CHAPTER 8

A VISION FOR THE FUTURE

Contents

CHAPTER 8

A VISION FOR THE FUTURE

Mental health is fundamental to health and human functioning. Yet much more is known about mental illness than about mental health. Mental illnesses are real health conditions that are characterized by alterations in thinking, mood, or behavior—all mental, behavioral, and psychological symptoms mediated by the brain. Mental illnesses exact a staggering toll on millions of individuals, as well as on their families and communities and our Nation as a whole. Appropriate treatment can alleviate, if not cure, the symptoms and associated disability of mental illness. With proper treatment, the majority of people with mental illness can return to productive and engaging lives. There is no "one size fits all" treatment; rather, people can choose the type of treatment that best suits them from the diverse forms of treatment that exist.

The main findings of the report, gleaned from an exhaustive review of research, are that the efficacy of mental health treatments is well documented and a range of treatments exists for most mental disorders. On the strength of these findings, the single, explicit recommendation of the report is to seek help if you have a mental health problem or think you have symptoms of a mental disorder.

Today, the *majority* of those who need mental health treatment do not seek it. The reluctance of Americans to seek and obtain care for mental illness is all too understandable, given the many barriers that stand in their way. If the information contained in this Surgeon General's report is to be translated into its recommended action—*to seek help for mental illness*—our society must resolve to dismantle barriers to seeking help that are sizable and significant, but not insurmountable.

This vision for the future proposes to the American people broad courses of action meant to hasten progress toward the major recommendation of this report. These calls to action constitute necessary first steps toward overcoming the gaps in what is known and removing the barriers that keep people from seeking and obtaining mental health treatment. Although these are not formal policy recommendations, they offer a focused vision that may inform future policy. They are intended for policymakers, service and treatment providers, professional and advocacy organizations, researchers, and, most importantly, the American people. The health of the American people demands that we act with resolve and a sense of urgency to place mental health as a cornerstone of health and address through research and education both the impact and the stigma attached to mental illness.

Continue To Build the Science Base

The Nation has realized immense dividends from 5 decades of investment in research focused on mental illness and mental health. Yet to realize further advances in treatment and, ultimately, prevention, the Nation must continue to invest in research at all levels. This Surgeon General's report is issued at a time of unprecedented scientific opportunity. Today, integrative neuroscience and molecular genetics present some of the most exciting basic research opportunities in medical science. Molecular and genetic tools are being used to identify genes and proteins that might be involved in the origins of mental illness and that clearly are altered by drug treatment and by the environment. Genes and gene products promise to provide novel targets for new medications and psychosocial interventions. The opportunities available underscore the need for the Federal mental health research community to

strengthen partnerships with both the biotechnology and the pharmaceutical industries. Gaining new knowledge about mental illness and health is everybody's business. A plethora of new pharmacologic agents and psychotherapies for mental disorders affords new treatment opportunities but also challenges the scientific community to develop new approaches to clinical and health services interventions research. Responding to the calls of managed mental and behavioral health care systems for evidence-based interventions will have a much needed and discernible impact on practice. Also, as this Surgeon General's report emphasizes, high-quality research is a potent weapon against stigma, one that forces skeptics to let go of misconceptions and stereotypes concerning mental illness and the burdens experienced by persons who have these disorders.

Special effort is required to address pronounced gaps in the mental health knowledge base. Key among these are the urgent need for research evidence that supports strategies for mental health promotion and illness prevention. Each chapter in this report has identified additional, specific gaps that must be addressed.

The vitality of clinical research hinges on the willing participation of clinical research volunteers. By law, subjects in federally sponsored research are required to give informed consent—that is, to agree to participate voluntarily after being informed about the purpose, benefits, and risks of the research, among other requirements (45 CFR 46). The law affords special protections for children and for persons with impaired decisionmaking capacity. Policies must be promulgated to ensure that vulnerable individuals are protected while they participate in research needed for the development of new treatments.

Overcome Stigma

The stigma that envelops mental illness deters people from seeking treatment. Stigma assumes many forms, both subtle and overt. It appears as prejudice and discrimination, fear, distrust, and stereotyping. It prompts many people to avoid working, socializing, and living with people who have a mental disorder. Stigma impedes people from seeking help for fear that the confidentiality of their diagnosis or treatment will be breached. It gives insurers—in the public sector as well as the private—tacit permission to restrict coverage for mental health services in ways that would not be tolerated for other illnesses. Chapter 1 reviewed the influence of stigma historically in separating mental health from the mainstream of health and its role in thwarting access to appropriate treatment. Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others.

For our Nation to reduce the burden of mental illness, to improve access to care, and to achieve urgently needed knowledge about the brain, mind, and behavior, stigma must no longer be tolerated. The issuance of this Surgeon General's Report on Mental Health seeks to help reduce stigma by dispelling myths about mental illness and by providing accurate knowledge to ensure more informed consumers. Organizations and individuals are encouraged to draw freely upon the report in their own efforts to combat the insidious effects of stigma.

Improve Public Awareness of Effective Treatment

The Surgeon General's report itself is expected to stimulate the demand for effective treatment for needed mental health care. Americans are often unaware of the choices they have for effective mental health treatments. In fact, as the preceding chapters demonstrate, there exists a constellation of treatments for most mental disorders. Treatments fall mainly under several broad categories—counseling, psychotherapy, medication therapy, rehabilitation—yet within each category are many more choices.

Individuals should be encouraged to seek help from any source in which they have confidence. If they do not improve with the help obtained initially, they should be encouraged to keep trying to obtain assistance. If the path of help-seeking leads to only limited improvement, an array of options still exists: the intensity of treatment may be changed, new treatments may be introduced, or another provider may be sought.

Family members, clergy, and friends often can help by encouraging a distressed person to seek help.

All human services professionals, not just health professionals, have an obligation to be better informed about mental health treatment resources in their communities. Managed care companies and other health insurers need to publish clear information about their mental health benefits (usually called "behavioral health benefits"). At present, many beneficiaries appear not to know *if* they have mental health coverage, much less where to seek help for problems.

Ensure the Supply of Mental Health Services and Providers

The service system as a whole, as opposed to treatment services considered in isolation, dictates the outcome of treatment (Goldman, 1998). The fundamental components of effective service delivery include integrated community-based services, continuity of providers and treatments, family support services (including psychoeducation), and culturally sensitive services. Effective service delivery for individuals with the most severe conditions also requires supported housing and supported employment. For adults and children with less severe conditions, primary health care, the schools, and other human services must be prepared to assess and, at times, to treat individuals who come seeking help. All services for those with a mental disorder should be consumer oriented and focused on promoting recovery. That is, the goal of services must not be limited to symptom reduction but should strive for restoration of a meaningful and productive life.

Across the Nation, certain mental health services are in consistently short supply. These include the following:

- Wraparound services for children with serious emotional problems and multisystemic treatment. Both treatment strategies should actively involve the participation of the multiple health, social service, educational, and other community resources that play a role in ensuring the health and well-being of children and their families;
- Assertive community treatment, an intensive approach to treating people with serious mental illnesses;
- Combined services for people with co-occurring severe mental disorders and substance abuse disorders;
- A range of prevention and early case identification programs; and
- Disease management programs for conditions such as late-life depression in primary care settings.

All too frequently, these effective programs are simply unavailable in communities. It is essential to expand the supply of effective, evidence-based services throughout the Nation.

The supply of well-trained mental health professionals also is inadequate in many areas of the country, especially in rural areas (Peterson et al., 1998). Particularly keen shortages are found in the numbers of mental health professionals serving children and adolescents with serious mental disorders and older people (Peterson et al., 1998). More mental health professionals also need to be trained in cognitive-behavioral therapy and interpersonal therapy, two forms of psychotherapy shown by rigorous research to be effective for many types of mental disorders.

Ensure Delivery of State-of-the-Art Treatments

State-of-the-art treatments, carefully refined through years of research, are not being translated into community settings. As noted throughout this report, a wide variety of community-based services are of proven value for even the most severe mental illnesses. Exciting new research-based advances are emerging that will enhance the delivery of treatments and services in areas crucial to consumers and families—employment, housing, and diversion of people with mental disorders out of the criminal justice systems. Yet a gap persists in the broad introduction and application of these advances in services delivery to local communities, and many people with mental illness are being denied the most up-to-date and advanced forms of treatment.

Multiple and complex explanations exist for the gap between what is known through research and what is actually practiced in customary care. Foremost among these are practitioners' lack of knowledge of research results; the lag time between the reporting of research results and the translation of new knowledge into practice; and the cost of introducing innovations in health systems. In addition, significant differences that exist between academic research settings and actual practice settings help account for the gap between what is known and what is practiced. The patients in actual practice are more heterogeneous in terms of their overall health and cultural backgrounds, and both patients and providers are subject to cost pressures. New strategies must be devised to bridge the gap between research and practice (National Advisory Mental Health Council, 1998).

Tailor Treatment to Age, Gender, Race, and Culture

This report presents clear evidence that mental health and mental illness are shaped by age, gender, race, and culture as well as additional facets of diversity that can be found within all of these population groups—for example, physical disability or a person's sexual orientation. The consequences of not understanding these influences can be profoundly deleterious.

To be effective, the diagnosis and treatment of mental illness must be tailored to individual circumstances, while taking into account, age, gender, race, and culture and other characteristics that shape a person's image and identity. Services that take these demographic factors into consideration have the greatest chance of engaging people in treatment, keeping them in treatment, and helping them to recover thereafter. The successful experiences of individual patients will positively influence attitudes toward mental health services and service providers, thus encouraging others who may share similar concerns or interests to seek help.

While women and men experience mental disorders at almost equal rates, some mental disorders such as depression, panic disorder, and eating disorders affect women disproportionately. The mental health service system should be tailored to focus on women's unique needs (Blumenthal, 1994).

Members of racial and ethnic minority groups account for an increasing proportion of the Nation's population. Mental illness is at least as prevalent among racial and ethnic minorities as in the majority white population (Regier et al., 1993). Yet many racial and ethnic minority group members find the organized mental health system to be uninformed about cultural context and, thus, unresponsive and/or irrelevant. It is partly for this reason that minority group members overall are less inclined than whites to seek treatment (Sussman et al., 1987; Gallo et al., 1995), and to use outpatient treatment services to a much lesser extent than do non-Hispanic whites. Yet it is important to acknowledge and appreciate that there exist wide variations within and among racial and ethnic minority groups with respect to use of mental health services. The use of inpatient treatment services by African Americans, for example, is much higher than use of these services by whites, a difference that cannot be accounted for by differences in prevalence alone (Chapter 2). The reasons for these disparities in utilization of services must be further understood through research. In the interim, culturally competent services—that is, services that incorporate understanding of racial and ethnic groups, their histories, traditions, beliefs, and value systems—are needed to enhance the appropriate use of services and effectiveness of treatments for ethnic and racial minority consumers. With appropriate training and a fundamental respect for clients, any mental health professional can provide culturally competent services that reflect sensitivity to individual differences and, at the same time, assign validity to an individual's group identity. Still, many members of ethnic and racial minority groups may prefer to be treated by mental health professionals of similar background. There is an insufficient number of mental health professionals from racial and ethnic minority groups (Peterson et al., 1998), a problem that needs to be corrected.

Facilitate Entry Into Treatment

The mental health service system is highly fragmented. Many who seek treatment are bewildered by the maze of paths into treatment; others in need of care are stymied by a lack of information about where to seek effective and affordable services. In recent years, some progress has been made in coordinating services for those with severe mental illness, but more can be accomplished. Public and private agencies have an obligation to facilitate entry into treatment. There are multiple "portals of entry" to mental health care and treatment, including a range of community and faith-based organizations. Primary health care could be an important portal of entry for children and adults of all ages with mental disorders. The schools and child welfare system are the initial points of contact for most children and adolescents, and can be useful sources of first-line assessment and referral, provided that expertise is available. The juvenile justice system represents another pathway, although many overburdened facilities tend to lack the staff required to deal with the magnitude of the mental health problems encountered. Of equal concern are the adult criminal justice and corrections systems, which encounter substantial numbers of detainees with mental illness (Ditton, 1999). Individuals with mental disorders often are neglected or victimized in these institutions.

It is essential for first-line contacts in the community to recognize mental illness and mental health problems, to respond sensitively, to know what resources exist, and to make proper referrals and/or to address problems effectively themselves. For the general public, primary care represents a prime opportunity to obtain mental health treatment or an appropriate referral. Yet primary health care providers vary in their capacity to recognize and manage mental health problems. Many highly committed primary care providers do not know referral sources or do not have the time to help their patients find services.

Some people do not seek treatment because they are fearful of being forced to accept treatments not of their choice or of being treated involuntarily for prolonged periods (Sussman et al., 1987; Monahan et al., 1999). For most, these fears are unwarranted: coercion, or involuntary treatment, is restricted by law only to those who pose a direct threat of danger to themselves or others or, in some instances, who demonstrate a grave disability. Coercion takes the form of involuntary commitment to a hospital; in about 40 states and territories, it includes certain outpatient treatment requirements. Advocates for people with mental illness hold divergent views regarding coercion. Some advocates crusade for more stringent controls and treatment mandates, whereas others adamantly oppose coercion on any grounds. One point is clear: the *need* for coercion should be reduced significantly when adequate services are readily accessible to individuals with severe mental disorders who pose a threat of danger to themselves or others (Policy Research Associates, 1998). As the debate continues, more study is needed concerning the effectiveness of different strategies to enhance compliance with treatment. Almost all agree that coercion should not be a substitute for effective care that is sought voluntarily.

Reduce Financial Barriers to Treatment

Financial obstacles discourage people from seeking treatment and from staying in treatment. Repeated surveys have shown that concerns about the cost of care are among the foremost reasons why people do not seek care (Sussman et al., 1987; Sturm & Sherbourne, 1999). As documented in Chapter 6 of this report, there is an enormous disparity in insurance coverage for mental disorders in contrast to other illnesses. Mental health coverage often is arbitrarily restricted. Individuals and families consequently are forced to draw on relatively—and substantially—more of their own resources to pay for mental health treatment than they pay for other types of health care. This inequity is a deterrent to treatment and needs to be redressed.

Recent legislative efforts to mandate equitable insurance coverage for mental health services have been heralded as steps in the right direction for reducing financial barriers to treatment. Still, for the more than 44 million Americans who lack *any* health insurance, equity of mental health and other health benefits is moot. For many who do have health insurance, coverage restrictions for mental health treatment

persist. Data reveal that access to and use of services have increased following enhancements of mental health benefits in private insurance, Medicare, Medicaid, and the Federal Employees Health Benefit Program. Chapter 6 of this report makes it clear that equality between mental health coverage and other health coverage—a concept known as "parity"—is an affordable and effective objective. In states in which legislation requires parity of mental health and general coverage, cost increases are nearly imperceptible as long as the care is managed. A recent paper suggests that the value of mental health treatment has increased in recent years—that is, effectiveness has increased—while expenditures have fallen (Frank et al., 1999). In light of cost-containment strategies of managed care, concerns about undertreatment still are warranted for individuals with the most severe mental disorders, but high-quality managed care has the potential to effectively match services to patient needs.

Conclusion

This Surgeon General's Report on Mental Health celebrates the scientific advances in a field once shrouded in mystery. These advances have yielded unparalleled understanding of mental illness and the services needed for prevention, treatment, and rehabilitation. This final chapter is not an endpoint but a point of departure. The journey ahead must firmly establish mental health as a cornerstone of health; place mental illness treatment in the mainstream of health care services; and ensure consumers of mental health services access to respectful, evidenced-based, and reimbursable care.

References

Blumenthal, S. J. (1994). Gender differences in mental disorders. *Journal of Clinical Psychiatry, 3,* 453–458.

Ditton, P. M. (1999). *Mental health and treatment of inmates and probationers.* (Special report NCJ 174463). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Frank, R. G., McGuire, T. G., Normand, S. L., & Goldman, H. H. (1999). The value of mental health services at the system level: The case of treatment for depression. *Health Affairs, 18,* 71–88.

Gallo, J. J., Marino, S., Ford, D., & Anthony, J. C. (1995). Filters on the pathway to mental health care, II. Sociodemographic factors. *Psychological Medicine, 25*, 1149–1160.

Goldman, H. H. (1998). *Organizing mental health services: An evidence-based approach.* Stockholm: Swedish Council on Technology Assessment in Health Care.

Monahan, J., Lidz, C. W., Hoge, S. K., Mulvey, E. P., Eisenberg, M. M., Roth, L. H., Gardner, W. P., & Bennett, N. (1999). Coercion in the provision of mental health services: The MacArthur studies. *Research in Community and Mental Health, 10*, 13–30.

National Advisory Mental Health Council. (1998). *Parity in financing mental health services: Managed care effects on cost, access and quality: An interim report to Congress by the National Advisory Mental Health Council*. Bethesda, MD: Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health.

Peterson, B., West, J., Tanielian T., & Pincus, H. (1998). Mental health practitioners and trainees. In R. W. Manderscheid & M. J. Henderson (Eds.), *Mental health United States 1998* (pp. 214–246). Rockville, MD: Center for Mental Health Services.

Policy Research Associates. (1998). *Final report on the Research Study of the New York City Involuntary Outpatient Commitment Pilot Program*. Delmar, NY: Author.

Regier, D. A., Farmer, M. E., Rae, D. S., Myers, J. K., Kramer, M., Robins, L. N., George, L. K., Karno, M., & Locke, B. Z. (1993). One-month prevalence of mental disorders in the United States and sociodemographic characteristics: The Epidemiologic Catchment Area study. *Acta Psychiatrica Scandinavica, 88*, 35–47.

Sturm, R., & Sherbourne, C. D. (1999). *Are barriers to mental health and substance abuse care still rising?* Manuscript submitted for publication.

Sussman, L. K., Robins, L. N., & Earls, F. (1987). Treatment-seeking for depression by black and white Americans. *Social Science Medicine, 24*, 187–196.

Title 45. Code of Federal Regulations, Part 46, Protection of Human Subjects (1991).