

# Setting the Stage for the Surgeon General's Report



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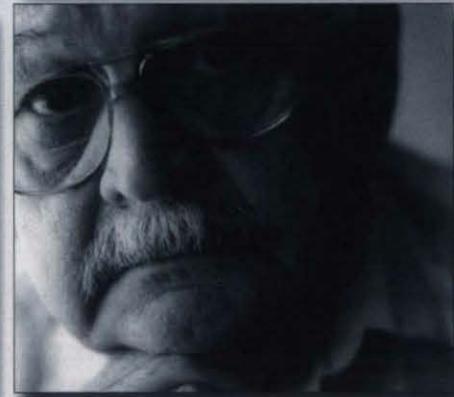
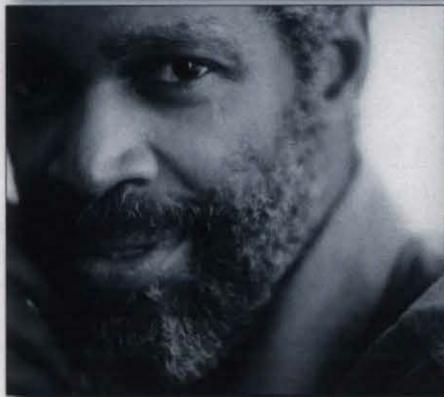
Fifteenth Annual  
Rosalynn Carter Symposium on  
Mental Health Policy



The Carter Center

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Rosalynn Carter Symposium on  
Mental Health Policy

# Setting the Stage for the Surgeon General's Report



*In November 1999, shortly before release of the first Surgeon General's report to focus on mental illnesses, the Fifteenth Annual Rosalynn Carter Symposium on Mental Health Policy gathered experts from across the nation to discuss the momentous opportunity for the future presented by the report — an opportunity to improve services and the quality of life for thousands of people with mental illnesses. — John Gates*

A high-contrast, black and white close-up photograph of a child's face, focusing on the eye and forehead. The child's expression is neutral, and the lighting is dramatic, highlighting the texture of the skin and the intensity of the gaze.

“The *Surgeon General’s Report on Mental Health* is an opportunity to engage the American people in a manner that can truly make a difference, a difference that can change the way we consider mental health, a difference in the way we talk about mental illnesses, a difference in the way we help individuals with mental diseases.”

KENNETH MORITSUGU



# Clarity and Conviction

The new Surgeon General's report offers exciting opportunities for outreach and understanding.

## Rosalynn Carter

Chair, The Carter Center Mental Health Task Force

It is an exciting time for those of us in the mental health field. I have been talking about mental health issues, more than usual, for the past two years, as I have been promoting my book, *Helping Someone with Mental Illness*. I have had the chance to travel around the country and think about how much things have changed since I began working in this field when Jimmy was governor of Georgia.

Back in 1971, few mentioned mental illness. Few admitted that a family member was mentally ill. We did not understand nearly as much about the brain then as we now know. We did not know how to treat mental illnesses, so most people were shut away out of sight.

Everything has changed since then.

We have the family consumer movement, which started in the early 1980s. Research has given us tremendous knowledge about the brain. And now we have the *Surgeon General's Report on Mental Health*.

The Carter Center Mental Health Task Force chose the Surgeon General's report as the topic for this year's symposium because it is important to galvanize the mental health community around the report to maximize its impact. It is important for us to work together so that the report can be meaningful.

We hope that the report will educate the public about mental health and



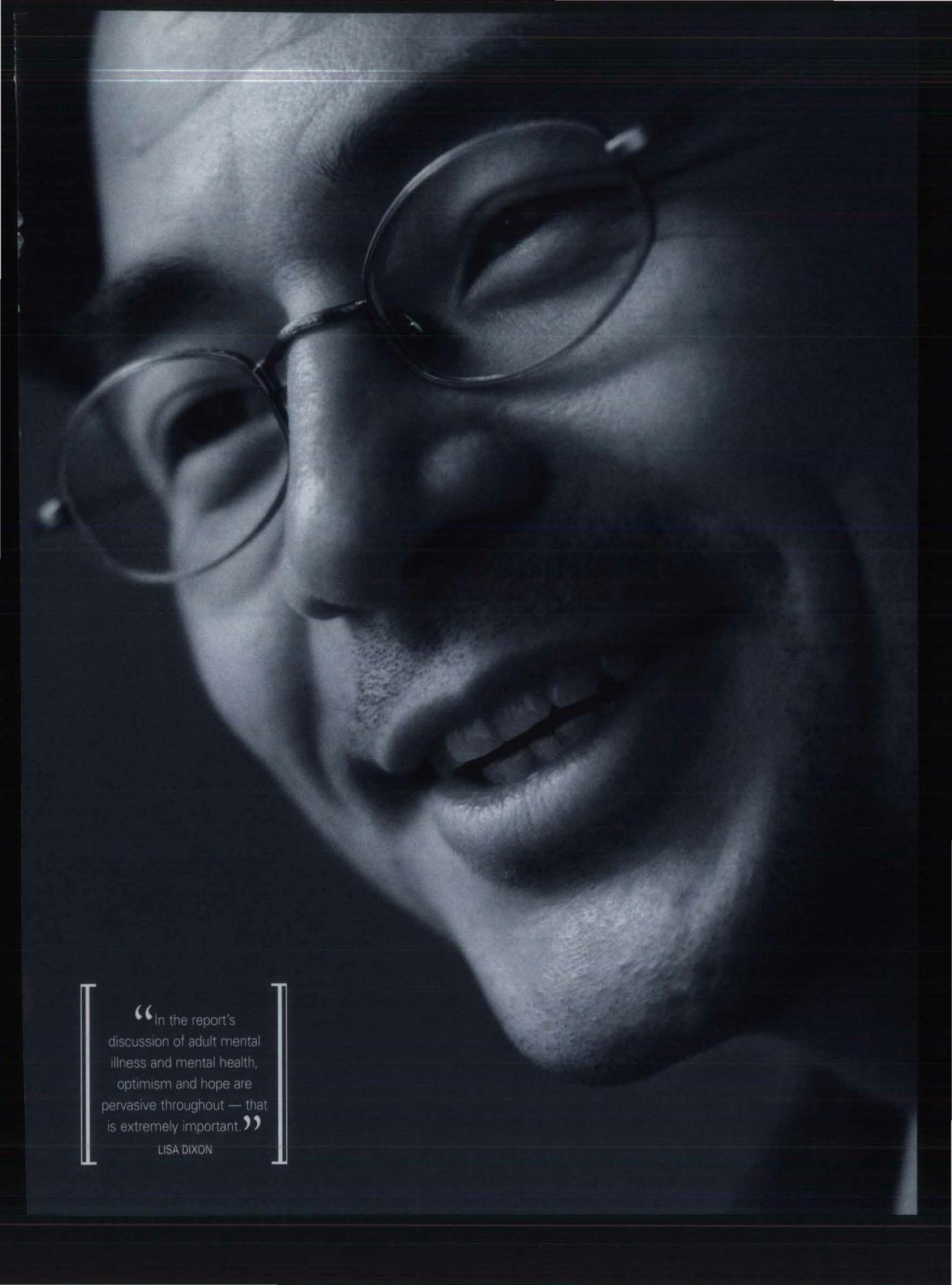
mental illnesses, just as the Surgeon General's Report on tobacco educated people about the dangers of smoking. Too many people do not know about new brain research. They do not know about new medications and new treatment methods. If we can inform the public about those things, maybe we can overcome the stigma of mental illnesses and get more people to seek help.

Another important goal of the report is to attract more professionals to the mental health field, including researchers.

The Carter Center Mental Health Program worked with the Surgeon General's office on the release of the report. Before the report was finished, and with support from the MacArthur Foundation, we commissioned a research firm to test key messages from the report across different sectors of American society. As a result, we learned what terms people respond to when talking about mental health issues, and which they do not. This awareness was incorporated into the final editing of the *Surgeon General's Report on Mental*

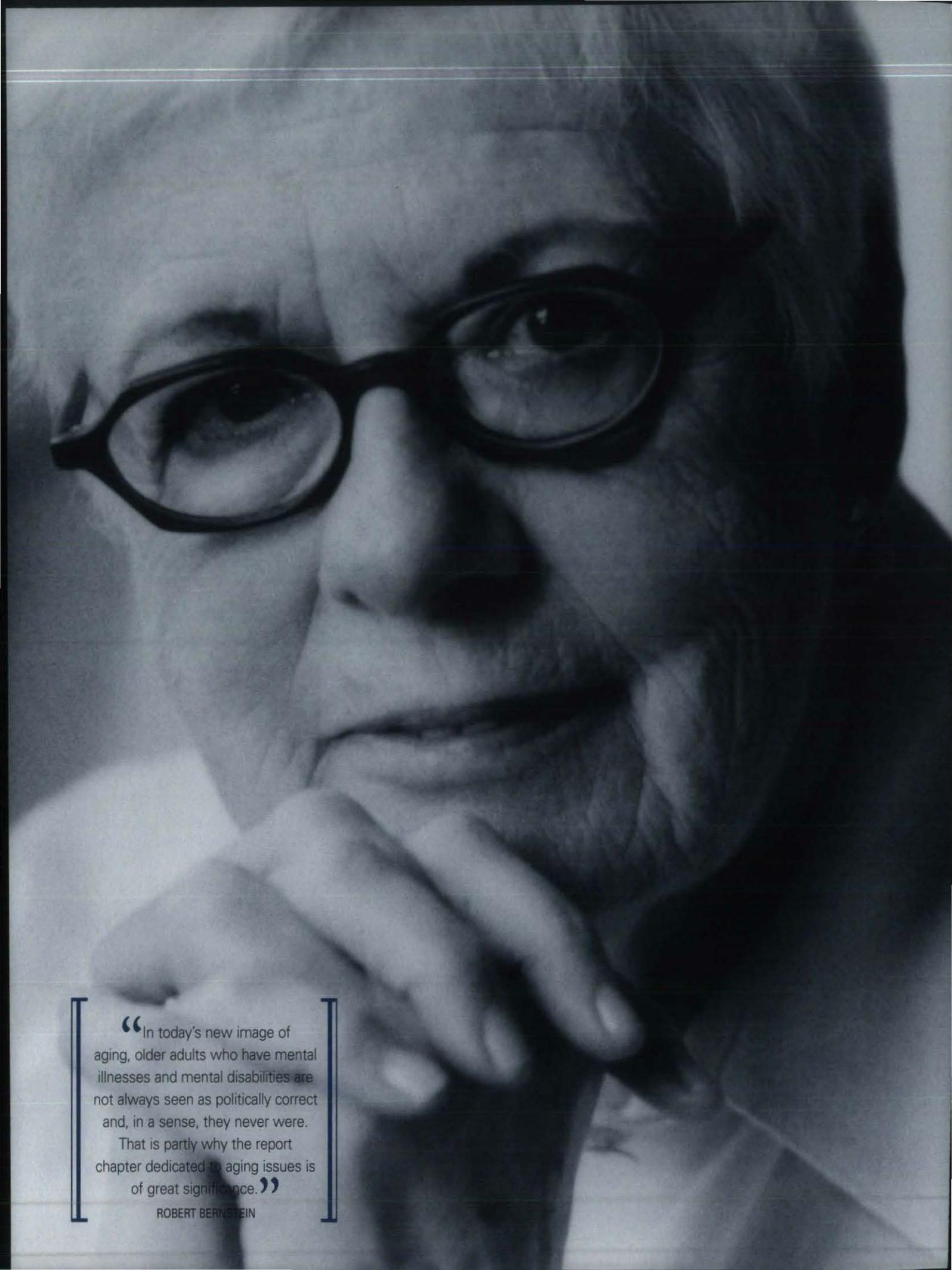
*Health*, making its content understandable by more people and its message of mental health recovery presented with a clarity and conviction seldom possible before.

“It is important to galvanize the mental health community around the new *Surgeon General's Report on Mental Health* to maximize its impact.”



“In the report’s discussion of adult mental illness and mental health, optimism and hope are pervasive throughout — that is extremely important.”

LISA DIXON



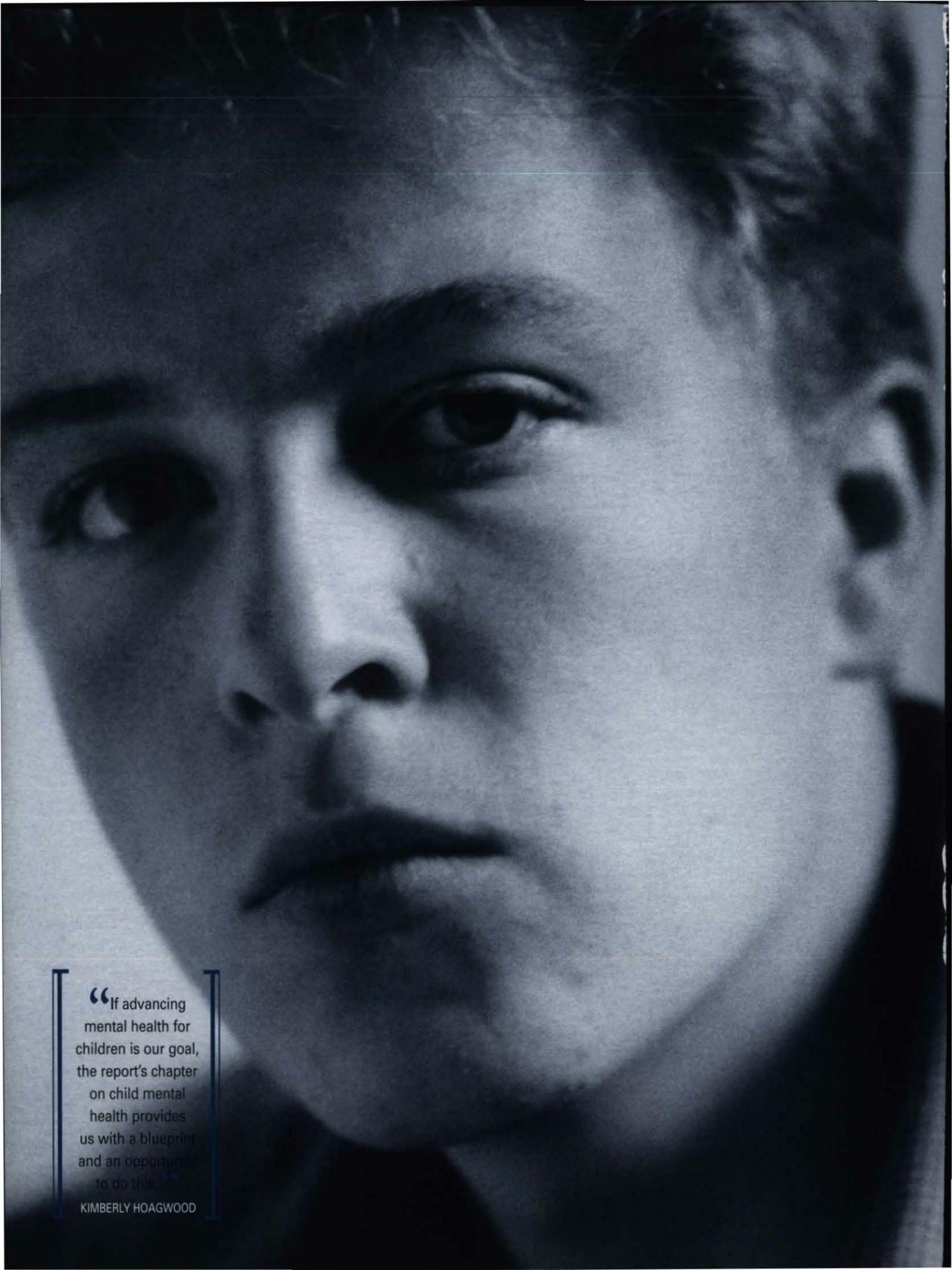
“In today’s new image of aging, older adults who have mental illnesses and mental disabilities are not always seen as politically correct and, in a sense, they never were.

That is partly why the report chapter dedicated to aging issues is of great significance.”

ROBERT BERNSTEIN

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“If advancing mental health for children is our goal, the report’s chapter on child mental health provides us with a blueprint and an opportunity to do this.”

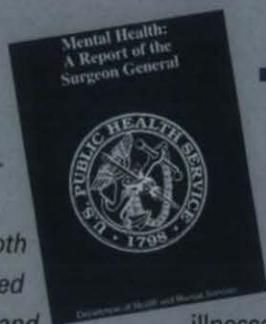
KIMBERLY HOAGWOOD

## At Issue: Public Awareness

The release of the first *Surgeon General's Report on Mental Health* presents opportunities for increased public discussion about a more comprehensive national view of health.

By David Satcher

*In 1997, Dr. David Satcher, a physician, scholar and lifelong public health advocate, became the 16th Surgeon General of the United States. He is also assistant secretary for Health, and only the second person to hold both positions simultaneously. Before that, he served as director of the Centers for Disease Control and Prevention (CDC) in Atlanta, working with The Carter Center on several initiatives on immunization and on mental health. From 1982 until coming to the CDC, he was president of Meharry Medical College. He has served as professor and chairman of the Department of Community Medicine and Family Practice at the Morehouse School of Medicine, and has developed and chaired King-Drew's Department of Family Medicine at King-Drew Medical Center in Los Angeles and directed the King-Drew Sickle Cell Center. A native of Alabama, he graduated from Morehouse College and was elected to Phi Beta Kappa. He received his M.D. and Ph.D. from Case Western University with election to Alpha Omega Alpha Honor Medical Society.*



The first ever *Surgeon General's Report on Mental Health* is a historic document. For too long, our nation has overlooked mental health as fundamental to overall health and has overlooked mental health promotion and prevention and has not considered treatment of mental illnesses as being essential to a quality health care system.

With the publication of this report, we hope to bring mental health and mental illnesses to the forefront of our nation's attention and to impact discussion on health and planning processes for our health care system.

The report reveals the dramatic scientific advances in our knowledge about mental illnesses and their treatment. It affirms that mental illnesses are real, that effective treatments are available, and that recovery is possible.

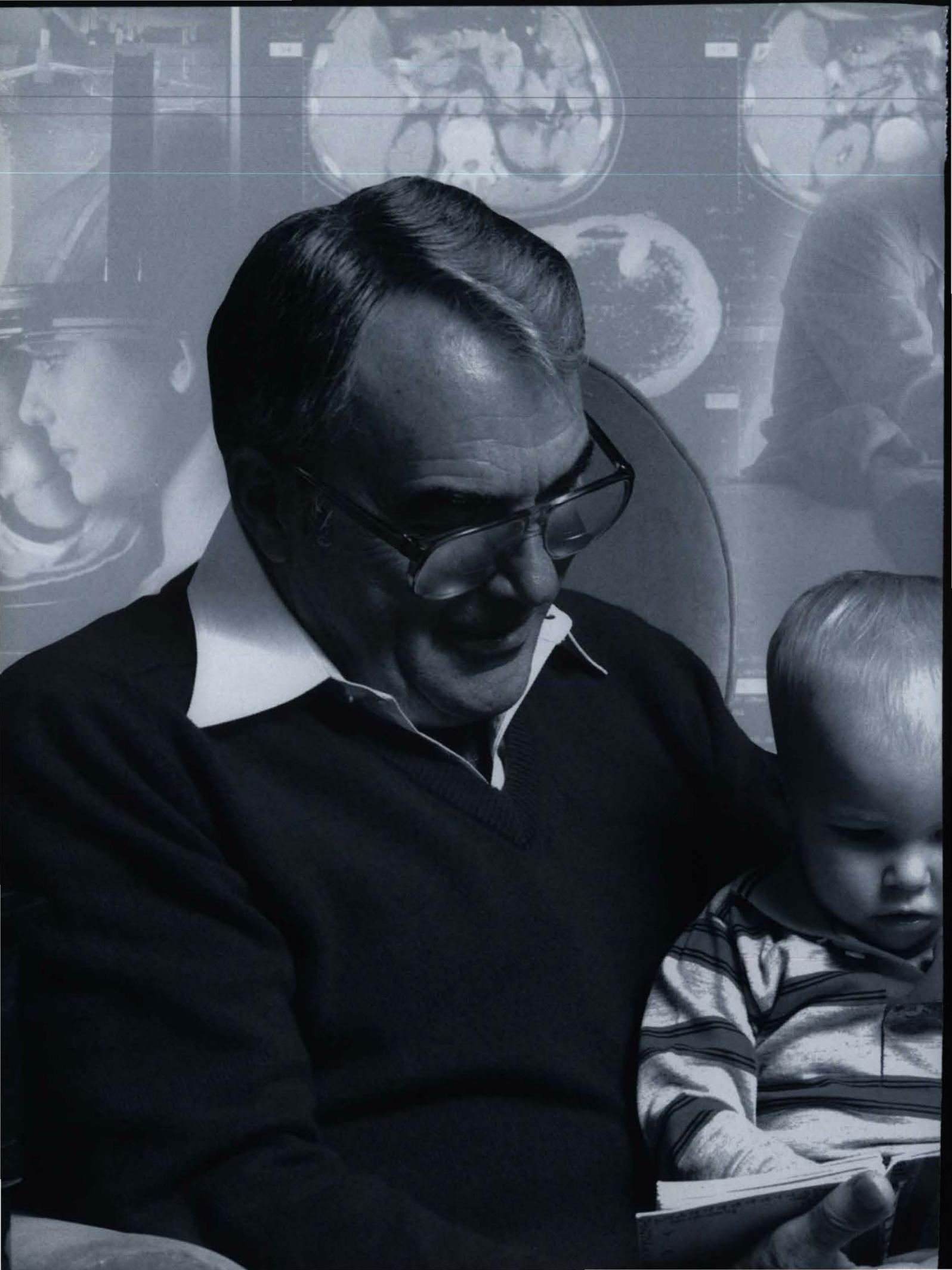
The report does not answer all the questions that we have about mental health and does not meet everyone's expectations, but it is an important start in many respects. It addresses mental health from a life-cycle approach. It shares the best science on prevention, treatment, and recovery; and it suggests a variety of policy opportunities for the nation.

I hope that it will be just the first of several Surgeon Generals' reports on mental health.

We want all who have concerns about mental health to take seriously this opportunity to make the release of the report only the first step in its utility. We need public support, especially from the mental

health community, to help us move the debate and its outcome toward our mutual goals in quality health care for all. These goals are impossible without mental health as a fundamental objective in our national agenda.

“With the publication of this report, we hope to bring mental health and mental illness to the forefront of our nation's attention.”



## An End and a Beginning

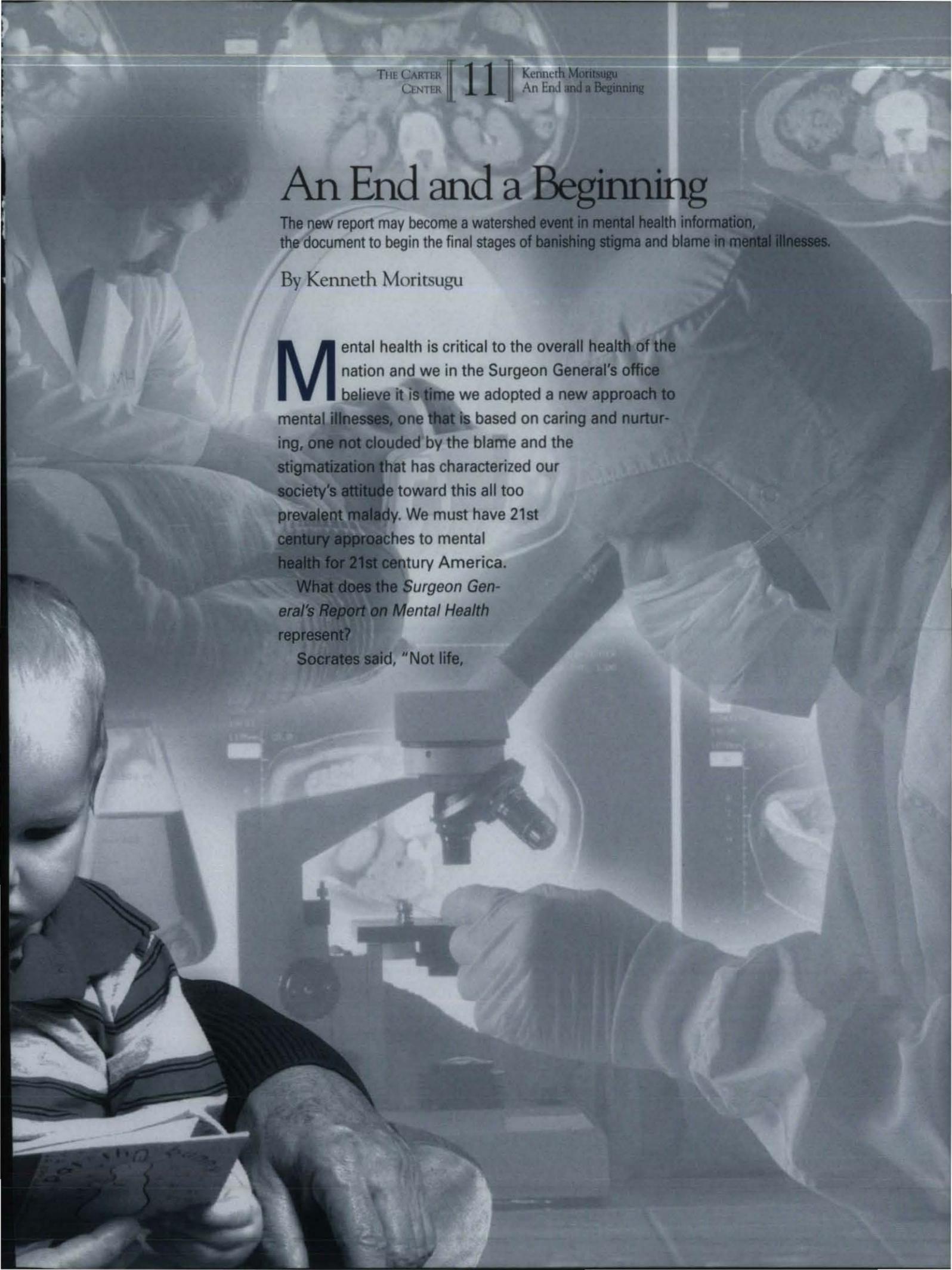
The new report may become a watershed event in mental health information, the document to begin the final stages of banishing stigma and blame in mental illnesses.

By Kenneth Moritsugu

**M**ental health is critical to the overall health of the nation and we in the Surgeon General's office believe it is time we adopted a new approach to mental illnesses, one that is based on caring and nurturing, one not clouded by the blame and the stigmatization that has characterized our society's attitude toward this all too prevalent malady. We must have 21st century approaches to mental health for 21st century America.

What does the *Surgeon General's Report on Mental Health* represent?

Socrates said, "Not life,



but good life is to be chiefly valued." We know that inherent in living a good life is good health, not just good physical health but also good mental health. Throughout the ages, great sages and philosophers have penned ideas pertaining to the importance of a sound mind and a sound body. Even parables in the Bible document evidence of mental illnesses, although they may not refer to them as such. So, this concept of mental health is not a new one. Neither are mental illnesses new, but one has to wonder why it has taken us so long to address mental health at this level.

In 1964, just 35 years ago, then Surgeon General Leonard Shealey released the landmark *Surgeon General's Report on Smoking and Health*. Since then, Surgeon Generals have published 52 reports in all, 28 of them on tobacco. But as important as all 52 reports are, we believe this one, *Mental Health: A Report of the Surgeon General*, holds special significance for several reasons.

Reason number one is that mental illnesses are a public health problem that we must all address. As Dr. Satcher has mentioned, this represents the first time ever that a Surgeon General's report has undertaken the topic of mental health. But beyond that, the report is significant because mental health is a critical public health problem crying out for a national response. This report, coupled with the *Surgeon General's Call to Action to Prevent Suicide*, released this past summer, answers that cry. It is an opportunity to engage the American people in a manner that can truly make a difference, a difference that can change the way we consider mental health, a difference in the way we talk about mental illnesses, a difference in the way we help individuals with mental diseases.

Every year, more than 51 million Americans experience diagnosable mental disorders. They strike close to home. Many of us know someone who has been affected by mental illness. Of these, more than 6.5 million are disabled by severe mental illnesses, including as many as 4 million children and adolescents. Major depression, schizophrenia, bipolar illness, eating disorders, anxiety disorders, and other mental illnesses frequently impair normal daily activities such as working, sleeping, and caring for oneself and others. And yet,

“Mental health is critical to the overall health of the nation, and we believe it is time we adopted a new approach to mental illnesses, one that is based on caring and nurturing and not clouded by the blame and the stigmatization that has characterized our society's attitude toward this all too prevalent malady.”

only one in four affected adults ever receives treatment. Only one-third of our young people who need mental health services get them.

We must ensure that we leave nobody behind in our approach to mental health, from the child with attention deficit hyperactivity disorder to the young adult combating depression to the senior struggling with Alzheimer's disease. Mental health/mental illness spans the full continuum of life. We need a system that responds appropriately throughout that entire continuum.

But age is only one factor. Mental illnesses transcend all walks and avenues of life, all races, and all levels of socioeconomic status. That is why we must ensure that mental health services are as widely available as other services within the health care delivery system, services that are also culturally appropriate.

One of the basic tenets of public health is that, to the extent we care for the needs of the most vulnerable amongst us, we do the most to protect the health of our nation. In addressing mental health as a public health issue, we protect and improve the health of our nation.

The second reason the report is important is because mental illnesses are real. We are witnessing a scientific revolution in our understanding of mental health and mental illnesses. Over the past 25 years, our understanding of brain behavior has improved markedly. This scientific revolution has brought with it the knowledge that mental illnesses impair thinking, feeling, and behavior; interfere with a person's capacity to be productive and enjoy fulfilling relationships; and that mental illnesses can include schizophrenia, manic depressive or bipolar illnesses, panic disorders, and other anxiety disorders.

The good news is that mental illnesses can be treated, but not until they are acknowledged. To maintain good mental

health, we have to be willing to acknowledge that psychological and emotional problems exist. Left untreated, mental illnesses can result in a host of other problems, including violence, substance abuse, homelessness, or imprisonment. By increasing awareness of mental illnesses and by reassuring people that mental illnesses are real, we,



As deputy surgeon general, **Rear Admiral Kenneth Moritsugu** assists the Surgeon General in addressing national health policy issues. A career officer in the Commissioned Corps of the U.S. Public Health Service since 1988, he was born and raised in Honolulu, Hawaii.

He received his B.A. with honors in classical languages from the University of Hawaii, his M.D. from George Washington University School of Medicine, and a M.P.H. in health administration and planning from the University of California in Berkeley. He began his public

health service career in 1968 and completed three tours of duty while in medical school. He has served as medical director of the Department of Justice's Federal Bureau of Prisons, a position responsible for the health care of nearly 120,000 federal inmates and detainees.

Admiral Moritsugu has received numerous honors and awards including the Surgeon General's Medal for Exemplary Service, the Surgeon General's Medallion, the Distinguished Service Medal, the Meritorious Service Medal, and the Outstanding Service Medal.

in essence, are opening the door for them to seek the treatment and the services they may need.

This leads me to the third reason the report is significant. There is new hope for the future. Mental illnesses can be treated. Not only are we able to better diagnose mental illnesses, but new knowledge also has led to a variety of effective treatments and services that can lead to recovery. That means we have the potential to improve lives once considered lost to illnesses we either did not understand or, worse, were not willing to understand. This also means that for the one in five Americans estimated to be directly affected by mental illnesses, there is new hope. Adding to their hope is that of millions of family members, friends, and co-workers who are affected by those suffering from mental disorders: all of them have a chance of new hope for the future, a new chance at a good life.

Why did it take so long?

Clearly, one of the main reasons has been our reluctance to deal openly with issues of mental health and mental illnesses. That is because they have traditionally been overshadowed by stigma. Anxiety disorders and depression are the most common mental disorders in America. Yet, many individuals with these disorders keep silent, ashamed. More importantly, they are unaware of the availability of excellent treatments discovered through clinical research.

These stigmas are not unlike ones that surrounded other diseases in America — syphilis in the 1940s, cancer in the 1950s and '60s, and HIV-AIDS in the 1980s. The progress we have

made destigmatizing mental diseases and opening the window of science and research to treatment is in large part due to the leadership of individuals such as Rosalynn Carter and Tipper Gore.

We have made progress in combating prejudice, but the war is not over. We must continue our battle to end the cruel stigma of mental illness, a stigma that feeds on myth and invites discrimination. We cannot afford to let our children continue to suffer, to let our teenagers continue to suffer, to let individuals in every stage of life continue to suffer when, in many cases, there are effective treatments available to help them.

Both science and history have taught us that to ignore serious illnesses because of shame and blame is to allow them to get the best of us. For both moral and medical reasons, we cannot, we must not, allow that to happen. Stigma and discrimination are the greatest barriers confronting us when it comes to addressing the issue of mental health.

While stigma may be one of our greatest barriers in achieving mental health, our greatest defense against stigmas is knowledge based on solid science and not on popular opinion.

The more we know about stigmas, the more we can find ways to overcome them, the better off we will all be. The more the public knows about mental health and mental illness, the better opportunity all Americans have to realize that mental disorders should be treated, and must be treated, with the same serious regard we give to other illnesses. People must know that it is as

“We must ensure that we leave nobody behind in our approach to mental health, from the child with an attention deficit hyperactivity disorder to the young adult combating depression to the senior struggling with Alzheimer's disease.”

important to be concerned about our brain and its healthy functioning as about the proper functioning and the health of our kidneys, our lungs, our liver, or our heart. If one of the other organs were to fail, we would respond immediately. We can afford to do no less when the brain malfunctions. So, this report is significant from a public health perspective, from a scientific perspective, and from the perspective of new hope.

What is the report not?

For everything the report is, it is not the final word on mental health. It is a long report, but there is still much we do not know and much that still needs to be studied and demystified about mental health. Nevertheless, the report is broad reaching. It is comprehensive. We have attempted to include as much as science would support because we knew this report needed to have breadth as well as depth to capture the attention of our nation. We realize some will criticize the report. After all, an effort of this magnitude cannot hope to escape controversy. Some will feel that "mental health" is not in the realm of health. Some may feel that we have included topics that are outside the realm of mental health. Some may feel that we have not included things that are in the realm of the science, while others may feel that we have included information outside the realm of accepted science.

And yet, we have been careful to assure that this report, just like other Surgeon Generals' reports, is based on the best available science. The key is to focus on the positive and not become bogged down in the negative.

The report represents an end as well as a beginning. We hope it will signify the end of an age when mental health is misunderstood, the end of an era when the topic of mental illness is hidden, the end of unnecessary pain, suffering, and disability due to mental disease.

We also hope the report represents a beginning — the beginning of increased awareness that mental illnesses are diagnosable and treatable; the beginning of more scientific research; the genesis of new and fresh dialogue about mental health; and the beginning of more reports that capture the attention and the commitment of our nation to truly engage in a strategy to make mental health as impor-

“This report represents both an end as well as a beginning. As we set the stage for its release, we hope it will signify an end of an age when mental health is misunderstood, the end of an era when the topic of mental illness is hidden, and the end of unnecessary pain, suffering, and disability due to mental disease.”

tant as physical health.

We hope the report will be like tossing a pebble into a pond, generating ripples that expand outward and have influence far beyond the size of that tiny little pebble. We hope the report is merely the first pebble that results in many more and that the ripples of its impact will be far reaching.

So, where do we go from here?

How do we make sure that as we open the door on the next century, we also begin to close the door on one of the biggest public health problems of this century? The answer goes far beyond the release of *Mental Health: A Report of the Surgeon General*. It is about making sure that we continue to bring the topics of mental health and mental illnesses out into the open. It is about believing in our hearts that good health for each of us depends upon good health for all of us, and that good health is both physical health and mental health. It is about offering an outstretched hand of hope to those who fear they never will see hope again and, most important, it is about never losing faith that we have the national will to succeed.

The Department of Health and Human Services continues its commitment to prevent and treat mental illnesses. We have proposed \$1.5 billion for mental health activities for fiscal year 2000. These funds will enable the National Institute of Mental Health (NIMH) to continue to support critical mental health research on the origins of mental illnesses, ultimately improving treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) will be able to further its programs that ensure that people with mental illnesses and their families have timely access to quality services.

The Surgeon General and the Department of Health and Human Services are fighting for improved mental health care and improved services at every turn. However, we cannot have

that successful public health agenda, one that protects and advances the mental health of all Americans, without help. We need each person involved in mental health issues, each organization dedicated to the cause of mental health, to help ensure that mental health needs are never overlooked.

We need continued input and ideas from the mental health community. We need



more and more and more people to stand up and speak out. We need, to continue to work together, to get the word out that mental health issues are family issues and are really national issues. It is thanks to organizations like The Carter Center and those represented by attendees at the 1999 symposium that mental health issues and interests have come this far, but there is much yet to be done.

I think a passage by Robert Frost characterizes this so well:

“We have attempted to include as much as science would support because we knew this report needed to have breadth as well as depth to capture the attention of our nation.”

*“The woods are lovely, dark and deep  
but I have promises to keep  
and miles to go before I sleep.”*

And so it is for all of us, when it comes to achieving a good life, to achieving mental as well as physical health for all Americans, we still have miles to go before we sleep.

Godspeed to all of us on the journey and may the Surgeon General's report be a major step that will take us to our goal.

# The “Balanced Life”

Americans respond to messages that stress the need for wholeness in mental and physical health; communication should begin with an emphasis on quality care for all, rather than issues of cost or treatment.

By Celinda Lake

In surveying opinion concerning mental illnesses, we found once again that the public is ahead of where conventional wisdom says. For example, we found:

- People have a startling amount of personal experience with mental illnesses and readily believe that they can affect any family. They believe, for example, that half of the people in any given room can be personally affected.
- Clearly, “mental health” and “mental illness” were the best terms to use in communicating information to people; they meant virtually the same thing.
- People respond to analogies that mental illnesses should be treated like physical illnesses and is fundamental to good health.
- Because of people’s ambivalence toward, and distance from, mental illness, language is critical. Personalizing the issue adds to the messages’ and conversations’ power, because it resonates with people’s experience. Yet people have different reactions to different terms; some words draw stereotypical images.

Those were among the most important findings in our study, but before we proceed, let me explain how we did our research.

We did a national random survey, then correlated the information with the results from more intensive focus groups sessions in several locations in Chicago and Pasadena, California. In the focus groups, we talked to a variety of people by socioeconomic class, race, and gender. We then verified our results with a nationwide telephone interview of adults aged 18 and older. The error on the survey is +/- three percent.

“Balancing” — a term people like — mental illness and physical illness, reminding people

that each should have equal treatment and both are fundamental to good health, is a powerful paradigm. They absolutely believe that you cannot separate the two and that you should not want to.

However, people understand the problem far better than they understand the solution. The language of messages regarding treatment, the language of the approach to inform people of treatment options, is very important: it can either tap into the resonance that already exists in the public mind or distance people.

The strongest language talks about the number of Americans affected. It personalizes the issue; it talks about treating mental illnesses as physical illnesses; it talks about the negative consequences of stigma. People believe there is stigma.

It is striking how much personal experience people have. People relate to mental illness from their work experiences — a policeman saying he had seen, first hand, mental illness; individuals saying they themselves have gone to a therapist or had family members go in time of need.

Focus group participants best understand mental health when it is framed in terms of illness. They also like the term “mental health,” which they see as very similar to “illness” although “illness” is slightly less confusing. Talking about treating mental illnesses like physical illnesses is facilitated by that language.

When we asked with what people associated “mental health,” they said, “Depression, state of mind, Alzheimer’s disease, illness, some kind of disturbance or state of emotional well-being.” When we asked people the same question, using “mental illness,” they said, “Depression, violent behavior, manic-depres-

“People readily respond to the analogy that mental illness should be treated like physical illness and is fundamental to good health.”



**Celinda Lake**, president of Lake, Snell, Perry and Associates, is known for cutting edge research on issues including the economy, health care, the environment, and campaign finance reform. A native of Montana, she holds a B.A. from Smith

College in Massachusetts and an M.A. in political science and survey research from the University of Michigan in Ann Arbor. She also has a certificate in political science from the University of Geneva in Geneva, Switzerland.

sive, erratic, losing your memory, not being able to speak for yourself." In repeating many of the same symptoms for both terms, people seem to confuse the distinctions between mental health and mental illnesses.

Then there are noncommunicative scientific terms many people absolutely do not understand. "Somatic" was at the top of the list. What is "somatic disorder?" we asked. The answers? "I have no idea." "It sounds serious." "I am not sure about it." "It may mean being unable to speak." "Is it a body function?" Most people did connect this with "mental." The lesson: Avoid technical language, don't use jargon, and you'll communicate more effectively.

Interestingly, language like "emotional disorders" or "emotional problems" did not work as well either. For one thing, they are perceived to be less severe to people. Men, more than women, treated the terms as less severe; some men even said, "Emotional disorders are more associated with women."

People also tended to equate "emotional disorders" with children who have self-esteem problems, which is not always to our benefit. "Mental disability" was also not a good term. People have strong and often not positive associations with the word "disability" — "It is a sham" was a common refrain. Other people said, "handicapped or debilitating," but the notions of fraud and abuse were accentuated when people were asked about "mental disability."

We read a number of messages and asked how convincing our groups found these statements. For example, we read: "At least one in five Americans is affected by a mental disorder: 44 million adults

and 13.7 million children experience a mental disorder each year. This is a problem that affects us all — our families, our friends, our neighbors, and our co-workers. Such an extensive problem that might well affect half the people in this room cannot be overlooked. We need to provide our families the help they need when they need it." Between 81 and 86 percent found this and similar statements "convincing" and 48 to 53 percent of those found them "very convincing."

The strongest two arguments were, "Mental health is a part of leading a balanced life," and "Good mental health is fundamental to the health of all people, and a concern to all people, but stigmas continue." People felt very strongly that there were still stigmas, particularly older people and Hispanics.

Hispanic people thought that in their community, more than in others, a stigma remained around mental health. Women and younger people particularly responded to the argument, "We need to destigmatize this illness so people can get the care they need."

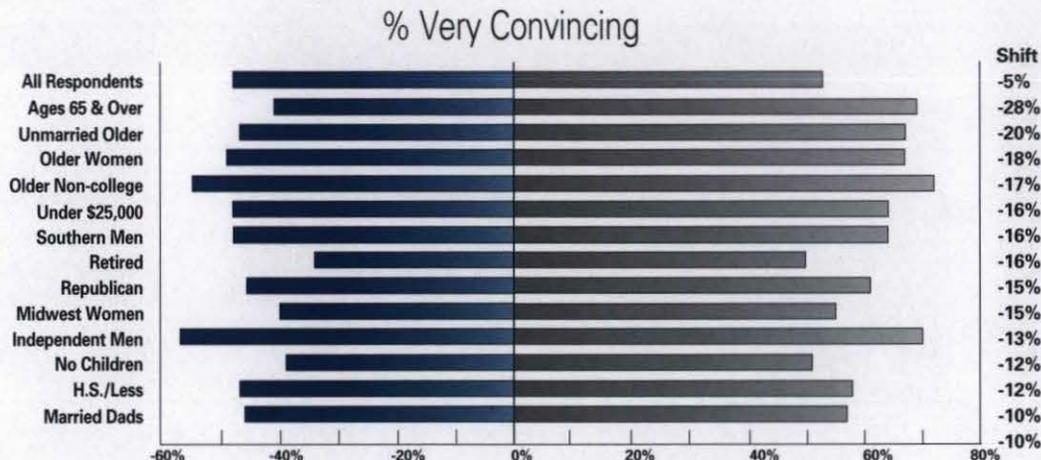
"Mental disorders affect many Americans," "one in five," "half of the room" were all statements people believed. The numbers did not surprise survey participants and the notion of immediacy were not contested — that mental illnesses can strike a family at any time with serious consequences, not just for the person, but for his or her family, friends, even neighborhood, and workplace.

“People seem to confuse the distinctions between mental health and mental illness.”

Respondents believe mental illness interferes with an individual's ability to cope and lead a meaningful life. Less convincing were messages

## The Balanced Life Issue

Respondents are most convinced by an argument comparing mental and physical illness when the message is stated positively and the phrase "balanced life" is included in describing mental health. Without this phrase, the largest drops in support occur among seniors, older unmarried respondents, the unemployed, older women, older non-college graduates, and households that earn less than \$25,000 a year.



### The Cost Factor Question

"Mental illness interferes with an individual's ability to cope and lead a **meaningful life**."

"Mental health is an invaluable component of leading a **balanced life**. Mental illnesses are a set of diseases like physical illnesses."

that focused on cost and on the effectiveness of existing treatments, but for different reasons. People did not like messages about costs because they thought expense of treatment is not something that should be evaluated merely in dollar terms. That does not mean they would agree to have their taxes raised to pay for treatments for everyone; it means merely that respondents, particularly women, do not like equating mental illness with money. Secondly, cost issues elevate concerns about fraud and abuse, which were not usually at the fronts of people's minds.

In fact, people we most wanted to influence on the cost argument — tax-sensitive voters, white Republican men — were completely unconvinced by cost arguments. Their opinions, especially those of men, included: "Well, that is a lot of wasted money." "Too much money." "... a cash cow." "I think it is a racket."

Money should not be a buzz word. The repercussions of mental illness to society and individual are what has an impact. To make the pocketbook an issue is to circumvent positive feelings and introduce negative ones.

#### Who cares what it costs?

If it helps you be a better person in our society, if it advances our collective safety and well-being, who cares what it costs? That is the bottom line. For most people, it does not appear relevant to

"Who cares what it costs? If it helps you to be a better person in our society, who cares what it costs?"

mention the financial figures. How can you break down the costs? How much is direct treatment, direct counseling, insurance? The issue of health and an individual with a mental or emotional problem should be to effect a cure as opposed to saving the government money. So, people think about mental illness in personal terms and they respond to it in personal terms.

Treatment arguments also are much less effective. The treatment arguments were really only effective with retired women who are also among those most responsive to all the arguments. People are ambivalent about the effectiveness of treatment. They are ambivalent about whether there is clear diagnosis. They also are unclear whether, unlike a physical illness, all need the same treatment; they recognize that different treatments for the same illness may be necessary. Listen to their voices: "How can they diagnose mental illness with a high degree of accuracy? I do not believe they can do that." "I thought it was ridiculous they were going to treat everybody the same, everybody is different." "Everyone has a different chemical

balance. It is not like treating cancer." Yet most believe mental illnesses are curable, although they require individualized treatment: "They can take pills and get you straight." "If he has one disease and I have another, they cannot give him the same

## The Cost Factor

Only about one-third of survey respondents find a cost argument very convincing. African Americans, Democratic women, older Democrats, adults ages 40-49, residents of the South Atlantic region, and non-college graduate women are among those groups most likely to respond favorably to messages that emphasize a cost factor in mental illness.

### The Cost Factor Question

Now I'm going to read you some short statements that some people have made regarding mental health and mental illness and how we should deal with them. For each one please rate it as very convincing, not too convincing, or not at all a convincing statement. **"Mental illness costs us money ..."**

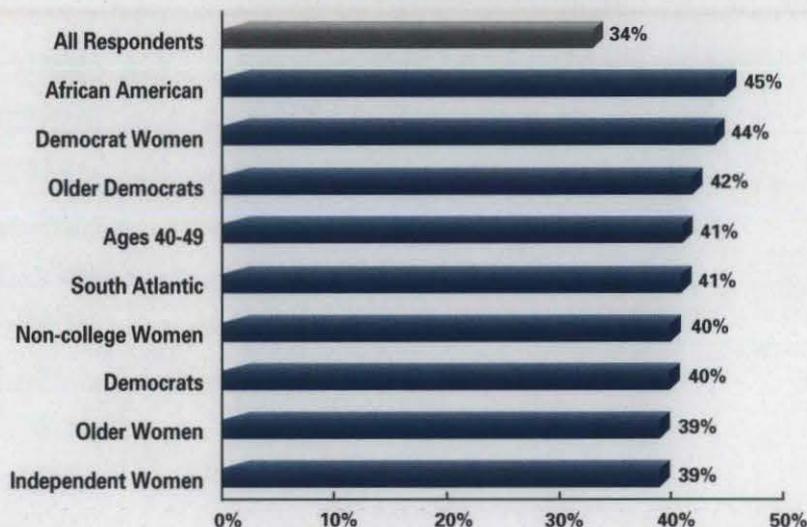
stuff they are giving me and make us both feel good." That suggests two things: one, the strongest message in the early stages of introducing concepts and mobilizing people for action is not cost; also, treatment messages are not as effective. Over the long run, the public must be educated about costs and especially treatments.

Respondents were especially convinced by arguments that compared mental illness to physical illness. They also responded to language of "balanced life." Without this phrase, there was a drop in support. Older people in particular responded to messages that equated mental illness to physical illness and also this notion of a balanced life. Older voters — older women in particular — were very responsive to the analogy of physical illness and mental illness.

Interestingly, mental illness is one of the few issue areas where explicitly focusing on children does not strengthen the message. People believe children experience mental illnesses, but they also think that this is a very serious adult disease. One of the things that unites them is the belief that mental illness can strike adults as readily as youngsters, and the consequences for an entire family may be greater when it does strike adults.

When the message, "Mental illness is the greatest killer ... greater than cancer and other

## % Very Convincing



diseases combined," was given, they did not believe it. The lesson: Do not overstate the case; mental illness is dramatic because of the number of people affected, the fact that it can strike anyone at any time, and the fact that it can have a broad affect on the total network of a mentally ill individual, including having a profound affect on the immediate family.

The message that mental disorders affect at least 20 percent of Americans and that they can affect anyone appeared stronger, particularly with men and with seniors, when it did not explicitly refer to children. They do not want to exclude children, quite the contrary; but concern about mental illness is aroused to a greater degree when focused on adults. One last note: Numbers particularly affect younger people and African Americans.

People appreciate the nature and severity of the illness, but are they ready to agree on public policies and health policies that respond to it? There is still work to do to educate the public about costs and treatment.

However, that lack of security and consensus about the effectiveness or cost-efficiency of care does not diminish people's support for treating mental illness like physical illness and having a much more aggressive approach toward it as a society. People are willing to gather at the mental health table because of their own experiences and because of the degree to

“The top message was one that talked about mental health is fundamental and connected to all people and that explicitly referred to stigma.”

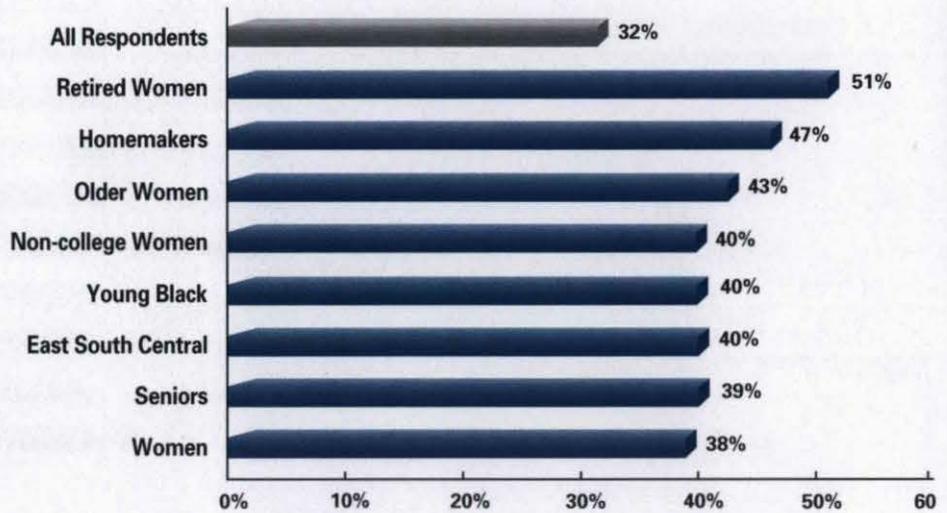
## The Treatment Question

Treatment arguments are less intense among both focus group and survey respondents. Overall, only 32 percent of respondents find an argument surrounding treatment very convincing. Females in general and young African Americans find the treatment argument more convincing than do other categories, including most categories of males.

### The Cost Factor Question

"**Effective** treatments exist for the majority of mental disorders and we are finding **new** treatments all the time ..."

## % Very Convincing



which they believe mental illness can have profound personal and societal effects: It can affect any family anytime and the reach of the problem can be quite broad.

On the basis of this fundamental, commonly held assertion comes the opportunity to help the public understand the need for equity of care for mental and physical illnesses within the context of a "balanced life" for all Americans.

## A Personal Issue

Because many people have had some experience with mental illness, focus group participants are affected by the possibility that it could touch their own family. They are not surprised when told half the people with whom they are gathered could have mental illness, or that 20 percent of the American people suffer some form of the disease. They believe "we need to provide our families the help they need when then need it." A few of their comments on what moved them in the interviews:

- "It was more or less that there are family mental problems out there and they do need help."
- "The part about half the people in the room. It makes you really think about it. It's a lot of people involved and that needs to be addressed."
- "The fact that mental illness can affect anybody at any time."
- "The part about the family; it's very destructive to families when they can't identify what is wrong."
- "... specifically mentioning that 50 percent of

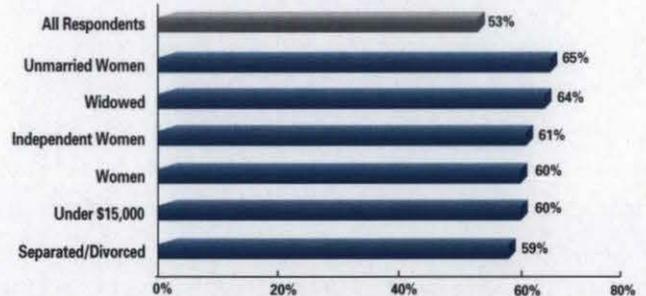
any group would be affected in some way."

- "I think that all kinds of people just don't recognize it. It's there, but they don't want to put a name on it. I think so many people are afraid to associate."
- "The part that mental health affects our family, our community, I can agree with that."

Focus groups also respond to arguments that mental health is fundamental to all people, but treatment is thwarted by the stigma attached to mental illness. Participants admit their own ignorance of the subject and own biases toward the mentally ill.

- "Well, it's true, a lot of people don't want to admit they are mentally sick and ... we need to get rid of that."
- "A lot of times when I read about these

## % Very Convincing



### The Stigma Handicap

"Mental health is fundamental to the health of all people and must be of concern ... However, **stigma** continues to shadow people with mental disorders."

[violent] crimes, I think about mental illness. I think you would have to be mentally ill to have done that."

- "I'm telling you it affected everybody. It affects everybody's life. Neighbors have to go out of their way for you. People have to do things for people with mental illness."
- "That is just so prevalent. In our society, people can't get help because they are going to be thought of as different."
- "People don't like [mental illness]. We want to be treated, but we don't want to say what we're being treated for."

# Comments & Questions

Audience members respond to Celinda Lake's message on communicating the report effectively.

**Peter Jensen**  
National Institute  
of Mental Health

*What was your sense of the most effective ways to communicate concerning children's mental health problems?*

**Celinda Lake**

We did not research it. When the nation was debating national health care reform awhile ago, we did research for the John D. and Catherine T. MacArthur Foundation around having insurance cover mental illnesses the same way it covers physical illnesses. What was interesting there is that people were very aggressive about wanting insurance companies to cover children because they thought it would be much less expensive than covering adults and that there was no excuse for not covering a child. So in that limited arena, leading with children actually was effective for us.

Indeed, in some research on insuring the uninsured, leading our questions by stressing children's conditions was the most effective approach. That is what was so startling about the lack of support in this instance. This is an area that needs more research. It is not that people are anti-treating children. That is not where they are coming from in their sense of urgency.

**Curtis Decker**  
Nat'l. Association  
of Protection and  
Advocacy Systems

*I was concerned about comments that disability equals abuse. Please explain in a little more detail what that means.*

**Celinda Lake**

I do not know if disability equals abuse in the public mind, but my sense of it is that survey respondents were thinking in terms of

“We did not hear about whether people really think people with mental illness labels are as good as other kinds of people.”

employment disability from mental illness can easily lead to abuse.

Indeed, one way opponents of equal policies for mentally ill persons justify their stance is to say mental illness is not like physical illness. You cannot tell if someone has it and therefore, is open to fraud and abuse by unethical people.

In our survey, people did not surface that concern very much, perhaps because we tried to avoid wording that invokes those notions. It was clear that people were not talking about “disability equals abuse” in the sense of a handicap, etc. They were thinking more of con artists who use mental disability to defraud financially a company or the government.

**Linda Andre**  
Committee for  
Truth in  
Psychiatry

*Do survey respondents think people with mental illness are equal to people who do not bear that “label”?*

*This is the stigma that affects our lives and we would like to know where these perceptions come from. We would like to see a dent made in the perception that people with mental illness are less capable, less honest, less responsible, do not have to be listened to, do not know what they are talking about, and that kind of thing.*

**Celinda Lake**

The scope of the research was limited; it was just to discover how people think about mental illnesses at the time the report was being prepared. The public seemed to agree with your opinions of the negative consequences of stigma and labeling. Yet there was some evidence they might also

label and help perpetuate stigmas — or at least be influenced by them. But there was also a conscious acknowledgment that stigmas are harmful and should be avoided.

**Howard Goldman** Devaluing people who have mental illness was not an issue in the focus group; it was not even an undercurrent. I am certain it translates into discrimination in real life, but it was not something endorsed by respondents. That was quite good news.

University of  
Maryland

**Celinda Lake** Because people think mental illness could strike a family member or a favorite coworker — perhaps even themselves — at any time, this becomes a powerful argument against devaluing people: It could be happening to my sister, my friend, my spouse, my coworker. This viewpoint is liberating because there is a more solid foundation of sympathy and understanding to work with in the public than conventional wisdom might have assumed.

**Bob Boorstin** *Did you test messengers? Whom do people actually believe when they hear messages relating to mental health and mental illness?*

Greenberg  
Quinlan Research

**Celinda Lake** People trust health care professionals. They were sometimes a little confused about the Surgeon General, whether he is a health care professional or bureaucrat, but they were glad to hear he has prepared a report about mental illnesses. They were also somewhat skeptical about “scientists” because they think that scientists are bought by both sides, pro and con, of an issue — that everybody buys their scientists to produce findings that slant the message in their favor.

What was more interesting, and may be more relevant, is that people did not need “experts” to

“The scope of the research as we were instructed was very limited; it was to understand how people think about mental illness on the eve of the report was being released.”

give them information and influence their opinions, at least concerning mental illness. They did not question our statements to any extent. No one said, for example, “I do not believe one out of five Americans has mental illness.” Or, “I do not believe half of the people could be affected by mental illness.”

People seem to have a general understanding of the depth and magnitude of the mental health issue, even though they may be vague on specifics, which is one reason it has this kind of untapped power to it.

**Lisa Dixon**  
University of  
Maryland

*The lack of belief in the efficacy of treatment: Is this about lack of effectiveness or about treatment experiences they received or did not receive? Did you learn from where this lack of belief in effectiveness comes?*

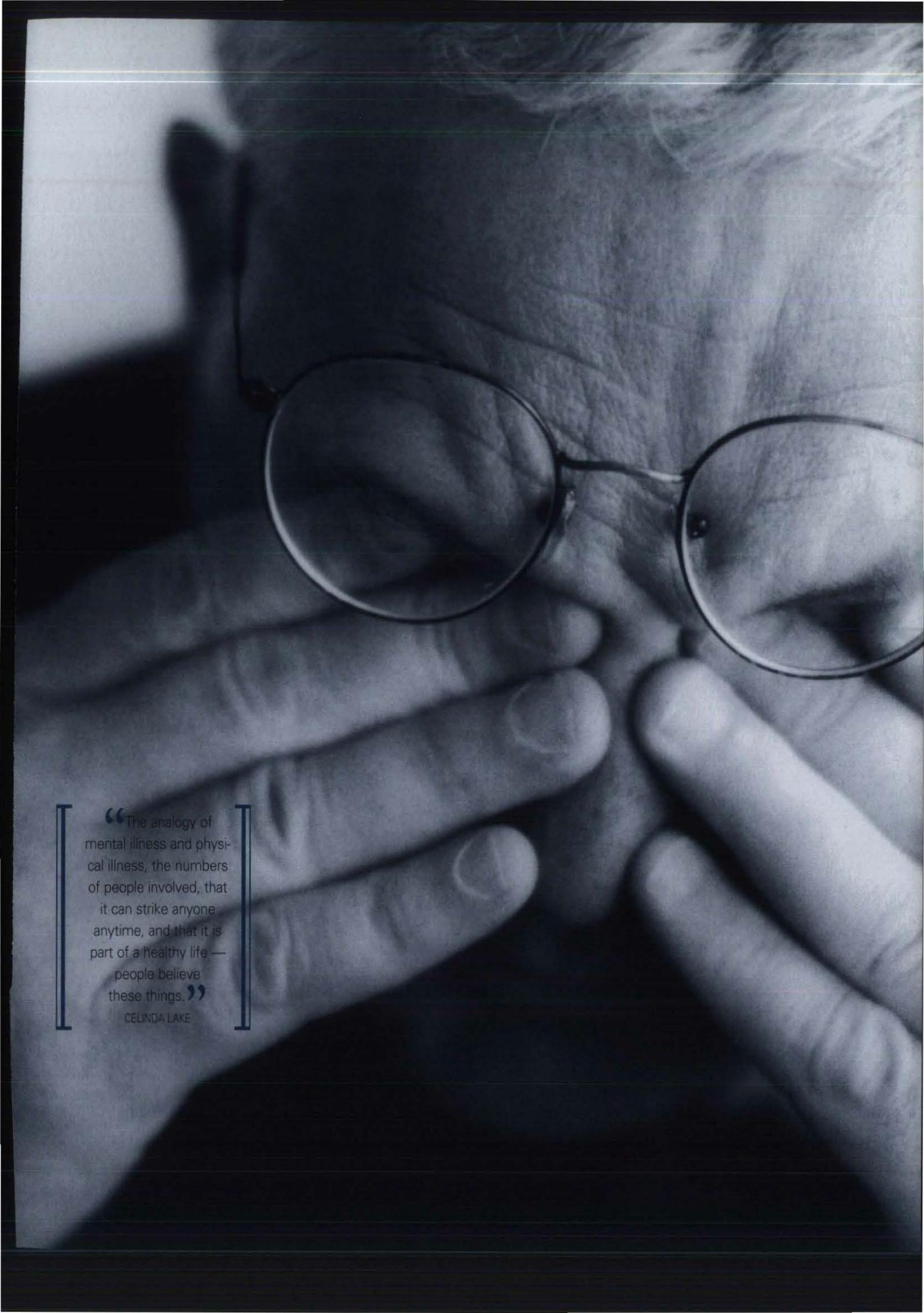
**Celinda Lake**

When we compared mental illnesses and physical illnesses, when we discussed the numbers of people involved, or that mental illnesses can strike anyone anytime, or that it is part of a healthy life, people were unambivalent and unreserved in their response. They believed those messages.

About the effectiveness of treatment they were more ambivalent — more than rejecting it, they felt ambivalence about.

In a focus group, some people are outgoing and willing to discuss their feelings, some seem to speak pretty authoritatively — as a moderator, you would believe these are things they have personally seen. But, for the purposes of this research, we did not push them to clarify statements or assumptions.

Another thing is that people are not even clear as to what the treatments are. It is not like cancer where they can list the regimen, even if it sometimes turns out wrong. Mental illness has no similarly “simple” answers.



“The analogy of mental illness and physical illness, the numbers of people involved, that it can strike anyone anytime, and that it is part of a healthy life — people believe these things.”

CELINDA LAKE

# The Process Begins

With the release of the *Surgeon General's Report on Mental Health*, advocates have a great opportunity to define progress in the field.

By Howard Goldman

Two things are striking about the *Surgeon General's Report on Mental Health*. One is how collaborative the process of preparing the document was. We spent a good deal of time listening to other people's ideas. The report in draft form was reviewed twice. An early draft was reviewed by nearly 100 external and 50 federal reviewers. It was then rewritten and re-edited, and that draft was circulated for federal comment.

The second thing is even more important: Surgeon General David Satcher is endorsing the focus on mental health. His and Ken Moritsugu's eloquent articulation of the report's main messages makes the report extraordinarily powerful.

As it was conceived, the report was to have eight chapters. Because the document was to be science-based, it was designed to have no policy recommendations, and while we who were to write its contents could understand the need and merit of that, it left some of us feeling this was a lost opportunity. Thus Chapter 8 was written to turn a science document into a policy relevant document, providing advocates and program planners with information to use in making evidence-based policy and program decisions. Our success at that will be a measure of the success of the report.

The main messages of the report are simple: Mental health is fundamental to health; mental disorders are health conditions similar to other medical conditions. An important and solid scientific base underscores these statements. The general public seems to understand this. Therefore, it is the mission of the report to describe that science base by combining psychological, behavioral, and biological research mate-

rial into an integrative neuro-scientific perspective.

The efficacy of mental health treatments is well documented. Important to the public, as evidenced in The Carter Center's survey and focus groups, is that a range of treatments for most disorders exist, so there are potential choices to suit individual preferences, whether for medication, for psychotherapy, or for a combination of the two. Over the years people have been hesitant about seeking help, not only because of the stigma associated with mental disorders and reservations about whether treatment will meet their needs, but also because they were uncertain that the treatment offered them would be suitable to them. Over the past two decades, treatments have evolved so that now we can say to an individual, "There is a choice of efficacious interventions and if one does not succeed or does not suit you, there is an alternative which you may choose."

Public opinion data show that adding a comment about having a choice to suit preferences produces an 8 percent increase in the acceptability of the message. The report explains that for a given condition there are several different approaches that might be effective. We also hope to take advantage of the tremendous placebo response of expectancy associated with help-seeking. These currents run through the entire report.

The personal health recommendation associated with these messages is to seek help if you have a mental health problem, or if you suspect that you have symptoms of a mental disorder.

People are encouraged to keep working through whatever entry point they might have into the health care field until they get a satisfactory result, one that suits them, and one that the report indicates might be effective. Not a surprising message to many, but one worth putting in black and white, in the

“The main messages of the report are simple: mental health is fundamental to health; mental disorders are health conditions similar to other medical conditions.”



Professor of Psychiatry **Howard Goldman, M.D., Ph.D.** is director of Mental Health Policy Studies and co-director of the Center for Mental Health Services Research, University of Maryland School of Medicine. He received a joint M.D., M.P.H. degree from Harvard in 1974. In 1978, he earned a doctorate in social policy research from the Heller School at Brandeis while completing a residency in public psychiatry in a unique National Institute of Mental Health training program. Dr. Goldman is an officer in the inactive

reserve of the U.S. Public Health Service, having served as the assistant institute director at NIMH from 1983 to 1985. Over the past 20 years, he has worked on three national plans for services and research produced by the NIMH.

Much of his time is spent in editorial roles.

He consults with public and private organizations on mental health care in the United States, the United Kingdom, and Sweden, and he is the scientific editor of the Surgeon General's Report on Mental Health.

voice of the Surgeon General, before the public, stressing the scientific base that supports statements that in the past were sometimes seen as unscientific or platitudinous. That was our goal.

The first chapter of the report lays out these main themes and messages and provides conclusions. It is an executive summary for the individual who will only read that far.

Another, free-standing executive summary contains all the conclusions but provides more substance. The second chapter of the report provides a framework that serves as a primer for the reader to understand most of the material that will come in remaining chapters.

It begins with a discussion of integrative neuroscience in human terms. The illustration of a child riding a bicycle makes the point that, while the brain and central nervous system may be the stimulus for behavior, behavior and experience also shape the central nervous system. Real structural and functional change comes from learning and from experience. This is a core concept of the newer way of thinking about neuroscience.

We review the epidemiology of mental disorders. Diagnoses can be made reliably even in the absence of lesions or laboratory abnormalities. Fifteen percent of those individuals who do have a mental disorder also are likely to have a substance abuse problem, yet the majority of individuals who have a mental disorder (and probably an even greater number of those with a set of

symptoms below the threshold of official diagnosis) do not receive services of any kind.

Here the policy message of this report begins to emerge. The primer also talks about the different types of treatments and foreshadows later chapters that discuss which are more efficacious and for which conditions.

Perhaps the most unusual part of the report is its acknowledgment and involvement with consumer and family movements, and with individuals who have personal experience with mental disorders and mental health problems. Consumers and family members have contributed an extensive section that talks about the growth of that movement over the past two decades. The unit also talks about a new recovery perspective that builds optimism into our thinking about the potential for people who have a mental disorder or a mental health problem. Recovery is a spirit that runs through the entire report and differentiates it from a routine textbook of mental health.

There is an extensive section also in this primer on the roles of culture, race, gender, physical disability, and sexual orientation, and how they shape people's help-seeking behavior. There also is a discussion about cultural competence.

The final section in the primer describes how the report itself takes a life-cycle approach. The idea of developmental issues is central to thinking in the mental health field and it resulted in chapters on children and adolescents, on mid-life, and on later life. These three chapters begin with a discussion of the goals of achieving mental health at each stage of the life cycle. They talk

“Perhaps the most unusual part of the report is its acknowledgment and involvement with consumer and family movements, and with individuals who have personal experience with mental disorders and mental health problems.”

about the effect of life events that may occur during those stages and what can be done in the framework of promotion of mental health in a somewhat less disease-oriented approach. Also, we talk about prevention, which was introduced along with treatments in the second chapter. Of course, in the child chapter, there is a bit more on specific or targeted interventions of a preventive nature. But, even where preventive interventions are useful in mid-life and late life, the report deals with what we know from the science.

We focus on specific mental disorders in each stage of the life cycle, but we did not have enough time or space to deal with every condition, so we highlight some that run across the life cycle (i.e., depression and anxiety). Within each stage, we also pick specific conditions that characterize its mental health problems and disorders. In early life, we focus on attention deficit hyperactivity disorder (ADHD), and we touch on suicide and its association especially with depression. In mid-life, we focus on schizophrenia as well as depression and anxiety. In the section on schizophrenia, we expand on the concept of severe and persistent mental disorders. Much of that research focuses on schizophrenia but can be generalized to other impaired populations.

We talk about the service system. In the child chapter, we discuss wrap-around services, and in mid-life, we talk about the need for supportive interventions, for housing in a broader context, mental disorder and rehabilitation, as well as treatment. In late life, we again focus on depression, and the extraordinarily high rate of suicide in males. We also discuss Alzheimer's disease in depth.

Each section discusses co-occurring substance abuse. Alcoholism and drug abuse are not specifically featured. Yet, while they were not part of the mandate for this report, it seemed impossible to draw a bright line between a mental health report and a consideration of alcohol and other substance abuse. We focus mostly on individuals who have more severe mental disorders and co-occurring severe substance abuse problems, and discuss treatment as well as services.

The section on later life talks about the problem of recognition of mental disorders and men-

tal health problems, especially in primary care settings. This is the predominant opportunity for entering a mental health care giving system. Unfortunately, more often than not, these settings fail to serve as portals of entry to mental health care. This is discussed at length.

So, each section suggests a research agenda for the future. By virtue of the opportunities offered by scientific evidence of efficacy and effectiveness, the report asks people what they expect from services, but it also underscores that the pathway is blocked by a number of barriers, so that help-seeking behavior does not always result in the receipt of effective treatment.

The sixth chapter of the report focuses on economic barriers. It talks about issues related to insurance: the lack of insurance in the general population; under-insurance, even among those who have health insurance, for treatment of mental disorders; the broad problem, on both ends of the spectrum, presented by a managed care set of strategies that may over-emphasize costs and eliminate from treatment people with mental health problems that do not meet criteria for mental illness on the one hand, and offer too little in the way of services for people with the greatest needs on the other hand. Yet managed care offers a number of opportunities, as well. It provides an opportunity to target and focus treatment on a case-by-case basis, rather than using cost-saving measures in the old way of deductibles and co-payments, which are crude tools.

There is evidence that over the past five years, the efficiency of treatment may have improved even though expenditures have declined dramatically. While that is not at all certain — there is way too little research on it — there is hope that for certain conditions, the effectiveness of treatment and its efficiency has increased such that the decline in expenditures has not been associated with untoward consequences. In fact, in some cases, treatment is better. One course of action is to unlock the financial barriers that still remain and to try to

reprogram the resources that might be saved through this efficiency to expand the base of people who can avail themselves of the opportunities reflected in the science.

One of the last barriers to help-seeking behavior has to do with concerns about confidentiality. In health care, that is a broad concern. In the

“The report makes it clear it is up to the community — to local, state, and federal governments, and advocates — to overcome barriers, whether they are structural, educational, behavioral, or financial.”

mental health care field, where the sensitivity of issues under discussion is often high, concerns about confidentiality run equally high. So the report speaks to confidentiality of medical records and the whole process of health care delivery.

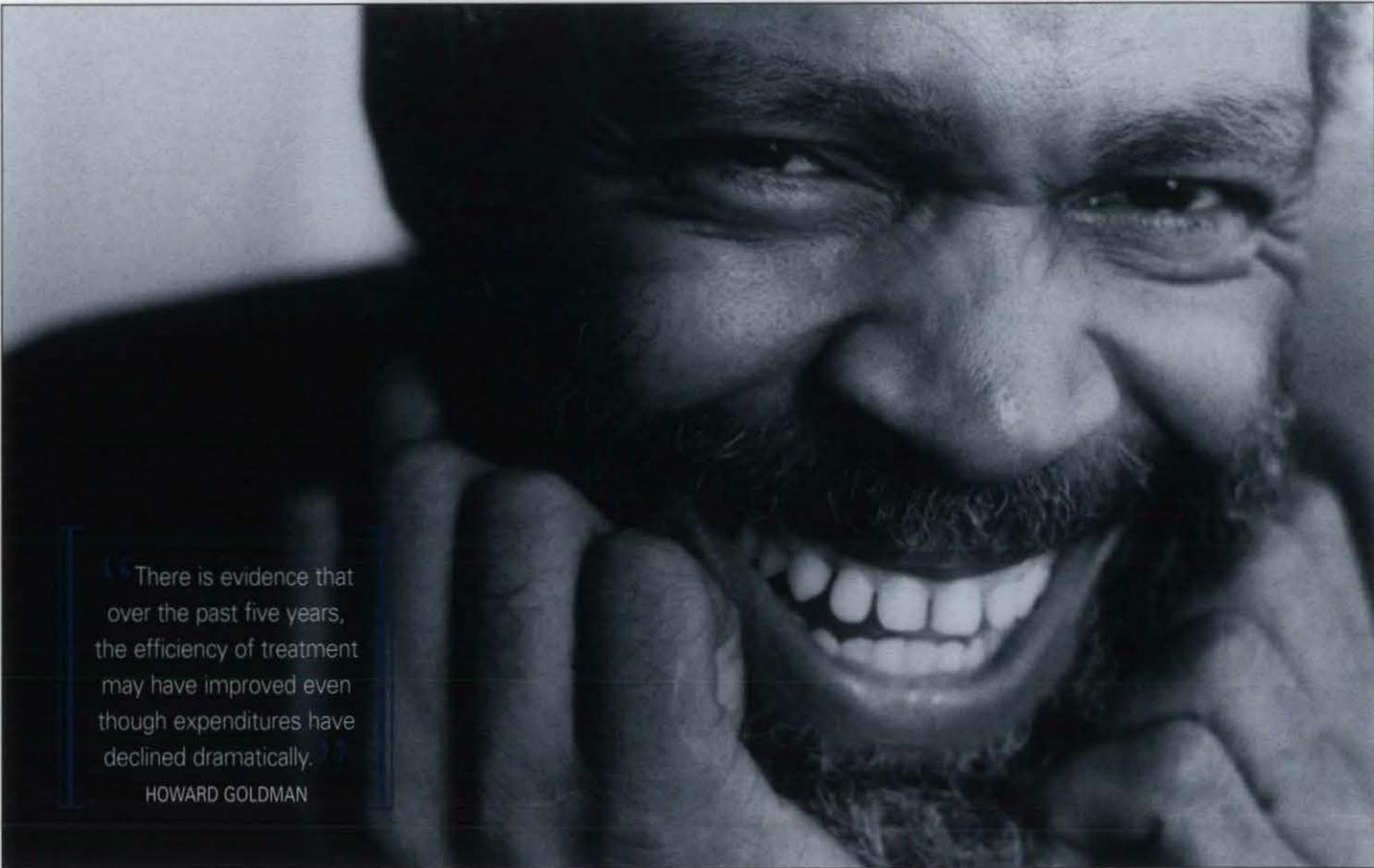
In its final chapter, the report points out courses of action that advocates, planners, and policy-makers might take. These range from building the science base to overcoming stigma to enhancing the supply of individuals who are skilled at the provision of services known to be efficacious. We do not have a supply of trained individuals to do all the things that science tells us could be effective. Moreover, there is a dearth of specific services, many of which are costly and intensive but have been demonstrated to be effective, from multisystemic treatment for conduct disorder and wrap-around services for children, to assertive community treatment and combined treatment programs with co-occurring disorders in mid-life, to disease management programs in primary care in later life. The report makes it clear that it is up to the community — to local, state, and feder-

al governments, and advocates — to overcome barriers, whether they are structural, educational, behavioral, or financial.

The vision for the future arises out of the opportunities standing next to barriers that exist, to realizing those opportunities for people of all kinds: people who have no insurance, members of racial and ethnic minority groups, people who, one way or the other, are stigmatized and discriminated against. The purpose of Chapter 8 is to articulate courses of action for each and every one of us to take up through our work, our organizational networks, our personal activities, our governmental involvement, to remove the barriers so that the promise of the science and the opportunities of our increased knowledge can be realized.

The report begins a process. The proof of its ultimate worth will be in what we do with it over the next decade. With the imprimatur of the Surgeon General of the United States, it has the power and the potential, the integrity and the inclusiveness, to shape attitudes about mental illness and mental health for decades to come.

I can only hope it will be a monumental success.



There is evidence that over the past five years, the efficiency of treatment may have improved even though expenditures have declined dramatically.

HOWARD GOLDMAN

# A Living Document

To affect changes in public discrimination and stigma, mental health advocates must get the *Surgeon General's Report on Mental Health* off the bookshelves and into use.

By Virginia Trotter Betts

In all of his time as Surgeon General, the priority from which Dr. Satcher has gotten the most response — the most letters, the most discussion after a speech — has been his focus on mental health, mental illness, and suicide prevention. He has gone more than half way around the world to discuss mental health, stigma, antidiscrimination, and issues of race disparities.

On a recent visit to New Zealand and Australia, for example, the report was welcomed for its life-cycle approach to mental health and for using the best science to examine prevention, treatment, and recovery. There was hope the report would motivate our nation, and the world, toward better understanding of mental health and mental illnesses, and agreement with including mental health in our common understandings and definitions of health, and mental health services in our common definition and understanding of what must be included in a health care delivery system.

We are behind Australia and New Zealand in that. Mental health and mental illness are included in their definitions of health, and mental illness services are included in their delivery system.

In July 1999, The Carter Center gave us at the Office of Public Health and Science (OPHS) an opportunity to sit with a group of media leaders who were providing advice to Mrs. Carter and members of her Mental Health Task Force about how best to communicate the contents of the Surgeon General's report, the first ever on mental health. We listened to that conference carefully. We plan to capture national attention throughout the year

2000 by having an event and a message a month that will address issues from this complicated report.

We want the entire nation to know that the Surgeon General is committed to improving the mental health of the nation through improving access, services, and continuing research. We want to make sure that the knowledge gap between new research and treatments and public awareness is bridged. We also want to work on the issues of discrimination and stigma, so all Americans are encouraged to seek help for themselves, a family member, or a significant other who has symptoms of a mental disorder or is experiencing a mental health problem.

For the Surgeon General's report to become what everyone wants it to be — a living document, that it not just sit on someone's shelf for later reference, but that affects public policy and social change — much depends upon us, our constituencies, and our member organizations.

The final chapter of the report, "A Vision for the Future," is incredibly important because, while it is not policy, it suggests policy. The "vision" is to decrease stigma and discrimination; increase access; grow the science base; improve effectiveness of services; build the mental health work force and the appropriateness of our services; and place treatment of mental illnesses into the mainstream of health care delivery.

“We want the entire nation to know that the Surgeon General is committed to improving the mental health of the nation through improving access, services, and through continuing research.”

Mental health is fundamental to health. Achieving that vision cannot come from the federal government. It cannot come from a state government. It cannot come from a local government. It must come from all of us, governments, nongovernmental organizations, con-



*In February 1998, Virginia Trotter Betts was appointed senior advisor on nursing and policy to the Secretary of Health, and to the assistant secretary of Health and Human Services. She is the immediate past president of the American Nurses Association, having served from 1992 to 1996. She has been involved in health care as a clinician, administrator, educator, researcher, and policy activist. A psychiatric nurse and an attorney, she is a graduate of the University of Tennessee, the Vanderbilt School of Nursing, and the Nashville School of Law. She is one of only 12*

*nurses to have been chosen for the prestigious Robert Wood Johnson Health Policy Fellowship. In 1995, she was appointed by the president to serve on the Military Health Care Advisory Committee. She is the author of many articles on nursing, health care, and health law, and has given presentations on health care issues to nursing, health, and community audiences across the country. She has led the Surgeon General's office in developing the Surgeon General's Report on Mental Health.*

sumer groups, professional groups. We have a common agenda: to improve health for all in our country.

This report is very long and very complex and sometimes boring. It also does not have all the answers. Very likely large sections of the report will attract little interest. Other parts will be controversial.

But taken as a whole, advocates and committed mental health workers will be pleased.

Your plan, your strategy, your implementation, cannot come from us, but we can share common commitments. One is that we discuss the Surgeon General's report without discounting it. Another is that we debate the report without damaging it. A third commitment is that we channel our energy so that together, we are able to build national consensus that mental health is fundamental to health.

“The “vision” is to decrease stigma and discrimination; increase access; grow our science base; improve effectiveness of services; build our work force and the appropriateness of our services; and place treatment of mental illnesses into the mainstream of health care delivery.”

# Comments & Questions

Audience members respond to Virginia Trotter Betts' encouragement to promote the key messages of the *Surgeon General's Report on Mental Health*.

**Julius Richmond** *The first Surgeons General reports were mainly related to smoking and health. During the Carter administration, we broke that cycle, largely as a result of experiences President and Mrs. Carter had had in Georgia trying to apply our newer knowledge of prevention. We therefore established the Surgeon General's report called Healthy People, and set 10-year goals. Healthy People is now developing goals for 2010. What thought has been given to continuation of the report and to its longer-term implications?*

**Virginia Trotter Betts** The answer is twofold. First, *Healthy People 2010* will include measures in the mental health chapter that derive from the Surgeon General's report for better public policy and better services.

Also, even though the report is long and complex, it could not deal with everything. Dr. Satcher already is planning additional mental health reports — one, on mental health, culture, race, and ethnicity will be developed soon. Substance abuse and addiction is another area that clearly needs more attention.

Second, we know much more about mental illnesses and their treatment than about mental health prevention; that area probably will generate another Surgeon General's report.

In the area of stigma, we are moving forward in a national campaign to address its terrible toll. Tipper Gore, the mental health policy advisor to President Clinton, and Dr. Satcher are co-chairing the effort.

**Bill Emmet** *How can we make sure the report is not perceived as a Gore 2000 election tool but is, in fact, received as a science-based, evidence-based look at mental illnesses and mental health?*

**Celinda Lake** From our research, I think that will not be a significant problem. No one we surveyed or talked to in focus groups, for example, doubted that one in five people were affected by mental illnesses, or that 50 percent of the people or their families could have an experience with mental illness, or that mental illness was a major problem in our country.

**Virginia Betts** Despite its complexity, we were determined to have the report come out in 1999, before the 2000 "State of the Union" message, and before we entered the "political season."

Dr. Satcher, while nominated by a Democratic administration, was confirmed by a Republican Senate. So when he speaks to the American people, he bases his remarks on the best science, not on political expediency or partisan politics.

**Hannah Hedrick** *One way to de-politicize the report is for each mental health organization to incorporate it into its planning and implementation for Healthy People 2010. Each person involved in this field can make the ongoing process valuable to all others by developing networks that address our particular issues.*

“*Healthy People 2010* will include measures in the mental health chapter that are an outgrowth of the Surgeon General's report.”



## An Exciting Path Toward Parity

The American people seem ready to address issues of treatment inequity between physical and mental illnesses.

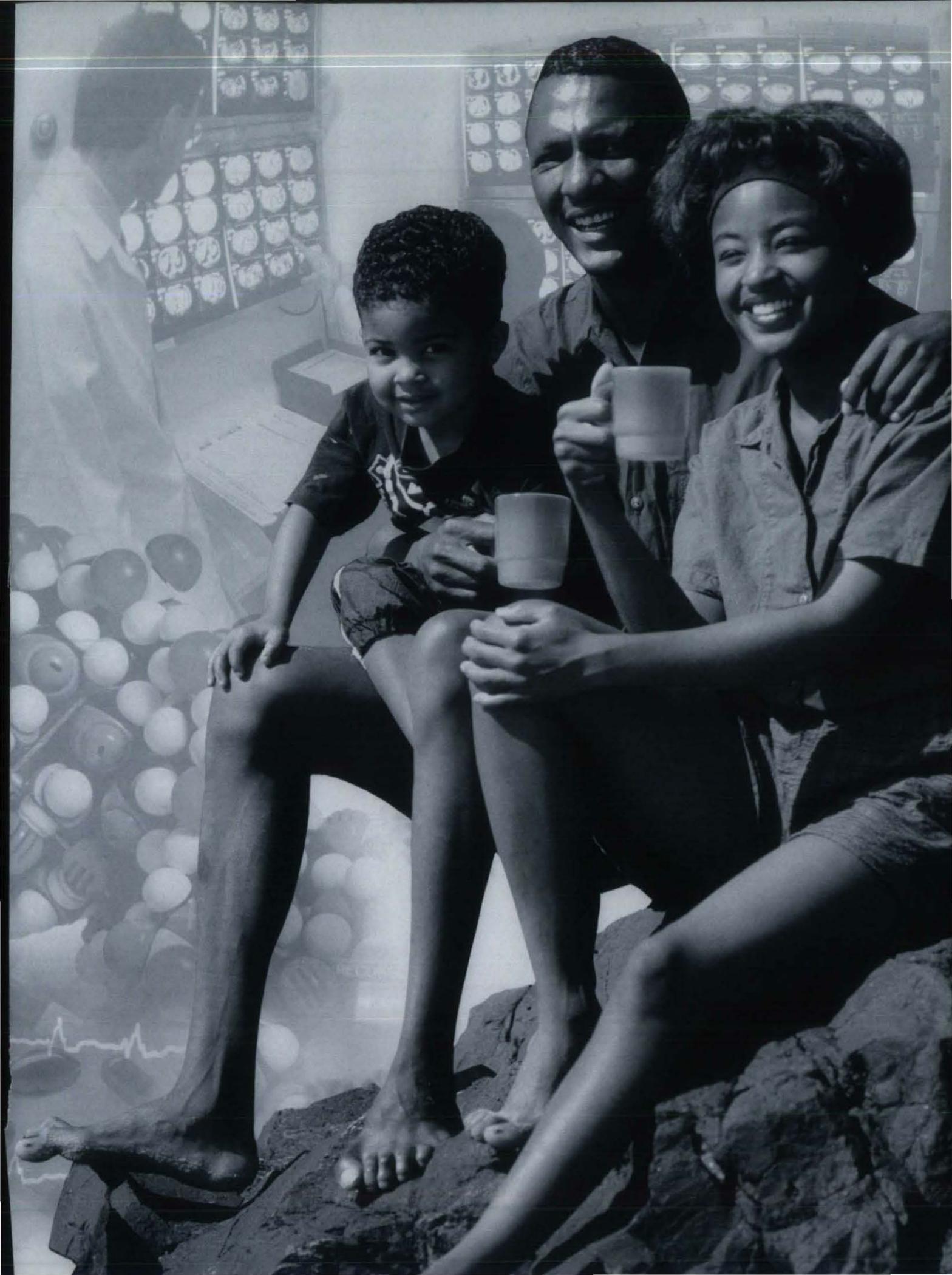
By Arlen Specter

**T**he time has come for mental illnesses to gain full parity and for us to harness our newfound knowledge and ongoing research on the brain and the genome.

My deep concern about mental illnesses dates back to the days when, as district attorney of Philadelphia, I visited Farview Mental Health Institution in Wayne County. That facility housed criminals who were not competent to stand trial. I was appalled to see patients treated as inmates, barely functioning, wandering around in what can only be characterized as medicated stupors.

I then tried to evaluate the public perception of mental illness and considered carefully the influence of popular culture.

“Unfortunately, many Americans form their ideas about the world based on what they see on television or in the movies.”



What immediately jumped to mind was the 1948 Olivia deHavilland movie, "The Snake Pit." It was one of the first popular movies to tackle seriously the subject of mental illness. The film affords us a disturbing look behind the walls of a mental institution through the eyes of a young woman who has a mental breakdown. Several scenes reinforce false perceptions of asylums and legitimize our fear of "going insane."

The epitome of celluloid portrayals of mental illness is "One Flew Over the Cuckoo's Nest." We laugh as rigid Nurse Ratched battles Jack Nicholson's R.P. McMurphy. We are comforted by the laconic presence of the giant Chief Bromden and we are heartened by the camaraderie of the patients. We are horrified by the tragic and brutal deaths of McMurphy and Billy and we are inspired by Chief's escape. But, again, the story in this classic movie does not give a full and accurate portrayal of people with mental illnesses.

Unfortunately, many Americans form their ideas about the world based on what they see on television or in the movies. Mental health organizations have been successful in dispelling many of these impressions, destigmatizing the mentally ill, and educating us all. The words "mental illness" no longer invoke thoughts of Olivia deHavilland trapped in an asylum or Chief's interminable incarceration.

The first civilizations of Egypt in the Near East thought mental illnesses were caused by malevolent deities and magical forces of evil. The civilizations of Greece and Rome established enduring psychiatric viewpoints despite psychiatry then being a province of religious cults. The writings of the physician Hippocrates reflected on the brain as the seed of life and its normal functioning required a balance between the four humors. Later, philosophers Plato and Aristotle wrote that mental illness occurred when the soul was subjected to various changes. These innovators of thought initiated the beginnings of psychotherapy through their encouragement of a verbal dialectic between philosopher and patient in order to counteract the divine disturbance of the soul.

In the 17th and 18th centuries, enlightenment and rational thought replaced belief and Hippocratic and demonic ideas. While

new theories were being formulated regarding the biological basis for mental diseases, many of Europe's insane were incarcerated in asylums under terrible conditions. But by the end of the 1700s, reforms were instituted that did away with such unnecessary restraints and moved us toward more humane treatment of those with mental illnesses.

During the 19th century, mental illnesses were indistinguishable from physical disorders, for psychiatrists believed, as did their general practice colleagues, that mental illnesses were caused by false impressions being sent to the mind because the body's sensory organs were malfunctioning. These 19th century *alienists*, as psychiatrists were then called, were forced to struggle with the question, "What is the right treatment?"

Institutionalization was the obvious answer, for the cornerstone of therapy was the removal of the patient from the environment that caused the false impressions in the first place.

In 1820, only one state hospital for the mentally ill existed in the United States. By the Civil War, virtually every state had established one or more public mental health institutions. During the 20th century, the American mental health treatment infrastructure endured sweeping changes. The tragic conditions of asylums in the early part of the century forced us to eventually recognize that outpatient treatment and community-based therapies were quite effective.

Thus began the 40-year movement toward deinstitutionalizing people with mental illnesses, the causes and relative successes or failures of which are still argued today. Those explanations range from shifting the cost burden of these institutions from state and local authorities to the federal government, to various civil rights arguments against involuntary commitment and horrific conditions in asylums, to the fundamental change in the American culture's views of those with severe mental illnesses.

I believe our cyclical struggle with how to treat mental illnesses has brought us to a unique crossroads in scientific knowledge and treatment breakthroughs. Most importantly, it points to the irony of our current struggle for mental health parity in both public policy and public perception.

Only a little over a century ago, physi-

“Mental health organizations have been successful in dispelling many of these impressions, destigmatizing the mentally ill, and educating us all. The words “mental illness” no longer invoke thoughts of Olivia deHavilland trapped in an asylum or Chief’s interminable incarceration.”



Pennsylvania Sen. **Arlen Specter** chairs the Veterans' Affairs Committee and the Appropriations Subcommittee on Labor, Health and Human Services, and Education, which oversees all the federal dollars spent on health, education, and labor.

Sen. Specter began his public service career as district attorney of Philadelphia. He has been active in health care issues, including helping

create a separate Women's Health Unit at the National Institutes of Health.

The son of immigrants, he was born in Kansas. He graduated Phi Beta Kappa from the University of Pennsylvania and in 1956 from Yale Law School.

He served on the Warren Commission investigating the death of President John Kennedy, and has been active in initiating legislation to ensure stiffer penalties for those convicted of crimes.

cians could not distinguish between the causes of mental and physical illnesses, and therefore treated those illnesses without hesitation or bias. We have come full circle now as we struggle for parity again in an age in which we know more about these disorders than we ever dreamed possible. Indeed, given the obvious societal benefit and apparent low cost of implementing mental health parity, I marvel at Congress' consistent reluctance to pass comprehensive mental health parity legislation.

I am pleased to be a co-sponsor of this year's Mental Health Equitable Treatment Act, which goes one step further than the 1996 Mental Health Parity Law that focused its mandates solely on equalizing lifetime and annual dollar limits for mental health benefits. This year's proposal would require parity for the number of covered hospital days and outpatient visits for all mental illnesses, and full parity would be required for illnesses such as schizophrenia, major depression, and autism. We need to act now to get this done. We have no more excuses.

Another step in fighting disparities in health insurance coverage is in the area of substance abuse. Alan Leshner, M.D. director of the National Institute on Drug Abuse (NIDA), has said that addiction is a brain disease and that it is important to view addiction as a chronic illness and to manage it appropriately over time. A small investment in additional treatment can save millions of dollars given that the complications from substance abuse can be the most expensive in all of medicine. In fact, a 1994 study by the California Drug and Alcohol Treatment

Assessment Survey found that each day of substance abuse treatment more than paid for itself, finding a 7 to 1 return on investment when addiction is treated early rather than letting addictions evolve into more serious and complicated medical conditions. These savings were achieved through reductions in hospitalizations and a decline in criminal activity.

On a related note, I have long been a proponent of the use of drug courts to redirect criminals with substance abuse problems out of the prison system and into treatment programs. A 1997 Department of Justice report found that drug courts significantly reduce drug use and recidivism among those criminals.

No longer can we point to costs as the reason for not implementing substance abuse parity in private health insurance, since independent analyses have consistently shown that the cost of such parity provisions would be negligible. In May 1999, a Rand Corporation study showed that managed care companies' costs would be just \$5 per person per year for employees of big companies to receive unlimited substance abuse benefits.

We often look to federal health programs to set precedents in appropriate manners of care and coverage. It would be natural to assume then that Medicare and Medicaid would cover mental

health and substance abuse ailments the same as physical ailments given the current struggle to achieve private health insurance parity for mental health and substance abuse treatment. But, sadly, that is not the case.

On the inpatient side, Medicare is inadequate. Regardless of condition, there is a 150-day yearly limit on coverage for inpatient hospital care, but

“This year's proposal would require parity for the number of covered hospital days and outpatient visits for all mental illnesses, and full parity would be required for illnesses such as schizophrenia, major depression, and autism.”

a 190-day lifetime limit on coverage of psychiatric hospitalization. On the outpatient side, Medicare traditionally pays for all medically necessary physician and outpatient services.

But in examining Part B benefits, I am troubled that a higher co-payment of 50 percent rather than the normal 20 percent is required for beneficiaries receiving treatment for mental, psychoneurotic, and personality disorders.

This policy is biased, antiquated, and inappropriate, especially given the disturbing rise in major depression in our elderly population. More than 2 million of the 34 million Americans aged 65 and older suffer from some form of depression. We are doing our nation's elderly, and the entire parity effort, an enormous disservice by forcing a higher out of pocket expense for a psychiatric visit than for a regular doctor visit.

Medicaid does better than Medicare in covering mental health treatment, albeit is patchwork from state to state. Although Medicaid does not have a specific mental health or substance abuse benefit, there are covered and optional services that can be made available to provide mental health and substance abuse treatment.

The ray of light on the federal health program horizon is the Federal Employee Health Benefit Program, which will require, by fiscal year 2001, all 285 participating health plans to provide full parity for both mental health and substance abuse services — a great achievement for the program's 9 million beneficiaries. I hope the foresightedness of the Office of Personnel Management will carry over into other federal safety-net programs and, for that matter, private insurers.

I learned a long time ago that if anything is to get done in Washington, it needs to be done in a bipartisan manner. I have crossed party lines many, many times during my tenure in the Senate and am convinced that constructive policy advances originate from the political center, not from the extremes. As chairman of the Appropriations Subcommittee on Labor, HHS and Education since 1995, I have worked closely with Sen. Tom Harkin, with whom I have switched as ranking and chairman of that subcommittee over the past decade. This partnership has worked well, particularly in the area of biomedical research.

“The ‘Decade of the Brain,’ as Congress and researchers have dubbed the 1990s, yielded many discoveries into the origins of mental illnesses that have paved the way for promising future research.”

We all remain enthralled by the advances spawned by the “Crown Jewel” of the federal government, the National Institutes of Health. Substantial investment in NIH is crucial to allow the continuation of breakthrough research into the next decade. In 1981, when I was first elected to the Senate, NIH funding was less than \$3.6 billion. In fiscal year 2000, we proposed \$17.9 billion, a 95 percent inflation-adjusted increase since 1981. Funding for the National Institute of Mental Health was only \$190.4 million in 1981 and has seen a 113 percent inflation-adjusted increase to today's proposed total of \$978 million.

The “Decade of the Brain,” as Congress and researchers have dubbed the 1990s, yielded many discoveries into the origins of mental illnesses that have paved the way for promising future research. Scientists now understand that vulnerability to mental illness has a genetic component. They now face the daunting task of mapping the entire human genome, on track to be sequenced by spring 2000. Linkage studies using powerful technologies to pinpoint genes from among the 50,000 genes expressed in the brain will eventually connect genetic variations with mental illnesses. Imaging tools such as MRI and PET scans are being used to study the pathways in the brain.

Researchers also are excited by the recent discovery that the brain can add nerve cells during adult life. Eventually brains damaged by a severe protracted mental illness may be able to be repaired precisely.

Scientists also are trying to discern why certain people do not respond to certain drugs used to treat mental illnesses. For instance, 30 percent of people with schizophrenia do not respond to the traditional pharmaceutical intervention. Through the relatively new field of pharmacogenomics, researchers are exploring whether there is something about these individuals' genetic instructions that prevents them from metabolizing the

drugs as intended. In essence, drugs may soon be designed to fit the patient's genetic makeup.

Epidemiological studies of mental illnesses among children also are a top priority of NIMH, and NIMH Director Steve Hyman, M.D., has stressed the need to gather more data on mental illnesses in children.

This year, after the school violence observed in Littleton, Colo., public attention was focused on research on violent behavior in youth. As a result of convening three extensive round-table discussions with experts from the Departments of Education, HHS, Labor, and Justice, including the Surgeon General's office, some \$884 million has been re-allocated to tackle this issue by focusing on the Safe and Drug Free Schools program, mental health services for children, character education, and literacy programs. These programs pick up on the conclusion that Surgeon General Koop drew in 1982, that juvenile violence is a national health problem.

In another research development, the HHS general counsel has ruled that federal funding of stem cell research does not violate the human embryo ban. In 1999, I held hearings to examine this controversial issue. According to NIMH, stem cells could potentially benefit treatment for schizophrenia, autism, manic-depressive illness, and memory disorders. Stem cells appear to be a veritable fountain of hope with their potential ability to replace damaged cells and tissues. We have a duty

to ensure that federal dollars are spent on the most promising avenues of research, and we should be running full-tilt to explore how stem cells can benefit all areas of modern medicine.

It is an inviting path we have not yet explored.

As David Ben Gurion, first prime minister of Israel, once said, "These people who do not believe in miracles, they are not realists." We are in a unique position now to reflect on past miracles in the face of new and imminent miracles in the treatment of people with mental illnesses; they will likely come in the form of parity in public and private health insurance coverage, as well as in the human genome project, brain imaging, and amazing pharmacological advances. I look forward to working with you to ensure that these miracles are borne out of our collective work.

Sen. Specter's remarks at the 1999 Rosalynn Carter Symposium on Mental Health Policy were delivered by Legislative Assistant Allison DeKosky, who advises Sen. Specter on health care, women's health, and family-related legislative issues. Ms. DeKosky is a graduate of Penn State University with a bachelor of science in health policy and administration. Before joining the senator's staff in 1997, she worked at the University of Pittsburgh's Medical Center in the Planning and Marketing Department, where she conducted market analysis and strategic planning.

“We have a duty to ensure that federal dollars are spent on the most promising avenues of research, and we should be running full-tilt to explore how stem cells can benefit all areas of modern medicine.”

## In the Service of Children

In its developmental outlook and age-based proposals, the *Surgeon General's Report on Mental Health* provides a blueprint for advancing children's mental health.

By Kimberly Hoagwood

If advancing mental health for children is our goal, it is important to keep the science base and policy reform moving hand in hand. The Surgeon General's report, particularly the chapter on child mental health, provides us with a blueprint and an opportunity to do this.

The editors, writers, contributors, and staff who worked arduously on the report have created a document of historical significance that marks a pivotal turning point in the way children's mental health problems are seen, understood, attended to, and respected.

Only about 25 years ago the first textbook on children's depression was published. In it depression was identified as a definable separate syndrome for children. Before that, children were thought to be impervious to mental illnesses and the strains, stresses, and processes that afflict adults. When reports about mental health were written, children's issues often were relegated to sections called "Special Populations" or "Special Issues." In the intervening years have

come major advances in understanding children's development, developmental trajectories, and the patterns that are irregular and that sometimes lead to disorders. Many of these accomplishments are reflected in the chapter in the Surgeon General's report on children's mental health.

The report traces scientific understanding of children's development, and the theoretical frameworks by which it is to be understood. The evidence base for treatments, prevention, services, and medications for children are described.

“The report traces scientific understanding of children's development. And the theoretical frameworks by which it is to be understood.”



The report has several other pivotal accomplishments, three of which are very important.

The first accomplishment is the developmental framework that permeates it. Not only does the report adopt a life-cycle approach, but within the children's chapter there is a continued emphasis on development. There is controversy and tension within the children's mental health field with respect to development. It exists between the need to recognize, name, and treat disorders, and the equally important need to understand that children are undergoing constant developmental changes at basic levels — hormonal, neuronal, cognitive, and emotional — and that these developmental changes happen at different rates, so there is no unitary progression. The tension reflects the need to identify, target, and treat mental illnesses and syndromes, versus the need to understand that the shifting sands of development make measurement of children's disorders difficult, even temporary in some cases, and that there is a need for ongoing monitoring, assessment, and preventive efforts.

The complex process has been made even more complicated by two externally driven events:

- One is the reimbursement system, which requires shoe-horning complex processes into diagnostic categories in order to pay for treatment. This sometimes butts against the equally important fact that children's biological systems are changing.
- Two, the slow progress that has been made in the measurement of these developmental processes is especially significant for young children and for assessment of functional impairments, functional strengths, and functional competencies. The field needs measures that are developmentally sensitive and reflect uneven developmental processes. By and large, progress has lagged in this area.

What is important in the report's chapter on children's mental health is that it has struck an important balance by bringing a developmental perspective to bear on the current understanding of children's mental illnesses. This is no small feat.

The chapter's second pivotal accomplishment has to do with neuroscience developments and their connection to clinical care. Among the major scientific accomplishments of

the past decade have been efforts to define the complexity of the brain, an organ comprising some one hundred billion distinct cell types, each of which may communicate with thousands of other cells, or neurons, by means of messages conveyed by a hundred or more different specialized chemicals called neuro-transmitters. As research has progressed, the field has moved from searching for the possible contribution to mental illnesses of individual components of the brain — one hemisphere versus another, for example — to examining the role of multiple dynamic parallel brain systems, or circuits, that process information, the raw material of our thoughts, emotions, and behaviors.

Scientific studies are increasingly studying the disruptions in this circuitry and trying to understand how they contribute to the development of mental disorders.

The report is unique among documents of its kind in that it describes some of these advances at the molecular and cellular levels and simultaneously points out why this work is important, and how it is going to help inform clinical and preventive care.

A third pivotal accomplishment is the synthesis of the evidence base. The report, in conjunction with at least six recent comprehensive reviews, synthesizes the research base that underpins knowledge about preventive interventions, service interventions, psychosocial treatments, and pharmacological interventions for children. Even five years ago, this kind of synthesis would not have been possible, at least for medication, services, and preventive interventions, because the evidence base was too slim to synthesize. This change is due to the productivity of the scientific community and, equally importantly, to the unabated pressure for reform from policy makers and

family groups who demanded valid information about effective care for children." Because of those two pressures, there now is an evidence base toward which we may point.

The report highlights those interventions whose impact and intended outcomes are known and can be specified, and differentiates those from interventions that are promising but not necessarily fully developed yet. As a result, the

“In the intervening years have come major advances in understanding children's development, developmental courses, the patterns of development, and the patterns that are irregular and that sometimes lead to disorders.”



Chief of the Child and Adolescent Mental Disorders Research Consortium, **Kimberly Hoagwood, Ph.D.**, is a member of a group of interdisciplinary scientists whose mission is to establish research priorities across a range of scientific program areas related to child and adolescent mental health. Chief of two research programs at NIMH,

Dr. Hoagwood earned her doctorate in school psychology in 1987 and practiced clinically for nine years.

She has held academic appointments at Pennsylvania State University and the University of Maryland.

report provides a blueprint to indicate where more targeted research efforts are needed and where opportunities for policy development and deployment occur.

From my perspective at the NIMH, I see the Surgeon General's report as providing a guideline for both science and policy development. This is especially important because we cannot be sure that it is a service to provide services that are untested. It may, in fact, be a disservice.

A recent article in the *American Psychologist* by Tom Dishian, Joan McCord, and Francois Poulet reported that peer group interventions that included group counseling sessions supervised by adults, and summer camps that were targeted for high-risk adolescents with anti-social behavior problems, actually increased the problem behavior, including substance abuse, delinquency, and violence. The authors referred to this as "deviancy training." Dr. Delbert Elliot, who helped to craft the Office of Juvenile Justice and Delinquency Prevention's Blueprint Program, recently pointed out that 95 percent of the programs for delinquent youth have no evidence base whatsoever. This is not a service to children.

There now exists an evidence base on preventive models, especially in the area of youth violence; a substantial literature on psychosocial treatment; and an equally grow-

ing research base on effectiveness of services and effect of medication treatments for children with specific mental health syndromes. These are all reflected in the report.

The next step is to use these findings to make sure that the evidence base is disseminated: included in professional training programs and used as a basis for federal, state, and locally supported programs. For example, there now exists strong evidence base for treatment of childhood depression, for attention deficit disorders, for programs to reduce child abuse, and for school-based programs to prevent childhood aggression. It would be a mistake for us not to use the opportunities that we now have to advance this agenda.

I do not say that the evidence base is equally strong in all areas. There are many gaps still in knowledge about children's mental health problems. How best to disseminate the evidence or how to implement it across different cultures — there are important questions for which few answers exist.

But I urge that, as progress is made in these areas and as the research becomes more rather than less policy relevant, these findings be deployed, that they be implemented actively and in concert with federal, state, and local policy-makers, family groups, and consumers. These findings merit implementation. It would be sad for them to sit heavily on yet another government bookshelf.

“What is important in the report's chapter on children's mental health is that it has struck an important balance by bringing a developmental perspective to bear on the current understanding of children's mental illnesses.”

# Benefits of the Big Picture

Optimism and hope are the essential ingredients of the *Surgeon General's Report on Mental Health's* presentation of adult mental illnesses.

By Lisa Dixon

As a family member of someone who has lived with schizophrenia for about 20 years, as an occasional consumer of mental health services myself, and as a professional researcher, educator, and clinician, I am thrilled that the information in the report's adult chapter furthers the big picture and messages of the entire report: Mental illness is a public health problem that we must all address; there has been a scientific revolution in our understanding of the mind, brain, and body; and mental illnesses are real.

The report relies on an empirical and scientific data base, or evidence base, that mental illnesses can be treated, that the consumer frequently can choose from a treatment menu that suits his or her own needs, and that recovery is possible. Optimism and hope are pervasive throughout the chapter — that is extremely important.

Mental health is not just the absence of mental disorders; mental health allows the successful performance of mental function. Personality traits are important. Self-esteem, optimism and resilience, neuroticism, avoidance, impulsivity, and sociopathy play a role in determining mental health. Stressful life events can spawn mental disorders in vulnerable individuals, and the chapter describes the impact of stressful life events and why some people develop mental disorders in the face of such events while others do not. The events of most lives, such as the death of a loved one, and the events of specific lives, such as trauma (sexual abuse, domestic violence, and the like) are discussed.

The report cites information on what services are available to help people deal with stressful life events including community services, self-help, couples therapy, and physical activity.

“The report cites information on what services are available to help people deal with stressful life events including community services, self-help, couples therapy, and physical activity.”

There is an all too brief section on the prevention of disorders of adulthood, reflecting how little we know about this. All through the chapter is information on the importance of culture on each of these issues.

The bulk of the chapter then goes into the three major groups of disorders: anxiety disorders, mood disorders, and schizophrenia. Each section has a description of the phenomenology and epidemiology of the disorder. The Epidemiological Catchment Area study provides the foundation for the National Comorbidity Survey. A table reveals the prevalence of these mental disorders. The DSM-IV is used heavily, so one gets a description of the disorders and learns what is known about the causes and course of illnesses, both psychological and psychosocial — a great deal of attention is given to what is going on in the brain — and then treatment.

For example, within the anxiety disorder section is included information on panic attacks and panic disorder, agoraphobia, specific phobias, social phobia, generalized anxiety disorders, OCD, and the acute and post-traumatic stress disorders. The etiology covers the shift in thinking in science. We have moved from the locus ceruleus as the mediator of the acute stress response, and therefore anxiety, to new views of anxiety with the hippocampus, the memory center in the amygdalla, an emotional center of the brain, as key regulatory centers of anxiety.

Neurotransmitter functions are included as are GABA, CRH, CCK, and an extensive discussion of the psychological aspects of anxiety including psychodynamic theories as well as cognitive theories of anxiety.

The chapter pulls in the evidence for different treatments. Included are issues on the



*Lisa Dixon, M.D., M.P.H., completed her medical degree at Cornell University, a research fellowship at the Maryland Psychiatric Research Center, and a master's degree in public health from Johns Hopkins University. Dr. Dixon's clinical experience and research are focused on persons with severe mental illnesses, especially those with co-morbid medical and substance abuse disorders. A mental*

*health researcher funded both by NIMH and private foundations, she is director of residency training at the University of Maryland's Department of Psychiatry.*

*Having a family member with severe mental illness has made her especially sensitive to their needs and she has worked in many family organizations.*

psychotherapeutic nonpharmacological side, emphasizing cognitive-behavioral approaches, because the evidence is strongest there, and medications such as benzodiazepenes and anti-depressants.

So information is presented about the scope of the problem, the science behind its validation as a real disorder, and its treatment. Medications are discussed, as are non-pharmacological modalities. The treatment choice expresses hope for resolution of symptoms.

In the mood disorder section, the disorders covered specifically are major depression, dysthymia, cyclothymia, and bipolar disorder. The section begins by emphasizing the impact of depression on disability and the complications and co-morbidities of depression, including suicide, physical health problems, and substance abuse disorders. (Substance abuse disorders are in all three sections.) The difference between sadness and grief is discussed, as is depression and the scientific basis behind our confidence in the reliability of a depression diagnosis.

What is the difference?

This is the kind of question people outside the mental health field ask, this is what they want to know. How can you tell the difference between being sad and having depression? The chapter includes a precise, well-written description of the symptoms of each of these disorders which, to an educated consumer and reader, would be informative.

The chapter addresses the importance of stressful life events on depression, cognitive factors, temperament, and gender issues. Why do women have more depression? Is it due to environment? To genes? Is there an interaction? These are the

“So much information is presented about the scope of the problem, the science behind its validation as a real disorder, and its treatment.”

kinds of issues that are important.

The treatment section is divided into the acute phase (the time period leading up to the initial treatment response), the continuation phase (after acute remission to prevent relapse), and the maintenance phase (to prevent future recurrences). The treatment section addresses both pharmacotherapy and psychotherapies. It is balanced with a sense of the menu of treatment options facing the consumer.

The schizophrenia section parallels the other two sections. At the end of the chapter is a section on service delivery and larger social issues that cut across all dimensions, including assertive community treatment, crisis care, dual diagnosis, consumer self-help, and consumer operated programs.

Two concluding notes:

One: Everyone who reads the report will be asking, “What does it say about my thing, my area?” It is important to look at the big picture and not get caught up in the accuracy and the precision of any particular section, because within every section there is going to be room for disagreement.

Two: As a family member and devotee of family support groups, I have been frustrated to be unable to cite the benefits of such programs and evidence-based reviews, because of the absence of controlled data. In my own work life, I am trying to get data. Thanks to the Robert Wood Johnson Foundation, we have begun to study the effectiveness of the family-to-family education program.

That is also part of the message of the report: If we are not satisfied with what it includes about a particular area, go out and get data that will improve the next report.

# New Hope for the Elderly

By increasing awareness, the *Surgeon General's Report on Mental Health* can help reduce the shame and isolation that burdens help-seeking behavior among older adults.

By Robert Bernstein

To those among the "mental health and aging" crowd, a full chapter in a report by the Surgeon General of the United States dedicated to aging issues is of great significance.

During the past 20 years or so, a notable change has occurred in public images of aging. The AARP has promoted the notion that aging is a period of vibrancy and social connectedness — the Winnebago image. This image supplants traditional negative stereotypes of aging, such as frailty and dependence.

But older adults who have mental illnesses and developmental disabilities are not always perceived through this new lens. They are not seen as politically correct and, in a sense, they never were. Older adults with mental health needs have a long history — most graphically embodied in pictures of geriatric back wards and state hospitals — of being deemed beyond help, unworthy of attention, best consigned to custodial care, and best segregated from society. Cohorts of older adults themselves hold similar views, older people raised in a generation when shame was attached to having a mental illness.

The Surgeon General's report documents the scientific basis for the new image of vibrant aging connected with society. However, it also shows the startling prevalence of mental illnesses among older adults and the value and promise of meaningful services that allow older adults with mental illnesses to be included in the new, more positive images of aging.

The issue of mental illness has never been more important among older adults. The average life span has increased from 47 years in 1900 to 75 years in the 1990s, and it is growing even further. Baby boomers constitute an aging

population bubble, raising expectations that the older population will be huge in the near future.

The good news in the report is that healthy, normal aging is not a myth. It is scientifically based. Normal aging is characterized in terms of generally stable intellectual functioning, a capacity for change and learning, and active social engagement. Normal aging also includes important life tasks such as creativity and summing up and making meaning of one's life. Some difficulty occurs with age, secondary to physical change, but extreme disability, including disability attendant to mental illness, seems to be on the decline. Even problems with memory — a significant symptom of Alzheimer's disease but also a common complaint in general among older adults — is found in recent research to be more subjective than actual among healthy adults. In fact, these memory problems may often be a consequence of untreated depression.

More good news: Although diagnosable mental health problems are significant among older adults, affecting as many as 20 percent of the older population, there are already effective treatments for many disorders.

Finally, prevention — in the past commonly limited to children and younger adults and not well researched in older people — may be particularly helpful to older adults. Further, life style

may outweigh genetic factors in influencing mental health outcomes. Life-style issues include education, activity level, and disease avoidance.

The problems facing older adults with mental illnesses relate directly to the remnants of the ingrained stereotypes and biases. Research in many areas important to mental

“Older adults with mental health needs have a long history most graphically embodied in the image of geriatric back wards and state hospitals, of being deemed beyond help, unworthy of attention, best consigned to custodial care, and best segregated from society.”



**Robert Bernstein, Ph.D.**, a recognized expert on public mental health services and serious mental illnesses, was the architect of, and ran for more than 19 years, an innovative system to serve older adults with persistent mental illnesses in an integrated community setting. He holds a doctorate in psychology from Wayne State University and is an experienced clinician, having worked

primarily with adolescents and young adults.

Dr. Bernstein now leads a national legal advocacy organization for people with mental disabilities, the Judge David L. Bazelon Center for Mental Health Law. He has been an articulate spokesperson focusing on the importance of including consumers in policy and planning of mental health services.

health and aging has lagged far behind that for other groups. Service systems are fragmented and not prioritized. Service delivery systems have not accommodated special needs and funding mechanisms have not been constructed to promote wellness and mental health among older adults. Research is particularly important because of increasing concern with purchasing services that produce good outcomes and are cost effective.

We need to better understand the interaction between mental and physical health and social status. Not only would such information promote good services and treatment to older adults experiencing mental illness, but it also could be the basis for preventive efforts aimed at reducing the risks of developing mental illness, preventing excess disability, and forestalling or preventing institutionalization.

The Surgeon General's report devotes substantial attention to depression among older adults, a group with a high rate of suicide that increases with age. White males age 85 and over have six times the suicide rate of the general population. The report also documents high risk factors for depression, such as bereavement. Some 800,000 Americans each year are widowed, 20 percent of them will exhibit depressive symptoms beyond the period of what is considered "normal grieving." People with Alzheimer's disease also are at high risk for depression. The report cites research showing that 40 to 50 percent of people with

Alzheimer's disease suffer from depression that produces excess disability in terms of attending to basic daily functions.

Although we have much more to learn, the report indicates that depression among older adults is treatable through counseling, medication, and self- and peer-support; effective treatments can reflect individual choice.

The problem is that the mental health services are not readily available. Older adults, raised in a period when stigma was attached to mental illness, do not demand these services.

The Surgeon General's report can do much to increase public awareness of depression among older adults and to reduce the sense of shame and isolation that burdens their help-seeking behavior. Currently older adults tend to rely heavily upon primary care physicians to get help and to express their problems in physical terms. These physicians feel ill-prepared to diagnose and treat depression among older adults. Research shows that of depressed older adults seeing primary care physicians, only 11 percent are receiving appropriate treatment for their depression, and 55 percent receive no treatment whatsoever. It is therefore not surprising to find another study showing that of older adults who commit suicide, 51 percent had seen their primary physician during the prior month.

“The report suggests that we consider a new diagnostic category for depression that is more reflective of the actual clinical profile of older adults.”

The issue is not only one of awareness and training among physicians. The report also references problems in our diagnostic system. Recent findings reveal that, although as many as 37 percent of older adults in primary care settings may have depressive symptoms, far

fewer numbers reach the current diagnostic standards for diagnosis of major depression. The report suggests that we consider a new diagnostic category for depression that is more reflective of the actual clinical profile of older adults. Without diagnosis, treatment does not follow, so this is a critical issue.

The report calls for further research on depression. What we know now is that depression is treatable and that newer medications are particularly effective, but that they tend to operate more slowly with older adults, sometimes taking a month longer. Counseling is effective and there is information about precisely what sort of counseling works and to what degree. Preventive programs like grief counseling also offer hope for averting depression among older adults.

Public mental health systems for years have shown ambivalence around the issue of Alzheimer's disease, officially excluding it as a diagnostic group of concern even though people with the most severe cases of Alzheimer's disease tend to drift into state psychiatric hospitals. Similarly, family members of people with Alzheimer's disease, sensing the shame attached to mental illness, often try to distance themselves from the mental health community and categorize the problem as being "medical" rather than "psychological" or "mental."

The report is significant in addressing Alzheimer's disease together with the other mental illnesses. Alzheimer's disease is not characteristic of all older adults. It affects approximately 15 percent of older adults, and the probability of developing it increases with advancing age, doubling every five years to about 30 to 45 percent for people age 85 and older. This should be qualified by the fact that most older adults do not actually develop Alzheimer's disease.

As with depression, Alzheimer's disease presents diagnostic problems that are unique and need greater attention. Its onset is insidious. There are no clear biological markers, yet it has tremendous impact on older individuals and their caregivers. There is a high probability of depression among people with Alzheimer's disease. Furthermore, caregivers, often spouses who are elderly themselves, are at extraordinarily high risk of depression themselves.

“The report conveys an urgency for finding accurate means of early diagnosis because treatments that slow the disease or reduce existing symptoms are more likely to be effective early on.”

The report conveys an urgency for finding accurate means of early diagnosis because treatments that slow the disease or reduce existing symptoms are more likely to be effective early on. In addition, early intervention would allow the teaching of coping strategies to people affected by Alzheimer's disease, the training and preparation of caregivers, perhaps insulating them from depression, and would allow people to make future plans through advance directives. It also makes cost sense. Caregiver support can delay institutionalization by an average of 300 days. That is significant at both human and fiscal levels.

Older adults diagnosed with schizophrenia often endured the worst of state psychiatric hospital systems that relegated them to custodial care. The report cites an indication that older adults with schizophrenia experience some lessening of positive symptoms such as hallucinations and delusions. The negative symptoms of schizophrenia, flattened affect and social withdrawal, persist, however. In addition, research shows that older adults with schizophrenia tend to have more significant functional impairments than younger populations. The good news is that the newer medications hold real promise. They tend to address the negative symptoms to which older adults are especially prone, but we need additional research on their specific action upon older adults, and the interaction of those medications with other physical problems that older adults may have. These medications are more costly, so the political issue of the "worthiness" of older adults to receive appropriate treatment comes to the fore.

The chapter concludes by placing the science of aging and mental health in the context of practice. It recognizes that although most older adults live in community settings, mental disabilities are the leading cause of their institutionalization. Because institutionalization is costly, early interventions are extraordinarily important. But services for older adults, when available, tend to be fragmented, incoherent, and very difficult to access.

We need to learn much more about extending services to diverse settings, such as primary care. We need to have a much greater understanding of the promise that prevention and the fledging self-help and peer support programs appear to offer. The latter issue is particularly

significant at this point in mental health history. Increasingly, as we have learned, consumers, ex-patients, and psychiatric survivors are speaking out and asking that they have a voice in shaping the system that is constructed to serve them. Even members of the population once consigned to geriatric back wards are organizing and speaking out to define the kind of help they want and need and to fight stigma, coercion, and self-hate.

The older adult chapter of the report, in reviewing existing data and, on that basis, recasting older adulthood in a positive light, is a powerful tool for older adult advocates. The report's review of the promise of treatment and prevention validates efforts to bring meaningful services to older adults with mental illnesses and supports the ambition that older adults with mental illnesses will no longer be marginalized and excluded from the mainstream. It lays the groundwork for significant change in service philosophy, in the outcomes we might expect, and in

accessibility to service delivery systems.

Based on what we have learned, advocates for change may be heartened to know that personal messages resonate with the public when relaying key mental health messages. If you consider that one in five older adults may have a mental illness, that the probability of Alzheimer's disease increases with age, and that the older adult population is growing, there is fertile ground for the Surgeon's General's good news. Also note that traditional families have four grandparents and that nontraditional families, step-families, may have even more, so the prevalence of older adults within family structures and the probability that there is some level of mental illness among them is very high.

I believe the positive messages of the Surgeon General's report will resonate with the public to bring about needed changes.



## Questions & Comments

Symposium participants reflect on the developmental approaches of the *Surgeon General's Report on Mental Health*.

**Laura Cipprotti** *Because one in five — 20 percent of Americans — experience mental illness each year, I urge the Surgeon General and the media planning group to allow 20 percent, or two to three of the monthly messages that are going to be presented in 2000, to be chosen by the consumer survivor community.*

**Leon Eisenberg** *One wants an evidence-based medical care system not only in mental health, but also in general health. However, doctors can do many things for patients that are not based on randomized control trials. Being able to get to see your doctor and have your doctor listen to you is helpful.*

*Children's mental health treatment has been unexamined and a number of things need to be done. While there may not be much documentation regarding children in families where there is spousal abuse, surely we know that watching their parents beat each other up is bad for children, even if they are able to survive. In fact, children are remarkably resilient.*

The Carter Center  
Mental Health  
Task Force

**Kimberly  
Hoagwood**

*So, I ask for temperance to the evidence-based business.*

Information about access to care, barriers to services, and different models of service system integration are covered in the report.

**Tony Jurich**  
Past President of  
the American  
Association for  
Marriage and  
Family Therapy

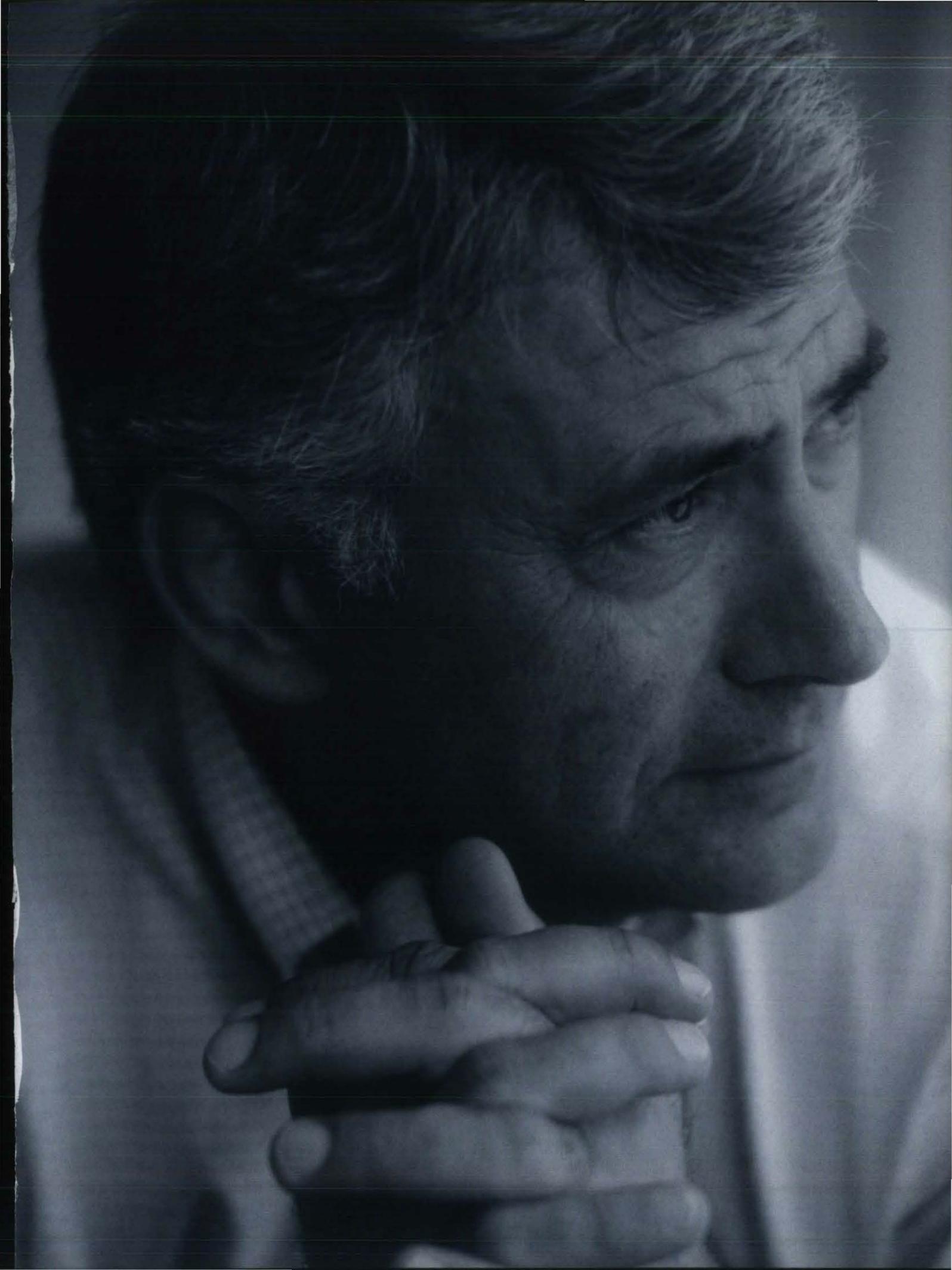
*I applaud the report's developmental approach. However, putting children and adolescents together sometimes masks the difficulty of mental health problems unique to each age group. Is the report developmentally oriented enough that we do not wind up addressing the two together to such a degree that we miss significant differences between adolescents and children?*

**Kimberly  
Hoagwood**

The developmental perspective adopted by the report goes beyond different age groups, but rather looks at developing biologic systems as well as developing the ability to understand and perceive the environment: it is very comprehensive in that sense. It reflects the increasing specialization we see across all fields.

“Children's mental health treatment has been unexamined and a number of things need to be done.”

LEON EISENBERG



# Advocates for Change

The contents of the *Surgeon General's Report on Mental Health* provides substance for influencing public perceptions about mental illness.

By William Emmet

The National Alliance for the Mentally Ill (NAMI) welcomes the *Surgeon General's Report on Mental Health*. As a grass roots organization, NAMI believes that the report will be embraced by our members and used in many ways.

NAMI has used other evidence-based reports and documents to lead us toward our goal of a better life for people with mental illnesses. We have always looked to science for guidance.

Our organization rose up 20 years ago in reaction to the then-pervasive drum beat of shame and blame that dominated thinking about mental illness and that still, unfortunately, is not completely eradicated. Using science has, over time, helped us change not only the thinking of our members, but also that of people our members go to for help and, more broadly, of the general public.

The Surgeon General's report gives us another platform from which to continue to inform the public. In fact, the report has the potential to drive a stake into the heart of the issues of shame and blame that have so long stigmatized people with mental illness.

One of NAMI's roles has been to translate scientific findings into messages that are, first of all, understood by our members — people who themselves are living with mental illnesses in their families and in their own lives. Through awareness, they learn to better live with their illnesses, how better to manage them, and how better to move forward and reconstruct their lives.

We also have translated the scientific findings into messages that help create a public understanding of mental illnesses that gets to the root of the problem, which, in so many cases, is the stigma associated with mental illness.

“The report, in fact, has the potential to drive a stake into the heart of the issues of shame and blame that have so long stigmatized people with mental illnesses.”

One example of what we have done is our Campaign to End Discrimination. This ongoing effort grew out of our dissatisfaction with what happened to mental illness and mental health in the early health care reform initiatives of the Clinton administration. Hope was built around the idea that mental health would be a part of the mainstream health care delivery system promised by the reform effort. But when the negotiators got down to brass tacks, the first thing off the table was mental illness and mental health.

We realized, first of all, that people did not perceive that there would be any political backlash to knocking mental illness off the table. Secondly, we realized they probably thought mental illnesses were not real and treatments were not effective. Mental health treatments and mental illnesses were still too fuzzy and poorly understood to be included in the same category as regular health care.

So we developed our Campaign to End Discrimination, which tries to impart some basic messages that are similar to those of the Surgeon General's report: “Mental illnesses are real. Mental illnesses are brain disorders. Treatment works. Discrimination is wrong.”

We have tried to translate those basic messages into political and social action. The most familiar is the state-level fight to create insurance parity laws where we use the science from the past several years demonstrating that mental illnesses are real. We found we could use pictures of brain scans showing the

brains of people with mental illnesses and the brains of people without mental illness and go to state legislatures and say, “Look, this demonstrates that mental illnesses are real.” The fact that there are now parity laws of some descrip-



**William Emmet** coordinates NAMI's efforts to provide support and education to people with mental illnesses. For eight years he was execu-

tive director of the NAMI in Rhode Island. He has been a member of the NAMI board of directors.

tion in 28 states begins to demonstrate that this is an effective strategy, that using science to get to policy-makers helps make a significant difference in some people's lives.

As a second example, the Patient Outcomes Research Team (PORT) study was released about a year and a half ago: It showed that we know much about how to treat schizophrenia. We know what interventions work in many cases. We know how people respond in many cases. But we are not making those treatments available. The PORT study showed this in very stark terms, showing where people were not getting treatment and who was not getting treatment. For example, the study showed that African Americans in particular were not getting treatment.

We took the findings of that study and converted them into a family and consumer treatment guide to schizophrenia treatment that has been disseminated broadly across the country, not only to our own members but through as many different dissemination avenues as possible: to treatment providers, to policy makers, to opinion leaders, just so they could understand that what we have in this country is a problem that exists on a cou-

ple of levels. Again, it is a problem that appears also to be addressed in the Surgeon General's report. We have effective treatments. There is a wide range of choices for treatment, but they are not available to many people — and if they are not available, those people with mental illnesses are being discriminated against in a very real sense.

Another brief example of what NAMI has done to try to make available evidence that treatment works is to take the Programs of Assertive Community Treatment, or the PACT programs, and showcase them as programs that, for certain people, are extremely effective. We have tried to elevate the visibility of PACT because it is a replicable model. It is something that can be used in many places. There is a 25-year history showing that it works and we want to make it available to people who need that sort of psycho-social intervention.

Again, our members have been empowered to be advocates for that kind of system change. The Surgeon General's report gives us another opportunity to inform NAMI's members and to educate policy-makers.

“There is a wide range of choices for treatment, but they are not available to people and if they are not available, those people with mental illnesses are being discriminated against in a very real sense.”

# Programs for the Least

Ethnic populations are growing nationwide, and the *Surgeon General's Report on Mental Health* needs to speak to their special needs and missed opportunities.

By Gloria Rodriguez

**W**e work in very high-risk communities. We are in about 80 family centers throughout Texas. The demographics are very bleak. Based on our research, 60 percent of our population has experienced depression. More than 50 percent witness violence at home or in the community. Over 50 percent were abused as children — sexual and physical abuse, and neglect.

We have been most effective in breaking the barriers to treatment by partnering with organizations in the community. In working with children, we deal with abuse and neglect issues, with delinquency — gangs — and mental illnesses. With the parents, we try to deal with depression, alcoholism, substance abuse, and family violence, providing help in mental health supported services as well as transportation, child care, peer support, education, and job skills.

For 26 years, I have observed in very poor communities people who are left out of mental health services. Their illnesses are not genetic but could be prevented — the product of the stressful, violent communities in which they live.

We want to promote positive mental health. We want to help individuals live a full life.

We believe comprehensive, community-based, continuous, integrative early childhood programs for families will prevent mental illnesses and promote mental health.

For example: A teen-age mother, despondent when she entered our program, had buried her child who had died of dehydration. After attending our program, she says, "Now I see the light. Now I know effective parenting skills. Now I can take care of my child." Her other two children, who were to be taken away from her had she not attended

Avance, have remained with her and have a chance to grow to be productive, healthy citizens.

Another example: A wife who witnessed the violent death of her husband and went into prostitution and drugs stated that without Avance she would have been in a mental institution. She says, after the program, "Avance has touched my heart and has touched my life."

Two children of a single mother saw their mother dragged from her home and killed by teen-agers in the neighborhood, because she had complained they were breaking into her home. She never attended Avance; we could not save her.

These are true stories. These are the stories I have seen in 26 years in our community.

Since 1973, we have saved thousands through our services. Eighty thousand people have been touched by Avance ... people who have so little to defend themselves against ignorance, violence, poverty ... people who do not have money for health insurance, who did not know how the system works, who did not have a social support system or transportation or child care or — most important among the Latino population we serve — the English language through which to explain their hurts and hopes.

We have crossed many barriers by providing an effective, culturally sensitive program: by providing transportation, child care, and support systems; but most important, by building a program based on their culture, their values, their beliefs, their

traditions, and their practices — using the language they speak, serving the food they eat, playing the music they hear, displaying their folk art, reflecting their values, hiring them to help in the work.

“We have been most effective in breaking the barriers to treatment by partnering with various organizations in the community.”



**Gloria Rodriguez, Ph.D.**, has been founder, president, and CEO of Avance Inc. since 1973. She is the author of a number of important works and her organization is a nationally recognized model and pioneer in parent education and family support. She has received many awards for her work with low-income children and their families. She serves on the Presidential Commis-

sion on Education Excellence for Hispanic Americans and many other advisory boards at the national level.

Dr. Rodriguez has been a consultant to television and other media on these issues. She has her Ph.D. in Early Childhood Education from the University of Texas.

We have designed a program integrating these principles into Avance, especially emphasizing the values that they hold dear: children, families, communities, the role of the father, the role of extended families, and most of all, using their language.

Whether black, brown, or white, Avance serves all ethnic groups, but Avance's number one principle is to treat people with dignity — as individuals worthy of respect regardless of their social, economic, and racial status. By our actions we touch their hearts and pierce their souls. It is the best medicine money can buy.

I heard that from someone who said, "We need a little bit more compassion in our neighborhoods."

No man — or woman — is an island. Through our family support programs, we develop relationships. We help build parent-child relationships, especially focusing on birth to age 3, by giving parents knowledge and discipline; by teaching the importance of demonstrating love; by demonstrating the necessity of building trust and of bonding. We promote interaction between parents and children in simple, effective ways: by making toys from scraps of materials, for example.

We strengthen the relationship between father and mother by having couples' programs. We teach communication and conflict resolution skills. We serve all family members — siblings, relatives, even *compadres* — friends. We strengthen the neighborhood through neighbor helping neighbor.

Our research at Avance, using a grant from the Carnegie Corporation, shows that our

approach is working, that we change knowledge, attitudes, and behavior. We are effective through our culturally sensitive approaches that enable us to reach a population in need and to connect them with services. Avance is the advocate. It is the catalyst for those who do not have a voice or the strength or the knowledge.

Programs like ours need to be in the *Surgeon General's Report on Mental Health*. They are effective but they are not funded well. We must seriously look at community-based programs. They are difficult to fund — I have been doing it for 26 years. But they are cost-effective in preventing mental illnesses in a large percentage of the population.

We created 80 family centers through partnerships with different funding sources.

To create them is one thing. To sustain them is another. We need more research to compare our strategies with others. We immunize the children and diagnose and treat them for different illnesses, but we want to enhance that. We enroll our families in the state Children's Health Insurance Program (CHIP), in Medicaid.

We want to prove that our strategy breaks any kind of barriers to treatment.

Lastly, we need funds for advocacy. We need more supporters

and more advocates because, in the next few years, the minority population — people of color — are going to be the largest group in America. In 50 years, one in four individuals will be Latino. Unfortunately, these are the people who are getting the least services.

"Whether black, brown, or white, Avance serves all ethnic groups, but Avance's number one principle is that we treat people with dignity and respect."

# Issues of Compassion

In the euphoria of new science, mental health advocates must speak not only with authority, but also with a sense of passion.

By Michael Faenza

Even in our field of community mental health, some say, “Those people are not our people,” because of diagnosis or lack of diagnosis, or, “Those issues are social services’ problems, they are not the target of community mental health.”

The National Mental Health Association (NMHA) uses an evidence base as the central tenet of our advocacy strategy and system-change strategy. The *Surgeon General’s Report on Mental Health* will help us promote what is important to us: a public health base, prevention and children, and adults with serious mental illnesses.

So, the report can substantiate and validate our work, and we are excited about that.

As we look back at the process, we will learn that some of the feelings and comments about the report and how it was developed reflect a change in community mental health.

The NMHA has done some real soul-searching over the past decade. We are an organization created by a person with a mental illness, yet we have asked ourselves: What do we really have to do with people who have mental illnesses? How real is mental illness in terms of our inclusiveness of folks who are the end-users of the services? We have struggled, and we have gained ground, yet we still have a lot to learn by reflecting on this process.

We are in a new age. Public policy and public messages are in a different ball game when it comes to inclusion — to hearing the voices of all participants — not in token ways, but in real ways.

A couple of things come to mind. One, there is a wealth of scientifically proven treatments and supports for people with mental disorders and their

families that has not been used effectively. The report can help with that.

Two, there also is something to learn if we look at the wealth of evidence on what works and then ask why we have just inched along in developing services and policy. It has to do with the advocacy. It has to do with the messages.

Many considerations in addition to scientific evidence become evident when policy is made and funds are appropriated. In my 26 years, I have sat in on hundreds of commissioner’s courts, county government sessions, state legislature committees, and city council meetings. Often scientific evidence was in the back seat or maybe even locked in the trunk. Political expedience and short-sighted cost management issues — and backslapping — recklessly drove the car. Obviously, the science base is not everything in terms of creating or shifting policy.

A related issue: At times we raise the bar so high for scientific evidence that it skews, in some way, how our leadership talks about policy and system issues in mental health. Yet everything in our field isn’t “fact.” Truth is important, and the truth is that it is extremely important for us to include compassion, a sense of justice, and a generosity of spirit when we speak about vulnerable people in public venues.

If we admit that hard evidence regarding treatment efficacy for specific populations in specific settings is vague or does not yet exist, at the same time, we have a responsibility to temper our message with hope and balance. Here’s one of many examples: We may say we need to know much more about how to provide alterna-

“One of the issues for the National Mental Health Association is that we do have a public health base, we care about prevention, we care about children, and we care about adults with serious mental illnesses.”



As president and CEO of the National Mental Health Association, **Michael Faenza** has brought NMHA to new heights. He has spent much of his life focusing on legislative advocacy and proving his organization's commitment to helping people with mental illnesses.

*He brings a public health perspective to issues*

*of community mental health.*

*He has held clinical and management positions in public sector organizations, including juvenile justice. He holds a bachelor of arts degree in sociology from Indiana University and an M.S.W. from the University of Texas, Arlington.*

tive treatments for youth who are incarcerated for minor offenses. At the same time, we must argue that tens of thousands of kids today are incarcerated because of mental disorders and substance abuse problems, and they get very little help. That they need help — even if we're not sure if boot camps work, or if incarceration can create change — must be part of our message. What we can say is that kids in those settings are often abused and that they deteriorate emotionally and physically. We can say there is an extremely poor prognosis for future positive outcomes. For the most part, kids locked up today feel hopeless, they feel despair, they feel anger. And there is an evidence base for that statement.

If the scientific community — often seen by policy-makers as the intelligencia of mental health and mental illness interests — does not communicate real concerns about human suffering and justice, we are just going to continue to inch our way along. And when history looks back at us, we will not be condemned for lack of scientific rigor, but — given all our wealth and science — for our lack of compassion and passion to reduce suffering and improve the quality of life of people.

Two quick illustrations:

One thing NMHA is working on is improving services for kids with mental disorders in justice systems.

We want to reduce incarceration, provide alternatives, and create public policy that is less punishing and more rational in responding to their real needs. Department of Justice investigations documented the prevalence of kids with

mental disorders in juvenile justice facilities in Georgia, Louisiana, and Kentucky.

We also have information from programs like the Wrap Around Milwaukee Services. One of the sites funded and delivered by the Center for Mental Health Services, it provides care for large numbers of kids out of the juvenile justice system who have mental disorders. It keeps them out of jail and residential placements. Outcomes are improved for those kids compared to kids that are not in that type of program.

The Department of Justice reported on the Wrap Around programs to Senator Paul Wellstone and he crafted alternative legislation. For the first time in the Office of Juvenile Justice and Delinquency Prevention, language talks about mental health needs. We got started.

Second, under the leadership of Dr. Laura Young at NMHA, we are disseminating best practices and model programs for people with severe and persistent mental illnesses.

One example is the Village Program run by the National Mental Health Association of Los Angeles. It is an integrated, comprehensive system of services that respects and empowers people with mental illnesses. People have access to the best

treatments and a wide range of supports. There is a research base about reduced costs and reduced hospitalizations for like populations. Laura and her colleagues use that information by putting on workshops and initiating community planning to improve systems there.

“If the scientific community — seen by policy-makers as the intelligencia of mental health and mental illness interests — does not communicate real concerns about human suffering and justice, we are just going to continue to inch our way along.”

# Effective Alternatives

A nationwide study of consumer, survivor-operated self-help programs reveals many successes.

By Laura Van Tosh

Paulo Delvecchio and I co-authored a technical report on consumer, survivor-operated self-help programs. This report was funded by the Center for Mental Health Services. To determine the effectiveness of self-help programs, we evaluated the results of consumer-operated, self-help demonstration sites in 13 states, from New Hampshire to California. We examined who was served, what services were provided, and we evaluated the feasibility of the programs based on criteria of effectiveness.

These findings are cited in the *Surgeon General's Report on Mental Health*. We found a broad range of individuals was served in these self-help programs. All had psychiatric disabilities. Most were impoverished. There was gender balance and cultural diversity, they were predominantly adults, and a substantial number were military veterans.

Overall, we found recipients had many positive things to report about these programs. Recipients noted increased self-efficacy as a result of these programs, as well as improved quality of life and an increase in their social supports. There were enhanced employment opportunities and expanded education and knowledge opportunities.

The study sites offered valuable recommendations. They felt they needed increased technical assistance and help in planning

programs. They required more adequate funding to meet recipient needs. They also would like to see increased participation by people of color, self-help providers, and users. They cited a need for more research, and out of that recommendation, the Center for Mental Health Services has been examining, in a more rigorous nature, consumer-run programs.

Their other recommendation was to fund projects directly, instead of through the states, which were dispersing the federal dollars.

Overall, our recommendations include:

- More training and technical assistance in nonprofit management should be offered.
- Governments of state and local communities, plus the federal government, should initiate more programs to increase public awareness of self-help programs. The *Surgeon General's Report on Mental Health* will help spread the news of the effectiveness of these consumer, survivor-run self-help programs.
- Examine benefits and drawbacks of integrating consumer-run services into a managed care environment.
- One of the key findings related to the study sites' ability to coordinate with a broad range of traditional and nontraditional human services agencies.

“The *Surgeon General's Report on Mental Health* will help spread the news of the effectiveness of consumer-run, self-help treatment programs.”

Laura Van Tosh is a consultant living in Silver Springs, Md. Her report was delivered by Lei Ellingson, assistant director of The Carter Center Mental Health Program, after a family death made it impossible for Ms. Van Tosh to attend the symposium.

# Prevention Is the Key

At Delta Air Lines, an awareness of passengers' and employees' health and safety merge to create an atmosphere of care and intervention.

By Tara Woodridge

One way which the *Surgeon General's Report on Mental Health* is valuable is that it gives us as a nation a better understanding that mental health care is equally important as physical health care. As long as health care benefits are tied to employment, employers have a vested interest in the literature and the science because what we learn helps us provide the right kinds of resources for our employees.

Looking at financial barriers to treatment, my frame of reference is a large corporation. Delta Air Lines is self-insured. We have 75,000 employees, which means almost 200,000 covered lives. We are a safety-sensitive industry. This perspective may be different from other employers', but there certainly is some common ground.

Are financial barriers real or perceived?

If we simply look at the dollars we spend on health care then we might see some significant barriers. At Delta, we have had a long history of rich benefits. Managed care did not come to us until 1994 when the airline industry was doing poorly and we recognized that costs had to be controlled. Delta brought in an insightful medical director who recognized the importance of health care: physical health care, dental care, medical care in general, including substance abuse and mental health care. We wanted to control costs, but we did not want to limit access to care.

In 1994, we spent \$274 per employee annually on mental health and substance abuse care. In 1998, that cost had gone down to \$153. The difference was not in limiting care. The difference was in managing care. We provided 50 percent reimbursement for outpatient care. You could go to anyone you wanted, and we paid 50

percent. Now we ask employees to provide a small co-payment for outpatient care and a \$100 co-payment for facility-based care, regardless of the length of stay when they use network providers.

It was difficult to adjust to the idea of limits: "I cannot go to the doctor my friend recommended because they are not in the network and that means I would have to pay a greater price." The concerns were more about limits rather than the care that was provided. We focused on quality and ensuring coverage for the full continuum of care because we recognized the importance of providing access to "the right care at the right time." Appropriate use of lower levels of care limits the need for expensive acute care and results in cost savings.

Our managed care vendor is an administrative-services-only contract, which means there is no incentive for limiting care by placing caps on the number of visits or length of stay. We pay for all employees' care. Care is provided on the basis of what's medically appropriate. Our plan covers a broad range of issues. If employees want to obtain marital counseling or address other troubling personal issues, it's covered. We do not want individuals to wait until there is a diagnosable illness before they seek assistance.

We recognize how important it is to look at preventive issues, not just crisis situations. When we instituted managed care, we also developed a strong employee assistance program to help

employees cope with life's challenges, recognize why it is important to access care early, and provide case management so that people see the right providers. The EAP also provides education about behavioral health care and works to eliminate stigma that can often serve as a barrier to access.

Delta knew that this was in its best interests.

"Delta brought in an insightful medical director who recognized the importance of health care: physical health care, dental care, medical care in general, including substance abuse and mental health care."



**Tara Wooldridge** has served as manager for Delta Air Lines' Employee Assistance Programs since 1994, providing services to more than 75,000 personnel. She has a bachelor of arts degree from Pitzer College and a master's degree in social work from Clark Atlanta University.

She is a licensed social worker in Georgia, a member of the National Association of Social Workers as well as the Employee Assistance Program Association, and serves on the board of the Employee Assistance Roundtable.

A McDonnell-Douglas study documented the efficacy of employee assistance programs based on a return on investment of four-to-one as a minimum. In 1995, an Abbott study looked at EAP users. Their mental health and substance abuse costs were \$1,800 higher per year than non-EAP users, but their total health care costs were \$2,000 less.

Are there financial barriers or are we looking at the wrong numbers? We have to consider all the costs that are included with care: direct costs, including treatment, laboratory, and medication, and indirect costs, including absenteeism, decreased productivity, increased safety risks, disability, and worker's compensation.

As a long-term employee, I can be out sick for 10 weeks and receive full pay. Who benefits if I do not get comprehensive care? Certainly not my employer who is paying me to be off to obtain adequate treatment, so limiting care actually drives up costs in the long run. Providing quality, comprehensive care is a catalyst for quick recovery to optimal functioning. That is what we have to get the financial folks to understand, not just what are we spending on health care dollars.

The National Institute of Mental Health's Depression Awareness Recognition and Treatment program (DART) has helped us understand the value of early intervention, global education in the work force, and access to good treatment. It promoted guidelines-based care, helping our primary care physicians understand depression treatment, and pushing for coordination between mental health and physical health

providers. The EAP used DART materials to train supervisors, educate employees about the disease, and advocate proactive intervention.

Depression is common in the largest working age group, people 25 to 44 years old. It is relatively easily treated, particularly if recognized early. It can, however, be expensive. Most expense is not from treatment — only 28 percent of the total cost — but from the loss of productivity, which represents 55 percent of the cost. So, as an employer, it is important to look at these kinds of issues and how we might better assist our employees with access to appropriate treatment. With good and effective treatment, we see 80 percent to 90 percent recovery with depression.

**W**hat are our interests at Delta? Primarily safety — the safety of our employees in their work environment and the safety of the flying public. It is important that we do not have impaired persons in the workplace. Productivity is also important.

We also look at the welfare of our people. We look at the costs of treatment, medical services in general, disability, and worker's compensation. Health promotion becomes important.

Delta has a strong substance abuse program that focuses on prevention, education, early intervention, and support for full recovery. We also have a structured after-care monitoring program, since many people who are treated for substance abuse relapse.

“We look at the welfare of our people. We look at the cost of treatment, medical services, disability and worker's compensation. Health promotion becomes important.”

We look at every avenue for prevention. We have a strong Critical Incident Stress Management program to ensure that employees affected by workplace trauma receive immediate emotional support. Again, our goal is prevention, keeping people healthy, and preventing post-traumatic stress disorder.

We interact with millions of passengers and, as a result, we deal with a few people who are aggressive and hostile. We handle medical emergencies fairly routinely. In 1996, major carriers had more than 10,000 medical emergencies, which means our crew members are dealing with people who require CPR or the use of automatic defibrillators that are now on board aircraft. These situations can be traumatic for our employees. How do we support them, help them stay healthy, and deal with these kinds of crises? We have about 30 employees in Istanbul who were effected by the earthquake. What do we do to support them and help them stay healthy as they deal with the trauma occurring

in their city? We continually seek answers to these kinds of questions as we look at the best interests of our employees, our most valuable asset.

Whether you call it stigma, prejudice, or discrimination, these are issues that impact people's willingness to accept help, that impact early recognition, and so it is important as an employer that we do our part to address those issues.

For the future, we need to make sure we broaden our vision in terms of what is total health care. We need to forge better partnerships. We need to dialogue with benefits administrators and disability managers. We need to dialogue with everybody at the table deciding what makes sense from a preventive perspective.

Every employer has a vested interest in the science and in making sure that employees have access to comprehensive quality health care.

“Our goal is to educate, to make sure that our employees have access to appropriate resources, and to do what we can to make sure that there are no barriers to treatment.”

## Comments & Questions

Conference participants express enthusiasm, encouragement, and criticism of the *Surgeon General's Report on Mental Health*.

**Cynthia Waincott** Because of the report, the phone is going to start ringing. People are going to say, "I need help. How do I get it?" Or, "I tried to get help and I could not get it." Or, "I got help and it did not help because it was not good quality."

National Mental Health Association of Georgia

It is important to those of us who work as advocates that the report be widely disseminated and discussed. Controversy can help get attention, but it can also muddy the messages.

**Rochelle Rollins** The report is important to the bureau because we are starting a substance abuse initiative. I was glad sexual orientation was included in chapter two. With the roll-out of a promised supplement on ethnic and minority differences, the report will become even more beneficial to our bureau, since we serve under-represented vulnerable populations.

Health Resource and Service Administration (HRSA), Bureau of Primary Health Care

**Susan Rogers** I would like to offer a statement of criticism of the *Surgeon General's Report on Mental Health*:

National Mental Health Consumers Self-Help Clearing House

"Whereas the draft *Surgeon General's Report on Mental Health* has recklessly endorsed electro-convulsive thera-

py (ECT) as safe and effective, despite overwhelming evidence to the contrary in the scientific literature as well as in the personal testimony of shock survivors, and whereas ECT routinely causes permanent and disabling memory loss and damage to cognitive abilities and has also resulted in epilepsy and death, and whereas standard consent forms do not inform potential ECT recipients of these dangers, we, individuals who support everyone's right to the opportunity for truly informed consent on ECT and all other psychiatric and medical procedures and treatments, call for the Surgeon General to work with the Committee for Truth in Psychiatry, the national organization of shock survivors, in order to develop a statement to be included in the *Surgeon General's Report on Mental Health* that accurately presents the risks involved in this very dangerous and controversial procedure.

"When Dr. Moritsugu referenced 'the best science, the best available science, and solid science,' he could not have been including ECT, for it constitutes bad science. It is not 'safe and effective,' as the report has said."

"It is important to those of us who work as advocates that the report be widely disseminated and discussed. Controversy can help get attention, but it can also muddy the messages."

CYNTHIA WAINSCOTT

**Linda Andre** Being ignored, being excluded, being laughed at, being yelled at, being invalidated, being hung up on, being told you do not count, being invisible ... I have had all these experiences in the past two years in trying to present the ECT survivor viewpoint to the *Surgeon General's Report on Mental Health*.

Committee for  
Truth in  
Psychiatry

What we are really talking about here is prejudice, prejudice against the inclusion of the viewpoints of psychiatric survivors. The Surgeon General's report talks the talk, but it does not walk the walk. By excluding the input of psychiatric survivors, the report perpetuates stigma.

Inclusion is a messy process, maybe a frightening process; inclusion of any minority group has always been difficult. Inclusion does not mean that it is inclusion only on certain issues but not on other issues. The Surgeon General's report shirked its responsibility to be inclusive, and this is why our organization and other national organizations cannot support the report.

**Al Guida**

National  
Mental Health  
Association

To great fanfare, United Managed Health Care (UMHC) recently announced its decision to rescind prior authorization for its medical/surgical benefits. A couple of days later it turned out that, in fact, prior authorization will only apply to its behavioral health component.

Dr. Solomon Feldman, executive director of UMHC, justified that decision, *The Washington Post* reported, by saying medical/surgical services enjoy more evidence-based practice than mental health and that mental health holds more imponderables than medical/surgical services.

**Leon Eisenberg** I appeal to everyone to recognize that given whatever pieces of the report we do not entirely agree with, that if

Harvard Medical  
School and  
The Carter  
Center Mental  
Health Task Force

“This is a chance we should not miss. I just urge us all, whatever reservations we have, to ask, “Is the report, on the whole, good for patients?””

LEON EISENBERG

indeed the substance of the report will improve the situation for persons with mental illness, it requires our support and commitment.

I hope the professional organizations can come together to support the base message without arguing about professional hegemony or supremacy.

The writers and editors who describe the report to the American people cannot listen to everybody. No report could say anything worthwhile without containing some controversial elements. It is a substantive document and some of its content is bound to be disputed. We must not get stuck arguing over the details, rather than recognizing the opportunity to have a national policy enunciated on behalf of a group that has been left out and is still being left out.

This is a chance we should not miss. I just urge us all, whatever reservations we have, to ask, “Is the report, on the whole, good for patients?” If it is, let's get together and support it.

**Jerry Weyrauch** *The Surgeon General's Call to Action to Prevent*

Suicide  
Prevention  
Advocacy  
Network

*Suicide*, issued in July 1999, is an amazing document, indicating for the first time that we can prevent suicide. Dr. Satcher acknowledges the report offers no new science but urges us to remember that through collaborative processes, we can get things done when we cannot do them individually.

Additionally, the World Health Organization has undertaken a five-year global program for suicide prevention that will have a strong bearing on mental health. Looking back 20 years, few mental health advocates even mentioned suicide. This new openness and new attention is another giant step in the right direction.

**Robert Epstein** Obviously, important things are happening in mental health, but no one has mentioned that the past decade, the decade of the 1990s, was, by Presidential Proclamation, the Decade of the Brain. At least 35 organizations are now lobbying to name the first decade of the new millennium, the 2000s, the Decade of Behavior.

**Claire Griffin-Francell** We support the Surgeon General's report, especially since it is science based. When we speak of severe mental illness, it is science based.

I recently visited Nanjing, Beijing, Xian, Shanghai, and Hong Kong in the People's Republic of China. I visited the mental health sites of the university and the practice sites. Wherever we went, they talked about involving families immediately in the care. They saw severe mental illnesses as medical disorders that were no one's fault. The family was never blamed.

They had not been exposed to Western thought that bad parenting, for example, was a cause of mental illness, a theory that is still sometimes espoused.

**Roxanne Kibben** I appreciate the comments about the mandate of the report not to include substance abuse. I understand to do so would be a massive job. I appreciate the incredible contribution the report will make. I believe it must be a vision for a future report, detailing what could be done for substance abuse.

Sometimes it seems that substance abuse is the step-child of stigma, but we are encouraged by the progress demonstrated by NAMI and some of the movements that happened in mental

health; they present something on the horizon that we look forward to.

**Leslie Scallet** As a consultant, I am working with the Center for Substance Abuse Treatment on a national plan to improve substance abuse treatment. The Surgeon General's report is great input, at least on this issue of co-occurring disorders.

Lewin Group and  
The Carter Center  
Mental Health  
Task Force

Our project is being designed to begin to do the same thing for the substance abuse field that the national plan for the chronically mentally ill did. I hope there will be an explicit strategy for working with groups beyond the mental health constituency — groups such as ours.

**Susan Rogers** Part of our problem with the report was with the process. If people with psychiatric disabilities had been involved from the beginning in a representative and adequate way, I do not think we would be seeing the problem with the section on ECT. It is four paragraphs out of a 1,000-page report. But it is not a minor part.

People in this country seek treatment daily, and they trust the Surgeon General. Everything in the report is going to be taken out of context at some point. We would like it to be as good as it gets. We would like it to reflect good science. We would like it to be a helpful document.

**Howard Goldman** Many consumer activists did participate in the preparation of the report. One may not agree with the process and who was included, but an effort to hear many voices was part of the process, and we continue to stand by it.

University of  
Maryland School  
of Medicine

“I hope there will be an explicit strategy for working with groups beyond the mental health constituency.”

LESLIE SCALLET

# Opportunities & Actions

Symposium participants suggest ways to use the *Surgeon General's Report on Mental Health* to inform the public about mental health.

**M**ental Health: A Report of the Surgeon General is *not just theory; not just a recitation of scientific evidence and current policies in the treatment of people with mental illnesses.*

*It is a call to action.*

*Participants at the symposium divided into groups to discuss ways to implement the Surgeon General's report and to initiate further discussions among shareholders, consumers, advocates, and the general public. Here is a list of their recommendations:*

## Group 1: Actions & Activities

- Form coalitions and action partnerships within and outside the mental health community to share and use the report.
- Incorporate the report into associations'/organizations' national, state, and local meetings.
- Identify and use nationally known spokespersons and other leaders as messengers of the report.
- Provide local media with ways to apply the report to community problems and needs.
- Provide major message points from the report to media.
- Inform and involve the National Governors Association, the National Council of State Legislators, and other elected officials.

## Group 2: Actions & Activities

- Enter highlights of the report on to Web sites/libraries.
- Encourage collaborative efforts among stakeholders and mental health advocates to promote the report's findings.
- Contact media (local and national) about the report.
- Write letters to newsletters and professional journals.

- Influence legislators/policy-makers.
- Initiate forums for discussion and changes/additions in curriculum to reflect the report's contents.
- Broaden audience of those who hear about the report: Contact businesses, labor unions, and other parties with a vested interest in the mental health of employees.
- Create fact sheets and legislative guides.
- Convene stakeholder groups (e.g., mental health directors, public health directors, consumers, families).
- Speak out on issues of particular public interest (e.g., involuntary treatment, informed consent, suicide).
- Print additional copies of the most salient sections or conclusions for wider distribution.
- Include consumers as spokespersons.
- Provide data sheets to support conclusions.

## Group 3: Actions & Activities

- Educate caregiving professionals and urge them to incorporate it into their training programs.
- Find ways to make the report news and keep it in the news at the constituent level.
- Focus on and repeat the key messages: Get everyone involved in promotion "on the same page."
- "Translate" the target message onto common item(s) and terms for better dissemination.
- Encourage better feedback mechanism for future reports.
- Tailor summaries with varied adaptable public relations materials for media and other interested parties.
- For increased effectiveness in communicating the report's message, use language that describes "discrimination and prejudice" instead of "stigma."

#### **Group 4: Actions & Activities**

- Initiate three strategies:
  1. Incorporate the report into the full range of organizational activities to make it accessible to members (e.g., Web sites, newsletters, training).
  2. Use the report as a catalyst for building coalitions to advocate for mental health.
  3. Use the report as a tool to leverage resources, legislation, media coverage, etc.
- Develop a media strategy kit to send to mental health organizations and others; put on a CD-rom; issue the report in other languages.
- On the state level, send a letter to all governors and state health officers.
- Send specifically targeted material to special populations (e.g., Hispanic-oriented materials to Hispanic outlets like organizations and newspapers).

#### **Group 5: Actions & Activities**

- Each organization commits during the first year to disseminating the central positive messages (stigma, effective treatment, etc.) through such methods as speakers, newsletters, Web sites, etc.
- Develop interactive mechanism in collaboration with businesses to reach every home and engage each family in the issues.
- Develop targeted messages for specific constituencies.

#### **Group 6: Actions & Activities**

- Organizations can use similar ways to incorporate the report.
- Most important activities:
  1. Targeting audiences
  2. Developing tools
  3. Training

# A Chance for Change

Now, as never before, mental health advocates need to “seize the day” for awareness and reform.

By Rosalynn Carter

A lot of us did not think this would ever happen. But now it has: the Surgeon General has released a report on mental health and mental illness. Those of us who are advocates now have an opportunity to use this report — this substantiation of our message over the years — and how we use it, the effectiveness of our approach, the thoroughness of our presentation, is going to be so important.

In *Setting the Stage for the Surgeon General's Report*, we have all learned a lot.

The release of the report gives us a great opportunity to focus attention on mental health issues and to close that huge gap between what the experts know and what the general public understands.

But this opportunity also places a great responsibility on us. This is something we have been waiting for for a long time, and it gives us a chance to present our case and to further our cause. I am so thankful for that.

We have listed some actions our organizations can take. I hope that you will bring some of these suggestions back to your

organizations. Members of The Carter Center Mental Health Task Force are exploring other ways to follow up on the *Surgeon General's Report on Mental Health*.

I hope you will let us know your plans — short-term and long-term — to incorporate the report into your organizations' outreach and public messages. It is going to be so important for all of us to work together to galvanize the mental health community around the report so that we can maximize its impact.

Mental health communities have worked together before. When national health care was prominent on the nation's agenda, mental health communities together started planning to make sure mental illness care was part of the reform. National health care reform failed, but the mental health community won, because we united.

Not everyone in all our disparate organizations will ever agree on every approach, every issue. We all know that. But we can come together and take advantage of this wonderful opportunity presented by the *Surgeon General's Report on Mental Health*.

We can, as is often said, “Seize the day.”

“Not everyone in all our disparate organizations will ever agree on every approach, every issue. We all know that. But we can come together and take advantage of this wonderful opportunity.”



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## Special Guests

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