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Dispelling the Myths and Stigma of Mental Illness: The Surgeon General's Report on Mental Health

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A discussion featuring

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Surgeon General's Report on Mental Health

The issuance of *Mental Health: A Report of the Surgeon General* on December 13, 1999, marked a milestone in American health policy. While this was the 51st report issued by a U.S. surgeon general since 1964, it was the first to deal with mental health and with mental illness—a group of disabling conditions that this report shows affects one in five Americans in any given year. Both a call to action and a compendium of policy-relevant scientific information, this report also notes: "In established market economies such as the United States, mental illness is the second leading cause of disability and premature mortality."

As was true with the very first surgeon general's report, *Smoking and Health*, the issuance of any report from the Office of the Surgeon General generates a high level of public attention and lends its topic an undeniable aura of importance. This has certainly been the case with the 28 reports on tobacco- and smoking-related issues that the surgeon general's office has released since 1964. Journalist Steven Roberts underscored this point on the Public Broadcasting System program *Washington Week in Review* on December 17:

> What [the surgeon general] has is the power to command the public spotlight. That's why all those reports all those years on tobacco, the warnings on the label, "Surgeon General says this is dangerous." What he is saying is, "Look, half of the Americans who have [serious] mental illness don't get treatment because of this enormous stigma associated with it." And he's saying, "Don't be afraid. Get treatment; it can help."

The visibility and authority of the Office of the Surgeon General clearly adds weight to what the report has to say.

But it is the findings of the report themselves that are of major importance, and some of them relate to why this is only the first surgeon general's report to address mental health issues. Since mental health relates to the mind and aberrant behavior, it has been traditionally viewed as something separate and distinct from the rest of health care. Further sharpening this division is the fact that a large part of the mental health delivery system is foreign to general health care, since it includes housing, social services, income support, and even employment. In addition, until recently, the science base of mental health has been suspected to be weaker than that of general medicine.

Yet, as Surgeon General David Satcher observed at the press conference releasing the mental health report: "There's no scientific reason to differentiate between mental health and other kinds of health. Mental illnesses are physical illnesses."[1] The report also clearly conveys the message that the science base of mental health is just as strong of that as physical medicine, particularly in light of advances in neuroscience and psychotherapeutic drug therapies.

This Forum meeting offers an opportunity to hear Satcher discuss the report, its public policy implications, and why he chose to make a priority issue of mental health at this time. This meeting will focus on the more general findings of the report; subsequent meetings may address those related to the three age groups singled out for special attention—the elderly, non-aged adults, and children—in its "lifespan approach" to discussing mental illness.

This issue brief attempts to highlight the report's most policy-relevant messages and discusses their significance. Clearly, however, the full report warrants the attention of everyone interested in health policy and will be a major reference tool for policymakers for years to come.

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BACKGROUND

While the report presents a number of significant findings, it is by no means a prescription for public policy. Instead, these findings are broad in scope and typically represent the consensus of physicians, social scientists, and others doing research in the field of mental health. Although the final chapter of the report—"A Vision for the Future"—presents what might be considered an action agenda, the agenda items are by and large noncontroversial and unlikely to elicit any partisan criticism. (They include things like "build the scientific base," "overcome stigma," and "facilitate entry into treatment.")

Indeed, one of the traditional strengths of surgeon generals' reports is that they have been "above politics" and present conclusions that are nonpartisan and scientific. Many have perhaps forgotten that the original 1964 report, *Smoking and Health*, was not a direct attack on the tobacco industry or smokers. Describing that report in his recent history of American policy on smoking, *Ashes to Ashes*, Richard Kluger observed:

> What emerged, finally, was a highly detailed, closely reasoned, but far from combative report. . . . Understated and embodying the lowest common denominator of agreement among [the Surgeon General's Advisory Committee on Smoking and Health], the report nonetheless offered as its final finding: "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action." With eloquent simplicity, the social challenge was put forth, but there was not a word about what form such a remedy might take. That was left, for the time being, to the politicians, who were in no hurry to address the consequences of a custom, however self-destructive, that so many of their constituents clung to so fiercely.[2]

In contrast, the most recent surgeon general's report does offer a set of findings that are much stronger and seem to constitute a tacit but direct case for action.

Initial Responses

The report received prominent coverage in many of the nation's news media and generally favorable comments from all interested parties. Some advocates expressed concerns that their areas of particular interest were not covered fully enough. Michael Faenza, president of the National Mental Health Association, observed in the December 15 edition of his organization's newsletter, *The Bell*:

> The Surgeon General points out the extraordinary advances in treatments that have occurred in recent years. They don't mean a hill of beans if people don't have access to them. We need to make good use of research advances by integrating them into public policies. Millions of children and adults don't get the care they need. I hope this report is the beginning of a real revolution, turning this terrible track record around.

The *Washington Post* reported that Laurie Flynn, president of the National Alliance for the Mentally Ill, remarked: "We're a little disappointed that the urgent focus on the public health crisis regarding the most serious mental illnesses has gotten lost." The Web site of the Bazelon Center for Mental Health Law expressed concern that the report had not thoroughly discussed issues related to coercion:

> This is especially regrettable because a climate of coercion significantly impedes the help-seeking behavior that is the Surgeon General's principal recommendation to the public. However, the report does point out that when people have access to an appropriate array of mental health care services the need for coercion declines dramatically.

But, for the most part, any disagreements with the report seemed more a matter of emphasis than content, with only one exception. Prior to the issuance of the report, some consumers objected to its conclusion that electroconvulsive therapy might be considered for treatment of depression when "first-line treatments" (antidepressant medication, psychotherapy, or a combination of the two) "are not effective or too slow." But they seemed less vocal after the report was released.

A TOOLBOX OR REFERENCE TOOL

In essence, the report represents a toolbox or reference tool. Its effect on health policy in this country will depend largely on the uses to which it is put by both policymakers and advocates for people with mental illness, including consumers themselves. While it conveys clear messages, its policy directions are more ambiguous.

In terms of how the report might be used, a comment made by David Mechanic and Donna McAlpine of Rutgers University about the enactment of federal parity legislation seems especially germane: "The passage of the Mental Health Parity Act in 1996 can be attributed in part to research evidence showing that management strategies could contain costs, even while benefits were expanded."[3] The surgeon general's report distills and makes available—for the most part in nontechnical language—a large volume of research that might be used in similar ways to rationalize mental health policy in this country.

Scope of the Report

Before turning to a discussion of its findings, it should be noted that the report explicitly omits discussion of developmental disabilities (such as mental retardation, cerebral palsy, and autism) and addictive disorders (such as alcoholism and drug abuse), with the exception of dual diagnoses of mental illness and chemical dependency.

KEY FINDINGS AND THEIR SIGNIFICANCE

Many of the report's major findings seem targeted to the "opportunity to dispel the myths and stigma surrounding mental illness" recognized in the introduction to the report. Since the very wording of the findings carries its own special import, a bulleted verbatim list of the findings of the report with particular policy relevance is presented below. These findings are followed by brief discussions of their significance.

Significance of Mental Illness

- ***Prevalence of mental disorders:***—About one in five Americans experiences a mental disorder in the course of a year.
- ***Co-occurrence of substance abuse***—Approximately 15 percent of all adults who have a mental disorder in one year also experience a co-occurring substance (alcohol or other drug) use disorder, which complicates treatment.
- ***Magnitude of spending***—In 1996, the direct treatment of mental disorders, substance abuse, and Alzheimer's disease cost the nation $99 billion; direct costs for mental disorders alone totaled $69 billion. In 1990, indirect costs for mental disorders alone totaled $79 billion.
- ***Consequences of untreated mental illness***—Untreated mental disorders can lead to lost productivity, unsuccessful relationships, and significant distress and dysfunction. Mental illness in adults can have a significant and continuing effect on children in their care.
- ***Personal impact of severe mental illness***—In fact, schizophrenia, mood disorders such as major depression and bipolar illness, and anxiety often are devastating conditions.

In essence, the report as a whole makes a strong case that mental illness and mental health are not areas that the country can afford to neglect. Actual mental disorders—defined as "health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning"[4]—directly affect 20 percent of the American population each year as well as countless family members, friends, and others with whom they come in contact. (The report is careful to distinguish between mental disorders and mental health problems, which it defines as "signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder." Short-term bereavement symptoms in older adults are given as an example.) Lest anyone doubt that it is addressing serious conditions, the report characterizes severe mental illness as often "devastating" for those involved.

While the report does not dwell on mental health financing, it does note that in 1996 mental health spending represented 7 percent of total U.S. health care expenditures.[5] It also accounts for 9 percent of total Medicaid spending and 18 percent of state and local government expenditures. Indeed, government sources of one kind or another pay 56.3 percent of behavioral health costs—including substance abuse treatment as well as mental health—but only 47.5 percent of total health care costs. Another way of looking at this is the share financed by private insurance—about 31.0 percent of total health spending but only 25.8 percent of behavioral health spending.[6]

Audrey Burnam and Jose Escarce of RAND point out in a recent article in *Health Affairs*:

> Perhaps the most distinguishable difference between the treatment of mental and other medical conditions in this country is the existence of a large, publicly funded and state-directed system of mental health care. The existence of such a system has created a sharp divergence between the populations served by private insurance and those served by direct public funds and Medicaid. . . . Because the uninsured and Medicaid populations include most persons with severe mental illness, public spending on mental health care ($35.1 billion in 1996) exceeds private spending ($31.6 billion in 1996).[7]

In a recent paper for the National Bureau of Economic Research, "Economics and Mental Health," Richard Frank and Thomas McGuire observe: "The availability of publicly funded and provided mental health care allows employers to strictly limit insurance coverage for mental health care while at the same time giving their employees recourse should a catastrophic mental illness strike."

Effectiveness of Diagnosis and Treatment

- ***Range of effective treatments***—There exists a constellation of several treatments of documented efficacy for most mental disorders.

- ***Reliability of diagnoses***—Diagnoses of mental disorders using specific criteria are as reliable as those for general medical disorders.
- ***Strength of diagnostic system***—No other sphere of health care has created such an extensive compendium of all of its disorders with explicit diagnostic criteria.

Historically, there has been widespread skepticism about whether mental health interventions are actually effective. Among other things, this has led to restrictive public and private insurance practices and has limited the availability of mental health services generally. The report is unequivocal in its endorsement of the effectiveness of mental health interventions and singles out the DSM-IV (the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition), published by the American Psychiatric Association and used across the country as the diagnostic system for mental illness, for particular recognition.

Among the reasons that questions have arisen about the efficacy of mental health interventions are (*a*) a failure to distinguish between chronic and acute care and (*b*) an unrealistic assessment of nonmental or general health care. While discussions of mainstream health policy usually include both acute and long-term care, these discussions are often compartmentalized. Long-term care (which includes not just medical attention but also housing, assistance with tasks of daily living, and social services) is generally considered an entirely separate area of health policy. With mental health, this is less the case, since severe and persistent mental illness is of much more central concern to public policymakers and is by definition typically a chronic illness.

Furthermore, general health care is not as exact a science as many people believe. For example, what is viewed as a dangerous cholesterol level has changed dramatically in recent years. In a recent article, the director of the National Institute of Mental Health and an associate point out that "in general medicine there is no lack of coverage for illnesses that have only temporary and mild disability and no effective treatments (such as viral upper respiratory tract infections) or for which treatments have low efficacy (such as pancreatic cancer)." They contrast this situation with mental health, where treatments of proven efficacy have been underfunded.[8]

Widespread Lack of Treatment

- ***General lack of treatment***—Nearly two-thirds of all people with diagnosable mental disorders do not seek treatment.
- ***Lack of treatment for severely ill***—Nearly half of all Americans who have a severe mental illness do not seek treatment.
- ***Encouragement to seek help***—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*.

The figures the report presents on the extent of untreated mental illness are among its most striking findings. It is difficult to conceive of physical conditions that would have been neglected to the same extent—especially major disabling conditions.

According to those involved it the report's preparation, some have misinterpreted its call to "seek help." What is actually being said here is: "If you sense you have a mental health problem or a mental disorder, find help somewhere—a mental health professional, a general practitioner, a member of the clergy, a friend, or a relative." No single source of help is endorsed over others. Mental illness is often an experience which isolates an individual, especially because of the stigma associated with it. The report's message is also: "Don't suffer alone. Reach out for help."

Access Problems and Their Causes

- ***Problems with access***—Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services.
- ***Racial and ethnic barriers***—The U.S. mental health system is not well equipped to meet the needs of racial and ethnic minority populations. Racial and ethnic minority groups are generally considered to be underserved by the mental health services system.
- ***Financial barriers***—Repeated surveys have shown that concerns about the cost of care are among the foremost reasons why people do not seek care.
- ***Parity as a solution***—Equality between mental health coverage and other health coverage, a concept known as parity, is an affordable and effective objective.

To single out mental health as an area "plagued by disparities in the availability of and access to its services" more than other areas of health and medicine is a significant statement in a nation with 44 million uninsured citizens and a large number of people lacking adequate coverage. The report deals at length with the need for culturally competent services, which it defines to be "equally effective to all sociocultural groups. The

treatments provided must not only be efficacious (based on clinical research), but also effective in community delivery." It describes how both clinical research and patterns of practice are geared primarily if not exclusively to the Anglo, white majority; it then underscores the need for recognizing ethnic and racial differences—ranging from the importance of family and social institutions to the ability to metabolize psychotherapeutic medications— and orienting services to accommodate them.

The report's ringing endorsement of parity is also significant, since the health insurance industry has for many years attempted to apply different limits to mental health coverage than it has to general health coverage. It has done so for a number of reasons that essentially boil down to a fear that mental health expenditures cannot be controlled. The resistance of the industry to the parity legislation that has now been enacted in nearly 30 states as well as at the federal level through the Mental Health Parity Act of 1996 (P.L. 104-204) has been noteworthy.[9] Responding to concerns historically raised by employers, the report points to both the proven efficacy of treatment and the demonstrated capacity of managed care to target mental health services to those with medical conditions that require such intervention as reasons for parity of coverage between mental health and general health benefits.

Significance of Stigma

- ***Stigma as an obstacle***—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. Research on brain and behavior that continues to generate ever more effective treatments for mental illnesses is a potent antidote to stigma.
- ***Impact of stigma***—Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others.
- ***Violence and mental illness***—There is very little risk of violence or harm from casual contact with an individual who has a mental disorder. . . . To put this all in perspective, the overall contribution of mental disorders to the total level of violence in society is exceptionally small.

The need to change public attitudes to minimize the stigma associated with mental illness and its treatment is a central message of the report. It points out that, although the knowledge base in mental health continues to expand, the stigma associated with mental illness has actually grown over the past 40 years. Some of the reasons for this are the reduced roles of state mental hospitals and other long-term inpatient treatment modalities, the increase in community placements of people with mental illness, and the growth in the homeless population, a significant percentage of whom have a mental disorder. Quite literally, people with serious mental illness are more visible than they were 40 years ago. Central to stigma is a fear of violence committed by people with mental illness, a fear stoked by media attention to a few noteworthy cases. Yet the report clearly indicates that the likelihood of violence is remote. At the same time, it points to the correlation of violence with co-occurring mental illness and substance abuse problems, thereby underlining the importance of preventing substance abuse among people with mental illness.

Prevention of Mental Illness

- ***Knowledge about prevention lags***—In the mental health field, progress in developing preventive interventions has been slow because, for most major mental disorders, there is insufficient understanding about etiology . . . and/or there is an inability to alter the *known* etiology of a particular disorder.

Candidly noting how relatively little we know about the origin of mental illness or how it might be prevented, the report calls for "research that explores approaches for reducing risk factors and strengthening protective factors for the prevention of mental illness."

CONCLUSION

The concluding paragraph of the report warrants citation in full, since it captures the central messages of the report very succinctly:

> 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, evidence-based, and reimbursable care.

ENDNOTES

1. The Report itself elaborates on the point:

   > Mental disorders are real health conditions . . . [and] are reflected in physical changes in the brain. . . . Instead of dividing physical from mental health, the more appropriate and neutral distinction is between "mental" and "somatic" health. . . . Mental disorders are those health conditions in which alterations in mental function are paramount. Somatic conditions are those in which alterations in nonmental functions predominate.

2. Richard Kluger, *Ashes to Ashes: America's Hundred-Year Cigarette War, the Public Health, and the Unabashed Triumph of Philip Morris* (New York: Alfred A. Knopf, 1996), 260-261.

3. David Mechanic and Donna D. McAlpine, "Mission Unfulfilled: Potholes on the Road to Mental Health Parity," *Health Affairs*, 18, no. 5 (September/October 1999): 7-21.

4. The Report distinguishes between *disorders* and *diseases* as follows:

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

5. While the United States spends more on mental health/substance abuse in absolute terms [8.3 percent] than do other western nations, it spends a lower proportion of personal health outlays than Great Britain (16.6 percent), Canada (11.4 percent), and Australia (8.4 percent). Richard G. Frank and Thomas G. McGuire, *Economics and Mental Health*, NBER Working Paper Series: Working Paper 7052, National Bureau of Economic Research, Cambridge, Massachusetts, March 1999, 6.

6. Data in this paragraph are from David McKusick, Tami L. Mark, Edward King, Rick Harwood, Jeffrey A. Buck, Joan Dilonardo, and James S. Genuardi, "Spending for Mental Health and Substance Abuse Treatment 1996," *Health Affairs*, 17, no.5 (September/October 1998): 147-157.

7. Audrey Burnam and Jose Escarce, "Equity in Managed Care for Mental Disorders," *Health Affairs*, 18, no. 5 (September/October 1999): 22-32.

8. Grayson Norquist and Steven E. Hyman, "Advances in Understanding and Treating Mental Illness: Implications for Policy," *Health Affairs*, 18, no. 5 (September/October 1999): 32-47.

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