care sector, at least in the short term. Can the nation afford it? Can patients - and that category includes all of us at one time or the other - afford not to have it? Recognition and management of psychosocial problems do lead to cost offsets by reducing inappropriate use of other medical and surgical care (Regier et al 1982; Mumford et al 1984). In addition, fees for technical procedures can be scaled downwards as needed to fund primary care. What matters is that good patient care will diminish suffering by addressing the sources of distress.

Stating goals is easy. Thinking up ways to meet them is not much harder. The crunch lies in demonstrating in actual office practice that the intervention has brought us closer to our goal: namely, improving the quality of primary medical care. The undertaking is a formidable one, but few investments are more important (Schulberg 1990; Barrett 1991).

To add to its importance, we are on the threshold of adopting a national health program. The incongruity of having 38 million uninsured Americans and a like number underinsured, despite the highest per capita health expenditures in the world will force action within the next year or two.

With this rare opportunity at hand, it would be tragic to end up with a national health plan perpetuating existing barriers to mental health services. As mental health advocates, we must seize this moment to demand universal access to services for prevention, early diagnosis and treatment. We must deflate the myth that mental health services are too costly to be insured. Neglect is what cannot be afforded. Proposals for a national health program must be measured against a high quality standard for mental health care. On behalf of patients, we cannot accept less.

**Julius Richmond, M.D.**

Thank you very much, Leon, for that very stimulating, provocative presentation. We will have a panel to discuss the presentations later.

I am very pleased to introduce another very distinguished leader in the field of mental health and psychiatry, a person well known to all of us. He started out as I did getting medical education in the midwest in Chicago, and graduated from Northwestern University Medical School. He then wended his way East through the National Institute of Mental Health and training at Columbia and for many years was on the faculty there. His writings are scattered across a wide array of subjects in the field of research, education, training, and also more broadly in educating people for all of the health professions.

In 1974, the Cornell University School of Medicine recruited Dr. Michels to join the medical school and to chair the department of psychiatry, where he has had a distinguished career and (as we also have heard about Dr. Jeffrey Houpt of Emory) has moved from the chairmanship of the department of psychiatry to become the dean of the medical school. We all bask in that reflected glory, if glory it is to be a dean these days.

We do have the confidence these days that people that come from the field of psychiatry will bring some very much needed leadership to medical education and to educating people in the health professions. Now when a psychiatrist becomes a dean, he has certain unique kinds of responsibilities. This takes me back to

those halcyon days at Case Western Reserve when they were in the leadership of medical education and revolutionized the medical curriculum in the 1950's, the first shake up in medical education since the turn of the century. Dr. Douglas Bond, who was chairman of the department of psychiatry there, was asked to succeed Dr. Wearn, who was the architect of that revolution in medical education. After Doug Bond had moved into the Dean's office and had been there about six weeks, I encountered him at a meeting and I said, "Doug, is it very different from being the departmental chairman of psychiatry?" He thought for a minute and said, "No, it really isn't all that much different, it's just that all my patients now have tenure."

Bob has agreed to talk to us on something he is very committed to for these many years: "Educating Primary Health Care Professionals for Mental Health Care." So, Bob, I am just delighted to introduce you.

## EDUCATING PRIMARY HEALTH PROFESSIONALS FOR MENTAL HEALTH CARE

Robert Michels, M.D.

There are close to thirty million visits per year to office based physicians by patients diagnosed as having mental or substance abuse disorders (based on 1990 statistics). Two thirds of these are to specialist psychiatrists, the remainder are to non-psychiatric physicians. Therefore, a third of the patients diagnosed as having a mental illness or substance disorder are seen by non-psychiatrists. Because failure to diagnose is far more common among non-psychiatrists than among psychiatrists, most of the undiagnosed mentally ill, are found in the offices of non-psychiatric physicians.

Studies of primary care patients using standardized interviews report mental illness prevalence rates from 11% to 36%. In addition, a large number of patients without mental or substance abuse disorders present to physicians with emotional symptoms or distress, problems in living, or problems related to the psychosocial aspects of physical illness and treatment. Many primary care patients who are impaired by anxiety or depression do not satisfy the official diagnostic criteria of the APA for mental disorders--criteria largely developed by psychiatrists working in specialists treatment settings. Of the two billion dollars spent annually on drugs related to psychiatric problems, more than half is spent on the so-called minor tranquilizers, the majority of these have been prescribed by non-psychiatric physicians. Thus it is apparent that a considerable proportion of mental health services are provided by physicians who are not psychiatrists.

It is widely suspected that many, if not most, of these non-psychiatric physicians are not very good at delivering mental health care. They largely don't enjoy this part of their work, they try to avoid it; they are not well trained for it; they fail to recognize the appropriate indications for it; and they perform poorly when they do become involved. The reasons for this are many, and in my opinion, the basic reasons are probably not educational. However there is an educational component and it is this issue that I will address.

There are some 65,000 medical students in the United States. Each year, somewhat over 16,000 graduate and become physicians. That number was increasing for a while, but has been relatively stable in the last five years. Although there has been a significant increase in the number of physicians in recent years, and there is widespread recognition of a need for primary care physicians, a diminishing percentage of medical school graduates have selected careers in primary care fields. Their choices reflect their appraisal of the opportunities and drawbacks, the rewards and

punishments that have been structured into primary care careers. The settings and conditions of work are less attractive than in other types of medical practice. The professional status and intellectual appeal are lower (and those who have entered before report lower levels of job satisfaction). The financial rewards are lower, a particularly potent issue for the many medical school graduates who are heavily burdened by debt.

The problems of the financial rewards of primary care are particularly disturbing because students from those segments of our population that are undeserved, disadvantaged, minority groups or those of lower economic status whose natural career patterns would be to enter such communities to practice medicine, frequently graduate medical school with the largest debt and are very strongly pressured to select personal careers that will allow them to pay off that debt in a reasonable amount of time. This means they have to avoid primary care if they are going to preserve some possibility of achieving that goal. The result is that physicians tend to avoid primary care and, closer to our theme today, even those who do enter primary care try to narrow the scope of their clinical focus. Of the several ways of doing this, avoiding psychiatric issues is one of the more appealing ways. The status of the patients and their caretakers, the scientific basis of many of the interventions available to primary care physicians, and the economic rewards for the work make caring for psychiatric problems primary care's primary care!

However, even accepting that medical education may not be the major deterrent to high quality and appropriate attention to psychiatric problems in primary care, it is still part of the problem. Medical school applicants are selected and select themselves with greater emphasis on their talent in the biomedical sciences than the social and psychological disciplines that are relevant to managing psychiatric problems. This selection process reflects widespread attitudes about medical practice that are prevalent among the public and among health professionals, but not consistent with well established facts of clinical epidemiology or with the public health needs of the community. The selection criteria constitute the beginning of a socialization process that trains physicians to believe that dealing with psychosocial issues is not practicing medicine.

In spite of the systematic bias in the selection process, the students who enter our medical schools are superbly qualified, highly motivated, and responsive to the impact of their experiences with the curriculum and the culture of the medical school. These experiences exert a powerful influence, often further directing their subsequent professional interests away from primary care and particularly away from psychiatric services in primary care.

Two aspects of the curriculum illustrate how this happens. First, most medical education emphasizes mastering basic sciences and

pathophysiology, and then applying this knowledge to the diagnosis and treatment of diseases. Patients are valued to the extent that they contribute to the curriculum. The best patient has an "interesting" disease that illustrates basic biological mechanisms and for which a treatment exists that can be understood as interacting with these disease mechanisms. Patients who have problems that aren't diseases or that don't illustrate these mechanisms, or treatments that help people but don't work through the known pathophysiological pathways, are intrusions into the curriculum rather than educational opportunities. In recent years there has been a growth of interest in curricula that are designed around solving problems, including the problems of patients who don't fit the standard curriculum. The study of such patients can be an exciting and interesting intellectual task if it is identified as the task, rather than experienced as an intrusion or a burden in some other task. But it requires a redefinition of curricular goals and educational strategy, a redefinition that has been attempted in several studies and is only beginning to get underway in the nation's 126 medical schools.

The second aspect of curriculum involves the clinical settings in which medical education occurs. Most clinical encounters occur near the entry point into the health care system. The prototype would be the ambulatory care office of the primary care practitioner. Most medical education takes place at the center rather than the periphery of the system. The tertiary care hospital would be the prototype. The result is that students get relatively little exposure to the kinds of clinical problems that are screened out at the primary level, and therefore the psychiatric aspects of primary care are excluded.

Shifting from the curriculum to the socialization of medical students, the opportunity for identification with role models is one of the major mechanisms of professional socialization. There are four fundamental physician roles to which the typical student is exposed: the scientist, the primary care physician, the specialist physician, and the clinical consultant who does not provide direct care but participates by advising other physicians. In the typical U.S. medical school of 1991, the primary care physician has the lowest rank, the lowest status, the lowest income, and generally the least job satisfaction of these four. Although these are the major physician models with whom medical students identify, most medical students are not primarily concerned with becoming physicians. They may be impressed, even awed, by the skills of some physician models, but they feel far removed from achieving those skills. They are far more likely to identify with more senior medical students and particularly with the house staff residents. This means that these identifications occur with models who are junior physicians at the point in their career when they have the strongest negative attitudes towards the psychiatric problems of primary care. It is only after some clinical experience--post residency in most disciplines--that this

attitude begins to soften and change.

Turning from the medical curriculum in general to the psychiatric curriculum in particular, the pattern is a familiar one. The exciting scientific advances in contemporary psychiatry have occurred in our understanding of the neurobiologic mechanisms and pharmacologic treatment of the major mental disorders. These are more important to psychiatrists than to primary care physicians, although they do influence the primary care management of panic disorder and depression. In contrast, the outpatient management of non-psychotic disorders and of maladaptation to psychosocial stressors such as physical illness are of major importance in primary care medicine, but of relatively little interest to academic psychiatrists and receive relatively little attention in medical school curricula. Psychiatry departments, like other departments, are usually more oriented toward teaching the exciting scientific advances in their discipline and recruiting students for specialty training than in preparing them for the problems presented in primary care settings. The recent shift in American psychiatry from psychosocial to biological paradigms and from a primary focus on less severe to more severe mental illnesses has meant a shift away from the most common psychiatric problems of primary care. Psychiatrists, and non-psychiatric physicians, are more comfortable collaborating in the assessment of physical illnesses with psychological symptoms than psychological illnesses with physical symptoms. These create interesting professional challenges rather than unwelcome burdens on clinical practice. This makes them ideal for the beginning educational effort, but if the curriculum stops here, the problems of greatest public health significance are not even addressed. The major problems of primary care are not the patients who present diagnostic dilemmas because one type of etiology leads to another type of symptom; rather they are the far more common diagnostically simple, mixed physical and psychosocial syndromes subthreshold syndromes, too mild to meet specialist criteria, but not too mild to impair the patients' lives.

The education of primary care physicians who will have the attitudes, knowledge and skills that will encourage appropriate attention to the psychiatric concerns of their patients will require: (1) attention to the recruitment and selection of medical students, (2) a review of the implicit messages of the structure and organization of the curriculum, (3) consideration of the role models and socialization experiences of medical students, (4) attention to the content of psychiatric curriculum, and particularly to the balance between the so-called major psychiatric disorders and other disorders along with problems of psychiatric interest that are not disorders; (5) a review of the settings of clinical medical and psychiatric training, and (6) a curriculum that extends throughout medical education employs multiple formats, and recognizes the individual differences in needs and interests of future primary care practitioners.

It is also necessary to prepare for the increase in case finding that will result from such a curriculum, so the student will have an opportunity to see the value of detection and diagnosis in improved outcome, rather than confirm a prejudice that the system does not provide time to care for such problems and that as a result case finding leads to increased burden without benefit. Such a curriculum has an initial effect of decreasing efficiency, but with a delayed effect of improved outcomes and decreased professional burnout and demoralization. It will be viewed as a failure by educators who do not understand this pattern or by a system that demands immediate payback and considers only short term benefits.

If these educational changes are accompanied by appropriate developments in the career opportunities available for primary care practice, we should see more enthusiastic and competent attention paid to the psychiatric needs of primary care patients.

**Julius Richmond, M.D.**

Thank you very much, Bob. We have had two very stimulating presentations. If you would indulge me with a personal observation: when I went to medical school just prior to World War II, the potent diagnostic and therapeutic armamentaria that we now have were just not available. As medical students, when we went through the text book of medicine, we found that there were really only five specifics in terms of therapy if we disregard surgical therapies. We had insulin for diabetes, liver extract for pernicious anemia, the arsenicals and heavy metals for syphilis, quinine for malaria and digitalis for heart disease. Those were the specifics. We had to rely in that era on the art of medicine which meant interpersonal interactions with patients.

With the revolution in biology, which took off after World War II, we began to develop all of these very potent diagnostic and therapeutic tools, and all of those, of course, have resulted in much improved care. What I think what Dr. Eisenberg and Dr. Michels have been telling us is that we, however, haven't re-institutionalized the educational process. I think that is not an impossible task. There has been a fair amount of writing and thought given to that. I think it now remains for the leadership in the fields of education and training to act on those potentialities for reinstitutionalizing all of this in a more effective way.

We are running a bit behind time, but if we can take ten minutes for coffee we do have a panel discussion of these papers to follow.

#### **Coffee Break**

I would like to just take a moment to introduce another distinguished leader in the field of mental health and psychiatry, Dr. Roy Menninger. One could say a great deal about his

professional background. He is a graduate of the medical school of which Dr. Michels is now the dean, Cornell Medical School. I'm pleased to say that he had much of his psychiatric training in the Harvard affiliated institutions in Boston, and he then ultimately went back to Topeka, and is the President of the Menninger Foundation.

Now as a Midwesterner, I do want to take just a moment to pay tribute to the leadership that he and his predecessors have manifested in fostering improved programs of prevention and care for the mentally ill. He is part of a long tradition of remarkable leadership, leadership not alone in education, in training, and in patient care, but leadership in how we institutionalize the arrangements by which we do all of these in a very creative and effective way. I think it was a great stroke of genius that this family in Kansas saw the wisdom of developing this unique institution in the heartland of the country. That institution is indigenous to that part of the country, but it also provides services to people all over the world. I can't help but think of Adlai Stevenson, who came from another part of that heartland of America, and who was inclined to reflect that it is from that heartland that you look to the east and to the west, and that you see the nation with a remarkable perspective. I mention that because people who live on either coast, often don't have that very broad and very sensitive perspective on what the needs of people throughout the country are.

So, Roy, we are very delighted that you have agreed to chair this panel. So why don't we just proceed.

**Roy Menninger, M.D.**

Thank you, Julie. It has been a singular honor each year to have been a part of this remarkable conclave. I am repeatedly impressed with the exquisite success that Rosalynn has had in bringing together people who normally don't have much to do with each other, and might intentionally avoid one another if they could. Under her elegant and gentle manner, she brings us together to talk about things that we should have been talking about together many years ago. I am glad that we finally get to do it now.

Just a week or two ago, I noted with some interest on the evening news, at the time that the state of Washington was seriously considering a euthanasia proposal that was to go before the voters several days hence, a doctor was being interviewed about the risks for people who had permission to commit suicide. "What if they were depressed?" said the interviewer. "Oh," he said. "I see a lot of people with serious illness. I don't see many who are very depressed. And when I do, I think I could recognize them." In those few words, he summarized a great deal of what we have heard this morning. Here was the prospect of a major tragedy for those patients who are terminally ill, struggling with serious illness and major depression. To allow them, in a moment, a surge of

depressive feelings, to take their lives on the assumption that their physician would have spotted the depression and treated it illustrates the very gap we are talking about--the gap between the patients with the problems the physicians who are responsible but not prepared, not aware, not qualified, not trained and not sensitive.

I did note the strategy of the organization that put this program together. They had only one physician on the panel and asked him to be moderator, which implies that I am supposed to shut up! That will be hard for me to do. But it is indeed an opportunity for non-medical persons to speak to issues raised by the physicians, issues to do with the education and training of primary health care professionals.

The first of these speakers is a psychologist. Ray Fowler is Chief Executive Officer of the American Psychological Association, and former President. He is, in that sense, very well prepared to understand a vast and significant "non-system" of mental health services. I could spend moments, which we don't really have, to describe in more detail his qualifications, but let me rest with the primary identifications, Ray, and ask that you proceed from there.

**Raymond Fowler, Ph.D.**

I was very much impressed with the presentations of Dr. Eisenberg and Dr. Michels. I agree with their observations, but my only comment is that I don't believe they go far enough. Of course their task was to examine specifically the issues with respect to the gap between physical and mental health, in the medical and physical provision of health. But the same problems exist throughout the entire system.

In the 1960's and 1970's, as community psychology and community psychiatry began, a really powerful movement began which was reflected in many of the other related mental health disciplines. Gerald Kaplan at Harvard was a very powerful spokesperson for the community approach, which focused on the whole system as opposed to simply the one-to-one interaction between the sick person and the caregiver. The two concepts that were most essential in this community orientation were the concepts of the gatekeepers and the caregivers. The Rosalynn Carter Institute has focused, and much of our meeting here has focused on the caregiving aspects of the system.

Dr. Michels and Dr. Eisenberg are speaking to another aspect of the system, the gatekeeper: those individuals through whom all of the people come to get to the caregiver system. The gatekeeper system is perhaps in worse repair even than the caregiver system. Somehow, one way or another, we've pieced together ways of helping people although they are not always very efficient. One of the big problems is the traditional gatekeepers. The primary care

physicians, the teachers, and the religious leaders are, for a variety of reasons, not functioning very well in properly identifying individuals with problems, and getting them into the caregiver system. We know the problems with overburdened teachers, who are fighting for their own lives and survival sometimes, and for whom mental health issues must be far down the continuum. We also know that religious leaders have difficulties when people come to them with problems, and the problems of the primary care physician have been amply chronicled by both Dr. Eisenberg and Dr. Michels. They both may not recognize mental health problems.

In the few minutes I have, I would like to tell you about a breakdown in the gatekeeper system and how it affected my nephew. My nephew is a very fine young man. He is very bright, he seems to glow with health and good spirits, and he relates extraordinarily well with people - except from time to time when bipolar symptoms come on, at which times he is agitated, anxious, depressed, and very upset. At age 26, he was one of the youngest merchant ship captains in the whole country when these symptoms began coming on. He went to the company physician and said, "I'm having these symptoms." The physician said to him, "You don't want to talk to me then, because I'll have to turn you in. If you have symptoms like this, you can't be on a ship." So he said, "Well, what do I do?" He said, "Well, the next time we are in New Orleans, maybe you can find some help there." He went to a physician there, described his symptoms, and was loaded up on minor tranquilizers, to which he rapidly became addicted, the first addiction in his young life, because he has been a very healthy young man.

He finally got to a hospital, where he was put on lithium. He had unfortunate secondary affects from the lithium and he was told he shouldn't be having those symptoms which led him to feel ashamed and embarrassed, because his body had "let down his physician." It eventually came to my attention, living some distance away, and I managed to get him into the hands of a very fine physician in Washington, a psychiatrist there who got his medications regulated (a very complicated set of interacting medications), and he is now almost symptom free and doing very well. But it took him two and a half years to go through that process. Obviously, he has better connections than most citizens to get some help, but it was still difficult and time consuming for him to do so. Imagine how much more difficult it is for the average citizen in the community.

The problem is that in our health care system there is no safety net for people who have mental and emotional problems. To say we have a mental health system is an oxymoron. Our system is not healthy and it isn't even a system; it's a disorganized net, and it's made up of a strange mixture of people, many of whom lack knowledge, are not interested, and are not familiar with the stress and illness connection.

I see important advantages to the media program that Mrs. Carter is helping to organize. I also see a great need for a highly targeted information program for primary care physicians. We can't throw out the net so broadly that we neglect really focusing in on this very important gatekeeper population - the general care physician. What do we need to teach them? If all psychiatry department heads were like Dr. Eisenberg, and all Deans were like Dr. Michels, that problem would probably take care of itself. Unfortunately, that's not the case. What do we need to teach?

This is what we need to teach: that seven out of ten of the major causes of death have strong psychological and psychiatric factors. That there is an interaction between physical and mental health that makes it practically impossible to treat some physical ailments, unless one takes into account the mental ailments. That many or most visits to physicians probably have psychological implications because people whose psychological problems are not being met come over and over and over again, and thus burden the system. Dr. Michels spoke of some ways of approaching this: recruiting a different kind of medical student, curriculum changes, attention to more psychiatric and behavioral factors in the curriculum and a review of settings. I think it goes beyond that even.

Of course we have to look at our medical training and our continuing education. But beyond that, we have got to look at a modification of our compensation system. In the recent issue of Psychiatric Times, one psychiatrist, looking hopelessly at the compensation system said it would be far better for him if instead of seeing his patients for 50 minutes of therapy, he saw them each week for a 15 minute evaluation. His compensation level would be higher because of the dumb system that seeing people for treatment is far less compensated than diagnosing them.

I'm going to conclude because our time is so brief. I would like to comment, though, that of all of these factors, medical training, continuing medical education, modification of compensation, and the public policies are the critical ones. We have not had public policies that recognize the importance of early care, preventive care, and the importance of seeing these is not just humane, but cost beneficial to our society. Thank you.

**Roy Menninger, M.D.**

Our second panelist is one of the champion volunteers of this world. I think that Beverly Long has been involved in the mental health movement--well I know she doesn't go back as far as 1923 when Clifford Beers invented it, surely for a great many years she has been in there pitching. I speak not so much in reference to her youth, because she is eternally that, but to her many years of committed service that this woman has shown.

I first met her when I was a member of the Task Force on Prevention of the Mental Health Commission in the late 70's. She has, like a dog with a very juicy bone, (although I know she feels that it gets a bit dry at times), hung on to a concept of prevention as a central thrust in psychiatry and mental health. For her persistent dedication to promoting the importance of prevention, Beverly deserves a special tribute. In fact, I understand that the American Psychological Association gave you that tribute recently to acknowledge your efforts. An Atlanta native, she is here to share her perspective with us.

### Beverly Long

When there are television interviews, the person being interviewed is asked questions. Often, the guest answers with whatever it is he or she is promoting without answering the questions directly. Well, I have something that I need to say this morning, and I'm going to do something that I look down my nose at when other people do it. I'm going to take some excerpts from an earlier presentation which I think express basic issues, and are highly relevant to closing the health-mental health gap.

"Much of our tax money is being spent on health related problems. It is being spent illogically. That is, the expenditures do not logically relate to the sources of the health problems. The President's Commission on Mental Health reported that mental health problems were even more prevalent and more serious than had been recognized in the past. The Commission, which was headed by Mrs. Carter, found that mental health is still neglected as part of overall health, and despite progress that has taken us out of the "snakepits" into a more enlightened era, the lack of awareness, the discrimination, and the remaining stigma relating to mental health problems are almost beyond belief.

I want to convey to you, what in my view is the most basic and fundamental barrier standing in the way of obtaining our mental health goals: the barrier is the lack of recognition that mental health is a major part of health. A second concern is the degree of effort devoted to prevention of mental disabilities.

As a member of the President's Commission, I became more and more aware and more and more puzzled about a very basic question, an elementary question that is rarely asked, and remains unanswered. The question is, how much of health is mental health? The facts are available, but they go unacknowledged. I imagine every one in this room is convinced that mental health is basic to health. I expect you would find it difficult to believe that a person can be healthy and mentally unhealthy. But answer this for me; Is mental health a sub-category of physical health, like measles or nearsightedness or a broken leg? Or are mental and physical health equal parts of overall health? I submit that mental health and mental disability are as basic to, are as complex, and are as related with overall health, as are physical health and physical

disability.

I find it strange that the fundamental nature, that the complexity of physical health and physical disability is acknowledged and recognized, but somehow, the fundamental nature and the complexity of mental health and mental disability is not recognized. And further, despite an enormous amount of documented data which show the interrelationship between physical and mental health, there is very little acknowledgement of those facts when federal resources are allocated for mental health.

A basic trouble point in achieving our mental health goal is not after we start looking at mental health problems, but at the time when available resources are targeted for overall health needs. I am speaking specifically of the federal government. One role of the federal government is to allocate tax dollars effectively, that is, for the benefit of the American people. The fact is, our government is spending vast amounts of money, billions on health, and utilizes no process for allocating the money so as to deal with health problems in relation to the human and financial cost of the categories of disability. The tax money is being spent without a starting point, and without regard to what the health problems are. The decibel level of lobbyists for specific disabilities largely determines the level of allocation.

Well, how much of health is mental health? Of course there is no simple answer. Much of the cost of mental and emotional disability is hidden in general health costs. We do know that about 12% of overall health costs goes for the direct care of mentally ill. But at least half of the treatment for diagnosed mental health disabilities is identified and treated not by mental health specialists, but by primary care physicians. And many "physical" conditions are substantially related to stress and emotional components: ulcers, some headaches, some gastrointestinal disorders, hypertension, asthma, common cold, etc. We haven't mentioned the cost of drugs and the shocking proportion used for mental and emotional reasons.

So I say, that if a method can be found by which all the costs of the emotional and mental disabilities can be totaled, there is little doubt that at least half will come out on the mental and emotional side. Well, what is the federal government doing about it?"

That is the end of the old quote--You have probably recognized that that speech was made after President Carter's Mental Health Commission, the last time there has been an overview of the field. That was in the late 70's--fourteen years ago! At that time less than 6% of federal health dollars were allocated to alleviate and reduce all the problems of mental health, plus those of alcohol and drug dependencies. And even more astounding, at that time, of all the research monies allocated by the federal government, less than

4% went to mental health, and if alcohol and drugs were added, it went all the way up to 6%!

When I first started citing such figures, mental health had a power base in government, the Carters were in office. We'd just finished a Commission, and we were embarked on developing a blueprint that would have lent some coherency to the mental health field as it is involved with general health. However, when the Carters went home as we all too well know, all that went on the shelf.

But today, if we are serious about impacting policy decisions, if we really want to close the mental health-health gap, and if we feel that these problems are not being adequately addressed, at great human and financial cost, we must ensure that these issues are brought before policy makers. We must make our voices heard where the power exists for making changes.

Nineteen Ninety One, today, we have lost more than a decade in forward motion for comprehensive mental health. The field is fragmented with turf wars. Treatment services are pitted against medical research, psycho-social against biomedical, treatment against prevention, chronic long-term dysfunction against other serious mental emotional disabilities. The mentally disordered are still suffering gross discrimination and are stigmatized. A balanced approach to research, services and education does not exist; mental health receives far less resources and attention than is rational, and the interface with general health is often overlooked. None of this is a new story, especially in a bureaucratic setting, and it won't change overnight. Mental health and mental disorder together with the interrelationship with general health remains a neglected dimension of health. However, despite the lack of coordinated leadership at the national level, there have been tremendous advances in the mental health field in the last decade.

There has been significant involvement outside of government. The MacArthur Foundation came on the scene about 12 years ago, and interestingly, recognized the lack of comprehensive mental health leadership almost from the beginning. MacArthur is the nation's single largest supporter of research outside the federal government. By supporting mental health as a key element in improving health and the quality of life, The MacArthur Foundation, has helped to fill the gap.

I said I had something to say. My message is that the way our tax dollars are allocated to health must be changed to bring some reason and management into the process. Objective and scientific assessment of needs in the mental and physical health fields and the urgency of recognition of the interrelationship must be a priority. It is completely defensible, both from common sense and from scientifically grounded facts, to insist that more equity in allocation of resources be brought to research, prevention, and

treatment in the mental health field. We must join together and become a powerful constituency; we must stand up together and make our voices heard.

But we need tools such as this edition of TIME (holds up current edition of magazine dated November 25, 1991. The cover is very dramatic, a bright picture depicting the urgency of the health care crisis. Inside are graphics showing the growth of costs, etc.) They say there are ten ways to help the crisis in health. I say they need to add another one. They need to get some sort of process to use our tax dollars, to use them logically.

We need some graphics, some tools that help us to present the facts on the Hill, to law makers and tax allocators. What we need to do is get the picture out there.

I'll bet that if I asked those of you who are members of agencies and advocacy groups that have been developed in the last 10 or 12 years, at least half of you would raise your hand. There is a lot going on. But we need to join together, collaborate, and to get up there on the "Hill" and fight for our share of the health care dollars. Start with a bigger, fairer share of the pie - before we spend time guarding our particular turf. Let's convince our own legislators that they need to get their act in order. Thank you.

**Roy Menninger, M.D.**

Now you have gotten some idea of what a formidable force she really is! She won't listen to any old moderator, but there is a metaphor in that. She is a model of behavior the rest of us could well emulate.

Anchor man on this panel, in effect "Tail End Charlie," is actually "Tail End Joseph." Joseph Rogers is Assistant Executive Director of the Mental Health Association of Southeastern Pennsylvania. But that's only a small reason that he is here. He has been a consumer of mental health services. He was early on a denizen of one of the state hospitals in this country. He had his own difficulties as he emerged from that experience over the years that followed, but it brought him to realize what kinds of services for the mentally ill were needed and would make a difference. In particular it led to the organization of the mental health consumer organization titled Project SHARE, the Self Help and Advocacy Resource Exchange, which began in 1984. It has served as a model for ways in which those afflicted with a mental disorder can find the resources to be the eloquent spokesmen and the advocates that our field so desperately needs. He is truly an exemplar of advocacy and, in fact, this too has been publicly recognized. I had not realized when I made reference to Clifford Beers earlier that there was another reason to refer to him. Last year Joe received the National Clifford Beers Award, presented by the National Mental Health Association, as the most effective consumer advocate in the United States. We are honored to have you with us.

**Joseph Rogers**

I want to thank Mrs. Carter for putting on this Symposium. Either my wife or I have been coming here for seven years. I go to a lot of meetings and this is one of the few meetings at which I feel consumers and advocates really play a major role and are welcomed. Each year, Mrs. Carter has really made it a comfortable place for me and for members of my organization to be here.

In response to our speakers this morning, I was in some ways overwhelmed by the dynamics and culture of medical schools. I mean it was a little much for me. I am glad to hear about it; it has educated me. But what could I bring to that? One of the things that we do at Project SHARE and in other organizations, such as the National Mental Health Consumers' Association and the National Association of Psychiatric Survivors is to try to work from the other angle, which I think in some ways is more relevant to many of us here. That is, educate the people who utilize medical services to basically be better patients, more aware patients, more active patients, people who can be active in their own care. I am glad to hear the speakers this morning looking at ways that physicians can be more aware themselves and that is where we have to go with medical treatment.

There is, in my experience, a greater understanding in the physical area than in the psychiatric area that health care is a partnership; and unless a patient is made knowledgeable about their health care needs, all the work the physician does can go for naught.

One of the areas that we are participating in to educate ourselves to be better consumers of mental health services, and better advocates for better services, is through a program that is done by White Light Communications. Paul Dorfner, who is the president of that program, is here and will talk to you about it. It is a very exciting program where we are utilizing satellite downlinks and all sorts of technology to communicate amongst ourselves. We just had the first one of these video conferences, where I was told about ten thousand individuals were linked up through satellite.

One of the things we are doing at Project SHARE is working with developing groups of people who come together and speak about their long-term illness needs. We speak about the fact that what we are struggling with is a life-long struggle. The issues that we are dealing with are long-term, life-long issues; and we need to be knowledgeable, we need to understand, we need to have an approach that is aggressive in understanding and working with the health care professional. A lot of times, in self-help groups, we just sit and exchange information and knowledge about how we can confront the medical profession, when we are scared to go into a doctor's office and talk about our medical needs and our mental health needs.

Many times when I'm in a new area and I'm beginning a new relationship with a doctor, I'm hesitant to tell him that I'm a former mental patient because there is a lot of stigma associated. In fact, a study done by The Robert Wood Johnson Foundation on the NIMBY (Not In My Back Yard) population actually identified that the worst "NIMBYs" in the world are doctors and people that have a lot of education. They are the worst ones in responding to this question of not wanting people in their back yards who have mental health problems. So, when I sit down with a doctor, I sit down with some feelings of fear. But I do end up talking to the doctor because I'm on all sorts of psychotropic medication and I need to share that information. So I find myself in the role many, many times of educating a doctor as to why, for example, I am on Tegretol for manic depression. Well, that's a relatively new treatment for manic depression, so I'm sitting there explaining to the doctor why I am not on lithium and why I am on Tegretol and maybe I will bring in the literature the next time I come in so he can understand this new approach to manic depression. I think that is something that we need to do more with people. Many of you are in mental health associations and health clinics, and it is important to work with developing self-help groups so that we can be active in our own care.

As a recovering alcoholic and drug addict in addition to being a mental patient, I add in bisexual so I really get three strikes and I'm out. We also are afraid of dealing with doctors because of the "pill" pushing that goes on. Many, many times, in group after group that I sit in, in Alcoholics Anonymous and Narcotics Anonymous, I hear that the people got started on their addictive disorder from prescription medication. If we can do something to roll that back, I think we will be going a long way. And anything medical schools can do to make doctors more aware of this fact will help. Thank you so much.

**Roy Menninger, M.D.**

At the risk of stealing two more minutes from the panel that follows, let me conclude with this observation. It's very hard to hear the description of a problem as we have heard so eloquently today without feeling the painful mixture of helplessness, annoyance, and distress as if somehow the diagnostician should be the therapist as well. I think one has to look a little further though, and to recognize that perhaps for those of you who are not physicians and are not directly related to the issues described, you have at least gained a modicum of understanding of how complex the problem is--that it is not simply ascribable to having bad personality or to the fact "he got out on the wrong side of the bed in the morning," if your physician is not functioning as adequately as you might wish.

I think, however, there's a more important message. Mental health has no clear constituency because so many of us are involved and are both users and providers. Further contributing to our limited

effectiveness as advocates is the extent to which we have been so badly splintered. Perhaps that reflects prevailing stigma, but it also reflects a curious particularization of the field in which each of us does his own thing, convinced that we are the only ones in the world who are struggling with the problem, and disturbingly resistant or even antagonistic to sharing a larger and more inclusive perspective.

If we do nothing more than to recognize that this is part of the problem, it can begin a process for an integration of these many pieces of this very complicated field. We not only have been part of the collective problem, we must be part of the collective solution. And to that end, may I conclude as I began with a special thanks to you, Rosalynn, for having made it all happen.

**Julius Richmond, M.D.**

We now come into the portion of the program in which we are going to be focusing on something Mrs. Carter talked about earlier, and that is some of the developments in relationship to the Carter Center Task Force on Mental Health. In order to put that into context, we ask Dr. William Foege, who is the Executive Director of the Carter Center to present us with a brief overview of some of the developments here at the Carter Center, the programmatic issues which it has tackled, so that we can see the Task Force on Mental Health in it's complex of activities. And I say complex of activities very advisedly; you'll soon recognize that it is indeed, so.

I can't help but make a very personal observation, that I was very delighted when President and Mrs. Carter announced that Bill Foege would serve as the Executive Director of the Carter Center. When I went to Washington to be the Assistant Secretary and Surgeon General in 1977 during the Carter Administration, I had the great privilege of interacting with Bill Foege who was then the Director of the Centers For Disease Control. What I learned quickly was that he personifies the best attributes for leadership that one would want to see.

Let me just make a couple of comments about creative ventures he has been involved in. He was one of the young physicians who was recruited by the World Health Organization when it made the commitment for a momentous public health campaign in the late 1960's, when the judgement was made that we had the knowledge base and we could develop the social strategy to eradicate Smallpox from the world. His colleague, Dr. D.A. Henderson (who directed the program) and he consulted their various members about whether they ought to undertake this task, and their mentors tended to discourage them and tell them that it probably was an impossible job. I like to, in talking to students about creativity, tell them that D.A. Henderson and Bill Foege took the job because they were too young to know it couldn't be done. They set out to do it. The charge was to do it in ten years, and they fulfilled that

commitment.

During the course of this, a very creative idea developed in that group, and I just wanted to mention it. As they went along with a program which started out to vaccinate everybody in the world, it suddenly occurred to some of them that since we were down to about 31 endemic areas of smallpox in the world, maybe we didn't need to vaccinate everybody in the world, that one could go to a containment strategy and circumscribe each outbreak as it developed. That turned out to be the clue; that, I think, was why it was possible to achieve that task within a ten year period.

I had the great privilege to lead our delegation to the World Health Assembly in 1980 when the World Health Organization pronounced that smallpox had been eradicated from the world. This was one of the great achievements of mankind, and due in no small measure to the creativity of D.A. Henderson, Bill Foege, and their other colleagues.

When I got to Washington, we were facing a situation in which there were 50,000 cases of measles in the United States in spite of the fact we had an effective vaccine. We put our heads together with those of Mrs. Carter and Mrs. Betty Bumpers, (the wife of Senator Bumpers) to develop a campaign to immunize all of the children of the United States, and thereby to bring those rates down. After all, that is a preventable disease. Bill Foege led his staff at the CDC to accept this responsibility. I must say, great resistance was encountered as we contemplated taking on this task. Bill talked with his colleagues at CDC, and the anxiety was that if we establish the goal of eradicating measles from the United States, we might fail. But, Bill, with characteristic courage said, "But we are going to do it." We set the target of immunizing 90% of the school children of the United States within two years, and Bill's colleagues and he completed that job in eighteen months. By 1983, we had virtually no measles, we were down to about 1500 recorded cases of measles in the country. Unfortunately, as we know, if one doesn't maintain those programs, if one is not vigilant, we can see a resurgence, and that, unfortunately, is what we have been seeing. We have again mobilized Mrs. Carter in an immunization campaign even though she doesn't have any direct public responsibility for it, but she has again gone back in the harness in developing a new immunization campaign labeled "Every Child by Two."

Bill has manifested the same energy and creativity in the development of programs here, and President Carter said to some of us last evening that there are something like 26 health programs here under the auspices of the Carter Center. Bill manages these with great equanimity, and resourcefulness and as I have said, creativity, and so Bill, would you take a few minutes to tell us about the Carter Center's programs.

**William Foege, M.D.**

Thank you Dr. Richmond. I'm proud to be one of a large army of students that sees Dr. Richmond as a mentor. Indeed, the story he was telling on immunization is directly related to what we are doing today. We actually reached one week with no reported case of measles in the United States. Because of this, in 1984, Jonas Salk and Robert McNamara went to the Rockefeller Foundation and asked if they would have a meeting to look at the question, "Could we apply the same techniques globally that were applied domestically?" This resulted in a task force being formed, and the task force really was a way for the U.N. agencies to meet every three months and look at their plans, to look at their objectives, to ask how they could work together, how they could motivate people, and this task force then became located here at the Carter Center. It's called The Task Force for Child Survival.

I remember Robert McNamara in 1984 saying, "If we could only raise \$100,000,000 a year for global immunization, we would change everything." People told him there was no way to raise that amount of money, the world was in a recession, it was not going to happen. But the fact that there was a task force gave the donors some confidence, and the fact that there was a global plan gave them confidence, and within two years, we were raising \$100,000,000 a year, and then \$200,000,000 a year and then \$300,000,000 a year and now \$350,000,000 million a year. The government of Italy alone gave \$100,000,000 for immunization in Africa, and Rotary International raised \$230,000,000 for polio. What is the result? Well, in six years, the immunization levels in the world went from less than 20 percent to over 80 percent. And six weeks ago, the United Nations had a ceremony where the Director of UNICEF, and the Director of the World Health Organization certified that 80 percent of children had been reached, and President Carter was a featured speaker at that ceremony. So, in essence, what happened was that there was a small secretariat, a task force, and then a way of communicating with the field in both directions. In one direction, a World Immunization News bulletin goes out to 15,000 people around the world to let them know where the immunization program is.

Well, John Jacques Rousseau in 1762 wrote, "Half of all children will die before their eighth birthday." He said, "This is nature's law, do not try to contradict it." We contradict it every day. And I think one of the foundation stones of programs at the Carter Center turns out to be that this is not a fatalistic world, that things can be changed. Because this first Task Force for Child Survival worked well, we formed other task forces. When the Merck Drug company realized that a drug that they had produced for heartworm in dogs - and some of you, undoubtedly have heard of Heartgard - it was a breakthrough, because instead of having to treat your dog once a day, you can now give medicine once a month. They realized in the 1980's that this drug, without any change (although you change the flavor so that it is not a meat flavored pill), could prevent blindness in humans who have onchocerciasis.

There are hundreds of thousands of people blind in the world, particularly in Africa, because of onchocerciasis. In humans, it is even more of a miracle drug because you only have to give it once a year. They came to us and asked if we could develop a program to see that it would get distributed to the right people, but would not get diverted to the veterinary market. We formed the equivalent of a task force, which will meet at the Carter Center next week again, the Mectizan Expert Committee, and with a small secretariat we have managed to treat over three million people in 24 countries, and we are aiming to get to six million a year.

We also formed a Task Force on Disease Eradication in the same way. A small secretariat and task force to look at what other diseases could follow smallpox, which was eradicated in 1977. We are now looking at Guinea Worm, which some of you will know from the Old Testament. It was one of the plagues of Egypt called the "Fiery Serpent," and the intent is to have Guinea Worm be the second disease eliminated from the world, and our goal is to do that within five years. We are also working through the Task Force for Child Survival at polio eradication. The last known case in this hemisphere was in April of this year. We have now gone six months without a case, and we are aiming for global eradication within ten years.

We have now formed a Task Force for Reforestation, and again, we are using the same model of a small secretariat and a task force. And, of course, some of you have been hearing about The Atlanta Project, and that has a secretariat and an advisory group that is like a task force. I won't go into all of the other programs, in agriculture, and conflict resolution, and human rights and Middle East peace and so forth, but the model has worked, and now we are trying it with mental health. Will it work? We can't be sure of that, but there is no reason that it shouldn't because the Task Force concept has allowed people to build effective networks. It has allowed coalitions, and it's allowed a way of doing this without being formal.

At our last meeting of the Task Force for Child Survival, it was pointed out that the great change in immunization took place without a single legal document. Now there's a lesson there. And that we did not even have a memo of understanding between WHO and UNICEF and World Bank and UNDP. So now, we would like to see the same thing happen with mental health.

In closing, let me mention one story. My wife teaches four year old children, and once a year I go to her class and put on a white coat and take a stethoscope and otoscope and so forth, and let children try using these instruments. This last spring, a four year old girl asked me a question that took me totally by surprise, and I said to myself "I'd sure like to follow her career.." She asked me, "Do doctors have bosses?" What I said to her is, "If they are good doctors, they do; the patients are the bosses." The

reason I bring this up is, this Task Force will not be the boss of anybody. In fact, if it is done right, it will be a servant, as it seeks equality, it will really mean that everyone is the boss of this task force. Thank you.

**Rosalynn Carter, Chairperson**

Thank you, Dr. Foege. We are fortunate to have Dr. Foege as The Executive Director of the Carter Center. One other thing that Julius didn't tell you, which tells a lot about Dr. Foege, is that he started his career as a Lutheran medical missionary to Biafra. He has been in public health, and I think he is the world's leading authority on prevention.

Since we are behind time, I am going to introduce to you the panel of Task Force members. To just repeat what Dr. Foege said, the Mental Health Task Force will need the input of everybody here. We want to develop some priorities and agendas for the 90's, and this is what we wrote down in our meeting: Build consensus on goals, generate action agendas, mobilize diverse constituencies, and mount specific initiatives to reduce stigma and improve mental health research and services in the 1990's. That's a tall order, and I am going to need the help of all of you. I look forward to working with you, and including you when we come upon specific issues.

We have had two meetings. I want to recognize Denis Prager and Laurie Garduque; they are both here, they are from the MacArthur Foundation. Thank you again, the MacArthur Foundation, for making this Task Force possible. John Hardman, you have met. He is the Director of the program here at the Carter Center. Dr. Julius Richmond is our Visiting Fellow to the Carter Center. We consider him the "Guardian Angel," the source of ideas, and the anchor of the Carter Center Task Force on Mental Health. I will name the members of the Task Force and recognize the ones that are here.

The other thing that I wanted to tell you before I get into that though, is that the blindness Dr. Foege was talking about is river blindness. Maybe you all knew that, I didn't know the scientific name for it until we started working on it.

One of the members of the Task Force is Dr. Johnnetta Cole. She is the President of Spelman College, and the first African American woman to head this historically black college for women. She has done some great things since she has been there. One of the programs that she has instituted is a student-volunteer outreach program into the Atlanta community. Forty percent of the young women at Spelman now volunteer in the community, some with our Atlanta Project. She was here yesterday.

Dr. Jane Delgado is the President, and Chief Executive Officer of the National Coalition of Hispanic Health and Human Service Organizations. She has a constituency as you can tell, and she

will be active with us.

Dr. Leon Eisenberg, you have heard this morning. He is a child psychiatrist and is a Professor in the Department of Social Medicine and in the Department of Psychiatry at Harvard University. He has taught Psychiatry at both Johns Hopkins and Harvard Medical School, and founded the Department of Social Medicine at Harvard in the 1980's. Dr. Eisenberg is on the platform.

Governor Bob Ray. Everything we do at the Carter Center is bipartisan or nonpartisan. We always have, with any kind of conference or study or project that we undertake, a major Republican involved with us in the meetings. Governor Bob Ray was Governor. He is the only Chief Executive in the state's history, in Iowa to be elected to five terms. I think that is almost a record in the history of our country. He served, (you can figure this up) five terms and he served 14 years. They must have changed the length of terms is all I can figure out. He is not only a Governor who can understand and bring us the input from the State's position, but he is also the President of Blue Cross & Blue Shield in Iowa at this time. He was with us yesterday.

Leslie Scallet is Executive Director and founder of the Mental Health Policy Resource Center in Washington, and she is with us today. The Center analyzes issues and trends, sponsors meetings and workshops and collaborates with organizations in mental health and other fields to improve knowledge and improve consensus about mental health issues. She does a wonderful job. If we need any kind of information, it is there. You all might keep her in mind. I don't know whether I am giving her extra work or not, but I think that is what she is there for: to furnish you with information about issues in the mental health field, and she can do that.

Bill Woodside is a businessman. He was coming, but he has the flu and couldn't be with us today. He is Chairman of Sky Chefs, Inc., and former CEO of American Can Company, and he has a commitment to education and family. Not only is he a businessman, but he has served and worked with these interests during his whole career. He served on the Institute for Educational Leadership, The National Forum on the Future of Children and Their Families, Public Education Fund Network, and so forth. He is very helpful to us for business orientation.

Joanne Woodward, you all know, is an actress and director in the theater, in television and motion pictures. Her recent projects include the role of Amanda in the theater production of *The Glass Menagerie*, and her latest films include *The Glass Menagerie* and *Mr. and Mrs. Bridge*. She has also just completed her B.A. degree at Sarah Lawrence College. In addition to her professional work, she serves on the National Advisory Council for Alzheimer's Disease and Related Disorders Association, The AIDS Medical Foundation, and the Council for Save the Children. She has been very helpful to us.

Ex-Officio members: these are the people that I have worked with on mental health issues for years, and we had to have them on the Task Force because they have just been so close to me and helped me so much.

Dr. Tom Bryant, you have already met, is the Chairman of The Non-Profit Management Associations, Inc., in Washington, D.C., and he was the Chairman of the President's Commission on Mental Health. You probably knew that from the years past because he has been here every year, and most of you have known Tom for a long time.

Kathy Cade is Vice President and a Senior Investment Banker at the Bank of Boston, where she is responsible for managing account relationships with housing and health educational financing authorities throughout New England. Kathy was my project secretary in the White House. We had many projects, and I had one secretary and I think she had one staff person. So Kathy and Tom and I really had a lot of work to do. She is active in a number of non-profit organizations, and currently serves as President of the Board of Trustees of Crittenden Hastings House, a provider of comprehensive services to pregnant and parenting teenagers in Boston. This is just an aside, but she worked with me on mental health programs all of those years and was looking for a place to live in Boston. The real estate woman who took her to look at the apartment she now lives in said that there was only one drawback to it. It had a group home for mentally ill children next door! I don't know how many communities we have worked with to get group homes established.

Dr. Jeffrey Houpt is Dean of the School of Medicine at Emory University, and he was the head of the Department of Psychiatry. I think you all are familiar with him, because he has been working with us on the Symposia every year.

The other ex-officio member is Dr. Toni Novello, the Surgeon General of the United States, who couldn't be with us today. She is meeting with the Pope in Rome. She has agreed to work with us so that will be very helpful.

Dr. Richmond is going to be the Moderator of this panel and he will give you the instructions from now.

**Julius Richmond, M.D.**

I think the audience ought to know that before Mrs. Carter began to work in mental health, she was as tall as Bill Foege. The Task Force Members and Mrs. Carter thought it might be well to try to provide you with some of our preliminary thinking. As Bill Foege has indicated, the Task Force has a complex kind of job before it: to map the terrain in the field of mental health with all of the complexity that these symposia over the seven years have suggested, and certainly from what we have heard during the course of the morning from our speakers and the panel.

It's really a hazard when one tries to interpret to a group, what the deliberations of our Task Force have been, because as you might imagine, our discussions have ranged very, very broadly. I couldn't help but think as I was walking up here with the responsibility in relatively few minutes to give you that interpretation of the story of a chairman who was moderating a meeting, in which the plenary sessions split up into sub-groups and the sub-groups came back together, and the recorder for each of the groups was asked to give a presentation. The recorder for the first group concluded his presentation, the chairman of the plenary session said "Well, that's very interesting. Is there a minority report?" and somebody popped up and said "Yes, Mr. Chairman, there is a minority report and you've just heard it." So I will try to reflect accurately on what the group has done.

First, I want to, on behalf of our Task Force members, express thanks both to Mrs. Carter and to the President and the Staff of the John D. and Catherine T. MacArthur Foundation for their leadership. The kind of leadership the President and the staff of the MacArthur Foundation have manifested across the country in stimulating research and improved programs in mental health is very important to the nation, particularly at a time when public support for various programs has been dwindling. We are still in the planning stage as you have heard from Mrs. Carter. We have had two meetings; the last one was yesterday. We are early enough in our deliberations, that we would like to invite you to communicate with the Task Force and the Carter Center Secretariat any thoughts that you have about how Mrs. Carter and the resources at the Carter Center can be utilized most effectively in fostering programs to advance prevention and the care of people with mental illness.

In this large group we are not going to really be in a position to invite you to share actively, but in the smaller groups this afternoon it will be feasible. I think the Task Force members were very mindful, as we met yesterday, of the rich history of the seven symposia, and the rich mix of people that were brought together and the organizations represented.

One of the areas that the Task Force has explored, relates to the matter of primary prevention, particularly in relationship to young children. We hope that as we develop our thinking about this, that there might be some usefulness of our suggestions for the emerging Atlanta Project. Of course we recognize that the Atlanta Project has a planning process of it's own, and it will be developing notions of it's own.

What we focused on, was the fact that the 1990's aren't the 1960's. We have a knowledge base about early child development that tells us a lot about prevention and early detection of disorders and particularly fostering optimal development in young children. What I am suggesting in terms of that knowledge base is that we now know that children do not develop learning capacity and learning skills

if they are in environments lacking in stimulation. Furthermore, as we have learned more about the social environment in which children thrive, we have also learned much more about how to evaluate programs that we have developed, the so-called intervention programs, of which Head Start, (of which I was fortunate to have been the first director). We have learned what kinds of impacts these interventions have. The evaluations seem to point in a positive direction.

Now that body of knowledge has been picked up by the governors of the country. You may recall when President Bush convened the Governors in 1989 in an unprecedented Governor's Conference on Education, the Governors focused on having children come to school prepared to learn. And subsequent to that Charlottesville meeting, Governors started to shape the health goals much as Dr. McGinnis has done for the public health service. They started to shape educational goals that would be the counterpart of the health goal of the nation. The first goal they have identified is having every child coming to school ready to learn. Now that's a tall order in a country as diverse as ours. We will be working toward this objective.

The timing seems to be right. The recent Rockefeller Commission Report, observes how children are faring in the nation and makes a number of suggestions in a comprehensive way. If you haven't seen that report, it is entitled "Beyond Rhetoric," a very valuable report that outlines the universe of needs which children are experiencing. So with reports like that upon which we can build, and with the knowledge base that we have, we hope that we can move toward the development of universal access on the part of those children in need for Head Start Programs and other early comprehensive child care programs.

As you have already heard, there are other areas on which we have begun to focus building on Mrs. Carter's long term interest in improving programs for the mentally ill. We hope that the new support will reinforce her efforts at reducing stigma. We know that she is the person who has done more than anyone in the world to work publicly at the reduction of the impact of stigma associated with mental illness. She has a "media initiative" going already, but I think we anticipate that there will be more intensive work with the media over time.

The other area that we certainly need your help with is the exploration of what kind of a mental health service system we really want to see in this nation, as we are more actively thinking of reshaping the system. The Mental Health Systems Act never was really implemented. That Act resulted from the work of President Carter's Commission on Mental Health of which Mrs. Carter was the Honorary Chairperson. Our system, as Ray Fowler so appropriately indicated, is kind of a "non-system." It is certainly in disarray. There has been a preoccupation with financing and in the process,

many State Departments of Mental Health no longer have the capacities they once had to carry on their work.

We want to consult widely with people in the public sector, like state commissioners of health, local commissioners of health, and legislators who have responsibility for their committees that deal with mental health issues. We also want input from the private sector. Since we have had the emergence of much more private activities in the delivery of services, this is extremely important.

I would also comment on what has been mentioned before, the National Health Care proposals that are emerging. I would direct your attention to the fact that there are now 30 bills in Congress. The perception of crisis across the country is now such that state legislators are catching on and introducing legislation. We think that in collaboration with other groups, like the various professional associations, we can try to identify what ought to be the generic criteria by which we ought set to judge national health programs. As speakers earlier today have indicated, certainly we want all of these programs to implement an equitable distribution of services. People who have mental health problems are just as entitled to the financing of those services, and just as entitled to appropriate systems for their care, as are people with other kinds of illness. It seems to me we cannot afford, as Dr. Eisenberg indicated, to do less.

Another area that Mrs. Carter has commented on is the issue of caregiving. As we deinstitutionalized patients across the country and the mentally ill are living predominantly in the community, the family members and other caregivers have had relatively little by way of organized programs of training. They have very little opportunities to share experiences and very little by way of respite care opportunities. All of these things together are being dealt with in the Rosalynn Carter Institute at Georgia Southwestern College as you heard earlier. How can we enhance the development of that program, which is being piloted on a regional basis? Can the learned experience from this program be brought to a broader audience and to greater fruition in the service of helping caregivers, particularly the family members who are caregivers?

Lastly, I would just comment on our focusing on the kinds of issues where there are unique opportunities to make some impact, and to relieve the burden of illness on individuals, on families, and certainly on the nation. We've talked about how one can take some of the notions that Dr. Eisenberg was presenting today about depressive constellations, and how we could foster the development of improved programs. Should there be better efforts at educating the public, and improved in-service training for health professionals of all kinds? Some of each of these we will be exploring. Just as we talked about a preventive program for the young, it's very clear that we need to pay more attention to our

older Americans. We need to think along with the caregivers programs, of other unique opportunities that may present themselves, to do improved programs for the elderly. These are some of the thoughts our Task Force members have had. Again we invite your suggestions as the Carter Center Mental Health Program evolves.

**Rosalynn Carter, Chairperson**

It is my pleasure to introduce Dr. Jeffrey Houpt, Dean of Emory University Medical School.

**Jeffrey Houpt, M.D.**

Thank you very much, Mrs. Carter. It's a pleasure to be here, and a pleasure to participate in this Symposium, as it has been in the previous six. This one is particularly interesting to me because my introduction to Mrs. Carter occurred at a time when I was called on, along with some other people, to write a background paper for the President's Commission. Our background paper was on the importance of mental health services for general health care. That basically, kind of cemented my role in psychiatry, where my primary responsibility was providing psychiatry services to the other medical services and teaching other physicians about mental health issues. And so, we have come full circle at this time for me to talk about that subject.

The time is late, and I won't say too much. I think what I want to do is emphasize how big the issues are before us. Both Dr. Eisenberg and Dr. Michels provided us with splendid papers. They were comprehensive. Even in the short period of time allotted them, I couldn't come up with new issues to be considered. But I do want to emphasize a few points, and maybe come at it in a different way.

When I was a psychiatry resident, I learned that behavior, even if maladaptive, exists for a purpose. I would suggest to all of us, that if we are viewing the system as maladaptive, (which is what we said this morning), that it's maladaptive for a purpose. It would be wise for us to try to understand why this system is the way it is before we attempt to try to make some changes.

Further, it's always wise politically to try to understand why it is people are holding views so strongly. The first is, that as a country, and I think even in this group, that mental events are not valued to the same degree as physical events. Broken thoughts are not equal to broken bones. We are guilty of this. We rush to embrace the biological correlates of abnormal behavior and make assumptions about etiology when relationships have not yet been worked out in many instances. What we are talking about today is trying to get some equity into the system, so that mental events are treated on a par with physical events. It's going to be difficult because it's not part of our belief system. In fact, you could review the entire history of Western civilization and the

history of philosophy and you would find that there isn't anybody who has come to some sort of satisfactory agreement. That's why we have so many schools of philosophic thought about how mind and body interact, and how we know what is real is really real. So we have that as a major problem before us as I see it.

The second resistance has to do with cost and reimbursement. We are currently on the bandwagon about cost and reimbursement; it's popular now. Governor Ray, who is now CEO of Blue Cross in Iowa, told us yesterday that if you provide employees a smorgasbord of benefits: mental, dental, and eyes, they always pick eyes and dental over mental. So when we are in an economy as we are at this time, and we are concerned about costs at this time, we don't have a lot of people on our side charging the "Hill" saying; "Lets get some expanded coverage for mental benefits." We choose our eyes and teeth over our head. We need to be aware of that so when Dr. Eisenberg tells us that he's discovered 75 million more encounters, you can see people running to the hills, and saying "Please, don't open Pandora's Box." He actually goes beyond that. He says not only are there 75 million more encounters, they have to be paid for in some way.

He says we have a whole category that don't reach DSM-IIIIR criteria that we haven't even taken into consideration - so we have a major problem. Now the news is not all bad in this regard. Governor Ray also told us yesterday that employees assistance programs like the one with GM has proved cost beneficial. To the degree we can get the cost beneficial message out, I think we will be more successful in taking our message to legislators.

Dr. Michels raised a very important issue, namely that we have a dwindling supply of people interested in going into primary care. The whole issue of educating these people to take care of mental health needs becomes moot if there are no primary care physicians. He made that point well. We have an interesting society where we feel people are permitted free choice. We have always permitted medical students to choose the specialty of their choice. We have never assigned them to a specialty.

I don't know how all other countries do it but I had the opportunity to visit France a couple of weeks ago. Do you know how they handle the issue of primary care physicians and supplies in France? First of all, their medical school is six years long. After the fourth year, you take a test. If you score in the bottom half of the class, you go into general practice. If you score in the upper half of the class, you choose to study specialties. I just raised the issue of free choice. Incentives might not be enough to drive the system in the United States. That's a major problem for us because alternative systems with quotas contradict all that we believe in.

Dr. Eisenberg reminded us that the proper venue for these activities is in the general health sector and I believe in that. I do think there is a possibility that in the next decade we'll see more health care provided in the work setting. The work setting might provide an even better opportunity for us to deal with this issue because we will have the potential for employers in health care, who actually observe the behavior of the people who work for them, to be involved in health care. One of the problems with the current health care system is that the patient often goes without a family member or some other person who can assist the physician by explaining what the behavior is. That might be of some help for us.

The last point I want to make is to throw a little mud in our direction as teachers of mental health issues. That relates to the period of time when I was trying to teach other physicians how to provide better mental health care. Other physicians said we weren't very good at explaining what they ought to be doing. In fact, there are two poles to the issues here. There are those psychiatrists, (and I would presume psychologists as well) who work in these settings who would take the point of view that you really can't do very much (you, the primary care physician) unless you have the same training as a psychiatrist (or psychologist) - and who really aren't very good at explaining what they do because they think that they are basically intuitive, gifted, insightful beyond the personal characteristics of the person to whom they are trying to treat, or teach.

I think all of us recognize the fact that some of the things we are trying to do in the mental health field do not reduce themselves to simple algorithms and symptom check lists and that's part of the problem. On the other hand, I don't think we've have made a vigorous enough effort in our teaching to reduce our activities to algorithms and to symptom check list, because I believe that all medical students can understand that. They are the masters at algorithms and symptom check lists. There is nobody better in the world than them when it comes to that. I think we can help in that degree.

There are many more comments that could be made. In the interest of time, I will stop at this point and just again express appreciation to the people who planned the program, to Dr. Eisenberg and Dr. Michels, to Mrs. Carter for making this all possible, and we look forward to seeing you at the eighth symposium next year. Thank you.

## Afternoon Session

Michael McGinnis, M.D., Facilitator

Julius Richmond, M.D.

We have an afternoon of work cut out for us. The design for the afternoon is to split into smaller groups which should facilitate our getting some of the work done that has been proposed for the day. In order to get us started I would just like to introduce our facilitator. I really do this with a great deal of pleasure.

Dr. Michael McGinnis and I had an opportunity to work together early in the Carter Administration, and without his help, we never would have been able to produce the report you have heard referred to as Healthy People, the Surgeon General's Report on Health Promotion and Disease Prevention. When Michael was a young physician who grasped these concepts, he had visions of the future because he grasped these concepts and was willing to go to work on them, even though there were many other career opportunities. He recognized that health promotion and disease prevention was the wave of the future in medicine and in health. He not only had that kind of vision, but he also had the perseverance to help in generating what was an extremely complex report. There had been no precedent for it, and just the organizational tasks were very vast. Not only did he do that, but he also demonstrated remarkable survival capacity because he has endured in the extension of these tasks over three different administrations. Now that's an achievement that is to be admired. As we indicated earlier, Michael's perseverance in this resulted in the institutionalization of the process of setting health goals on a ten year basis so that in 1979 we set health goals for 1990 and now Michael has led the Public Health Service and health groups from around the country into a process that has generated health goals for the year 2000. I feel very pleased to have him with us. He is the afternoon facilitator of the discussion. I am very pleased to introduce Dr. Michael McGinnis.

Michael McGinnis, M.D.

Joe Rogers, in his comments earlier, emphasized the fact that health care is a partnership. I think that in many ways that provided the theme for this afternoon session. The focus in this session is forging partnerships to define and carry forward an agenda for improved mental health for the American public. I was asked to review for you the Task Force model that we developed in forming partnerships and to set public health goals and objectives for the decade of the 80's as one example of the way these kinds of activities can work. In addition, I will address the potential applicability to the mental health arena, giving special emphasis to the partnership aspect.

Dr. Richmond has noted that in the late 1970's, we in public health found ourselves confronted with the situation in which, on the one hand, we are gaining more and more information about the relationships between various identifiable risk and long term health prospects, but on the other hand, that information seemed to present so many issues--not to mention cross purposes--that there was some difficulty in trying to identify a cohesive course to improving the public's health. It was at that point that Dr. Richmond set out the task of developing a Surgeon General's Report on Health Promotion and Disease Prevention, and at which he, Bill Foege and I worked together with many others (some of whom are in this room) to develop the 1990 objectives for the nation.

In Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention, the report that he mentioned to you, five broad, quantified targets were established in 1979 to be accomplished over the decade of the 80's: to reduce infant mortality by 35% by 1990, to a level of 9 deaths per 1000 live births; to reduce childhood mortality by 20%; to reduce adolescent and young adult mortality by 20%; to reduce adult deaths by 25%; and for older adults, to reduce sick days by 20% by the year 1990.

Although the establishment of the goals was formalized with the publication of Healthy People, it was clear from the outset that in order to move the nation toward the goals, we needed to develop a series of partnerships to enlist people from around the nation in the process of charting the course. So, even before those goals were finalized and the report released, a coalition of individuals and organizations was mobilized.

Bill Foege served as the host when he was Director of the Centers for Disease Control. Around 200-250 people came together in Atlanta for an intense three-day meeting. Divided into fifteen working groups, people representing organizations, scientific expertise, and academic institutions from around the country sat down to hammer out a draft set of objectives - measurable objectives in the 15 priority areas deemed necessary to accomplish over the decade of the 80's to reach our broad goals. The objectives were then published in the Federal Register in draft form, and circulated widely to several thousand groups and individuals around the country.

Based on the review and comment, the report was revised and issued in 1980 as Promoting Health and Preventing Disease: Objectives for the Nation. The 226 objectives for the nation represented an interesting blend of outcome and process targets. An attempt was also made to identify the relationship between health outcomes in a given dimension with the risks that anteceded those outcomes, with the services that could be targeted to effect the profile, and with the monitoring system that was necessary to track how we were doing in providing services reducing risk and improving health outcomes.

The implementation of progress toward these objectives was taken as a national, as distinct from federal, challenge. Implementation took on a tripartite character, with the federal government developing an implementation and monitoring plan for its own contribution, but also working extensively with states for development of state plans for their contributions and with the private and voluntary sectors performing their roles. By 1985, about a third of the states had developed state implementation plans. By 1988, the share had reached nearly 90%.

I'd like to move directly to the results of the enterprise, specifically to the results in terms of the broad goals (Figure 1, Appendix B). The target of reducing infant mortality by 35%, to 9 deaths per 1,000 live births has been virtually accomplished (with a level of 9.1.). The target of reducing childhood mortality by 20% has been exceeded with an accomplishment of about a 29% reduction. The target for adolescents and young adults of a 20% reduction in deaths has not been met. The result was only about a 9% reduction. It should be noted in this regard that at the time the target was actually set, we had emerged from a period in which the death rate for this group had actually increased. Setting a target of a 20% reduction, therefore, was perhaps a bit too ambitious.

The results for adults in many ways are the most interesting. The target of a 25% reduction to 400 deaths per 100,000 people was virtually accomplished with a level of 400.4, according to 1990 provisional data. Obviously, this is a good news story for the nation as a whole. Obscured by this good news, however, are the failures for specific vulnerable populations. I won't belabor this issue in this context, but it is a very important challenge.

Instead, let me elaborate on the process, which in many ways was more important than the results. The setting of these targets, and their accomplishments, is a tribute to the existence of the objectives and to the projects and coalitions that have been developed around the country as a result of our greater appreciation of the opportunities.

We found in our poll of the organizations in the private and voluntary sectors, at the state level and the local level, testimony to this fact. First, they found that the process of target setting in a collective fashion was helpful to clarify the opportunities. Our efforts are enhanced by having a sense of the magnitude of the gains achievable. And it's useful to have a means of registering our successes when possible.

Second, and in my view even more important, these targets offer a means of holding ourselves accountable for our failures. I mentioned the problems in certain low income populations. In 1985, when it became apparent that we were not going to meet the target of closing the gap between blacks and whites in infant mortality,

headlines were generated in *The Washington Post* and *The New York Times*, and editorials around the country criticizing us for that failure. That's exactly what ought to happen when we, as society, don't make the kinds of improvements the best authorities in the nation feel ought to be achievable over a decade's time. We should be held accountable for those failures, and forced to reexamine our strategies.

Third, we heard from our partners involved in the process that the targets were helpful in unifying activities and in helping to pull together different groups who might not otherwise have worked together--e.g., the transportation sector, the education sector, the environmental sector, the housing sector. All these were important to accomplishment of the targets in disease prevention and health promotion.

Fourth, we heard that the effort was useful in helping to validate local initiatives. Having a national target has proved useful to people at the local level who have otherwise had difficulty in marshalling support for their efforts with regard to the importance of an activity. We heard, for example, from the State Maternal and Child Health Director in Mississippi that it was easier to make the case to the legislature and to the Governor there about the importance of certain MCH programs by virtue of having the national target in hand.

The last example I'll give of testimony that we heard from the field about the utility of the process was its utility in helping to monitor progress. There were 226 of these objectives across fifteen areas. They were ferreted out from literally thousands of candidates, and they represented a priority set. Importantly, they represented a mutually agreed upon priority set of targets to be accomplished by the nation, and therefore, an agreed upon set of priorities for our tracking system. It helped us to improve the extent that we could actually monitor progress along the way and then move to changing our course where we found we weren't doing as well.

Several characteristics of this process are relevant for work in the field of mental health. First, is the focus of these objectives on prevention. We have as a first priority preserving the mental health of our children, and identifying those pressure points that are vulnerable to intervention as we seek to improve the long-term mental health prospects for our citizens. Prevention is clearly the watchword as we structure our priorities.

Second is the focus of the objectives on the issues relevant to the entire population. While discrete objectives did focus on certain sub-groups, the effort took the population as a whole as its mission. It was intended that the general population feel that these were targets relevant to their own lives and families, in order that they might be more widely accepted as their own

mandates.

Third is the focus on fostering partnerships and consensus at each level, national and local level as the essential hallmark of the effort.

As we think about the application of these characteristics to the work of the Task Force and the agenda setting effort in mental health, there are obviously a number of "givens" that give shape to our perspectives. An important one is the fact that issues in mental health and psychological development are issues of great relevance to more Americans. The nature of the relationship varies substantially from individual to individual, and we must account for that variation as we structure our efforts. As a result of the individual differences from individual to individual in these relationships, there are many different perspectives on the priorities for action. As a consequence of these different perspectives, we unfortunately have a potential dispersal of energies. That is one compelling reason that we are all in this room today--to help forge the partnerships around commonalities and give a collective focus to the efforts.

The challenges that we face as a result of some of these forces are numerous. I would like to mention four in particular. First, we have a challenge to foster the development of a common vision--a framework for dealing with these issues that can help clarify the nature of the relationships among factors bearing on the major outcomes we desire. Which services are most likely to yield the greatest good for the greatest number? The problems of children might offer a common point of entry. There can be little quarrel with the need to focus on prevention and on prevention programs for children.

Second, we have a challenge to counter directly some prevalent social stigmas and social trends, in particular: the erosion of the family, the erosion of primary and elementary schools, and the adverse incentives currently confronting primary care settings that we have heard so much about this morning. These are all trends that need to be countered because they are moving in the wrong direction right now.

The third challenge we have is to mobilize participants from various disciplines and sectors. I will not belabor this because that is what this Task Force is about and will be focused upon later.

Fourth, we have the challenge of educating the public directly about the relevance of these issues to themselves and their families, about the priorities that emerge from analyzing possibilities at hand, and about what actions each of us can take to advance the mental health agenda.

In this latter context, I would like to give two examples that offer some hope for efforts to enlist the general public in behavior change. We don't know a great deal about the effects of health education in general, but we do know that effective health education efforts have certain commonalities.

First, the message must be derived from a solid scientific basis. Second, the message should be reinforced from a variety of different perspectives, perspectives of the sort represented in this audience. Third, the message must be sustained over a long period of time. We have evidence from other public health programs not only that change can occur, but that it can be catalyzed by a diverse, and concentrated effort.

The first example is that of tobacco. (Figure 2, Appendix B) shows per capita consumption of cigarettes from 1930 to 1980. Two things can be seen in this trend line: 1) the expected trend absent a concentrated public health intervention effort; 2) the actual trend. There was a fairly definitive and important break in the early 60's with the release of the Surgeon General's Report on Tobacco and Health, leading to a turnaround in use rates.

The first Surgeon General's Report on Tobacco was released in 1964, and it captured the essence of the scientific understanding that served as a sustained rallying point for various public health actions over the subsequent years. Although the gains we've made thus far are incomplete, they point to an ability to catalyze a change and accelerate the pace of change through a concentrated public health effort.

In some ways more relevant to the issues in Mental Health is a second example of progress in nutrition (Figure 3, Appendix B). Because dietary issues are complex, the various component issues must be compartmentalized in a coherent fashion and each addressed from a variety of different perspectives. It can be seen from Figure 3 that even in the face of what are often perceived as frequently contradicting and confusing press reports on the relationship between diet and health, from 1984 to 1991 people's understanding of the issues in nutrition changed dramatically in the right direction. The Food and Marketing Institute asked people: "What is it about the nutritional content of food you eat that concerns you and your family most? In 1984, seven short years ago, the number one concern was chemicals, reported by about 25% of the population. The concern of chemicals was followed by sugars, salt, fat, and cholesterol. Seven years later, a much different set of answers emerged. Fats and cholesterol are represented at 40% or above for each, salt at around 25%, sugars at 10-15%, and chemicals at the bottom with below 10%. For those of you who are involved in nutrition issues, it can be seen right away that this is about the correct relative order of magnitude for nutritional concerns. It is encouraging that we can, through a concentrated effort involving the food industry, government agencies, health

professionals, and the clinical community (i.e. involving virtually all elements of our society) clarify perspectives about issues that people may be confused about over a relatively short period of time. This tells me that one of the most fundamental steps in catalyzing change is getting multiple partners involved. It was through partnerships that these kind of improvements were realized. That is the key change to the work group today: not necessarily to come up with solutions to problems, but to forge alliances that can be turned to addressing the issues.

**Group 1. "The Relationship Between Physical and Mental Health: Closing the Gap"**

**David Pruitt, M.D.**

Thank you Michael, our group really did start at 8:45 this morning. We had "The Relationship Between Physical and Mental Health: Closing the Gap" as our topic, and it was a continuation of the active morning discussion. I will attempt to highlight and focus in my ten minutes and will send John Hardman a written report.

What we did to focus our group was to look at coronary artery disease. What are the risk factors in coronary artery disease. In a ten minute period of time we were able to list all the biologic, psychological, and social risk factors in coronary artery disease and were amazed at the amount of information we had on that illness. We went to the question of "Since we know so much about that illness, why don't we have the same sort of understanding of brain diseases, psychiatric illnesses, mental illnesses?" Throughout the discussion, there was debate and discussion about which terms were best to utilize.

I think basic to our hope was that information, as it becomes available, will bring about attitudinal changes and then we will have the appropriate closure of the physical and mental health gap.

We went on to address what recommendations could be taken in order to close this gap between physical and mental illnesses. We listed five areas, the first being public awareness through the media. The importance of public awareness has been stressed repeatedly at this gathering and has been a main focus of many of these symposia in past years.

I think the other area that we found fascinating was the role and responsibility of the physician and patient. This morning, they were talking about the message often given to patients by physicians: "Don't talk about mental illness." We feel that consumer advocacy and a knowledgeable consumer base is very important to combating this message.

The second area that we have recommendations regarding closing the gap is funding. The recommendations are to financially reward clinicians for getting to know their patients, to reshape the

funding scheme, and to appropriately cost allocate the physical and mental illness components to the overall cost of health care.

The third area is education. Again this area was extensively dealt with by Drs. Eisenberg and Michels and involves education not only of medical students, but also social workers, psychologists and nurses. All the helping professionals need is to have their educational agenda changed and evolve to integrate physical and mental illnesses.

The fourth area is research. Again the statement was made this morning, we don't know more than we do know. There was discussion in our group about how this lack of information leads to stigma, how it leads to partial compartmentalized answers and how we must act on information that we presently have, yet look for new information through research. I think out of this discussion came the message that we need to repair and prevent further splintering among and between mental health professionals and consumers, develop coalitions and develop political strategies to address the different agendas.

The final area was demonstration projects. This dealt with the question of implementation of our present knowledge base. Dr. Eisenberg pointed to model physician office practices, Dr. Michels pointed to model medical school curricula, and the Carters to the Atlanta Project. All of these projects we feel will bring about some of the necessary information to close the physical, mental gap. Thank you.

## Group 2. "Mental Health Objectives for the Year 2000"

Paul Fink, M.D.

Listening to David, I wish we had a narrower subject than all of the world, which we tried to solve in about an hour and fifteen minutes.

Essentially, our group had parallel tracks, talking about macro systems and micro systems: things that we can fix and things that we cannot fix, things that we know are relevant and important to the mental health of the nation, but which are outside of the sphere of the mental health professions. It's important that we state that caveat because, as one of our members said, we tried that experiment where we thought we could solve all the problems in the world through taking care of the mentally ill or even the not so mentally ill, and that is not a good idea.

Then we had another level which I'll call micro systems in which we talked about things that really need to be fixed by the year 2000 or worked on so in that list which I will give you, you can see that there are clearly environmental, social, and familial parameters that are critically important to be changed if we are to

have a healthier world and a healthier community in which to live.

In the first category, there was discussion about the long term effects of "stigma," which we have renamed "discrimination" because it's a more felicitous term and fits in with many other discriminatory activities in the nation. That is a major area that we alone can certainly not handle, but needs to be dealt with if we are to change the ways in which the mentally ill are perceived, have access, and are treated.

Secondly, a major overriding factor in today's society is violence and abuse. There is a general consensus that violence needs to be addressed in a specific way, and it has to be seriously reduced as a way of life, and a way of conflict resolution.

Third was the question of homelessness and poverty which clearly have a significant effect on how serious mental illness is observed, and what happens to the seriously mentally ill who are made more poor, and are homeless, and are not cared for.

Fourth, there was a sense that we need a rational, national system for allocating resources for the mentally ill. We need national policies to guide the states in the utilization of their resources. It was mentioned earlier today that much more money was spent on the state level on the mentally ill than was spent on the national level. We don't have a single overriding systematic set of policies that guide the states in the way that they will respond to the needs of the mentally ill.

Fifth, there was clear consensus in our group that financing the care of the mentally ill needs to be addressed, and a system needs to be developed in which the mentally ill receive both parity and equity. There was some discussion about broader issues. I hate to use the following term because no one mentioned it in the group, but trying to have a "kinder, gentler world" and the role that indifference, callousness and selfishness have in shaping the world in which the mentally ill find themselves. We need to put that in the forefront of the national agenda without claiming that it's our territory. We do not believe that psychiatrists, psychologists, and social workers are going to make this into a less indifferent, less callous, less selfish world; but it's part of what we think is necessary on the national agenda before we are going to have a system that reduces the amount of mental illness or gives the mentally ill access to adequate care.

Finally, among the macro systems, there was a sense that not only do we need coalitions as represented in this room among the mental health professions, mental health advocacy groups, and mental health organizations, but we also need to have equal coalitions between the mental health oriented organizations and the non mental health groups in government and outside of government that will help us to achieve some of these goals.

On the micro level, there was a sense that number one, we have to have a system that gives access to mental health care to all Americans. The second area was that we need to have single stream funding. The use of funds of many sources are broken up, and used mostly for non-patient care related activities. That is wrong, and needs to be altered by having governmental and non-governmental funds acting together in a single stream that would go directly to patient care. Third, we need to have services responsive to demographics and to status. There was a lot of discussion about the changing demography of America. Some of that was mentioned when someone said the emergency rooms in New York have to have 80 different languages available. There has to be some way that the changing demographics can be addressed as we begin to develop more serious, in-depth services for people in this country, and also related to the status of those people. If they are demeaned and discriminated against, they will get less services. The services, then, ought to be responsive to both demographics and status.

We had a long discussion about the effect of work and the availability of work for people who have been mentally ill and are able to work. Will work be available, and will we be able to resolve some of the stigma issues that keep people who are able bodied and able to work out of the work place?

We talked about a list of things that we think are relevant to mental health and need to be addressed within the mental health consortium. They have to do with the need for reducing the number of teenage pregnancies, the provision of prenatal care across the board, addressing the question of malnutrition which clearly has an effect on mental illness, the development and maintenance of mental illness, the availability of a safe environment for people of all ages, and a healthy environment for all children, which really is a broader statement, but deals directly with the question of safety.

The question of the family structure: perhaps not tying ourselves to earlier visions of what families were like, but to make sure that all parents know how to parent. There also needs to be a significant reduction in the amount of suicides and homicides in the community which we think would result from addressing all of that which I have already stated.

It's an overwhelming agenda, obviously, but to summarize, we looked at macro systems and micro systems, items that address things that we can fix and things that we want to fix, but that we have to become part of the greater society in order to do it. Thank you.

### Group 3. "The Chronically Mentally Ill: Programmatic Needs for Optimal Functioning and Well-Being"

Charles Nemeroff, M.D.

The summary statement, in brief is that there are simply not enough resources for all of the needs, and the decisions are therefore very difficult for all of us. We come from such different places, backgrounds, and disciplines, and it's really hard to know what's right. One could argue for major support in research, and the argument is a relatively persuasive one. When a major research breakthrough occurs, the cost that you save is so large, that the expenditures are easy to justify.

The Clozapine example is a good example. No matter how conservative one interprets the data, if 1% or 3% of patients who previously had to reside in a state mental institution no longer need to because of the beneficial effects of Clozapine, then literally millions of dollars are saved. But the fact is that we have a relative absence of data concerning the chronically mentally ill. To start with, we don't have a universally agreed upon definition of the chronically mentally ill, and we talked in our groups about that at some length. We decided that it wasn't fair to limit the definition to a particular illness; the chronically mentally ill, includes schizophrenia, bipolar (manic-depressive) illness, anxiety disorders, depressions and a number of entities that we normally don't think of as part of the chronically mentally ill.

In the absence of a great data base, concerning how to treat chronic patients, we are left with the art of psychiatry, the art of psychology, and the art of patient management. To do that, you must have more resources than you do to treat other patients. If you compare a patient with cardiac disease or diabetes to a patient with chronic schizophrenia, the resources required to treat schizophrenia are considerably higher. It involves a social worker, a case manager, a psychiatrist, a psychologist, occupational therapy, vocational rehabilitation and on and on.

Where are the resources going to come from? We talked about the question of whether one entity should control the resources. Should one local authority control all of the finances or should they come from various sources? There are arguments pro and con for each approach. We had to deal with sensitive guild issues. I thought we were gentle with each other about it but guild issues did come up. These were issues related to how we were trained, psychologist vs. psychiatrist, nurses vs. social workers, etc. We know we must work together as a team. What we do know, is that there are too few of each of us. Don't believe it when it is said that there are enough physicians. There are not, certainly not enough psychiatrists, social workers, or nurses. We can't find enough professionals to provide service, and when you do hire these individuals, they do not stay very long.

There are special populations that present particular problems including the V.A. medical centers and the armed forces. For example you can't treat panic disorder with benzodiazepines in the armed forces, because you can't use benzodiazepines there. There are major problems with providing high risk populations with access to diagnostic and treatment opportunities. We all have the dream of continuity of care i.e. from the "womb to the tomb," but this is still a dream. We don't have a clue as to what to do with someone who is at risk from birth; someone who has schizophrenic parents, who has had a brain viral infection, who has had a birth trauma. We don't know what do you do with these "high risk" individuals? What do you do with them biologically, medically, psychologically, pharmacologically?

We talked a lot about how poor health coverage is for the chronically mentally ill. Look at your own policies. We are really doing badly with third party payment for psychiatric services. You all know that. We have to move towards some kind of national health insurance. We have to promote self-help groups, which have done very well in substance abuse and alcohol, have done not as well in schizophrenia, have done a little bit better in bipolar illness. There are lots of things that our group didn't know. We didn't know what per cent of the tax dollar is actually spent on mental health, what per cent of it comes out of the "health" dollar. We also acknowledged the fact that chronic psychiatric patients need to be helped to obtain jobs and housing, because even if they were without psychiatric problems they are not going to feel very good if they don't have a minimal standard of living.

Finally, we acknowledged the fact that maybe we, as professionals, play a role in the stigma. Maybe we have too often accepted pejorative terms from each other about patients. Maybe we need to stop and clean up our own house as well. I think the hardest thing we dealt with was the fact that there is no sign that there are going to be unlimited resources for us, or even barely sufficient resources for the chronic mentally ill. We are going to have to make hard decisions. None of us really know the appropriate decision to make because our decision-making is not data based. The decisions are based on our experiences and our gut instinct.

#### Group 4. "Mental Health and the Media: Overcoming Stigma and Promoting the Concepts of Wellness, Prevention, and Improved Quality of Life"

Carole Szpak

In looking at media issues, our group really came to the conclusion that there are some short-term things that we need to do and some long-term projects.

In the short term, there are some issues coming up that will give us a window of opportunity and potentially a problem if they are not addressed. All of the discussions about national health

insurance, for example, have the potential to leave mental illness issues out unless we are vocal and our issues are clearly understood, not only by legislators and businessmen, but also by the general public. There is a sense of some urgency to make sure that we are making some short-term efforts.

There is also the sense that there are some longer term things that we need to do. For example, what should our message be? We have had quite a long discussion on some of what should be presented, yet more research might need to be done to make sure we understand the long-term impact of the various messages that we may be delivering. We took a look at what actually has worked when dealing with the media. It became pretty clear that personal contacts are the primary way to influence the media, particularly entertainment media and television. Those sorts of efforts need to be continued.

Another theme that seemed to come out was that messages have to be sustained. I think that is one thing that needs to be encouraged. What doesn't work for us appears to be some of the terminology. I was interested to hear that Dr. Fink's group came to the same conclusion - stigma is a word that the group felt does no one any good. We spoke instead about discrimination.

We also began to talk about what messages we can begin to deliver together. First, we realize that messages can't be bland - they have to be heard and understood by the people we are presenting them to. We began to discuss some of the common messages that may be possible. Clearly the fact is that mental illnesses are treatable. The message of hope is one that should be presented by organizations. Mental illnesses are real, and people need to begin to understand that it can happen to them, that it is not "us vs. them."

The specific discussion about the disability movement is one that I am sure we will continue this afternoon in further discussions of the media coordinators. A model was presented using the notion of discrimination in access when dealing with psychiatric disabilities, and I think that may be an area we all can focus on.

Long-term, the bottom line was the group believed all of the organizations need to make a strong commitment to working together and to overcoming some of the organizational boundaries that we have traditionally had and begin to find a message that we all can get behind.

**Michael McGinnis, M.D.**

I think that the workgroups you have participated in represent a very important start for the collaborative efforts of your organizations in the context of the Task Force. The vigor, creativity, and commitment of the discussions I heard in the course of my roaming from group to group is certainly a tribute to the

leadership of Mrs. Carter and The Carter Center. I think it is also a tribute to the skill of our work group leaders to working under time constraints. I would like, as we turn the meeting back over to the Carter Center, and to Julie Richmond to move on with a round of applause for those work group leaders.

#### Closing Remarks

**Julius Richmond, M.D.**

I would just like to add my words of appreciation to all of the members of the workgroups. It is clear that you were very diligent indeed, and listening to the reports, one would say you were really encyclopedic in terms of the coverage of the significant issues. I am very pleased in looking at the program that my role here is titled "Closing Remarks" rather than "Summary" because there is no way one could summarize what we have heard.

In addition to expressing appreciation to all of you as members of the group, I think I would add my words of thanks to those of Michael, to the Chairpersons of the groups. Because I think we have had a remarkably condensed and lucid presentation of what certainly must have been extremely active and rich discussions.

When so much comes at once, I can't help but think of an anecdote that the late Dr. Alan Gregg (who, for many years was the Vice President for Health Affairs at the Rockefeller Foundation) was fond of telling at a time like this. He described himself as having had gotten off the train in Central Station in downtown Tokyo one day and he walked out on the street and he looked at a building across the street. It had a big sign on it, "D. Matsumoto and Sons - Forwarding Agents, Your Baggage Sent in All Directions." It seems to be we really have been encyclopedic and we have covered a great deal. Now since we are running a bit overtime, and that takes away time from a very important function, the reception, what I would like to do is to make a semi-editorial comment on where I think we are.

Mrs. Carter has provided the leadership together with the help Dr. Houpt and his colleagues in the Department of Psychiatry at Emory over the years to maintain continuity among the representatives from the various organizations who have been at this symposium and at prior ones has been an extremely important function. Because of the relatively limited staff support, the activities in between have been largely on the basis of Mrs. Carter's personal efforts.

I see a turning point in this symposium series; Mrs. Carter has now been able to establish here, a Secretariat and Task Force. We have the potentiality for continuity between the symposia for dealing with issues. I think this is very relevant for the work of the Task Force which she has assembled, and which we have heard about today. So, Mrs. Carter, I think that we are at kind of a landmark

in the development of these symposia. I think what this means is that we need to take the richness of these presentations this morning, the panel discussions of those presentations and the contributions from each of the working groups here this afternoon and the interactions with Task Force members.

I thank the Secretariat, for facilitating the work of the Symposium and the Task Force and Dr. Hardman and his colleagues. I think we stand on the threshold of a whole new thrust in mental health thanks to the leadership and the resources that Mrs. Carter has developed here. So, with that, I will turn the meeting back to Mrs. Carter.

**Rosalynn Carter, Chairperson**

Thank you, Julie. Julie has said it better than I can because I do think we have an opportunity now, thanks to The MacArthur Foundation, to be able to pull the information together with the Task Force and try to effect the social strategy as Dr. Richmond was talking about in one of the work sessions.

We need more time for brainstorming. It was wonderful going from one meeting to another. I do value all of your opinions, your remarks, your knowledge. It is so important to us as we try to affect policy changes. So, I thank you all again for coming today, I look forward to working with all of you, not only at our annual meeting, but through the year. I hope you will stay in touch with me. And now, I think everybody is a little bit nervous about the time, so we stand adjourned. I'll look forward to hearing from you. Thank you.

Appendix A

Bibliography - "Closing the Gap Between Knowledge and Practice:  
the Treatment of Depression in Primary Care"  
Leon Eisenberg, M.D.

Barrett, J. (1991) Treatment practices in primary care: setting directions for health outcome research. *Journal of Family Practice* 33:19-21

Barrett, J.E., Barrett, J.A., Oxman, T. et al. (1988) The prevalence of psychiatric disorders in a primary care practice. *Archives of General Psychiatry* 45:110-1106.

Beck, A.T., Rush, A.J., Shaw, B.F. et al (1979) Cognitive Therapy of Depression. N.Y., Guilford.

Bridges, K., Goldberg, D., Evans, B. et al. (1991) Determinants of somatization in primary care. *Psychological Medicine* 21:473-483

Broadhead, W.E., Blazer, D.G., George, L.K. et al. (1990) Depression, disability days and days lost From work in a prospective epidemiologic Survey. *Journal of the American Medical Association* 264:2524-2528.

Coulehan, J., Schulberg, H., Block, M. et al. (1991) Medical comorbidity of major depression in primary medical practice. *Archives of Internal Medicine*. In Press

Eisenberg, L. (2988) Science in medicine: too much or too little and too limited in scope? *American Journal of Medicine* 84:483-91.

Elkin, I., Shea, M.T., Watkins, J.T. et al (1989) NIMH Treatment of Depression collaborative Research Program: general effectiveness of treatments. *Archives of General Psychiatry* 46:971-982

Frank, E., Kupfer, D.J., Perel, J.M. et al. (1990) Three-year outcomes for maintenance therapies in recurrent depression. *Archives of General Psychiatry* 47:110-1105.

Gask, L., Goldberg, D., Porter, R. et al. (1989) The treatment of somatization: evaluation of a teaching package with general practice trainees. *Journal of Psychosomatic Research* 33:697-703.

Goldberg, D. and Gater, R. (1991) Estimates of need: a document prepared for the South Manchester District Health Authority. *Psychiatric Bulletin* 15:593-595.

Goldberg, D. and Huxley, P. (1992) Common Mental Disorders: A Biosocial Model. London, Routledge.

Good, M.J.D., Good, B.J. and Cleary, P.D. (1987) Do patient attitudes influence physician recognition of psychosocial problems in primary care? *Journal of Family Practice* 25:53-59.

- Katon, W., von Korff, M., Lin, E. et al (1991a) Adequacy and duration of antidepressant treatment in primary care. Unpublished manuscript.
- Kirmayer, L.J. (1988) Mind and body as metaphors. In Lock, M. and Gordon, D. (Eds.) Biomedicine Examined. Dordrecht, Kluwer, pp. 57-93.
- Kleinman, A. (1988) The Illness Narratives. New York, Basic Books.
- Klerman, G.L., Budman, S., Berwick, D. et al (1987) Efficacy of a brief psychosocial intervention for symptoms of stress and distress among patients in primary care. *Medical Care* 25:1078-1088.
- Klerman, G.L. and Weissman, M.M., Rounsaville, B. et al (1984) Interpersonal Therapy for Depression. N.Y., Basic Books.
- Lipowski, Z.J. (1988) Somatization: the concept and its clinical application. *American Journal of Psychiatry* 145:1358-1368
- Mishler, E. (1984) The Discourse of Medicine: Dialectics of Medical Interviews. Norwood, NJ: Ablex Publishing Co.
- Mumford, E., Schlesinger, H. Glass, G. et al (1984) A new look at evidence about reduced costs of medical utilization following mental health treatment. *American Journal of Psychiatry* 10:1145-1158.
- National Center for Health Statistics (1991). Phone information service.
- Orleans, C.T., George, L.K., Houpt, J.L. et al (1985) How primary care physicians treat psychiatric disorders: a national survey of family practitioners. *American Journal of Psychiatry* 142:52-57.
- Ormel, J., van den Brink, W., Koetter, M.W.J. et al. (1990) Recognition, management and outcome of psychological disorders in primary care: a naturalistic follow-up study. *Psychol. Med.* 10:909-923.
- Paykel, E.S., Freeling, P., Hollyman, J.A. (1988a) Are tricyclic depressants useful for mild depression? A placebo controlled trial. *Pharmacopsychiatry* 21:15-18.
- Paykel, E.S., Hollyman, J.A., Freeling, P. et al. (1988b) Predictors of therapeutic benefit from amitriptyline in mild depression. *Journal of Affective Disorders* 14:83-95.
- Potter, W.Z., Rudorfer, M.V. and Manji, H. (1991) The pharmacologic treatment of depression. *New England Journal of Medicine* 325:633-642.

- Regier, D.A., Goldberg, I., Burns, B. et al (1982) Specialist/Generalist division of responsibility for patients with mental disorders. *Archives of General Psychiatry* 39:219-224.
- Regier, D.A., Hirschfeld, R., Goodwin, F. et al (1988) the NIMH Depression Awareness, Recognition and Treatment program: structure, aims, and scientific basis. *American Journal of Psychiatry* 45:351-357.
- Robbins, J.M. and Kirmayer, L.J. (1991) Physician characteristics and the accuracy of recognition of depression in family medicine. NIMH Conference on Mental Disorders in Primary Care. Washington, D.C. (September).
- Rovner, B.W., German, P.S., Brant, L.J. et al (1991) Depression and mortality in nursing homes. *Journal of the American Medical Association* 265:003-996.
- Schulberg, H.C. (1990). Mental disorders in the primary care setting: research priorities for the 1990s. In Mayfield, J. and Grady, M.L. (Eds.): Primary Care Research: An Agenda for the 1990's. DHHS Pub. No. (PHS) 90-3460, U.S. Govt. Printing Office.
- Schulberg, H.C. and McClelland, M. (1987) A conceptual model for educating primary care providers in the diagnosis and treatment of depression. *General Hospital Psychiatry* 9:1-10.
- Shapiro, S., German, P.S., Skinner, E.A. et al (1987) An experiment to change detection and management of mental morbidity in primary care. *Medical Care* 25:327-339.
- Shepherd, M., Fisher, N., Kessel, N. et al. (1959) Psychiatric morbidity in an urban practice. *Proceedings of the Royal Society of Medicine* 52:269-274.
- Shepherd, M., Wilkinson, G. and Williams, P. (1986) Mental Illness in Primary Care Settings. London, Tavistock.
- Wells, K.B., Stewart, A., Hays, R.D. et al. (1989) The functioning and well being of depressed patients: results from the medical outcome study. *Journal of the American Medical Association* 262:914-919.

Appendix B

# National Goals for Health Promotion

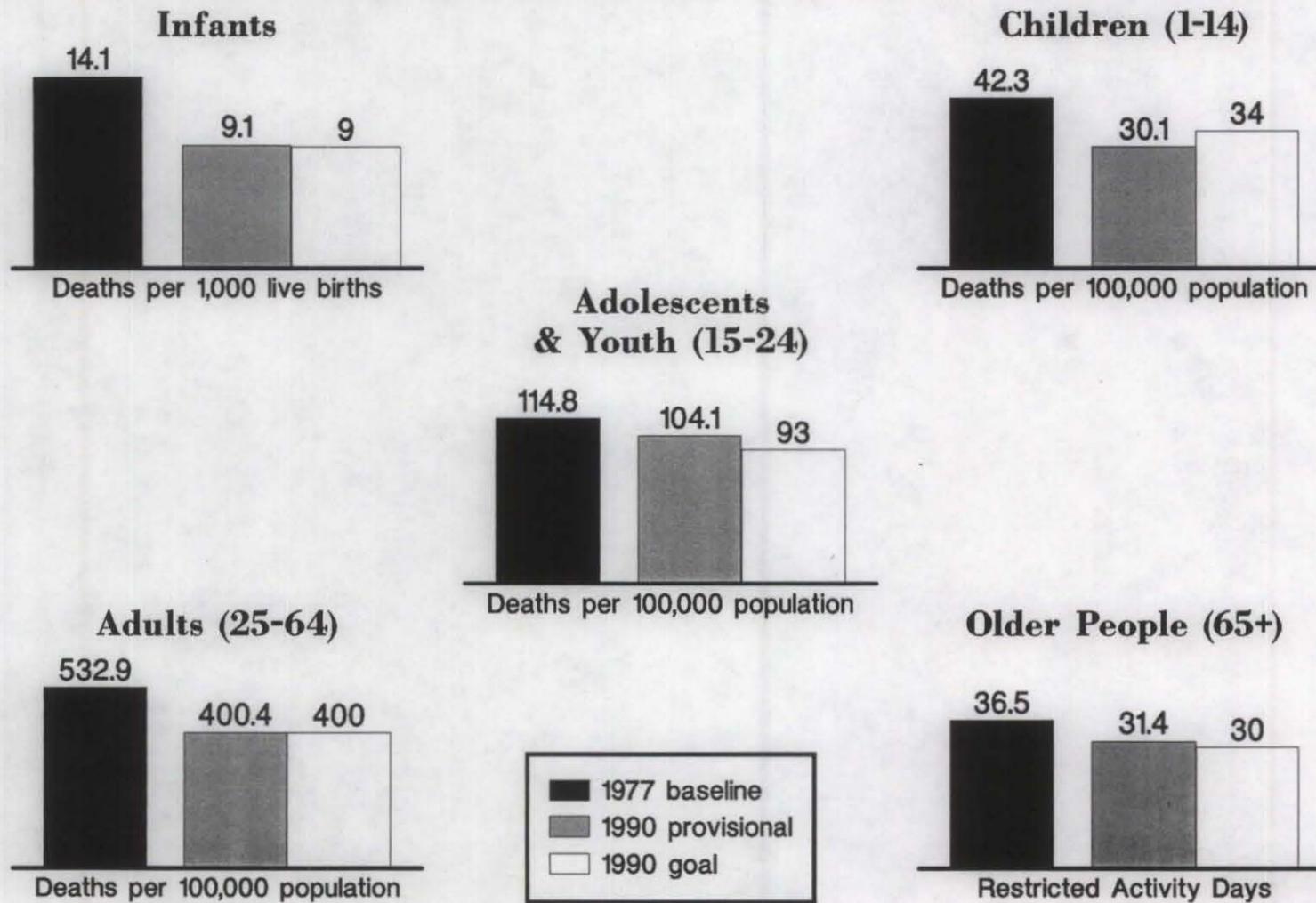


Figure 1

## Trends in Cigarette Consumption\*

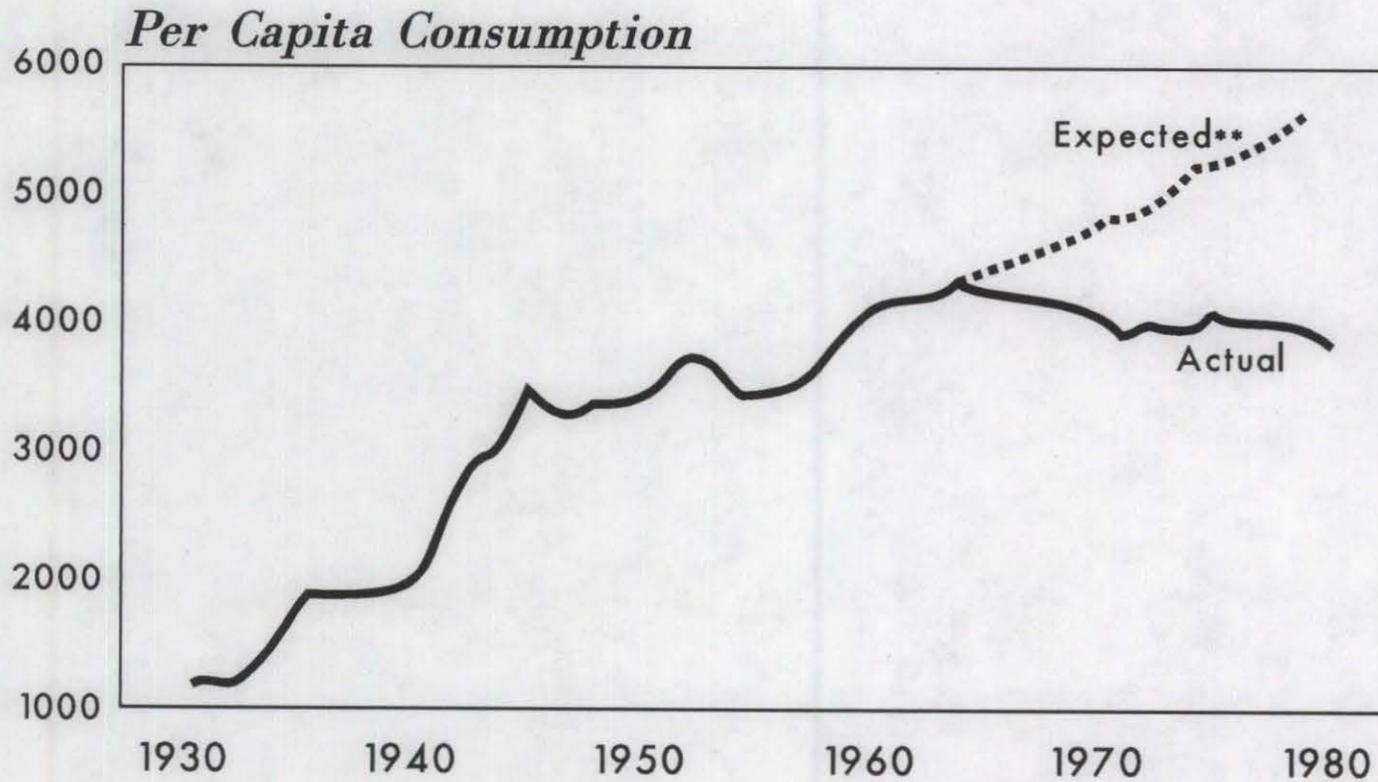


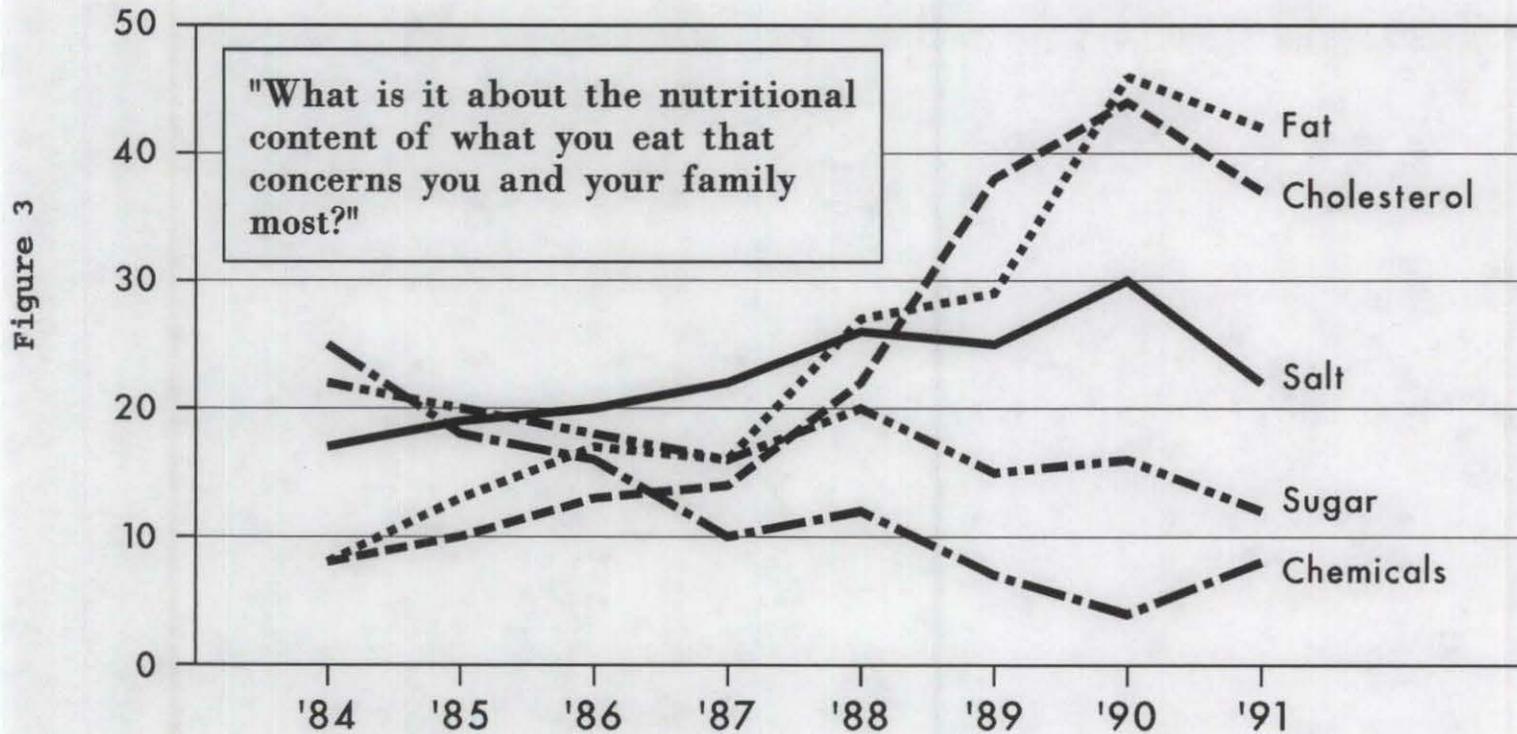
Figure 2

\* K.E. Warner, in *Science*, February 13, 1981, p. 730

\*\* Consumption predicted in the absence of antismoking campaign and with assumed price constancy

# Changing Attitudes Toward Food Content

Levels of the shopping public's concern about key food contents, in percent\*



68

SOURCE: Food Marketing Institute

\*Survey based on multiple responses