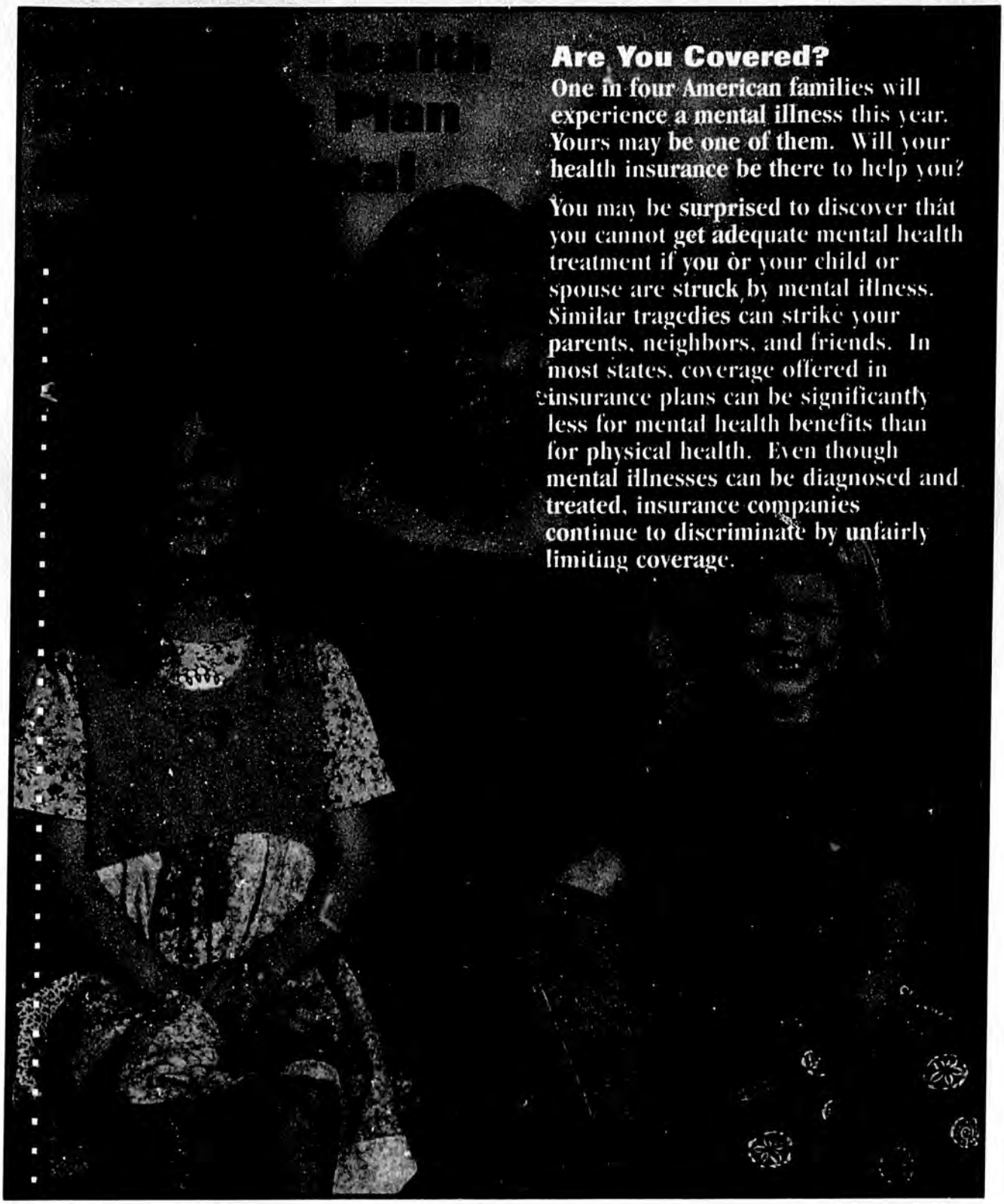
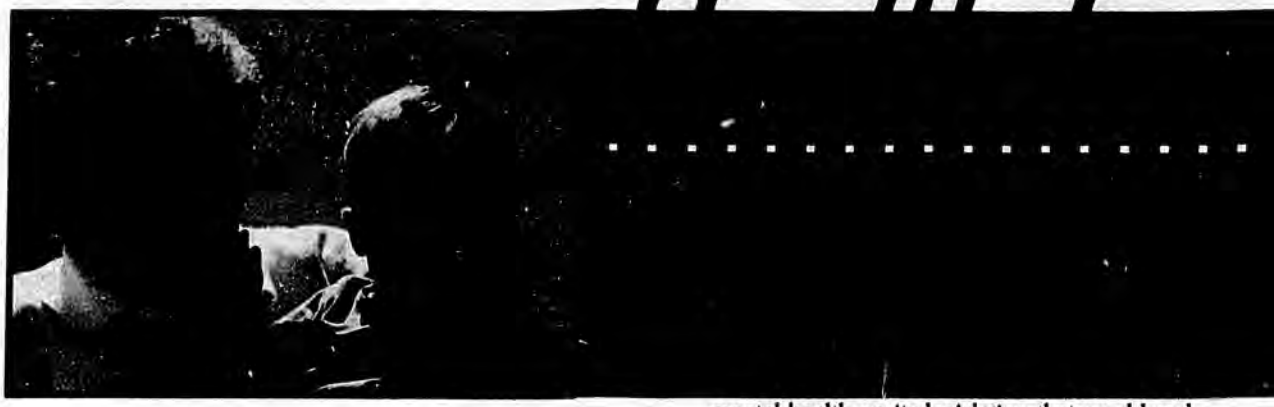


Are You Covered?

One in four American families will experience a mental illness this year. Yours may be one of them. Will your health insurance be there to help you?

You may be surprised to discover that you cannot get adequate mental health treatment if you or your child or spouse are struck by mental illness. Similar tragedies can strike your parents, neighbors, and friends. In most states, coverage offered in insurance plans can be significantly less for mental health benefits than for physical health. Even though mental illnesses can be diagnosed and treated, insurance companies continue to discriminate by unfairly limiting coverage.



Insurance Discrimination is Common.

- In most parts of the country, health care plans cover mental disorders but have significantly more restrictions on the scope and type of services covered.
- Insurance policies typically impose higher co-payments and more restrictive day and visit limits for mental health care than they do for physical health care.

What are Mental Illnesses?

Mental illnesses are real, common and treatable disturbances in thought and/or behavior. Each year, 51 million Americans suffer from mental and emotional disorders ranging from phobias to psychoses. In comparison, 100 million Americans have a physical illness in a given year, ranging from the flu to cancer.

Doctors and mental health specialists use a recognized, standardized compendium – the Diagnostic and Statistical Manual (DSM) – to diagnose a broad range of mental illnesses. A wide variety of specialized treatments are available, ranging from behavioral therapies and modern medicines to psychotherapy and self-help activities. Sadly, due to stigma and discrimination, many people with mental illnesses do not receive the treatment that they need.

mental health parity legislation that would end practices that unfairly limit mental healthcare or deny access to needed treatment." By enacting parity, insurance companies would be required to provide the same level of mental health coverage as is offered for physical health care needs.

How Much Will Parity Cost?

- Preventing insurance discrimination means only minimal increases in insurance premiums. Some studies estimate only a few extra pennies per month.
- Providing insurance protections to all Americans is only marginally more expensive than protecting only those with a narrow range of diagnoses.

Ending insurance discrimination is not only the right thing to do, but it is also affordable. Mental illnesses can be treated effectively and affordably if access to equitable health care coverage and appropriate services are available.

Discrimination

used to describe a specific group of mental illnesses. Unfortunately, limiting mental health parity to those with "severe mental illness" discriminates against children and adults whose illnesses can also be seriously disabling. Diagnoses typically excluded in these bills include dementia, multiple personality disorders, anorexia nervosa and bulimia, learning disorders associated with brain damage, phobias, post traumatic stress disorder, as well as serious emotional disorders (SED) affecting children – diagnoses that can be just as severe and debilitating.

Those who argue that equity in insurance coverage should only be offered to those with a limited group of diagnoses ignore the mental health needs of millions of Americans. All Americans should be protected from insurance discrimination.

Didn't the Federal Government Already Pass Mental Health Parity?

Yes, but in limited form. In 1996, the federal government took a first step by requiring group health plans that offer mental health services to provide the same lifetime and annual spending limits as they do for physical illness. The National Mental Health Association advocates that Congress pass comprehensive mental health parity for all Americans which would include equity in other benefits such as treatment limitations and co-payments. Until this happens, it is up to the states to pass parity laws that protect their residents.

What Have States Done to End Insurance Discrimination?

Several states have already passed limited mental health parity laws. With the exceptions of Maryland, Minnesota, and Vermont, however, these laws cover only limited types of benefits, exclusively protect those with specific diagnoses, or have other significant limitations. In all other states, much work remains in our efforts to eliminate discrimination in health insurance.

Act Now! Join the Mental Health Association Movement to Pass Parity!

On both the national and state levels, the National Mental Health Association works with broad-based coalitions to advocate for parity in coverage for mental and physical health care. These efforts have met with significant success resulting in new protections written into federal law and in a growing number of states. However, it is clear that the greatest battles are still ahead of us. Parity advocates are too often willing to accept legislation that would only protect individuals with specific diagnoses that continue to discriminate against children and adults.

Join the Mental Health Association movement in our efforts to end insurance discrimination for all Americans. To find out about mental health parity campaigns in your state, contact the National Mental Health Association's Information Center at 1-800-969-NMHA.

[redacted]

[redacted]

[redacted] is a powerful reminder of the harrowing treatment individuals once endured.

Now the symbol of NMHA, the Bell tolls to end misunderstanding and discrimination, and rings out hope in the fight for victory over mental illnesses.

1021 Prince Street

Alexandria, VA 22314-2971

Main (703) 684-7722

Toll-free (800) 969-6642

TTY (800) 433-5959

Fax (703) 684-5968

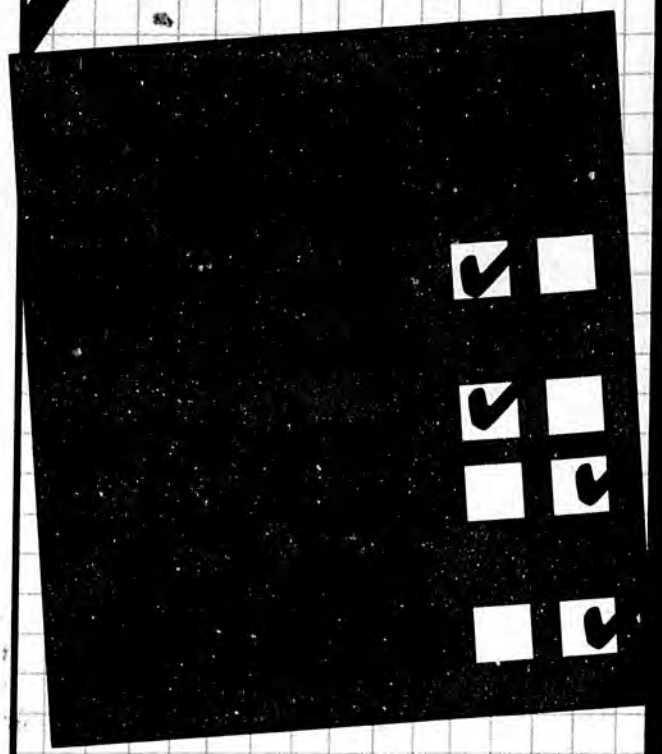
Stigma Watch (800) 969-6642

Web site - http://www.nmha.org

National Mental Health Association®

Health Insurance Discrimination:

Will Your Plan Cover Mental Illness?



National Mental Health Association®

PRICEWATERHOUSECOOPERS

MENTAL HEALTH
PARITY ISSUES AND COSTS

INFORMATION TO ASSIST STATES IN THE UNDERSTANDING AND DEVELOPMENT OF LEGISLATION

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Principal
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(404) 870-1388

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*** Documents similar to these were used in an educational meeting with the Interim Insurance Availability Commission, State of Missouri**

Definitions of Mental Health Parity
Original Federal Language

In the case a group health plan or an individual health plan that provides both medical and surgical benefits and mental health benefits, such **plan shall not impose** treatment limitations or financial requirements on the coverage of mental health benefits if similar limitations or requirements are not imposed on medical and surgical benefits.

Nothing in this section shall be construed as:

(a) requiring the provision of mental health benefits where none were previously offered;

Alternative: (a) requiring a group health plan to provide any mental health benefits.

(b) requiring parity coverage between treatments for mental illness and preventive care; or

(c) prohibiting a group health from

(i) negotiating separate reimbursement rates and service delivery systems, such as but not limited to a mental health carve-out plan; or

(ii) managing the provision of benefits through common methods including but not limited to pre-admission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental illness only to those that are deemed medically necessary; or

(iii) limiting services to those authorized according to the health plan contract.

Definitions:

(a) the term "treatment limits" refers to limits on the number of outpatient visits and inpatient hospital days covered by a group health plan or individual health plan;

(b) the term "financial requirements" refers to copayments, deductibles, out-of-pocket contributions, fees, annual limits, and lifetime aggregate limits imposed on covered individuals;

(c) the term "group health plan" and "individual health plan" do not refer to Medicare, Medicaid, Medicare Supplement, hospital indemnity plans, cancer policies, accidental death policies, and other specific disease policies.

Definitions of Mental Health Parity
Maryland Language

(1) Subject to the provisions of this section, each contract or policy of health insurance delivered or issued for delivery within this State to an employer or an individual on a group or individual basis that provides coverage for health care on an expense-incurred basis **may not discriminate** against any person with a mental illness, emotional disorder or a drug abuse or alcohol abuse disorder by failing to provide benefits for treatment and diagnosis of these illnesses under the same terms and conditions that apply under the contract or policy for treatment of physical illness.

(2) It shall not be considered to be discriminatory under section (1) if at least the following benefits are provided:

(i) With respect to inpatient benefits provided in a licensed or certified facility, which shall include hospital inpatient benefits, the total number of days for which benefits are payable shall be:

1. (for the first year after effective date of legislation) at least 60 days in any calendar year or a benefit period of not more than 12 months under the same terms and conditions that apply to benefits available under the contract or policy for physical illness; and

2. (one year after the effective date of legislation) at least equal to the same terms and conditions that apply to the benefits available under the contract or policy for physical illness;

Definitions of Mental Health Parity
Minnesota Language

(a) All health plans that provide coverage for mental health or chemical dependency services, **must comply** with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency services **must not** place a greater financial burden on the insured or enrollee, or **be more restrictive than** those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical services **must not** place a greater financial burden on the insured or enrollee, or **be more restrictive than** those requirements and limitations for outpatient medical services.

Definitions of Mental Health Parity
Vermont Language

A health insurance plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition.

A health insurance plan shall be construed to be in compliance with this section if at least one choice for treatment of mental health conditions provided to the insured within the plan has rates, terms, and conditions that place no greater financial burden on the insured than for access to treatment of physical conditions. The commissioner may disapprove any plan that the commissioner determines to be inconsistent with the purposes of this section.

Definitions of Mental Illness

1. The term "mental illnesses" includes mental disorders defined in the **Diagnostic and Statistical Manual IV** or subsequent editions published by the American Psychiatric Association, except those codes defining substance abuse disorders (291.0 to 292.9 and 303.0 to 305.9) and the "V" codes.

2. Mental disorder diagnosis codes are limited to the diagnosis range of 290.0 to 301.9, inclusive, and 306.0 to 315.9, inclusive contained in the **ICD-9-CM.**

3. The term "mental health benefits" means benefits with respect to mental health services, as defined under the **terms of the plan** or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.

4. **SAMHSA** (Substance Abuse and Mental Health Services Administration):

Children: children with a serious emotional disturbance are persons from birth up to age 18, who currently or at any time during the past year, have had a diagnosable mental behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most recent edition of the **Diagnostic and Statistical Manual** of Mental Disorders published by the American Psychiatric Association, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Adults: adults with a serious mental illness age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria within the most recent edition of the **Diagnostic and Statistical Manual** of Mental Disorders published by the American Psychiatric Association that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

5. The term "severe mental illness" means an illness that is **defined through diagnosis,** disability and duration, and includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, bipolar disorder, dementia, autism, and other pervasive developmental disorders, as well as severe forms of other disorders such as major depression, panic disorder, obsessive compulsive disorder, multiple personality disorder, anorexia nervosa, bulimia, learning disorder associated with brain damage, phobia associated with significant functional impairment, and disruptive behavior disorders of childhood as **determined by the Insurance Commissioner.**

6. **National Advisory Mental Health Council Definition of SMI**: The term "severe mental illness" is **defined through diagnosis,** disability, and duration, and includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, manic depressive disorder, autism as well as severe forms of other disorders such as major depression, panic disorder, and obsessive compulsive disorder.

Definition of Eligible Expenses

1. **BC/BS FEHBP**: All benefits are subject to the definitions, limitations and exclusions in the policy and are payable when **determined by the Carrier to be medically necessary.** The Carrier has the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. The Plan pays all covered outpatient care (including related services and supplies, such as psychological testing) for treatment of a mental condition, including substance abuse.

What is not covered:

1. Marital, family, educational, or other counseling or training services.
2. Services rendered or billed by a school or halfway house or a member of its staff.
3. Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present.
4. Services and supplies that are not medically necessary.

2. **Free State Health Plan (BC/BS)** - To the extent shown below, this Plan provides the following medically necessary services for the diagnosis and treatment of mental illness, or emotional disorder, drug abuse and alcohol abuse. This Plan provides medical and hospital services such as acute detoxification for the medical non-psychiatric aspects of drug abuse and alcohol abuse, **under the same terms and conditions as for any other illness or condition.** Outpatient visits to Plan mental health providers for follow-up care are covered, as well as inpatient services necessary for diagnosis and treatment.

1. Diagnostic evaluation
2. Psychological testing
3. Psychiatric, drug abuse and alcohol abuse treatment (including individual and group therapy).
4. Hospitalization (including inpatient professional services)

What is not covered:

1. Care for psychiatric, drug abuse and alcohol abuse conditions which in the professional judgment of Plan doctors are not treatable.
2. Psychiatric, drug abuse and alcohol abuse evaluations or therapy on court order, or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
3. Psychological testing that is not medically necessary to determine the appropriate treatment of a condition.
4. Treatment which is not authorized by a Plan doctor.

3. **Maryland** - Eligible expenses: ...expenses arising for treatment of mental illnesses, emotional disorders, drug abuse and alcohol abuse which in the professional **judgment of practitioners** is medically necessary and treatable.

4. **Medically Necessary Definition** (typical Insurance Policy)

Medically Necessary means a service or supply that is required to diagnose or treat an Injury or Sickness. It must:

a. be performed and/or prescribed by a Physician; and
b. be consistent with the diagnosis and treatment of such Injury or Sickness; and
c. be in accordance with generally accepted standards of medical practice; and
d. not be solely for the convenience of the Insured Person or Insured Dependent or any other person who provides care for the Insured Person or Insured Dependent.

Mental Health Parity

A Framework for Discussing the Continuum of Options

I. Introduction and Background

This paper proposes a framework for discussing legislative options for mental health parity legislation. To better understand many of the issues, a continuum of progressive and related options are presented. These are not the only options that can be considered, but should form a basis of common understanding before more complex options are presented.

The federal legislation, the Mental Health Parity Act of 1996 (MHPA), forced states to pass comparable legislation or have regulatory oversight on the issue default to the federal government. As a consequence, the historical tension between federal and state regulation of insurance was heightened and, in general, most states passed or are in the process of passing appropriate mental health legislation to retain state oversight.

In terms of coverage and cost, the MHPA is fairly minimal. A recent Rand corporation study estimated the cost impact of MHPA to be $1 per member per year ($.08 per month). The requirement of the Act is that any plan offering mental health benefits must not impose any annual or lifetime dollar limits on mental health care than is not imposed on other medical and surgical benefits. The Act provides a "minimum standard" of coverage whenever the benefit is offered. However, mental health benefits are not a required coverage, and other internal limits (other than dollar limits) can act as proxies to create a limited plan of mental health benefits.

Following passage of the federal legislation in 1996, there was and continues to be a flurry of activity at the state level to pass broader more comprehensive mental health parity that would extend the federal legislation. Mental health parity legislation is currently being discussed and debated in nearly every state on the Union. Thirty seven states have introduced 86 bills attempting to address the issue of limited mental health coverage. While at least 10 states have enacted parity legislation, most states are still struggling with the issue. State laws can only affect insured plans. They can not affect large self-insured ERISA plans that fall under federal control. Additional federal legislation is more likely if and when state actions indicate a movement to parity at the state level.

As can be expected, states are the laboratories for new ideas and the diversity of opinions. No two states seem to be alike in their approach to mental health parity. Various compromises and political realities of each state form any final legislation and regulatory language. To facilitate the discussion in Missouri, C&L has developed a series of alternatives along a continuum of steps that provide for incremental analysis of mental health parity.

II. Parity Options

Option #1 (MHPA of 1996) is the Mental Health Parity Act of 1996 (MHPA). The MHPA is a federal law that became effective January 1, 1998. The federal act is a partial parity law that prevents differing lifetime or annual dollar limitations between mental health and non-mental health insurance coverage. Most states are passing parallel legislation to prevent the automatic federal oversight that occurs in the absence of state legislation. The MHPA is not a mandate. It does not require or mandate that mental health coverage be provided under any plan. However, if mental health coverage is provided, the plan can not impose annual or lifetime dollar limitations on mental health coverage that are not imposed on other coverages. The C&L cost estimate for this legislation is 0.13% of total plan costs.

Option #2 (Limited Parity) extends the MHPA to outpatient day and inpatient visit limits. Following the approach of MHPA, there is no mandated coverage. That is, while no mental health coverage is required, if mental health coverage is provided, the plan can not impose day or visit limits on mental health coverage that are not imposed on other coverages.

The C&L estimate of cost is 0.7% of total plan costs. However, this does not include potential adjustments to the mental health deductible, coinsurance/copayments, maximum out-of-pocket, movement to managed care, competitive bidding of the plan, etc. that could be made to offset the impact of this option. The C&L estimate after offsets affecting only the mental health coverages is a 0.3% or lower cost increase.

Option #3 (Catastrophic Parity) includes the features of limited parity (option #2) and adds a maximum out-of-pocket (OOP) limit. Maximum OOP limits are common features for non-mental health coverages provided by many insurance plans (particularly indemnity plans). This feature protects an individual or family from the financial ravages of a catastrophic cost where even the traditional 20% coinsurance paid by the patient can accumulate to an amount that threatens a family's financial resources.

The maximum OOP limit is the total amount of eligible expense cost sharing for which a covered member is responsible. The maximum OOP can be separate and distinct from any non-mental health maximum OOP. Again, following the MHPA approach, there is no mandated coverage. However, if mental health coverage is provided, the plan can not impose a maximum out-of-pocket limit on mental health greater than any imposed on other coverages. By including a maximum out-of-pocket limit, option #3 provides catastrophic protection.

The C&L estimate of increased cost for option #3 is 1.1% of total plan costs. However, this does not include adjustments to mental health deductibles, coinsurance/copayments, movement to managed care, competitive bidding of plan, etc. that could be made to offset the impact of this option. The C&L estimate after offsets affecting only the mental health coverages is a 0.44% or lower cost increase (less than one-half of one percent).

Option #4 (Significant Parity) includes parity provisions of Options 1-3 and extends the parity provisions to the coinsurance/copayment features of an insurance plan design. This partial parity design could be implemented on a no mandate basis for employers with more than 50 employees. However, if legislation is to include groups of 5 or more employees, a state-wide requirement is arguably needed to create a level playing field for all insurers and to allow for appropriate spreading of risks across a large population.

It is at this point of the parity continuum that optional mental health parity (especially for small employers) begins to breakdown and becomes potentially self-defeating. That is, anti-selection begins to play a part of the cost estimate. More small employers are likely to opt for no mental health rather than accept the cost of significant parity. However, as a statewide requirement, where a broad pooling of risk can occur without the anti-selection, the increased cost estimate is only 1.6% of current total plan costs. With cost offsetting actions, the net cost increase is estimated at 0.64%.

Option #5 (Financial Parity) represents financial parity where all plan reimbursement features for existing plan eligible expenses are made on the same basis as non-mental health eligible expenses. Under this option (especially for groups of 5 or more employees) a state-wide requirement would be needed to keep the cost increase impact at the estimated 2.4%. Only a state-wide requirement would allow for a spreading of the risks and a structure to avoid anti-selection.

Employers will respond to any potential increase in benefit costs in a variety of ways including competitively bidding the plan to obtain lower premiums, intensely negotiating lower provider costs, cutting plan administrative costs, increasing plan costsharing by members, increasing premium contributions by members, reducing other benefits, and in the extreme, dropping plan coverages and reducing wages (or wage increases). C&L estimates the net cost to employers for option #5 is 0.96% of total plan costs.

Option #6 (Comprehensive Parity) is comprehensive mental health parity that includes financial parity, expanded access, and coverages not necessarily provided under all plans in the market today. Option #6 may include a "horizontal" expansion of mental health coverage to include new eligible expenses and/or provider services. There are number of concerns that mental health advocates voice regarding overly restrictive managed care rules that interfere with appropriate treatment protocols, exclusions for necessary care, burdensome paper work, and seemingly arbitrary applications of medical necessity. These issues would fall under option #6.

C&L has not priced option #6.

III. Summary

There is general recognition and acceptance that legitimate medically necessary mental health care costs are not now being covered by most policies (due to inside plan limitations that are unique to mental health coverage) and that families need insurance protection against at least the cost of catastrophic costs. There is less agreement (between providers, carriers, HMOs, and employers) on the importance of increased access, broader coverage, early intervention, preventive care, efficacy of some treatments, and medical offsets through proper mental health care.

The document for discussion can assist in the development of what to cover, who to cover, and what other considerations of coverage, access and cost should apply when mental health benefits are provided.

Grid of Mental Health Parity Options

	Mental Health Parity Option #					
	1	2	3	4	5	6
Parity Feature:	MHPA of 1996	Limited Parity	Catastrophic Parity	Significant Parity	Financial Parity	Comprehensive Parity
Lifetime $	Y	Y	Y	Y	Y	Y
Annual $	Y	Y	Y	Y	Y	Y
Day & Visits	N	Y	Y	Y	Y	Y
Maximum Out-of-Pocket	N	N	Y	Y	Y	Y
Coinsurance/Copays	N	N	N	Y	Y	Y
Deductible	N	N	N	N	Y	Y
New Benefits	N	N	N	N	N	Y
Applied to:						
Individuals	N/A	N/A	N/A	N/A	N/A	N/A
1-4 Employees	N/A	N/A	N/A	N/A	N/A	N/A
5-50 Employees	N/A	Y	Y	Y	Y	Y
50+ Employees	Y	Y	Y	Y	Y	Y
Mandate *	N	N	N	Y	Y	Y
Cost Est. ** (Gross)	0.13%	0.70%	1.10%	1.60%	2.40%	Not Avail
(Net)	0.05%	0.30%	0.44%	0.64%	0.96%	Not Avail

Grid of Mental Health Parity Options

	Mental Health Parity Option #					
	1	2	3	4	5	6
Parity Feature:	MHPA of 1996	Limited Parity	Catastrophic Parity	Significant Parity	Financial Parity	Comprehensive Parity
Lifetime $	Y	Y	Y	Y	Y	Y
Annual $	Y	Y	Y	Y	Y	Y
Day & Visits	N	Y	Y	Y	Y	Y
Maximum Out-of-Pocket	N	N	Y	Y	Y	Y
Coinsurance/Copays	N	N	N	Y	Y	Y
Deductible	N	N	N	N	Y	Y
New Benefits	N	N	N	N	N	Y
Applied to:						
Individuals	N/A	N/A	N/A	N/A	N/A	N/A
1-4 Employees	N/A	N/A	N/A	N/A	N/A	N/A
5-50 Employees	N/A	Y	Y	Y	Y	Y
50+ Employees	Y	Y	Y	Y	Y	Y
Mandate *	N	N	N	Y	Y	Y
Cost Est. ** (Gross)	0.13%	0.70%	1.10%	1.60%	2.40%	Not Avail
(Net)	0.05%	0.30%	0.44%	0.64%	0.96%	Not Avail

* MH coverage is not required. Like the Mental Health Parity Act of 1996 (MHPA), if Mental Health (MH) is covered the parity legislation standards must be met.

** Average Cost Estimates are provided by Coopers & Lybrand (includes indemnity, PPOs, and HMOs) as a composite percentage of current total plan costs. Net costs are after employer changes to offset gross costs.

a. Option #1 is the Mental Health Parity Act of 1996 which is current law (passed by federal Congress) that goes into effect January 1, 1998.

b. Option #2 extends the MHPA to groups of 5 or more and includes parity for day and visit limits.

c. Option #3 extends the MHPA to groups of 5 or more, includes parity for day and visit limits, and establishes a separate MH maximum out-of-pocket limit of no more than $1000 per person per calendar year. This is the most inclusive option to provide catastrophic mental health parity without requiring a benefit mandate.

d. Option #4 includes the partial parity provisions of Options 1-3 and extends partial to include equal coinsurance and/or copayments.

e. Option #5 represents financial parity where all plan reimbursement features for existing plan eligible expenses are made on the same basis as non-mental health eligible expenses.

f. Option #6 is comprehensive mental health parity that includes financial parity and expanded access and coverages not necessarily provided under all plans in the market today.

Mental Health Parity Cost Estimates in Other States

Similar analysis performed in other states resulted in the following cost estimates:

I. C&L Cost Estimates by State

Arkansas - H.B. 1525
Cost of Mental Health Parity

Type of Delivery System	#	Distribution	Percentage Increase in Base Medical Plan for Change to Type of Parity			
			Partial	SMI	Full	Comprehensive
Fee-for-Service	1	40%	1.2%	2.3%	2.8%	3.1%
Managed Indemnity	2	30%	0.9	1.7	2.2	2.8
PPO & POS	3	20%	0.3	1.6	2.0	2.5
HMO & Gatekeeper	4	15%	0.4	0.8	1.0	1.2
Composite Market Analysis			0.8%	1.8%	2.3%	2.7%
Composite PMPM			$.91	$2.04	$2.61	$3.07

Delaware - H.B. 156
Cost of Mental Health Parity

Type of Delivery System	#	Distribution	Percentage Increase in Base Medical Plan for Change to Type of Parity			
			Partial	SMI	Full	Comprehensive
Fee-for-Service	1	25%	1.2%	2.6%	3.3%	4.2%
Managed Indemnity	2	30%	0.9	2.0	2.5	3.4
PPO & POS	3	20%	0.5	1.8	2.3	2.8
HMO & Gatekeeper	4	25%	0.4	0.8	1.0	1.3
Composite Market Analysis			0.8%	1.8%	2.3%	2.9%
Composite PMPM			$1.05	$2.44	$3.05	$3.92

North Carolina - H.B. 563
Cost of Mental Health Parity

Type of Delivery System	#	Distribution	Percentage Increase in Base Medical Plan for Change to Type of Parity			
			Partial	SMI	Full	Comprehensive
Fee-for-Service	1	35%	0.9%	2.0%	2.5%	2.7%
Managed Indemnity	2	25%	0.7	1.6	2.0	2.2
PPO & POS	3	25%	0.5	1.6	2.0	2.3
HMO & Gatekeeper	4	15%	0.5	0.8	1.0	1.1
Composite Market Analysis			0.7%	1.6%	**2.0%**	2.2%
Composite PMPM			$0.76	$1.77	**$2.22**	$2.46

Pennsylvania - H.B. 1286
Cost of Mental Health Parity

Type of Delivery System	#	Distribution	Percentage Increase in Base Medical Plan for Change to Type of Parity			
			Partial	SMI	Full	Comprehensive
Fee-for-Service	1	30%	1.1%	2.8%	3.5%	4.2%
Managed Indemnity	2	35%	0.8	2.1	2.7	3.4
PPO & POS	3	15%	0.6	2.0	2.5	2.8
HMO & Gatekeeper	4	20%	0.5	0.9	1.2	1.3
Composite Market Analysis			0.8%	2.1%	**2.6%**	3.1%
Composite PMPM			$1.12	$2.83	**$3.53**	$4.26

Vermont - H.B. 57
Cost of Mental Health & Substance Abuse Parity

Type of Delivery System	#	Distribution	Percentage Increase in Base Medical Plan for Change to Type of Parity			
			Partial	SMI	Full	Comprehensive
Fee-for-Service	1	30%	1.3%	3.5%	4.3%	4.9%
Managed Indemnity	2	25%	0.9	2.5	3.1	3.6
PPO & POS	3	10%	0.6	2.3	2.9	3.8
HMO & Gatekeeper	4	35%	0.6	1.0	1.3	1.8
Composite Market Analysis			0.9%	2.3%	**2.8%**	3.4%
Composite PMPM			$0.91	$2.33	**$2.84**	$3.45

II. Interim Report to Congress by the National Advisory Mental Health Council

A report entitled "Parity in Coverage of Mental Health Services in an Era of Managed Care" is a product of the Department of Heath and Human Services, the National Institutes of Health and the National Institute of Mental Health. This report is an interim report to Congress by the National Advisory Mental Health council. The study's major findings are:

> "1. Based upon empirical studies and economic simulations across diverse populations, managed care approaches, and parity structures suggest that the introduction of parity in combination with managed care results in lowered costs and lowered premiums (or, at most, very modest cost increases) within the first year of parity implementation.
>
> 2. These findings do not support earlier concern about potentially high financial costs caused by parity. Prior estimates were based on fee-for-service (FFS) models that are no longer valid for a market dominated by managed care and likely to become even more so."

A. Texas

On September 1, 1992, the State of Texas implemented legislation requiring parity in mental health insurance coverage for State and local government employees. Parity was also required for the treatment of chemical dependency. Experience for 170,000 members in managed FFS/PPO/POS (non-HMO) coverage for the years 1992 through 1995 shows a 47.9% decrease in the cost of care for mental health and chemical dependency.

B. Maryland

On July 1, 1995, the State of Maryland implemented parity legislation that applied to all insurers. The legislation applied to those mental health and addictive disorders determined to be medically necessary and treatable. After parity was instituted, a small increase was observed in the number of inpatient admissions per 1000; that increase was more than offset by a more significant decrease in the average length of inpatient stays. Outpatient visits decreased as much as 9%, although isolated instances of increased outpatient utilization were seen.

For one insurer, the proportion of the total medical premium attributable to the mental health benefit actually decreased by 0.2 percent after the implementation of full parity. A second managed care company with extensive experience in Maryland subsequently confirmed that their average that their average expense per member per month increase by less than 1.0 percent during the first 7 months after full implementation of parity.

C. Rhode Island

On January 1, 1995, the State of Rhode Island implemented limited parity legislation. After parity was instituted in Rhode Island, there was a moderate increase in the number of inpatient admissions per 1000 members, and a moderate reduction in the average length of inpatient stays, with an overall increase in days per 1000 members. The average overall mental health cost increases resulted in an increase of total plan costs of less than 1 percent (specifically 0.33 percent of total benefit).

III. Other Studies on the Impact of Mental Health Parity

A. Minnesota

Minnesota passed full parity effective August 1, 1995. Language to accomplish full parity is included in the Minnesota's insurance statutes. The statute is similar to the following wording with separate sections to independently describe inpatient and outpatient parity. To date, there has been no recognized cost concerns or exodus of insured plans to ERISA status in order to avoid the Minnesota parity mandate.

According to John Gross, Director of Health Care Policy - Insurance Federation, "No one has cited rising mental health costs as reasons for premium increases." The Minnesota Department of Commerce, the state agency that regulates indemnity insurance, estimated costs of 1% of total premium dollars for mental health parity. Medica, an independent consulting organization, estimated Minnesota costs for mental health parity is $.26 per member per month.

Minnesota legislation includes the following:

All health plans that provide coverage for mental health or chemical dependency services, must comply with the following:

> Cost-sharing requirements and benefit or service limitations for mental health and outpatient chemical dependency services must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for medical services.

B. North Carolina

The North Carolina State Employee Health Plan includes mental health benefits with full comprehensive parity of coverage. The background on the state benefits include:

1. Full coverage parity with medical conditions since 1992,
2. No separate additional deductible for mental health services,
3. Full freedom of choice of mental health providers,
4. Moderate management of benefits compared to many managed behavioral mental health programs,
5. Broad demographic mix of 400,000 covered lives.

Since 1992 when parity was established and a single deductible was implemented, mental health payments as a portion of total health payments decreased from 6.4% to 3.7% of total health care costs for the fiscal year ending June 30, 1995.

C. New Hampshire

A Lewin Group study of the impact of mental health parity in New Hampshire showed "no increase in overall costs were reported as a result of a state law requiring equal health insurance coverage for severe mental illness. Lewin surveyed 11 insurers accounting for the majority of lives in the state. According to the study, "increases in premiums ranged from non-existent to small or moderate." Respondents indicated that the legislation "was not a major factor of discussion or concern among those at the employer group level."

IV. Comparison to Congressional Budget Office Calculations

In a letter to Senator Nancy Kassebaum (R-KS) dated April 23, 1996, the Congressional Budget Office (CBO) estimated the cost impact of the mental health and substance abuse parity proposal by Senators Domenici (R-NM) and Wellstone (D-MN) at 4.0%. The mental health portion of the Domenici-Wellstone proposal is similar to the Comprehensive Parity options presented in this paper. However, in most states (except Vermont) substance abuse is excluded. Without substance abuse, the CBO cost impact would likely be in the 3.0-3.5% range,

With substance abuse included, the CBO cost estimate is 5.3% for Fee-for-Service plans and 4.0% for the market composite that includes managed care plans. As written in the CBO letter, "Because employers would be better able to control costs for mental health services, CBO assumed that the average premium increase initially would be 4 percent."

Impact of MH Parity on Employer with Five Employees

North Carolina

Cost Increase for Five (5) Employee Group
Mental Health Only

		TYPE OF PLAN				
		Indemnity	Managed Indemnity	PPO/POS	HMO or Gatekeeper	Composite Average
Gross Cost Per Person/Month		$3.09	$2.51	$2.43	$1.11	$2.46
x Plan Offsets/Adjustments	(1)	0.4	0.4	0.4	0.4	0.4
Net Cost Per Person/Month		$1.24	$1.00	$0.97	$0.44	$0.98
x Employers Portion of Cost Increase	(2)	0.5	0.5	0.5	0.5	0.5
Net Employer Cost Per Person/Month		$0.62	$0.50	$0.49	$0.22	$0.49
#Persons (5 Ees + 10 Dependents)		15	15	15	15	15
Total Monthly Cost Increase for Employer		**$9.27**	**$7.53**	**$7.29**	**$3.33**	**$7.38**

(1) Plan Offsets occur as employers adjust plan designs to mitigate the impact of any rate increase. Actions include: competitive bidding of plan to other carriers, increasing plan deductibles for all coverages, moving more towards managed care, negotiating provider reimbursements, lowering wage increases, reducing other ancillary benefits,

(2) The employer portion of the cost is approximately 50% of any premium due for the benefit plan. Employees pay the remaining 50% of costs. Some employers pay the employee premium with employees paying the dependent premium.

NC COMPREHENSIVE MAJOR MEDICAL PLAN FOR TEACHERS AND STATE EMPLOYEES

Mental Health Costs

Fiscal Year Ending

	June-97	June-96	June-95	June-94	June-93 (Full MH Mgmt)	June-92 (No Outpatient Cap or MH Mgmt)	June-91	June-90
TOTAL: Actives & Dependents	292,572	305,924	322,627	322,900	322,088	330,613	351,189	341,098
TOTAL: Covered Lives	393,965	404,210	415,225	412,529	409,302	415,302	433,069	420,184
Total Mental Health Payments	$19,008,825	$19,936,678	$20,424,916	$23,138,778	$25,612,004	$32,361,152	$30,830,831	$27,914,870
— Total Payments PMPY*	$48.25	$49.32	$49.19	$56.09	$62.57	$77.92	$71.19	$66.43
— Total Payments PMPM*	$4.02	$4.11	$4.10	$4.67	$5.21	$6.49	$5.93	$5.54
— % of Total of all Medical Claims Paid	3.3%	3.4%	3.7%	4.5%	5.2%	6.4%	6.1%	6.6%
Total Administrative Payments	$2,452,923	$2,493,405	$2,476,755	$2,404,000	$2,273,662			
— Total Payments PMPY	$6.23	$6.23	$5.96	$5.72	$5.56			
— Total Payments PMPM	$0.52	$0.52	$0.50	$0.48	$0.46			
Breakdown of Cost Per Member Per Month								
— Mental Health PMPM	$4.02	$4.11	$4.10	$4.67	$5.21			
— Administrative PMPM	$0.52	$0.52	$0.50	$0.48	$0.46			
Total Cost Per Member Per Month	$4.54	$4.61	$4.60	$5.15	$5.67	$6.49	$5.93	$5.54

***Note: PMPY and PMPM - is actually per covered life per year or per month**

Prepared by NC Psychological Association from data supplied by the NC State Health Plan Office **5/98**

NC COMPREHENSIVE MAJOR MEDICAL PLAN FOR TEACHERS AND STATE EMPLOYEES

Mental Health Experience (Excluding Substance Abuse)
Inpatient/Outpatient Data

Fiscal Year Ending

	FY 6/97	FY 6/96	FY 6/95	FY 6/94	FY 6/93	FY 6/92	FY 6/91	FY 6/90
Inpatient (Actives & Dependents Only)								
# of Admissions	781	876	971	1,092	1,142	1,276	1,403	1,367
Adm/10,000	26.7	28.6	30.3	34.1	35.5	38.2	39.5	39.8
Days/10,000	269.8	308.5	318.9	391.6	484.9	807.1	859.6	917.9
ALOS	10.1	10.8	10.5	11.5	13.7	21.1	21.7	23.1
ALOS (outliers greater than 50 days excluded)	(10.1)	(8.3)	(9.2)	(10.8)	(12.2)			
Outpatient (Actives & Dependents Only)								
# Patients	20,113	20,519	20,562	19,674	19,659	20,520	21,092	18,913
Patients as %	6.8%	6.7%	6.4%	6.1%	6.1%	6.1%	6.0%	5.6%
# Visits	160,666	170,225	172,664	185,866	193,601	217,944	212,612	192,488
# Visits/1000 members	549	551	539	557	602	653	609	567
# Visits/Patient								
— Median	4.0	4.0	4.0	4.0	4.0	5.0	5.0	5.0
— 75th Percentile	11.0	11.0	12.0	13.0	13.0	13.0	14.0	14.0
— Mean	8.0	8.3	8.5	9.2	9.8	10.6	10.1	10.2
Utilization > 26 Visits								
— # of patients	1,203	1,216	1,508	1,642	1,842	2,482	2,499	2,173
— % of patients	6.0%	5.9%	7.3%	8.3%	9.4%	12.1%	11.8%	11.5%
— % of covered lives	0.41%	0.40%	0.47%	0.51%	0.57%	0.75%	0.71%	0.64%

Prepared by NC Psychological Association from data supplied by the NC State Health Plan Office

5/98

Analysis of Catastrophic MH Parity Cost Impact on Small & Large Employers

*** Based on 1996 Foster Higgins National Survey of Employer-sponsored Health Plans**
Premium Increase Estimates are before any Plan or Other Changes that Might Mitigate Increases

	Small Employers			Large Employers		
	Indemnity	PPO	HMO	Indemnity	PPO	HMO
Monthly Cost per Employee*	$260	$237	$218	$296	$260	$264
C&L Cost Estimates: % Cost of Option #3 Catastrophic MH Parity	1.28%	1.10%	0.60%	1.28%	1.10%	0.60%
Monthly Cost Per Employee	$3.34	$2.61	$1.30	$3.80	$2.86	$1.57

# Employees	Current Total Monthly Premium			Current Total Monthly Premium		
	Indemnity	PPO	HMO	Indemnity	PPO	HMO
250	$65,087	$59,290	$54,539	$73,998	$65,111	$65,935
200	$52,070	$47,432	$43,631	$59,198	$52,089	$52,748
150	$39,052	$35,574	$32,723	$44,399	$39,067	$39,561
100	$26,035	$23,716	$21,816	$29,599	$26,044	$26,374
75	$19,526	$17,787	$16,362	$22,199	$19,533	$19,781
50	$13,017	$11,858	$10,908	$14,800	$13,022	$13,187
40	$10,414	$9,486	$8,726	$11,840	$10,418	$10,550
30	$7,810	$7,115	$6,545	$8,880	$7,813	$7,912
20	$5,207	$4,743	$4,363	$5,920	$5,209	$5,275
10	$2,603	$2,372	$2,182	$2,960	$2,604	$2,637
5	$1,302	$1,186	$1,091	$1,480	$1,302	$1,319

# Employees	Total Monthly Premium Increase Before Plan Design Offsets			Total Monthly Premium Increase Before Plan Design Offsets		
	Indemnity	PPO	HMO	Indemnity	PPO	HMO
250	$835	$652	$325	$950	$716	$393
200	$668	$522	$260	$760	$573	$314
150	$501	$391	$195	$570	$430	$236
100	$334	$261	$130	$380	$286	$157
75	$251	$196	$97	$285	$215	$118
50	$167	$130	$65	$190	$143	$79
40	$134	$104	$52	$152	$115	$63
30	$100	$78	$39	$114	$86	$47
20	$67	$52	$26	$76	$57	$31
10	$33	$26	$13	$38	$29	$16
5	$17	$13	$6	$19	$14	$8

# Employees	Total Monthly Premium Increase After Plan Design Offsets (60%)			Total Monthly Premium Increase After Plan Design Offsets (60%)		
	Indemnity	PPO	HMO	Indemnity	PPO	HMO
250	$334	$261	$130	$380	$286	$157
200	$267	$209	$104	$304	$229	$126
150	$200	$157	$78	$228	$172	$94
100	$134	$104	$52	$152	$115	$63
75	$100	$78	$39	$114	$86	$47
50	$67	$52	$26	$76	$57	$31
40	$53	$42	$21	$61	$46	$25
30	$40	$31	$16	$46	$34	$19
20	$27	$21	$10	$30	$23	$13
10	$13	$10	$5	$15	$11	$6
5	$7	$5	$3	$8	$6	$3

Analysis of Catastrophic MH Parity Cost Impact on Small & Large Employers

* Based on 1996 Foster Higgins National Survey of Employer-sponsored Health Plans
Premium Increase Estimates are before any Plan or Other Changes that Might Mitigate Increases

	Small Employers			Large Employers		
	Indemnity	PPO	HMO	Indemnity	PPO	HMO
Monthly Cost per Employee*	$260	$237	$218	$296	$260	$264
GAHMO Cost Survey: % Cost of Option #3 Catastrophic MH Parity	5.90%	5.90%	2.80%	5.25%	5.25%	1.60%
Monthly Cost Per Employee	$15.36	$13.99	$6.11	$15.54	$13.67	$4.22

# Employees	Current Total Monthly Premium			Current Total Monthly Premium		
	Indemnity	PPO	HMO	Indemnity	PPO	HMO
250	$65,087	$59,290	$54,539	$73,998	$65,111	$65,935
200	$52,070	$47,432	$43,631	$59,198	$52,089	$52,748
150	$39,052	$35,574	$32,723	$44,399	$39,067	$39,561
100	$26,035	$23,716	$21,816	$29,599	$26,044	$26,374
75	$19,526	$17,787	$16,362	$22,199	$19,533	$19,781
50	$13,017	$11,858	$10,908	$14,800	$13,022	$13,187
40	$10,414	$9,486	$8,726	$11,840	$10,418	$10,550
30	$7,810	$7,115	$6,545	$8,880	$7,813	$7,912
20	$5,207	$4,743	$4,363	$5,920	$5,209	$5,275
10	$2,603	$2,372	$2,182	$2,960	$2,604	$2,637
5	$1,302	$1,186	$1,091	$1,480	$1,302	$1,319

# Employees	Total Monthly Premium Increase Before Plan Design Offsets			Total Monthly Premium Increase Before Plan Design Offsets		
250	$3,840	$3,498	$1,527	$3,885	$3,418	$1,055
200	$3,072	$2,798	$1,222	$3,108	$2,735	$844
150	$2,304	$2,099	$916	$2,331	$2,051	$633
100	$1,536	$1,399	$611	$1,554	$1,367	$422
75	$1,152	$1,049	$458	$1,165	$1,025	$316
50	$768	$700	$305	$777	$684	$211
40	$614	$560	$244	$622	$547	$169
30	$461	$420	$183	$466	$410	$127
20	$307	$280	$122	$311	$273	$84
10	$154	$140	$61	$155	$137	$42
5	$77	$70	$31	$78	$68	$21

# Employees	Total Monthly Premium Increase After Plan Design Offsets (60%)			Total Monthly Premium Increase After Plan Design Offsets (60%)		
250	$1,536	$1,399	$611	$1,554	$1,367	$422
200	$1,229	$1,119	$489	$1,243	$1,094	$338
150	$922	$840	$367	$932	$820	$253
100	$614	$560	$244	$622	$547	$169
75	$461	$420	$183	$466	$410	$127
50	$307	$280	$122	$311	$273	$84
40	$246	$224	$98	$249	$219	$68
30	$184	$168	$73	$186	$164	$51
20	$123	$112	$49	$124	$109	$34
10	$61	$56	$24	$62	$55	$17
5	$31	$28	$12	$31	$27	$8

Public's attitude about mental illness shifting

By Andy Miller
STAFF WRITER

Nine of ten Georgians believe mental illness can be treated successfully — and that insurance policies should cover it on an equal basis with general physical illnesses, a new survey finds.

But lack of insurance or ability to pay, along with lingering stigma about mental illness, remain barriers to people getting treatment, according to the survey released Friday.

And about half of Georgians surveyed said they would not want their employer to know they were being treated for a mental illness.

The results of the September survey of 404 Georgia households, conducted by the University of Georgia, were released at the Rosalynn Carter Georgia Mental Health Forum.

The survey showed great advances in the public's understanding of mental illness, said Carter. Almost 95 percent of Georgians believe people with mental illness can be helped through treatment, she noted.

"That is a huge step forward," Carter said. "It was not very long ago that people thought of mental illness as a weakness."

More than 80 percent said they would support a political candidate who had been treated for mental illness if the person were the best for the job. That shows great progress from 1972, when Sen. Thomas Eagleton withdrew from the Democratic ticket over concerns about a past treatment for mental illness, Carter said.

In other survey findings, 40 percent know someone who had been diagnosed with a mental illness, which the survey listed as major depression, schizophrenia or obsessive-compulsive disorder, among others.

And 88 percent said they would knowingly employ or recommend someone for a job who had received mental health treatment. Still, almost 50 percent said they would not want their employer to know if they were seeking treatment for mental illness.

"It's an ongoing fear of people losing their job and insurance coverage," said Darrell Kirch, dean of the School of Medicine at the Medical College of Georgia. People seeking treatment, he said, may fear they will be seen as not competent to do a job.

Doug Bachtel of the University of Georgia added many people work for small firms, "where you don't necessarily have all the safeguards as you would if you were working for state government or a large corporation."

Ron Finch of consulting firm Coopers & Lybrand said although the stigma still exists, the employer issue may involve the right to privacy.

"There's so much paranoia over downsizing," Finch said. "Many employees don't want their employer to know anything about their health," including conditions such as heart disease and hypertension.

Carter noted that Congress recently passed a bill requiring that annual or lifetime caps on mental health benefits be on par with those for physical illnesses.

"It's a real victory," though broader benefits parity is needed, she said.

Added Cynthia Wainscott of the Mental Health Association of Georgia: "We need to have employers understand they can save money by treating depression."

289.59 Other
Lien migrans
Perisplenitis
Splenic:
abscess
atrophy
cyst
Splenic:
fibrosis
infarction
rupture, nontraumatic
Splenitis
Wandering spleen
EXCLUDES *bilharzial splenic fibrosis (120.0-120.9)*
hepatolienal fibrosis (571.5)
splenomegaly NOS (789.2)

289.6 Familial polycythemia
Familial:
benign polycythemia
Familial:
erythrocytosis

289.7 Methemoglobinemia
Congenital NADH [DPNH]-methemoglobin-reductase deficiency
Hemoglobin M [Hb-M] disease
Methemoglobinemia:
NOS
acquired (with sulfhemoglobinemia)
hereditary
toxic
Stokvis' disease
Sulfhemoglobinemia
Use additional E code to identify cause

289.8 Other specified diseases of blood and blood-forming organs
Hypergammaglobulinemia
Myelofibrosis
Pseudocholinesterase deficiency

289.9 Unspecified diseases of blood and blood-forming organs
Blood dyscrasia NOS
Erythroid hyperplasia

5. MENTAL DISORDERS (290-319)

In the *International Classification of Diseases, 9th Revision* (ICD-9), the corresponding Chapter V, "Mental Disorders," includes a glossary which defines the contents of each category. The introduction to Chapter V in ICD-9 indicates that the glossary is intended so that psychiatrists can make the diagnosis based on the descriptions provided rather than from the category titles. Lay coders are instructed to code whatever diagnosis the physician records.

Chapter 5, "Mental Disorders," in ICD-9-CM uses the standard classification format with inclusion and exclusion terms, omitting the glossary as part of the main text.

The mental disorders section of ICD-9-CM has been expanded to incorporate additional psychiatric disorders not listed in ICD-9. The glossary from ICD-9 does not contain all these terms. It now appears in Appendix B, which also contains descriptions and definitions for the terms added in ICD-9-CM. Some of these were provided by the American Psychiatric Association's Task Force on Nomenclature and Statistics who are preparing the *Diagnostic and Statistical Manual*, Third Edition (DSM-III), and others from *A Psychiatric Glossary*.

The American Psychiatric Association provided invaluable assistance in modifying Chapter 5 of ICD-9-CM to incorporate detail useful to American clinicians and gave permission to use material from the aforementioned sources.

1. Manual of the *International Statistical Classification of Diseases, Injuries, and Causes of Death*, 9th Revision, World Health Organization, Geneva, Switzerland, 1975.
2. American Psychiatric Association, Task Force on Nomenclature and Statistics, Robert L. Spitzer, M.D., Chairman.
3. *A Psychiatric Glossary*, Fourth Edition, American Psychiatric Association, Washington, D.C., 1975.

PSYCHOSES (290-299)

EXCLUDES *mental retardation (317-319)*

ORGANIC PSYCHOTIC CONDITIONS (290-29

INCLUDES psychotic organic brain syndrome
EXCLUDES *nonpsychotic syndromes of organic etio 310.9)*
psychoses classifiable to 295-298 and impairment of orientation, comprehen calculation, learning capacity, and j but associated with physical disease condition affecting the brain [eg., fo childbirth] (295.0-298.8)

● **290 Senile and presenile organic psychotic conditions**
Use additional code to identify the associated neurological condition
EXCLUDES *dementia not classified as senile, presenile, arteriosclerotic (294.1)*
psychoses classifiable to 295-298 occurring in se senium without dementia or delirium (29 298.8)
senility with mental changes of nonpsychotic s (310.1)
transient organic psychotic conditions (293.0-293.9)

290.0 Senile dementia, uncomplicated
Senile dementia:
NOS
simple type
EXCLUDES *mild memory disturbances, not amounting to dementia, associated with senile brain disease (310.1)*
senile dementia with:
delirium or confusion (290.3)
delusional [paranoid] features (290.20)
depressive features (290.21)

● **290.1 Presenile dementia**
Brain syndrome with presenile brain disease
EXCLUDES *arteriosclerotic dementia (290.40-290.43)*
dementia associated with other cerebral conditions (294.1)

290.10 Presenile dementia, uncomplicated
Presenile dementia:
NOS
Presenile dementia:
simple type

290.11 Presenile dementia with delirium
Presenile dementia with acute confusional state

290.12 Presenile dementia with delusional features
Presenile dementia, paranoid type

290.13 Presenile dementia with depressive features
Presenile dementia, depressed type

● **290.2 Senile dementia with delusional or depressive features**
EXCLUDES *senile dementia:*
NOS (290.0)
with delirium and/or confusion (290.3)

290.20 Senile dementia with delusional features
Senile dementia, paranoid type
Senile psychosis NOS

290.21 Senile dementia with depressive features

290.3 Senile dementia with delirium
Senile dementia with acute confusional state
EXCLUDES *senile:*
dementia NOS (290.0)
psychosis NOS (290.20)

● **290.4 Arteriosclerotic dementia**
Multi-infarct dementia or psychosis
Use additional code to identify cerebral atherosclerosis (437.0)
EXCLUDES *suspected cases with no clear evidence of arteriosclerosis (290.9)*

290.40 Arteriosclerotic dementia, uncomplicated
Arteriosclerotic dementia:
NOS
simple type

290.41 Arteriosclerotic dementia with delirium
Arteriosclerotic dementia with acute confusional state

290.42 Arteriosclerotic dementia with delusional features
Arteriosclerotic dementia, paranoid type

290.43 Arteriosclerotic dementia with depressive features
Arteriosclerotic dementia, depressed type
◆290.8 Other specified senile psychotic conditions
Presbyophrenic psychosis
◆290.9 Unspecified senile psychotic condition

●291 Alcoholic psychoses
EXCLUDES *alcoholism without psychosis (303.0-303.9)*
291.0 Alcohol withdrawal delirium
Alcoholic delirium Delirium tremens
EXCLUDES *alcohol withdrawal (291.81)* ◆
291.1 Alcohol amnestic syndrome
Alcoholic polyneuritic psychosis
Korsakoff's psychosis, alcoholic
Wernicke-Korsakoff syndrome (alcoholic)
◆291.2 Other alcoholic dementia
Alcoholic dementia NOS
Alcoholism associated with dementia NOS
Chronic alcoholic brain syndrome
291.3 Alcohol withdrawal hallucinosis
Alcoholic: Alcoholic:
hallucinosis (acute) psychosis with hallucinosis
EXCLUDES *alcohol withdrawal with delirium (291.0)*
schizophrenia (295.0-295.9) and paranoid states (297.0-297.9) taking the form of chronic hallucinosis with clear consciousness in an alcoholic
291.4 Idiosyncratic alcohol intoxication
Pathologic: Pathologic:
alcohol intoxication drunkenness
EXCLUDES *acute alcohol intoxication (305.0)*
in alcoholism (303.0)
simple drunkenness (305.0)
291.5 Alcoholic jealousy
Alcoholic: Alcoholic:
paranoia psychosis, paranoid type
EXCLUDES *nonalcoholic paranoid states (297.0-297.9)*
schizophrenia, paranoid type (295.3)
●291.8 Other specified alcoholic psychosis
291.81 Alcohol withdrawal ▼
Alcohol:
withdrawal syndrome or symptoms
abstinence syndrome or symptoms ▲
EXCLUDES *alcohol withdrawal:* ▽
delirium (291.0)
hallucinosis (291.3)
delirium tremens (291.0) △
291.89 Other ◆
◆291.9 Unspecified alcoholic psychosis
Alcoholic:
mania NOS
psychosis NOS
Alcoholism (chronic) with psychosis

●292 Drug psychoses
INCLUDES drug-induced mental disorders
organic brain syndrome associated with consumption of drugs
Use additional code for any associated drug dependence (304.0-304.9)
Use additional E code to identify drug
292.0 Drug withdrawal syndrome
Drug:
abstinence syndrome or symptoms
withdrawal syndrome or symptoms
●292.1 Paranoid and/or hallucinatory states induced by drugs
292.11 Drug-induced organic delusional syndrome
Paranoid state induced by drugs
292.12 Drug-induced hallucinosis
Hallucinatory state induced by drugs
EXCLUDES *states following LSD or other hallucinogens, lasting only a few days or less ["bad trips"] (305.3)*
292.2 Pathological drug intoxication
Drug reaction: NOS, idiosyncratic, pathologic — resulting in brief psychotic states
EXCLUDES *expected brief psychotic reactions to hallucinogens ["bad trips"] (305.3)*
physiological side-effects of drugs (e.g., dystonias)
●292.8 Other specified drug-induced mental disorders
292.81 Drug-induced delirium
292.82 Drug-induced dementia
292.83 Drug-induced amnestic syndrome
292.84 Drug-induced organic affective syndrome
Depressive state induced by drugs
292.89 Other
Drug-induced organic personality syndrome
292.9 Unspecified drug-induced mental disorder
Organic psychosis NOS due to or associated with drugs

●293 Transient organic psychotic conditions
INCLUDES transient organic mental disorders not associated with alcohol or drugs
Code first the associated physical or neurological condition ◆
EXCLUDES *confusional state or delirium superimposed on senile dementia (290.3)*
dementia due to:
alcohol (291.0-291.9)
arteriosclerosis (290.40-290.43)
drugs (292.82)
senility (290.0)
293.0 Acute delirium
Acute:
confusional state
infective psychosis
organic reaction
posttraumatic organic psychosis
psycho-organic syndrome
Acute psychosis associated with endocrine, metabolic, or cerebrovascular disorder
Epileptic:
confusional state
twilight state
293.1 Subacute delirium
Subacute:
confusional state
infective psychosis
organic reaction
posttraumatic organic psychosis
psycho-organic syndrome
psychosis associated with endocrine or metabolic disorder
●293.8 Other specified transient organic mental disorders
293.81 Organic delusional syndrome
Transient organic psychotic condition, paranoid type
293.82 Organic hallucinosis syndrome
Transient organic psychotic condition, hallucinatory type
293.83 Organic affective syndrome
Transient organic psychotic condition, depressive type
293.84 Organic anxiety syndrome ◆
293.89 Other
293.9 Unspecified transient organic mental disorder
Organic psychosis: Organic psychosis:
infective NOS transient NOS
posttraumatic NOS Psycho-organic syndrome

●294 Other organic psychotic conditions (chronic)
INCLUDES organic psychotic brain syndromes (chronic), not elsewhere classified
294.0 Amnestic syndrome
Korsakoff's psychosis or syndrome (nonalcoholic)
EXCLUDES *alcoholic:*
amnestic syndrome (291.1)
Korsakoff's psychosis (291.1)

294.1 Dementia in conditions classified elsewhere
Code first any underlying physical condition, as:
dementia in:
Alzheimer's disease (331.0)
cerebral lipidoses (330.1)
epilepsy (345.0-345.9)
general paresis [syphilis] (094.1)
hepatolenticular degeneration (275.1)
Huntington's chorea (333.4)
Jakob-Creutzfeldt disease (046.1)
multiple sclerosis (340)
Pick's disease of the brain (331.1)
polyarteritis nodosa (446.0)
syphilis (094.1)
EXCLUDES *dementia:*
arteriosclerotic (290.40-290.43)
presenile (290.10-290.13)
senile (290.0)
epileptic psychosis NOS (294.8)

294.8 Other specified organic brain syndromes (chronic)
Epileptic psychosis NOS
Mixed paranoid and affective organic psychotic states
Use additional code for associated epilepsy (345.0-345.9)
EXCLUDES *mild memory disturbances, not amounting to dementia (310.1)*

294.9 Unspecified organic brain syndrome (chronic)
Organic psychosis (chronic)

OTHER PSYCHOSES (295-299)

Use additional code to identify any associated physical disease, injury, or condition affecting the brain with psychoses classifiable to 295-298

295 Schizophrenic disorders
INCLUDES schizophrenia of the types described in 295.0-295.9 occurring in children
EXCLUDES *childhood type schizophrenia (299.9)*
infantile autism (299.0)

The following fifth-digit subclassification is for use with category 295:
0 unspecified
1 subchronic
2 chronic
3 subchronic with acute exacerbation
4 chronic with acute exacerbation
5 in remission

295.0 Simple type
Schizophrenia simplex
EXCLUDES *latent schizophrenia (295.5)*

295.1 Disorganized type
Hebephrenia
Hebephrenic type schizophrenia

295.2 Catatonic type
Catatonic (schizophrenia): agitation, excitation, excited type, stupor, withdrawn type
Schizophrenic: catalepsy, catatonia, flexibilitas cerea

295.3 Paranoid type
Paraphrenic schizophrenia
EXCLUDES *involutional paranoid state (297.2)*
paranoia (297.1)
paraphrenia (297.2)

295.4 Acute schizophrenic episode
Oneirophrenia
Schizophreniform: attack
Schizophreniform: disorder, psychosis, confusional type
EXCLUDES *acute forms of schizophrenia of:*
catatonic type (295.2)
hebephrenic type (295.1)
paranoid type (295.3)
simple type (295.0)
undifferentiated type (295.8)

295.5 Latent schizophrenia
Latent schizophrenic reaction
Schizophrenia: borderline, incipient, prepsychotic
Schizophrenia: prodromal, pseudoneurotic, pseudopsychopathic
EXCLUDES *schizoid personality (301.20-301.22)*

295.6 Residual schizophrenia
Chronic undifferentiated schizophrenia
Restzustand (schizophrenic)
Schizophrenic residual state

295.7 Schizo-affective type
Cyclic schizophrenia
Mixed schizophrenic and affective psychosis
Schizo-affective psychosis
Schizophreniform psychosis, affective type

295.8 Other specified types of schizophrenia
Acute (undifferentiated) schizophrenia
Atypical schizophrenia
Cenesthopathic schizophrenia
EXCLUDES *infantile autism (299.0)*

295.9 Unspecified schizophrenia
Schizophrenia: NOS, mixed NOS, undifferentiated NOS
Schizophrenic reaction NOS
Schizophreniform psychosis NOS

296 Affective psychoses
INCLUDES episodic affective disorders
EXCLUDES *neurotic depression (300.4)*
reactive depressive psychosis (298.0)
reactive excitation (298.1)

The following fifth-digit subclassification is for use with categories 296.0-296.6:
0 unspecified
1 mild
2 moderate
3 severe, without mention of psychotic behavior
4 severe, specified as with psychotic behavior
5 in partial or unspecified remission
6 in full remission

296.0 Manic disorder, single episode
Hypomania (mild) NOS
Hypomanic psychosis
Mania (monopolar) NOS
Manic-depressive psychosis or reaction: hypomanic, manic
} single episode or unspecified
EXCLUDES *circular type, if there was a previous attack of depression (296.4)*

296.1 Manic disorder, recurrent episode
Any condition classifiable to 296.0, stated to be recurrent
EXCLUDES *circular type, if there was a previous attack of depression (296.4)*

296.2 Major depressive disorder, single episode
Depressive psychosis
Endogenous depression
Involutional melancholia
Manic-depressive psychosis or reaction, depressed type
Monopolar depression
Psychotic depression
} single episode or unspecified
EXCLUDES *circular type, if previous attack was of manic type (296.5)*
depression NOS (311)
reactive depression (neurotic) (300.4)
psychotic (298.0)

296.3 Major depressive disorder, recurrent episode
Any condition classifiable to 296.2, stated to be recurrent
EXCLUDES *circular type, if previous attack was of manic type (296.5)*
depression NOS (311)
reactive depression (neurotic) (300.4)
psychotic (298.0)

296.4 Bipolar affective disorder, manic
Bipolar disorder, now manic
Manic-depressive psychosis, circular type but currently manic
EXCLUDES *brief compensatory or rebound mood swings (296.99)*

● **296.5 Bipolar affective disorder, depressed**
Bipolar disorder, now depressed
Manic-depressive psychosis, circular type but currently depressed
EXCLUDES *brief compensatory or rebound mood swings (296.99)*

● **296.6 Bipolar affective disorder, mixed**
Manic-depressive psychosis, circular type, mixed

◆ **296.7 Bipolar affective disorder, unspecified**
Atypical bipolar affective disorder NOS
Manic-depressive psychosis, circular type, current condition not specified as either manic or depressive

● **296.8 Manic-depressive psychosis, other and unspecified**

296.80 Manic-depressive psychosis, unspecified
Manic-depressive:
reaction NOS
syndrome NOS

296.81 Atypical manic disorder

296.82 Atypical depressive disorder

296.89 Other
Manic-depressive psychosis, mixed type

● **296.9 Other and unspecified affective psychoses**
EXCLUDES *psychogenic affective psychoses (298.0-298.8)*

296.90 Unspecified affective psychosis
Affective psychosis NOS
Melancholia NOS

◆ **296.99 Other specified affective psychoses**
Mood swings: brief compensatory
Mood swings: rebound

297 Paranoid states
INCLUDES paranoid disorders
EXCLUDES *acute paranoid reaction (298.3)*
alcoholic jealousy or paranoid state (291.5)
paranoid schizophrenia (295.3)

297.0 Paranoid state, simple

297.1 Paranoia
Chronic paranoid psychosis
Sander's disease
Systematized delusions
EXCLUDES *paranoid personality disorder (301.0)*

297.2 Paraphrenia
Involutional paranoid state Paraphrenia (involutional)
Late paraphrenia

297.3 Shared paranoid disorder
Folie à deux
Induced psychosis or paranoid disorder

◆ **297.8 Other specified paranoid states**
Paranoia querulans Sensitiver Beziehungswahn
EXCLUDES *acute paranoid reaction or state (298.3)*
senile paranoid state (290.20)

◆ **297.9 Unspecified paranoid state**
Paranoid: disorder NOS, psychosis NOS
Paranoid: reaction NOS, state NOS

298 Other nonorganic psychoses
INCLUDES psychotic conditions due to or provoked by:
emotional stress
environmental factors as major part of etiology

298.0 Depressive type psychosis
Psychogenic depressive psychosis
Psychotic reactive depression
Reactive depressive psychosis
EXCLUDES *manic-depressive psychosis, depressed type (296.2-296.3)*
neurotic depression (300.4)
reactive depression NOS (300.4)

298.1 Excitative type psychosis
Acute hysterical psychosis Reactive excitation
Psychogenic excitation
EXCLUDES *manic-depressive psychosis, manic type (296.0-296.1)*

298.2 Reactive confusion
Psychogenic confusion Psychogenic twilight state
EXCLUDES *acute confusional state (293.0)*

298.3 Acute paranoid reaction
Acute psychogenic paranoid psychosis
Bouffée délirante
EXCLUDES *paranoid states (297.0-297.9)*

298.4 Psychogenic paranoid psychosis
Protracted reactive paranoid psychosis

298.8 Other and unspecified reactive psychosis
Brief reactive psychosis NOS
Hysterical psychosis
Psychogenic psychosis NOS
Psychogenic stupor
EXCLUDES *acute hysterical psychosis (298.1)*

298.9 Unspecified psychosis
Atypical psychosis
Psychosis NOS

● **299 Psychoses with origin specific to childhood**
INCLUDES pervasive developmental disorders
EXCLUDES *adult type psychoses occurring in childhood, as:*
affective disorders (296.0-296.9)
manic-depressive disorders (296.0-296.9)
schizophrenia (295.0-295.9)

The following fifth-digit subclassification is for use with category 299:
0 current or active state
1 residual state

● **299.0 Infantile autism**
Childhood autism Kanner's syndrome
Infantile psychosis
EXCLUDES *disintegrative psychosis (299.1)*
Heller's syndrome (299.1)
schizophrenic syndrome of childhood (299.9)

● **299.1 Disintegrative psychosis**
Heller's syndrome
Use additional code to identify any associated neurological disorder
EXCLUDES *infantile autism (299.0)*
schizophrenic syndrome of childhood (299.9)

● **299.8 Other specified early childhood psychoses**
Atypical childhood psychosis
Borderline psychosis of childhood
EXCLUDES *simple stereotypes without psychotic disturbance (307.3)*

● **299.9 Unspecified**
Child psychosis NOS
Schizophrenia, childhood type NOS
Schizophrenic syndrome of childhood NOS
EXCLUDES *schizophrenia of adult type occurring in childhood (295.0-295.9)*

NEUROTIC DISORDERS, PERSONALITY DISORDERS, AND OTHER NONPSYCHOTIC MENTAL DISORDERS (300-316)

● **300 Neurotic disorders**

● **300.0 Anxiety states**
EXCLUDES *anxiety in:*
acute stress reaction (308.0)
transient adjustment reaction (309.24)
neurasthenia (300.5)
psychophysiological disorders (306.0-306.9)
separation anxiety (309.21)

300.00 Anxiety state, unspecified
Anxiety: neurosis, reaction
Anxiety: state (neurotic)
Atypical anxiety disorder

300.01 Panic disorder
Panic: attack
Panic: state

300.02 Generalized anxiety disorder

300.09 Other

● **300.1 Hysteria**
EXCLUDES *adjustment reaction (309.0-309.9)*
anorexia nervosa (307.1)
gross stress reaction (308.0-308.9)
hysterical personality (301.50-301.59)
psychophysiologic disorders (306.0-306.9)

300.10 Hysteria, unspecified

300.11 Conversion disorder
Astasia-abasia, hysterical
Conversion hysteria or reaction
Hysterical
blindness
deafness
paralysis

300.12 Psychogenic amnesia
Hysterical amnesia

300.13 Psychogenic fugue
Hysterical fugue

300.14 Multiple personality
Dissociative identity disorder

◆ **300.15 Dissociative disorder or reaction, unspecified**

300.16 Factitious illness with psychological symptoms
Compensation neurosis
Ganser's syndrome, hysterical

◆ **300.19 Other and unspecified factitious illness**
Factitious illness (with physical symptoms) NOS
EXCLUDES *multiple operations or hospital addiction syndrome (301.51)*

● **300.2 Phobic disorders**
EXCLUDES *anxiety state not associated with a specific situation or object (300.00-300.09)*
obsessional phobias (300.3)

◆ **300.20 Phobia, unspecified**
Anxiety-hysteria NOS
Phobia NOS

300.21 Agoraphobia with panic attacks
Fear of:
open spaces, streets, travel } with panic attacks

300.22 Agoraphobia without mention of panic attacks
Any condition classifiable to 300.21 without mention of panic attacks

300.23 Social phobia
Fear of: eating in public, public speaking
Fear of: washing in public

◆ **300.29 Other isolated or simple phobias**
Acrophobia, Animal phobias, Claustrophobia, Fear of crowds

300.3 Obsessive-compulsive disorders
Anancastic neurosis, Compulsive neurosis, Obsessional phobia [any]
EXCLUDES *obsessive-compulsive symptoms occurring in:*
endogenous depression (296.2-296.3)
organic states (eg., encephalitis)
schizophrenia (295.0-295.9)

300.4 Neurotic depression
Anxiety depression, Depression with anxiety, Depressive reaction, Dysthymic disorder, Neurotic depressive state, Reactive depression
EXCLUDES *adjustment reaction with depressive symptoms (309.0-309.1)*
depression NOS (311)
manic-depressive psychosis, depressed type (296.2-296.3)
reactive depressive psychosis (298.0)

300.5 Neurasthenia
Fatigue neurosis
Nervous debility
Psychogenic:
asthenia
general fatigue
Use additional code to identify any associated physical disorder
EXCLUDES *anxiety state (300.00-300.09)*
neurotic depression (300.4)
psychophysiological disorders (306.0-316.9)
specific nonpsychotic mental disorders following organic brain damage (310.0-310.9)

300.6 Depersonalization syndrome
Depersonalization disorder
Derealization (neurotic)
Neurotic state with depersonalization episode
EXCLUDES *depersonalization associated with:*
anxiety (300.00-300.09)
depression (300.4)
manic-depressive disorder or psychosis (296.0-296.9)
schizophrenia (295.0-295.9)

300.7 Hypochondriasis
Body dysmorphic disorder
EXCLUDES *hypochondriasis in:*
hysteria (300.10-300.19)
manic-depressive psychosis, depressed type (296.2-296.3)
neurasthenia (300.5)
obsessional disorder (300.3)
schizophrenia (295.0-295.9)

● **300.8 Other neurotic disorders**

300.81 Somatization disorder
Briquet's disorder
Severe somatoform disorder

300.82 Undifferentiated somatoform disorder
Atypical somatoform disorder
Somatoform disorder NOS

◆ **300.89 Other**
Occupational neurosis, including writer's cramp
Psychasthenia
Psychasthenic neurosis

◆ **300.9 Unspecified neurotic disorder**
Neurosis NOS, Psychoneurosis NOS

● **301 Personality disorders**
INCLUDES character neurosis
Use additional code to identify any associated neurosis or psychosis, or physical condition
EXCLUDES *nonpsychotic personality disorder associated with organic brain syndromes (310.0-310.9)*

301.0 Paranoid personality disorder
Fanatic personality
Paranoid personality (disorder)
Paranoid traits
EXCLUDES *acute paranoid reaction (298.3)*
alcoholic paranoia (291.5)
paranoid schizophrenia (295.3)
paranoid states (297.0-297.9)

● **301.1 Affective personality disorder**
EXCLUDES *affective psychotic disorders (296.0-296.9)*
neurasthenia (300.5)
neurotic depression (300.4)

◆ **301.10 Affective personality disorder, unspecified**

301.11 Chronic hypomanic personality disorder
Chronic hypomanic disorder
Hypomanic personality

301.12 Chronic depressive personality disorder
Chronic depressive disorder
Depressive character or personality

301.13 Cyclothymic disorder
Cycloid personality, Cyclothymia, Cyclothymic personality

● **301.2 Schizoid personality disorder**
EXCLUDES *schizophrenia (295.0-295.9)*

◆ **301.20 Schizoid personality disorder, unspecified**

301.21 Introverted personality

301.22 Schizotypal personality

301.3 Explosive personality disorder
Aggressive personality reaction, Aggressiveness, Emotional instability (excessive), Pathological emotionality, Quarrelsomeness
EXCLUDES *dyssocial personality (301.7)*
hysterical neurosis (300.10-300.19)

301.4 Compulsive personality disorder
Anancastic personality
Obsessional personality
EXCLUDES *obsessive-compulsive disorder (300.3)*
phobic state (300.20-300.29)

● **301.5 Histrionic personality disorder**
EXCLUDES *hysterical neurosis (300.10-300.19)*

◆ **301.50 Histrionic personality disorder, unspecified**
Hysterical personality NOS

301.51 Chronic factitious illness with physical symptoms
Hospital addiction syndrome
Multiple operations syndrome
Munchausen syndrome

◆ **301.59 Other histrionic personality disorder**
Personality: emotionally unstable
Personality: psychoinfantile
labile

301.6 Dependent personality disorder
Asthenic personality
Passive personality
Inadequate personality
EXCLUDES *neurasthenia (300.5)*
passive-aggressive personality (301.84)

301.7 Antisocial personality disorder
Amoral personality
Asocial personality
Dyssocial personality
Personality disorder with predominantly sociopathic or asocial manifestation
EXCLUDES *disturbance of conduct without specifiable personality disorder (312.0-312.9)*
explosive personality (301.3)

● **301.8 Other personality disorders**
301.81 Narcissistic personality
301.82 Avoidant personality
301.83 Borderline personality
301.84 Passive-aggressive personality

◆ **301.89 Other**
Personality: eccentric
Personality: masochistic
"haltlose" type
psychoneurotic
immature
EXCLUDES *psychoinfantile personality (301.59)*

◆ **301.9 Unspecified personality disorder**
Pathological personality NOS
Personality disorder NOS
Psychopathic: constitutional state
personality (disorder)

● **302 Sexual deviations and disorders**
EXCLUDES *sexual disorder manifest in:*
organic brain syndrome (290.0-294.9, 310.0-310.9)
psychosis (295.0-298.9)

302.0 Ego-dystonic homosexuality
Ego-dystonic lesbianism
Homosexual conflict disorder
EXCLUDES *homosexual pedophilia (302.2)*

302.1 Zoophilia
Bestiality

302.2 Pedophilia

302.3 Transvestism
EXCLUDES *trans-sexualism (302.5)*

302.4 Exhibitionism

● **302.5 Trans-sexualism**
EXCLUDES *transvestism (302.3)*

◆ **302.50 With unspecified sexual history**
302.51 With asexual history
302.52 With homosexual history
302.53 With heterosexual history

302.6 Disorders of psychosexual identity
Feminism in boys
Gender identity disorder of childhood
EXCLUDES *gender identity disorder in adult (302.85)*
homosexuality (302.0)
trans-sexualism (302.50-302.53)
transvestism (302.3)

● **302.7 Psychosexual dysfunction**
EXCLUDES *impotence of organic origin (607.84)*
normal transient symptoms from ruptured hymen
transient or occasional failures of erection due to fatigue, anxiety, alcohol, or drugs

◆ **302.70 Psychosexual dysfunction, unspecified**
302.71 With inhibited sexual desire
302.72 With inhibited sexual excitement
Frigidity
Impotence
302.73 With inhibited female orgasm
302.74 With inhibited male orgasm
302.75 With premature ejaculation
302.76 With functional dyspareunia
Dyspareunia, psychogenic

◆ **302.79 With other specified psychosexual dysfunctions**

● **302.8 Other specified psychosexual disorders**
302.81 Fetishism
302.82 Voyeurism
302.83 Sexual masochism
302.84 Sexual sadism
302.85 Gender identity disorder of adolescent or adult life

◆ **302.89 Other**
Nymphomania
Satyriasis

◆ **302.9 Unspecified psychosexual disorder**
Pathologic sexuality NOS
Sexual deviation NOS

● **303 Alcohol dependence syndrome**
Use additional code to identify any associated condition, as:
alcoholic psychoses (291.0-291.9)
drug dependence (304.0-304.9)
physical complications of alcohol, such as:
cerebral degeneration (331.7)
cirrhosis of liver (571.2)
epilepsy (345.0-345.9)
gastritis (535.3)
hepatitis (571.1)
liver damage NOS (571.3)
EXCLUDES *drunkenness NOS (305.0)*

The following fifth-digit subclassification is for use with category 303:
◆ **0 unspecified**
1 continuous
2 episodic
3 in remission

● **303.0 Acute alcoholic intoxication**
Acute drunkenness in alcoholism

◆ ● **303.9 Other and unspecified alcohol dependence**
Chronic alcoholism
Dipsomania

● **304 Drug dependence**
EXCLUDES *nondependent abuse of drugs (305.1-305.9)*

The following fifth-digit subclassification is for use with category 304:
◆ **0 unspecified**
1 continuous
2 episodic
3 in remission

● **304.0 Opioid type dependence**
Heroin
Meperidine
Methadone
Morphine
Opium
Opium alkaloids and their derivatives
Synthetics with morphine-like effects

● **304.1 Barbiturate and similarly acting sedative or hypnotic dependence**
Barbiturates
Nonbarbiturate sedatives and tranquilizers with a similar effect:
chlordiazepoxide
diazepam
glutethimide
meprobamate
methaqualone

● **304.2 Cocaine dependence**
Coca leaves and derivatives
● **304.3 Cannabis dependence**
Hashish Marihuana
Hemp
● **304.4 Amphetamine and other psychostimulant dependence**
Methylphenidate Phenmetrazine
● **304.5 Hallucinogen dependence**
Dimethyltryptamine [DMT]
Lysergic acid diethylamide [LSD] and derivatives
Mescaline
Psilocybin
● **304.6 Other specified drug dependence**
Absinthe addiction Glue sniffing
EXCLUDES *tobacco dependence (305.1)*
● **304.7 Combinations of opioid type drug with any other**
● **304.8 Combinations of drug dependence excluding opioid type drug**
● **304.9 Unspecified drug dependence**
Drug addiction NOS Drug dependence NOS

● **305 Nondependent abuse of drugs**
Note: Includes cases where a person, for whom no other diagnosis is possible, has come under medical care because of the maladaptive effect of a drug on which he is not dependent and that he has taken on his own initiative to the detriment of his health or social functioning.
EXCLUDES *alcohol dependence syndrome (303.0-303.9)*
drug dependence (304.0-304.9)
drug withdrawal syndrome (292.0)
poisoning by drugs or medicinal substances (960.0-979.9)

The following fifth-digit subclassification is for use with codes 305.0, 305.2-305.9:
0 unspecified
1 continuous
2 episodic
3 in remission

● **305.0 Alcohol abuse**
Drunkenness NOS "Hangover" (alcohol)
Excessive drinking of alcohol NOS Inebriety NOS
EXCLUDES *acute alcohol intoxication in alcoholism (303.0)*
alcoholic psychoses (291.0-291.9)
physical complications of alcohol, such as:
cirrhosis of liver (571.2)
epilepsy (345.00-345.91)
gastritis (535.3)
305.1 Tobacco use disorder
Tobacco dependence
EXCLUDES *history of tobacco use (V15.82)*
● **305.2 Cannabis abuse**
● **305.3 Hallucinogen abuse**
Acute intoxication from hallucinogens ["bad trips"]
LSD reaction
● **305.4 Barbiturate and similarly acting sedative or hypnotic abuse**
● **305.5 Opioid abuse**
● **305.6 Cocaine abuse**
● **305.7 Amphetamine or related acting sympathomimetic abuse**
● **305.8 Antidepressant type abuse**
● **305.9 Other, mixed, or unspecified drug abuse**
"Laxative habit"
Misuse of drugs NOS
Nonprescribed use of drugs or patent medicinals

● **306 Physiological malfunction arising from mental factors**
INCLUDES psychogenic: physical symptoms / physiological manifestations } not involving tissue damage
EXCLUDES *hysteria (300.11-300.19)*
physical symptoms secondary to a psychiatric disorder classified elsewhere
psychic factors associated with physical conditions involving tissue damage classified elsewhere (316)
specific nonpsychotic mental disorders following organic brain damage (310.0-310.9)

306.0 Musculoskeletal
Psychogenic paralysis Psychogenic torticollis
EXCLUDES *Gilles de la Tourette's syndrome (307.23)*
paralysis as hysterical or conversion reaction (300.11)
tics (307.20-307.22)
306.1 Respiratory
Psychogenic: air hunger, cough, hiccough Psychogenic: hyperventilation, yawning
EXCLUDES *psychogenic asthma (316 and 493.9)*
306.2 Cardiovascular
Cardiac neurosis
Cardiovascular neurosis
Neurocirculatory asthenia
Psychogenic cardiovascular disorder
EXCLUDES *psychogenic paroxysmal tachycardia (316 and 427.2)*
306.3 Skin
Psychogenic pruritus
EXCLUDES *psychogenic:*
alopecia (316 and 704.00)
dermatitis (316 and 692.9)
eczema (316 and 691.8 or 692.9)
urticaria (316 and 708.0-708.9)
306.4 Gastrointestinal
Aerophagy
Cyclical vomiting, psychogenic
Diarrhea, psychogenic
Nervous gastritis
Psychogenic dyspepsia
EXCLUDES *cyclical vomiting NOS (536.2)*
globus hystericus (300.11)
mucous colitis (316 and 564.1)
psychogenic:
cardiospasm (316 and 530.0)
duodenal ulcer (316 and 532.0-532.9)
gastric ulcer (316 and 531.0-531.9)
peptic ulcer NOS (316 and 533.0-533.9)
vomiting NOS (307.54)
● **306.5 Genitourinary**
EXCLUDES *enuresis, psychogenic (307.6)*
frigidity (302.72)
impotence (302.72)
psychogenic dyspareunia (302.76)
306.50 Psychogenic genitourinary malfunction, unspecified
306.51 Psychogenic vaginismus
Functional vaginismus
306.52 Psychogenic dysmenorrhea
306.53 Psychogenic dysuria
306.59 Other
306.6 Endocrine
306.7 Organs of special sense
EXCLUDES *hysterical blindness or deafness (300.11)*
psychophysical visual disturbances (368.16)
306.8 Other specified psychophysiological malfunction
Bruxism Teeth grinding
306.9 Unspecified psychophysiological malfunction
Psychophysiologic disorder NOS
Psychosomatic disorder NOS

● **307 Special symptoms or syndromes, not elsewhere classified**
Note: This category is intended for use if the psychopathology is manifested by a single specific symptom or group of symptoms which is not part of an organic illness or other mental disorder classifiable elsewhere.
EXCLUDES *those due to mental disorders classified elsewhere*
those of organic origin
307.0 Stammering and stuttering
EXCLUDES *dysphasia (784.5)*
lisping or lalling (307.9)
retard[illegible] development of speech (315.31-315.39)

307.1 Anorexia nervosa
EXCLUDES *eating disturbance NOS (307.50)*
feeding problem (783.3)
of nonorganic origin (307.59)
loss of appetite (783.0)
of nonorganic origin (307.59)

● **307.2 Tics**
EXCLUDES *nail-biting or thumb-sucking (307.9)*
stereotypes occurring in isolation (307.3)
tics of organic origin (333.3)
◆ **307.20 Tic disorder, unspecified**
307.21 Transient tic disorder of childhood
307.22 Chronic motor tic disorder
307.23 Gilles de la Tourette's disorder
Motor-verbal tic disorder

307.3 Stereotyped repetitive movements
Body-rocking
Head banging
Spasmus nutans
Stereotypes NOS
EXCLUDES *tics (307.20-307.23)*
of organic origin (333.3)

● **307.4 Specific disorders of sleep of nonorganic origin**
EXCLUDES *narcolepsy (347)*
those of unspecified cause (780.50-780.59)
◆ **307.40 Nonorganic sleep disorder, unspecified**
307.41 Transient disorder of initiating or maintaining sleep
Hyposomnia
Insomnia
Sleeplessness
| associated with intermittent emotional reactions or conflicts
307.42 Persistent disorder of initiating or maintaining sleep
Hyposomnia, insomnia, or sleeplessness associated with:
anxiety
conditioned arousal
depression (major) (minor)
psychosis
307.43 Transient disorder of initiating or maintaining wakefulness
Hypersomnia associated with acute or intermittent emotional reactions or conflicts
307.44 Persistent disorder of initiating or maintaining wakefulness
Hypersomnia associated with depression (major) (minor)
307.45 Phase-shift disruption of 24-hour sleep-wake cycle
Irregular sleep-wake rhythm, nonorganic origin
Jet lag syndrome
Rapid time-zone change
Shifting sleep-work schedule
307.46 Somnambulism or night terrors
◆ **307.47 Other dysfunctions of sleep stages or arousal from sleep**
Nightmares:
NOS
REM-sleep type
Sleep drunkenness
307.48 Repetitive intrusions of sleep
Repetitive intrusion of sleep with:
atypical polysomnographic features
environmental disturbances
repeated REM-sleep interruptions
◆ **307.49 Other**
"Short-sleeper"
Subjective insomnia complaint

● **307.5 Other and unspecified disorders of eating**
EXCLUDES *anorexia:*
nervosa (307.1)
of unspecified cause (783.0)
overeating, of unspecified cause (783.6)
vomiting:
NOS (787.0)
cyclical (536.2)
psychogenic (306.4)
◆ **307.50 Eating disorder, unspecified**
307.51 Bulimia
Overeating of nonorganic origin
307.52 Pica
Perverted appetite of nonorganic origin
307.53 Psychogenic rumination
Regurgitation, of nonorganic origin, of food with reswallowing
EXCLUDES *obsessional rumination (300.3)*
307.54 Psychogenic vomiting
307.59 Other
Infantile feeding disturbances
Loss of appetite
| of nonorganic origin

307.6 Enuresis
Enuresis (primary) (secondary) of nonorganic origin
EXCLUDES *enuresis of unspecified cause (788.3)*

307.7 Encopresis
Encopresis (continuous) (discontinuous) of nonorganic origin
EXCLUDES *encopresis of unspecified cause (787.6)*

● **307.8 Psychalgia**
307.80 Psychogenic pain, site unspecified
307.81 Tension headache
EXCLUDES *headache:*
NOS (784.0)
migraine (346.0-346.9)
◆ **307.89 Other**
Psychogenic backache
EXCLUDES *pains not specifically attributable to a psychological cause (in):*
back (724.5)
joint (719.4)
limb (729.5)
lumbago (724.2)
rheumatic (729.0)

307.9 Other and unspecified special symptoms or syndromes, not elsewhere classified
Hair plucking
Lalling
Lisping
Masturbation
Nail-biting
Thumb-sucking

● **308 Acute reaction to stress**
INCLUDES catastrophic stress
combat fatigue
gross stress reaction (acute)
transient disorders in response to exceptional physical or mental stress which usually subside within hours or days
EXCLUDES *adjustment reaction or disorder (309.0-309.9)*
chronic stress reaction (309.1-309.9)
308.0 Predominant disturbance of emotions
Anxiety
Emotional crisis
Panic state
| as acute reaction to exceptional [gross] stress
308.1 Predominant disturbance of consciousness
Fugues as acute reaction to exceptional [gross] stress
308.2 Predominant psychomotor disturbance
Agitation states
Stupor
| as acute reaction to exceptional [gross] stress
◆ **308.3 Other acute reactions to stress**
Acute situational disturbance
Brief or acute posttraumatic stress disorder
EXCLUDES *prolonged posttraumatic emotional disturbance (309.81)*
308.4 Mixed disorders as reaction to stress
308.9 Unspecified acute reaction to stress

● **309 Adjustment reaction**
INCLUDES adjustment disorders
reaction (adjustment) to chronic stress
EXCLUDES *acute reaction to major stress (308.0-308.9)*
neurotic disorders (300.0-300.9)

309.0 Brief depressive reaction
Adjustment disorder with depressed mood
Grief reaction
EXCLUDES *affective psychoses (296.0-296.9)*
neurotic depression (300.4)
prolonged depressive reaction (309.1)
psychogenic depressive psychosis (298.0)

309.1 Prolonged depressive reaction
EXCLUDES *affective psychoses (296.0-296.9)*
brief depressive reaction (309.0)
neurotic depression (300.4)
psychogenic depressive psychosis (298.0)

● **309.2 With predominant disturbance of other emotions**
309.21 Separation anxiety disorder
309.22 Emancipation disorder of adolescence and early adult life
309.23 Specific academic or work inhibition
309.24 Adjustment reaction with anxious mood
309.28 Adjustment reaction with mixed emotional features
Adjustment reaction with anxiety and depression
309.29 Other
Culture shock

309.3 With predominant disturbance of conduct
Conduct disturbance | as adjustment reaction
Destructiveness |
EXCLUDES *destructiveness in child (312.9)*
disturbance of conduct NOS (312.9)
dyssocial behavior without manifest psychiatric disorder (V71.01-V71.02)
personality disorder with predominantly sociopathic or asocial manifestations (301.7)

309.4 With mixed disturbance of emotions and conduct

● **309.8 Other specified adjustment reactions**
309.81 Prolonged posttraumatic stress disorder
Chronic posttraumatic stress disorder
Concentration camp syndrome
EXCLUDES *posttraumatic brain syndrome:*
nonpsychotic (310.2)
psychotic (293.0-293.9)
309.82 Adjustment reaction with physical symptoms
309.83 Adjustment reaction with withdrawal
Elective mutism as adjustment reaction
Hospitalism (in children) NOS
309.89 Other

309.9 Unspecified adjustment reaction
Adaptation reaction NOS
Adjustment reaction NOS

● **310 Specific nonpsychotic mental disorders due to organic brain damage**
EXCLUDES *neuroses, personality disorders, or other nonpsychotic conditions occurring in a form similar to that seen with functional disorders but in association with a physical condition (300.0-300.9, 301.0-301.9)*

310.0 Frontal lobe syndrome
Lobotomy syndrome
Postleucotomy syndrome [state]
EXCLUDES *postcontusion syndrome (310.2)*

310.1 Organic personality syndrome
Cognitive or personality change of other type, of nonpsychotic severity
Mild memory disturbance
Organic psychosyndrome of nonpsychotic severity
Presbyophrenia NOS
Senility with mental changes of nonpsychotic severity

310.2 Postconcussion syndrome
Postcontusion syndrome or encephalopathy
Posttraumatic brain syndrome, nonpsychotic
Status postcommotio cerebri
EXCLUDES *frontal lobe syndrome (310.0)*
postencephalitic syndrome (310.8)
any organic psychotic conditions following head injury (293.0-294.0)

310.8 Other specified nonpsychotic mental disorders following organic brain damage
Postencephalitic syndrome
Other focal (partial) organic psychosyndrome

310.9 Unspecified nonpsychotic mental disorder following organic brain damage

311 Depressive disorder, not elsewhere classified
Depressive disorder NOS | Depression NOS
Depressive state NOS
EXCLUDES *acute reaction to major stress with depressive symptoms (308.0)*
affective personality disorder (301.10-301.13)
affective psychoses (296.0-296.9)
brief depressive reaction (309.0)
depressive states associated with stressful events (309.0-309.1)
disturbance of emotions specific to childhood and adolescence, with misery and unhappiness (313.1)
mixed adjustment reaction with depressive symptoms (309.4)
neurotic depression (300.4)
prolonged depressive adjustment reaction (309.1)
psychogenic depressive psychosis (298.0)

● **312 Disturbance of conduct, not elsewhere classified**
EXCLUDES *adjustment reaction with disturbance of conduct (309.3)*
drug dependence (304.0-304.9)
dyssocial behavior without manifest psychiatric disorder (V71.01-V71.02)
personality disorder with predominantly sociopathic or asocial manifestations (301.7)
sexual deviations (302.0-302.9)

The following fifth-digit subclassification is for use with categories 312.0-312.2:
0 unspecified
1 mild
2 moderate
3 severe

● **312.0 Undersocialized conduct disorder, aggressive type**
Aggressive outburst | Unsocialized aggressive
Anger reaction | disorder

● **312.1 Undersocialized conduct disorder, unaggressive type**
Childhood truancy, unsocialized | Tantrums
Solitary stealing

● **312.2 Socialized conduct disorder**
Childhood truancy, socialized | Group delinquency
EXCLUDES *gang activity without manifest psychiatric disorder (V71.01)*

● **312.3 Disorders of impulse control, not elsewhere classified**
312.30 Impulse control disorder, unspecified
312.31 Pathological gambling
312.32 Kleptomania
312.33 Pyromania
312.34 Intermittent explosive disorder
312.35 Isolated explosive disorder
312.39 Other

312.4 Mixed disturbance of conduct and emotions
Neurotic delinquency
EXCLUDES *compulsive conduct disorder (312.3)*

● **312.8 Other specified disturbances of conduct, not elsewhere classified**
312.81 Conduct disorder, childhood onset type
312.82 Conduct disorder, adolescent onset type
312.89 Other conduct disorder

312.9 Unspecified disturbance of conduct
Delinquency (juvenile)

● **313 Disturbance of emotions specific to childhood and adolescence**
EXCLUDES *adjustment reaction (309.0-309.9)*
emotional disorder of neurotic type (300.0-300.9)
masturbation, nail-biting, thumbsucking, and other isolated symptoms (307.0-307.9)

313.0 Overanxious disorder
Anxiety and fearfulness | of childhood and
Overanxious disorder | adolescence
EXCLUDES *abnormal separation anxiety (309.21)*
anxiety states (300.00-300.09)
hospitalism in children (309.83)
phobic state (300.20-300.29)

313.1 Misery and unhappiness disorder
EXCLUDES *depressive neurosis (300.4)*

● **313.2 Sensitivity, shyness, and social withdrawal disorder**
EXCLUDES *infantile autism (299.0)*
schizoid personality (301.20-301.22)
schizophrenia (295.0-295.9)

313.21 Shyness disorder of childhood
Sensitivity reaction of childhood or adolescence

313.22 Introverted disorder of childhood
Social withdrawal | of childhood or
Withdrawal reaction | adolescence

313.23 Elective mutism
EXCLUDES *elective mutism as adjustment reaction (309.83)*

313.3 Relationship problems
Sibling jealousy
EXCLUDES *relationship problems associated with aggression, destruction, or other forms of conduct disturbance (312.0-312.9)*

● **313.8 Other or mixed emotional disturbances of childhood or adolescence**
313.81 Oppositional disorder
313.82 Identity disorder
313.83 Academic underachievement disorder
◆ **313.89 Other**

◆ **313.9 Unspecified emotional disturbance of childhood or adolescence**

● **314 Hyperkinetic syndrome of childhood**
EXCLUDES *hyperkinesis as symptom of underlying disorder—code the underlying disorder*

● **314.0 Attention deficit disorder**
314.00 Without mention of hyperactivity
Predominantly inattentive type
314.01 With hyperactivity
Combined type
Overactivity NOS
Predominantly hyperactive/impulsive type
Simple disturbance of attention with overactivity

314.1 Hyperkinesis with developmental delay
Developmental disorder of hyperkinesis
Use additional code to identify any associated neurological disorder

314.2 Hyperkinetic conduct disorder
Hyperkinetic conduct disorder without developmental delay
EXCLUDES *hyperkinesis with significant delays in specific skills (314.1)*

◆ **314.8 Other specified manifestations of hyperkinetic syndrome**
◆ **314.9 Unspecified hyperkinetic syndrome**
Hyperkinetic reaction of childhood or adolescence NOS
Hyperkinetic syndrome NOS

● **315 Specific delays in development**
EXCLUDES *that due to a neurological disorder (320.0-389.9)*

● **315.0 Specific reading disorder**
◆ **315.00 Reading disorder, unspecified**
315.01 Alexia
315.02 Developmental dyslexia
◆ **315.09 Other**
Specific spelling difficulty

315.1 Specific arithmetical disorder
Dyscalculia

◆ **315.2 Other specific learning difficulties**
EXCLUDES *specific arithmetical disorder (315.1)*
specific reading disorder (315.00-315.09)

● **315.3 Developmental speech or language disorder**

315.31 Developmental language disorder
Developmental aphasia
Expressive language disorder ◆
Word deafness
EXCLUDES *acquired aphasia (784.3)*
elective mutism (309.83, 313.0, 313.23)

315.32 Receptive language disorder (mixed) ▼
Receptive expressive language disorder ▲

315.39 Other
Developmental articulation disorder
Dyslalia
EXCLUDES *lisping and lalling (307.9)*
stammering and stuttering (307.0)

315.4 Coordination disorder
Clumsiness syndrome | Specific motor development
Dyspraxia syndrome | disorder

315.5 Mixed development disorder
315.8 Other specified delays in development
315.9 Unspecified delay in development
Developmental disorder NOS

316 Psychic factors associated with diseases classified elsewhere
Psychologic factors in physical conditions classified elsewhere
Use additional code to identify the associated physical condition, as:
psychogenic:
asthma (493.9)
dermatitis (692.9)
duodenal ulcer (532.0-532.9)
eczema (691.8, 692.9)
gastric ulcer (531.0-531.9)
mucous colitis (564.1)
paroxysmal tachycardia (427.2)
ulcerative colitis (556)
urticaria (708.0-708.9)
psychosocial dwarfism (259.4)
EXCLUDES *physical symptoms and physiological malfunctions, not involving tissue damage, of mental origin (306.0-306.9)*

MENTAL RETARDATION (317-319)

Use additional code(s) to identify any associated psychiatric or physical condition(s)

317 Mild mental retardation
High-grade defect
IQ 50-70
Mild mental subnormality

● **318 Other specified mental retardation**
318.0 Moderate mental retardation
IQ 35-49
Moderate mental subnormality
318.1 Severe mental retardation
IQ 20-34 | Severe mental subnormality
318.2 Profound mental retardation
IQ under 20
Profound mental subnormality

◆ **319 Unspecified mental retardation**
Mental deficiency NOS | Mental subnormality NOS

6. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS (320-389)

INFLAMMATORY DISEASES OF THE CENTRAL NERVOUS SYSTEM (320-326)

● **320 Bacterial meningitis**
INCLUDES arachnoiditis, leptomeningitis, meningitis, meningoencephalitis, meningomyelitis, pachymeningitis } bacterial

320.0 Hemophilus meningitis
Meningitis due to Hemophilus influenzae [H. influenzae]
320.1 Pneumococcal meningitis

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Advance Data

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From Vital and Health Statistics of the CENTERS FOR DISEASE CONTROL/National Center for Health Statistics

Serious Mental Illness and Disability in the Adult Household Population: United States, 1989

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Introduction

Significance of the problem

Estimates of the prevalence of serious mental illness (SMI) and information on persons with SMI in the United States are critical to the development of policy for this population in a broad range of areas, such as planning and development of necessary mental health, health, and social services, including housing; development of disability policy (for example, Supplemental Security Income and/or Social Security Disability Insurance eligibility); and training, recruitment, and placement of psychiatric and other mental health staff. However, such data have not been readily available because of the difficulty of defining the population, the lack of relevant operational measures, and the lack of appropriate survey mechanisms outside of treatment settings. This report is designed to address this deficit for the civilian noninstitutionalized population of the United States.

Deinstitutionalization of mentally ill persons and demographic trends in the United States, that is, the aging into adulthood of "baby boomers" and the overall graying of America, have resulted in an increase in the absolute number of SMI persons generally and in those living in the community. Currently, the National Institute of Mental Health (NIMH) estimates that there are between 4 and 5 million SMI persons in the adult population of the United States, including both institutional and community residential settings (1). Thus, some sense of urgency exists to improve knowledge about this large, disabled population.

Definition of the population

Historically, the definition of SMI was based principally upon psychiatric diagnosis. Over the years this definition has evolved to a more refined notion, including psychiatric disabilities. It has become increasingly recognized that the SMI population is a heterogeneous group with different diagnoses, levels of disability, and duration of disability, and therefore, different service needs (2). At present, a more precise definition is being developed by NIMH to encompass this diversity.

Because of the complexity of the interface among psychiatric diagnosis, type and level of disability, and duration of the disability, SMI has been defined for the present survey as any psychiatric disorder present during the past year that seriously interfered with one or more aspects of a person's daily life. In this context, specific measures of disability and their duration represent variable characteristics of persons in the population rather than defining criteria. This approach represents a more flexible application of the diagnosis, disability, and duration criteria employed in the past (3–5).

Previous estimates

The most recent survey prior to the present, the 1978 Social Security Administration Survey of Disability and Work, estimated that 1.1 million persons in households were "seriously disabled mentally ill" (6). The definition of the population was based on persons 20–64 years of age who were limited in the kind or amount of work or housework they could do and who had been disabled or were expected to be so for a

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period of at least 12 months, mainly use of mental illness or nervous or emotional problems.

The estimate of 1.1 million persons was known to be an undercount of the population in the community because data were not collected on functional limitations beyond the work domain, or on limitations of a shorter duration than 1 year, that is, people with recent or episodic disabilities. Elderly persons, the fastest growing segment of the population in the United States were not included and no data were collected on the use of mental health services or participation in programs by persons with psychiatric disabilities.

Present survey

In 1989, NIMH collaborated with the National Center for Health Statistics (NCHS) on a special supplement to the National Health Interview Survey (NHIS). The purpose was to update previous estimates using a more flexible operational definition of the number of SMI persons in the household population of the United States, and to examine the use of mental health services and disability program participation of this population.

Highlights

Based on respondent-reported information collected in the NHIS, in 1989 there were approximately 3.3 million adults 18 years of age or older in the civilian noninstitutionalized population of the United States who had a serious mental illness in the past 12 months, a rate of 18.2 adults per 1,000 persons. Approximately 2.6 million, or 78.8 percent of these adults, have one or more specific limitations in work, school, personal care, social functioning, concentrating, or coping with day-to-day stress attributed to SMI.

Approximately 1.4 million adults between the ages of 18 and 69 were currently unable to work (829,000) or limited in work (529,000) because of their SMI, and over 82 percent of these adults have had this work limitation for a year or longer.

Among the 390,000 adults 70 years of age and over with SMI, about 85 percent had current limitations in one or more of the specific activities described above because of SMI, and approximately 80 percent of these adults had been limited by SMI for a year or longer.

About 703,000 adults with SMI in the household population receive a disability payment through a Government program because of their mental disorder. By race, 76 percent of these adults are white persons and 22 percent are black persons. Almost 43 percent of black adults with SMI receive a Government disability payment compared with about 21 percent of white adults with SMI.

Data and methods

Design

The NHIS is a continuous cross-sectional nationwide survey of the resident household population of the United States. Every year since 1957, basic demographic and health information has been collected from a nationally representative sample of households in face-to-face interviews conducted by staff of the U.S. Bureau of the Census. Certain types of noninstitutional group quarters, such as small group homes and halfway houses, are included and residents interviewed when these places fall into the sampling frame. The term "household" is used to denote all residential places in the NHIS sample. Information is collected on each member of the family (or families) residing in the household, by proxy if the person is not at home at the time of the interview or is not competent to self-respond. For the NHIS-Mental Health, the same respondent or respondents present for the basic interview were asked questions on mental health about all family members.

Respondents

In 1989, information was collected on about 113,000 persons for the NHIS-Mental Health. This represented a response rate of 97 percent of respondents for which information was collected on the basic questionnaire and about 92 percent of the total NHIS sample. Nonresponse for the basic NHIS was about 5 percent.

In the entire 1989 NHIS sample, over 58 percent of all adults responded for themselves, and about 68 percent of adults reported to have SMI responded for themselves. As might be expected, self-response was lower among those persons most seriously disabled by SMI. Of those reported to be unable to carry out one or more activities for a year or longer, 52 percent responded for themselves compared with 77 percent of those for whom no specific current limitations were reported.

Validity of the data

Clearly, the quality of these data is dependent on the person with SMI or a family member's awareness of and willingness to report both the condition and the resulting disability. Because there is still some stigma attached to mental illness and because this survey was not designed to "diagnose" mental disorders, these data are likely to underestimate the true prevalence. In this survey, both diagnosed and undiagnosed conditions were reported; but among those persons with a current limitation due to the mental disorder, about 95 percent reported that a health professional had diagnosed the disorder. Among all persons reported to have SMI, over 92 percent reported that the disorder had been diagnosed.

Methods

The three main concepts in the NIMH definition of "serious mental illness," diagnosis, disability, and duration of disability (3–5) were operationalized in the survey in the manner described below.

Information about a mental or emotional disorder diagnosis was determined using a checklist of specific severe mental disorders and

SECTION G MENTAL HEALTH

Enter person number(s) of respondent(s).

PERSON 1 — Person number(s) of respondent(s)

These questions are about mental and emotional disorders.

1a. DURING THE PAST 12 MONTHS, did anyone in the family have —

If "Yes," ask 1b and c.

b. Who is this?

Mark box in appropriate person's column.

c. DURING THE PAST 12 MONTHS, did anyone else have —

A. Schizophrenia (split-mih-free'-nee-uh)?	☐ Yes	☐ No	A.	1 ☐ Schizophrenia
B. Paranoid or delusional disorder, other than schizophrenia?	☐ Yes	☐ No	B.	1 ☐ Paranoid disorder
C. Manic episodes or manic depression, also called bipolar disorder?	☐ Yes (Specify)	☐ No	C.	1 ☐ Manic episodes 1 ☐ Manic depression
D. Major depression? Read if necessary: A depressed mood and loss of interest in almost all activities FOR AT LEAST TWO WEEKS.	☐ Yes	☐ No	D.	1 ☐ Major depression
E. Anti-social personality, obsessive-compulsive personality, or any other SEVERE personality disorder?	☐ Yes	☐ No	E.	1 ☐ Personality disorder
F. Alzheimer's (ahlz'-hi-merz) disease or another type of senile disorder?	☐ Yes	☐ No	F.	1 ☐ Senility
G. Alcohol abuse disorder?	☐ Yes	☐ No	G.	1 ☐ Alcohol abuse
H. Drug abuse disorder?	☐ Yes	☐ No	H.	1 ☐ Drug abuse
I. Does anyone in the family NOW have mental retardation?	☐ Yes	☐ No	I.	1 ☐ Mental retardation

2a. DURING THE PAST 12 MONTHS, did anyone in the family have any OTHER mental or emotional disorders? Include ONLY those disorders which SERIOUSLY interfere with a person's ability to work or attend school, or to manage their day-to-day activities.

☐ Yes ☐ No (Check item 1)

b. Who is this? Anyone else? Mark box in appropriate person's column. — 2b. 1 ☐ Other

Ask for each person with "Other" in 2b:

c. What would you call the disorder — — here? — 2c.

CHECK ITEM 1	Refer to 1A—F and 2b.	CK 1	1 ☐ One or more entries in 1A—F or 2b (Check item 3) 0 ☐ All others (NIU or Section F)
CHECK ITEM 2	Enter disorder(s) from 1A—F and 2c. DO NOT RECORD G, H, OR I.	CK 2	(Check item 3)

Notes

Figure 1. Mental disorder checklist

Additional question about the presence of "any other mental or emotional disorder" that seriously interfered with a person's ability to work or attend school or to manage their day-to-day activities. The reference period for these questions was during the past 12 months. The mental disorder checklist appears in figure 1.

Questions were subsequently asked about if and when the reported disorder was diagnosed by a health professional, if and when a mental health or other health professional was last seen for the disorder, the type of mental health professional last seen, and the use of prescription medication for the disorder.

Alcohol abuse disorder, drug abuse disorder, and mental retardation were asked on the checklist but no followup questions were asked about these conditions. Persons reporting only one or more of these disorders are excluded from the data in this report because they are not included in the NIMH definition of "serious mental illness." These conditions were asked on the checklist in order to avoid having them reported as "other" mental or emotional disorders, which would have required coding before deleting them from this analysis.

Among those with SMI, disability was measured through a series of questions about current limitations in activities and functions and a series of questions about the receipt of Government disability payments. The limitation questions asked whether the person was entirely prevented from working or limited in work, and, for persons 18–24 years old and not in the labor force, in attending school or college; whether they appropriately and adequately took care of personal care needs (eating, dressing, bathing, and going to the toilet) and specific instrumental activities of daily living (managing money, doing everyday household chores, shopping, and getting around outside the home); and the degree of difficulty with certain aspects of social and cognitive functioning. The time reference for the disability questions was "now," that is, the present time. Each of these questions was phrased to refer only to limitations due to the reported mental disorder. Obviously, to the extent that persons have multiple health problems and cannot parcel out disability resulting from each, this was a difficult question to answer. Similar questions have been used previously by NIMH as part of surveys of SMI in treatment settings (7) as well as in household surveys (8).

The duration of disability concept was measured simply by asking how long any identified limitation due to the mental disorder had been present.

The "Technical notes" section that appears at the end of this report contains more information on the survey design, sampling procedure, and NHIS questionnaire documents. Methods for constructing approximate standard errors and tests of significance for estimates and percents presented in this report also appear in these notes. Unless otherwise noted, the comparisons made within the text are significant at the .05 level.

This report presents estimates of the 12-month prevalence, demographic and socioeconomic characteristics, current disability, service utilization, and disability program participation of the adult SMI household population of the United States. A facsimile of the mental health questions is provided in "Current Estimates From the National Health Interview Survey, 1989" (9).

Results

Prevalence and demographic characteristics

The 1989 12-month prevalence estimate of SMI in the U.S. adult household population is 18.2 per 1,000 persons. About 79 percent of these persons had one or more current limitations attributed to their mental disorder but these estimates varied greatly between subgroups of the population (table 1). The rate of SMI was generally higher in the oldest age group than in any other. More females than males were reported to have SMI (20.6 compared with 15.5 per 1,000 persons).

Neither the prevalence of SMI nor the proportion of persons with resulting current disability is significantly different for black and white persons. The prevalence rate among "other" races is about one-half that of black or white persons.

Both the prevalence of SMI and resulting disability are clearly related to poverty status. SMI was over 2 1/2 times as likely among adults in poverty than among those not in poverty, and proportionally more poor than nonpoor adults with SMI had resulting disability.

Lower educational attainment is strongly related to prevalence and disability from SMI. Among adults with less than 12 years of education, the rate of SMI is almost twice that among those with more than 12 years; and the percent with disability among the least educated group is 86.5 percent compared with 70.7 percent of the highest educated group.

Respondent-assessed health status

Data on assessed health status are acquired in the basic NHIS by asking respondents to assess their own health and that of family members living in the same household as excellent, very good, good, fair, or poor. Respondent-assessed health status has been shown to be highly correlated with more objective measures of health status and to predict mortality (10, 11).

Table 1 shows a strong negative correlation between reported health status and prevalence rate of SMI, and the same pattern holds for the proportions of persons reporting current limitations. Among adults with "poor" health status, the rate of SMI was 118.3 per 1,000 persons, or more than six times the rate for the total adult population; and almost

Table 1. Number and percent distribution of the adult household population, adults with serious mental illness and rate per thousand, adults currently limited by serious mental illness and percent limited, by selected characteristics: United States, 1989

Characteristic	Adult household population		All adults with serious mental illness			Adults currently limited by serious mental illness		
	Number in thousands	Percent distribution	Number in thousands	Percent distribution	Rate per thousand	Number in thousands	Percent distribution	Percent
Total[1]	179,528	100.0	3,294	100.0	18.2	2,571	100.0	78.0
Age[1]								
18–24 years	25,401	14.2	361	11.1	14.2	291	11.3	80.6
25–34 years	48,814	27.2	707	21.7	16.5	501	19.5	70.8
35–44 years	36,862	20.0	744	22.8	20.7	600	23.3	80.6
45–64 years	46,114	25.7	918	28.2	19.9	748	29.1	81.5
65–69 years	8,909	5.5	142	4.4	14.3	99	3.9	70.0
70–74 years	7,823	4.4	102	3.1	12.9	82	3.2	79.8
75 years and over	11,291	6.3	268	8.3	25.3	249	9.7	92.6
Sex[1]								
Male	85,257	47.5	1,330	40.4	15.5	1,105	43.0	83.7
Female	94,272	52.5	1,944	59.6	20.5	1,466	57.0	75.4
Race[1]								
White	163,763	85.6	2,812	86.1	16.9	2,194	85.3	78.0
Black	19,932	11.1	399	12.0	19.7	325	12.7	82.8
Other	5,834	3.2	59	1.8	10.1	52	2.0	87.1
Poverty status[2]								
Below poverty threshold	15,464	9.5	609	21.0	39.4	525	23.1	86.3
At or above poverty threshold	147,070	90.5	2,294	79.0	15.6	1,750	76.9	76.7
Education[2]								
Less than 12 years	39,809	22.4	1,063	33.8	27.2	937	37.3	88.6
12 years	68,563	38.6	1,130	34.9	16.5	886	34.5	77.4
More than 12 years	69,369	39.0	1,002	31.3	14.4	708	28.2	70.7
Respondent-assessed health status[2]								
Excellent	62,577	34.8	337	10.3	5.4	192	7.5	56.9
Very Good	60,941	28.5	620	19.1	12.2	414	16.1	66.7
Good	43,789	24.5	812	24.9	18.5	617	24.1	75.9
Fair	15,585	8.7	755	23.2	48.5	648	25.3	85.9
Poor	6,207	3.5	734	22.5	118.3	695	27.1	94.7

[1] Includes persons with unknown poverty status, education, and/or self-assessed health status.
[2] Percent denominators exclude persons with this characteristic unknown.

95 percent of those adults have a current limitation resulting from the SMI.

Work and other limitations

An estimated 47.2 percent of persons 18–69 years of age with SMI, or 1.4 million persons, were reported to be unable to work (28.9 percent) or limited in work (18.4 percent) because of their mental disorder (table 2). By race, more black persons with SMI (43.4 percent) were unable to work because of their mental disorder than white persons with SMI (26.8 percent).

Among SMI persons who are ble to work, 94.1 percent reported additional limitations, and among those limited in work, 91.3 percent reported additional limitations (table 3). Not surprisingly, persons with SMI who are unable to work or limited in work are more likely to have one or more of the other specific limitations shown in table 3 than their peers who do not report work limitations. However, more than one-half (58 percent) of persons 18–69 years of age with SMI who reported no current work limitation, and about the same proportion of those who reported not working for other reasons or for whom work limitation was unknown, reported other limitations. For these two groups of persons, "coping with day-to-day stress" was the most frequently reported limitation, (52.6 and 54.3 percent), although between 21 and 32 percent were reported to have difficulty making and keeping friendships ("social functioning") and "concentrating long enough to complete tasks."

Reporting of each type of limitation is higher for persons with SMI who are unable to work than for those who are limited in work, but the differences in difficulty "coping with day-to-day stress" and "concentrating long enough to complete tasks" are not statistically significant.

Considering the range of limitations asked about in this survey, persons with SMI who are unable to

...le 2. Number and percent distribution of adults 18–69 years of age with serious mental illness by current work limitation status ...cording to race: United States, 1989

Work limitation status[1]	Total[2]	White	Black	Total[2]	White	Black
	Number in thousands			Percent distribution		
Total	2,674	2,471	346	100.0	100.0	100.0
Total with work limitation due to serious mental illness	1,868	1,116	216	47.2	46.2	62.1
Unable to work	829	663	150	28.9	26.8	43.4
Limited in work	539	454	65	18.4	18.4	18.7
No current work limitation	1,032	934	79	38.9	37.8	22.8
Does not work for other reasons or work limitation status unknown	485	420	51	16.9	17.0	14.8

[1] Approximately 1 percent (11,000) of those shown in "unable to work" or "limited in work" were persons aged 18–24 who were not in the labor force and who were reported as being "unable" or "limited" in school attendance.
[2] Includes "other" race.

Table 3. Number of adults 18–69 years of age with serious mental illness by current work limitation status and percent reporting other limitations, and number and percent of adults 70 years of age and over with serious mental illness reporting limitations: United States, 1989

Age and work limitation status[1]	SMI[2] population	Any other limitation	Personal care activities of daily living[3,4]	Instrumental activities of daily living[5]	Social functioning[6]	Coping with day-to-day stress	Concentrating long enough to complete tasks
	Number in thousands	Percent					
Total 18–69 years of age	2,674	74.8	2.7	22.9	46.8	67.7	46.5
Unable to work	829	84.1	7.7	48.8	70.4	86.6	72.9
Limited in work	539	91.8	2.6	30.2	61.2	80.1	67.2
No current work limitation	1,032	58.0	- - -	4.6	26.8	52.8	21.4
Does not work for other reasons or work limitation status unknown	485	58.7	- - -	9.8	30.7	54.3	32.9
70 years of age and over	390	84.8	24.3	62.9	89.8	70.8	69.8

[1] Approximately 1 percent (11,000 persons) of those shown in "unable" or "limited" in work were persons age 18–24 who were not in the labor force and who were reported as being "unable" or "limited" in school attendance.
[2] SMI is seriously mentally ill.
[3] Includes eating, dressing, bathing, and going to the toilet.
[4] Questions about personal care limitations were not asked of adults 18–64 years of age with no work or school limitations resulting from the serious mental illness.
[5] Includes managing money, doing everyday household chores, shopping, and getting around outside the home.
[6] Includes forming and keeping friendships.

Table 4. Number and percent distribution of adults with serious mental illness by selected services, according to limitation status, and percent currently limited by serious mental illness: United States, 1989

Selected services	Total		Currently limited		
	Number	Percent distribution	Number	Percent distribution	Percent
Receipt of Government disability payment[1]					
Yes	703	23.2	685	27.8	97.5
No	2,294	76.8	1,782	72.2	78.7
Use of prescription medication for the mental disorder in the past year[2]					
Yes	1,891	69.2	1,573	67.9	83.2
No	881	31.8	744	32.1	84.5
Last visit to a mental health professional[3]					
Less than one month	1,085	39.5	896	35.8	84.8
One month to less than one year	836	27.2	663	26.4	79.3
One year or more	509	16.6	436	17.4	84.7
Never[3]	700	22.7	530	20.7	74.2

[1] Percent denominators exclude adults with this characteristic unknown.
[2] Percent denominators include only adults who have ever seen a doctor for the disorder, and exclude adults with this characteristic unknown.
[3] Among the 700,000 adults who reported never seeing a mental health professional, 447,000, or 63.8 percent, did report seeing another doctor or health professional for the mental disorder and 83.8 percent of these adults reported limitations.

work are the most likely to be disabled in other activities by their mental disorder, even more so than persons with SMI who are 70 years of age and over (94.1 percent compared with 84.8 percent reporting other limitations). However, persons 70 years of age and over with SMI were much more likely than younger persons to be limited in personal care and instrumental activities of daily living. More than three times as many persons 70 years of age and over were reported to be unable to take care of their personal care needs because of the mental disorder than SMI persons 18–69 years of age who were unable to work.

Receipt of disability payments

About 703,000, or 23.2 percent of adults with SMI in households currently receive disability payments through a Government program because of their mental disorder. (table 4). About 98 percent of these persons had current limitations due to the disorder. The discrepant two percent is due to proxy respondents who reported "don't know" to the limitation questions.

Respondents were asked whether this payment was through Social Security Disability Insurance (SSDI), through Supplemental Security Income (SSI), through the Veterans' Administration (VA), or through some other program. The Social Security Administration (SSA) administers several programs that provide cash payments or other benefits to persons who are, by SSA standards, disabled. Persons with adequate work histories usually receive monthly cash payments as social security benefits (SSDI), and persons with minimal resources and insufficient work history usually receive a monthly payment under the SSI program. VA disability payments are provided for service-incurred disability. As shown in table 5, most respondents with a disability payment reported SSDI (46.0 percent) or SSI (43.5 percent) as the source.

Data in table 6 indicate that adults with SMI who are 35–64 years of age, male, black, in poverty, have

Table 5. Number and percent of recipients of disability payment for mental illness, by source of payment: United States, 1989

Source	Number in thousands	Percent[1]
Social Security Disability Insurance	328	46.0
Supplemental Security Income	306	43.5
Veterans' Administration	88	12.3
Other	53	7.5

[1]Percents add to more than 100 because of multiple sources of payment.

Table 6. Number and percent of adults with serious mental illness who received Government disability payment for the mental disorder, by selected characteristics: United States, 1989

Characteristic	Number in thousands	Percent[1]
Total[2]	709	23.2
Age		
18–24 years	*39	*11.9
25–34 years	123	19.1
35–44 years	199	28.3
45–64 years	299	35.1
65 years and over	48	8.4
Sex		
Male	402	33.9
Female	301	16.8
Race		
White	637	20.6
Black	199	43.8
Other	*19	*22.7
Poverty status[3]		
Below poverty threshold	196	33.6
At or above poverty threshold	406	19.2
Education[4]		
Less than 12 years	317	30.9
12 years	212	20.8
More than 12 years	142	15.8
Respondent-assessed health status[5]		
Excellent	*34	*11.9
Very good	93	19.1
Good	140	18.8
Fair	199	27.3
Poor	241	35.1
Use of prescription medication in the past year for the mental illness[6]		
Yes	648	29.7
No	148	16.4
Last saw mental health professional for the mental disorder[7]		
Less than one month	396	36.7
One month to less than one year	196	23.2
One year or more	92	18.9
Never	*26	*3.8

[1]All percent denominators exclude persons with unknown receipt of disability payment (237,000, or 7.5 percent of adults with serious mental illness.
[2]Percent denominator for total includes persons with unknown poverty status, education, health status, time since last saw a mental health professional, and use of prescription medication.
[3]Percent denominator excludes persons with this characteristic unknown.

NOTES: Estimates of less than 41,000 and percents based on these estimates have 50 percent or more relative standard error (RSE); see Technical notes for description of the calculation of standard errors. Estimates with 30 percent or more RSE are indicated with an asterisk.

less than a high school education, have poor overall health status, used prescription medication in the past year for their mental disorder, or have recently (past month) seen a mental health professional, are disproportionately likely to receive Government disability payments. The most striking finding in this table is that almost 44 percent of black adults with SMI receive disability payments compared with about 21 percent of white adults with SMI. Overall, 22.1 percent of adults with SMI receiving disability payments for the disorder were black persons, although black adults are not significantly overrepresented among SMI in general or in the proportion of the SMI population with current limitations.

Comparing the source of disability payments by race, table 7 shows that black adults with SMI are more than twice as likely to report receiving SSI for their mental disorder than white adults with SMI. The higher proportions of black adults receiving SSDI and VA disability payments are significant at ≥ .10 level.

These findings related to SSDI and SSI benefits are consistent with those from a recent report by the General Accounting Office (GAO) (12). In April 1992, the GAO issued findings from a study of racial differences in disability decisions for SSDI and SSI benefits. This report analyzed the circumstances surrounding the lower allowance rate for black applicants compared with white applicants for disability benefits. One of the findings was that while black applicants are less likely to be awarded benefits than white applicants, in the general population a higher proportion of black adults were receiving benefits than white adults. The report attributed this higher rate in the population to the fact that black adults apply at a higher rate than white adults, and it goes on to speculate that this may be due in part to poorer economic circumstances among black persons. Additional work is in progress to identify factors that might account for these racial differences.

As noted in table 2, a higher proportion of black adults with SMI in this survey are unable to work because of their disorder than white adults with SMI. Black adults are more likely than white adults (both in the general population and among adults with SMI) to be in poverty, to have less than a high school education, and to have fair or poor self-assessed health. Since all of these factors are related to receipt of disability payments, it is not surprising that black persons with SMI are more likely to receive disability payments because of their mental disorder.

Prescription drug use

Prescription drug use was highly prevalent in the population reporting SMI; about 68 percent of the adult SMI population who saw a doctor or other health professional for the mental disorder used prescription medication for the disorder during the past 12 months (table 8). Taking prescription medication was not related to limitation status. The lowest use of prescription medication for the disorder during the past year was among the youngest and oldest age groups (table 8). The proportion using prescription medication generally increased with age through the age group 65–69 years and decreased thereafter. Persons with SMI in "poor" health, those who received Government disability payments, and those who recently saw a mental health professional were most likely to have used medication.

The various types of prescription drugs used by persons with SMI during the past 12 months for the mental disorders reported are shown in table 9. Actual drug names were obtained from respondents and then coded by major class of drugs. Antidepressants were used by almost 41 percent of the 1.9 million persons using prescription medication in the past year, and were the most commonly reported type of drug used. This is not surprising, since "major depression" was reported for approximately 45 percent of persons reported to have SMI. Antianxiety and antipsychotic drugs were used by 26.3 and 25.2 percent of persons, respectively. Various other drugs, not considered to be drugs for mental health problems, were used for the mental disorders by about 18 percent of those who used prescription drugs. Table 10 shows that almost one-half of all persons with SMI using prescription medication for the disorder during the past year used more than one drug.

Visits to mental health professionals

About 77 percent of the SMI population in households (2.4 million persons) have seen a mental health professional for the mental disorder reported (table 4). Among the 700,000 persons with SMI who have never seen a mental health professional, most (about 64 percent) had seen a doctor or other health professional for the disorder. In table 11, characteristics of the SMI population who have seen a mental health professional for the reported mental disorder(s) are displayed. In the oldest age group, only 37 percent of persons with SMI had seen a mental health professional for the reported disorder but about 90 percent of this age group had seen another type of doctor or health professional for their disorder.

Table 7. Percent of adults with serious mental illness receiving disability payment for their mental disorder, by race and source of payment: United States, 1989

Source	White	Black
	Percent	
Social Security Disability Insurance	16.9	16.7
Supplemental Security Income	5.9	20.0
Veterans' Administration	2.4	7.9
	1.6	8.7

Table 9. Number and percent of adults with serious mental illness who used prescription medication during the past year for the mental disorder, by selected characteristics: United States, 1989

Characteristic	Number in thousands	Percent[1]
Total[2]	1,890	68.2
Age		
18–24 years	198	55.7
25–34 years	347	61.8
35–44 years	463	69.2
45–64 years	636	78.8
65–69 years	100	82.1
70–74 years	62	75.0
75 years and over	112	80.0
Sex		
Male	732	57.4
Female	1,158	69.8
Race		
White	1634	69.2
Black	221	70.3
Other	*25	*56.4
Poverty status[3]		
Below poverty threshold	373	70.1
At or above poverty threshold	1313	68.4
Education[3]		
Less than 12 years	858	68.4
12 years	646	68.9
More than 12 years	963	66.1
Respondent-assessed health status[3]		
Excellent	182	61.4
Very good	357	67.7
Good	448	68.4
Fair	420	64.8
Poor	502	77.0
Receipt of Government disability payments[3]		
Yes	549	79.4
No	1303	64.1
Last saw mental health professional for the mental disorder[3]		
Less than one month	849	85.0
One month to less than one year	396	74.9
One year or more	201	40.2
Never	220	52.5

[1] All percent denominators exclude persons who have not seen any health professional for the disorder (248,000, or 7.5 percent of adults with serious mental illness and exclude persons with unknown "use of prescription medication for the disorder" (247,000, or 7.5 percent of adults with serious mental illness).

[2] Percent denominator for total includes persons with unknown poverty status, education, health status, disability pay, and time since last saw a mental health professional.

[3] Percent denominator excludes persons with this characteristic unknown.

NOTES: Estimates of less than 41,000 and percents based on base estimates have 30 percent or more relative standard error (RSE); see Technical notes for description of the calculation of standard errors. Estimates with an RSE of 50 percent or more are indicated with an asterisk.

Table 8. Number and percent of adults with serious mental illness who took prescription drugs in the past year for mental disorder, by type of drug: United States, 1989

Type of drug	Number in thousands	Percent
Antidepressant	769	40.6
Antianxiety	497	26.3
Antipsychotic	477	25.2
Antimanic	233	12.3
Other psychotropic drug	65	3.4
Other drug	337	17.8
Unknown drug name	46	2.4

Table 10. Number and percent distribution of adults with serious mental illness who took prescription drugs in the past year for the mental disorder, by number of drugs reported: United States, 1989

Number of drugs	Number in thousands	Percent distribution
Total	1,890	100.0
Number of drugs		
One	876	46.3
Two	478	25.3
Three	251	13.3
Four	85	4.5
Five or more	68	3.6
Unknown	135	7.1

Persons 35–64 years of age were more likely than any other age group to have seen a mental health professional.

Persons who used prescription medication for their mental disorder during the past year and persons who received disability payments for the disorder were more likely to have seen a mental health professional than others with SMI.

Summary and conclusions

The major significance of the current report is that it provides estimates and characteristics for that portion of the civilian SMI population living in households. Survey results show that approximately 3.3 million adult Americans have mental disorders that seriously interfere with one or more aspects of daily life and that about 2.6 million of these persons are currently limited in one or more functional areas. These results suggest that the household component of the SMI population is comprised of between 2.6 and 3.3 million adults, depending upon the criteria employed for inclusion. Undoubtedly, both of these numbers are conservative because of the likelihood of underreporting in the survey.

Placed in the context of the entire adult population, these findings suggest that the SMI population can be conservatively estimated to include 4 to 5 million adult Americans, or 2.1 to 2.6 percent of the adult population. In addition to the household population, it is estimated that 200,000 SMI persons are homeless on any given day (13). An additional 1 million to 1.1 million are residents of nursing homes (14), approximately 50,000 to 60,000 are patients of mental hospitals, and approximately 50,000 are inmates of State prisons (15).

A major remaining need is to collect similar data on all SMI persons, whether their residence is a household, an institutional or noninstitutional group quarter, or some other setting, including streets and shelters. In order to formulate more effective national policy to address the needs of these disabled Americans, a need exists to examine the longitudinal relationship between course of disorder and functioning as they relate to service and program participation.

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Table 11. Number and percent of adults with serious mental illness who have ever seen a mental health professional, by selected characteristics: United States, 1989

Characteristic	Number in thousands	Percent[1]
Total[2]	2,380	77.3
Age		
18–24 years	275	80.3
25–34 years	809	75.8
35–44 years	690	87.8
45–64 years	710	82.5
65–69 years	80	88.5
70–74 years	70	90.5
75 and over	85	87.0
Sex		
Male	959	77.9
Female	1,421	76.8
Race		
White	2,042	76.6
Black	292	80.3
Other	46	79.7
Poverty status[3]		
Below poverty threshold	470	79.1
At or above poverty threshold	1833	78.1
Education[3]		
Less than 12 years	796	74.9
12 years	804	76.4
More than 12 years	762	80.5
Respondent-assessed health status[3]		
Excellent	344	82.6
Very good	464	78.7
Good	606	78.2
Fair	530	74.4
Poor	630	75.8
Use of prescription medication for the mental disorder[4]		
Yes	1648	89.2
No	657	76.7
Receipt of Government disability payment[3]		
Yes	686	86.4
No	1686	71.3

[1]All percent denominators exclude persons with unknown [illegible] had seen a mental health professional (104,000, or 3.5 percent of total adults with serious mental illness).

[2]Percent denominator for total includes persons with unknown poverty status, education, health status, prescription [illegible] use, and/or disability pay.

[3]Percent denominator excludes persons with this characteristic unknown.

[4]Percent denominator includes only persons who have ever seen a doctor or other health professional and excludes persons with this characteristic unknown.

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Symbols

---	Data not available
. . .	Category not applicable
-	Quantity zero
0.0	Quantity more than zero but less than 0.05
Z	Quantity more than zero but less than 500 where numbers are rounded to thousands
*	Figure does not meet standard of reliability or precision

Technical notes

Source and description of data

The estimates presented in this report are based on data from the 1989 National Health Interview Survey (NHIS), an ongoing survey of households in the United States conducted by the National Center for Health Statistics (NCHS). Each week, a probability sample of the civilian noninstitutionalized population of the United States is interviewed by personnel of the U.S. Bureau of the Census. Interviewers obtain information about the health and other characteristics of the households included in the NHIS sample.

NHIS consists of two parts: (a) a basic health and demographic questionnaire that remains the same each year and is completed for every household member and (b) special topics questionnaires that vary from year to year, some of which may be completed only for selected persons in each family. In 1989, the special topics included health care coverage, adult immunization, mental health, dental health, diabetes, orofacial pain, digestive disorders, and knowledge and attitudes about acquired immunodeficiency syndrome (AIDS).

The total interviewed sample for 1989 for the basic health and demographic questionnaire consisted of 45,711 households containing 116,929 persons. The noninterview rate was 5.1 percent. NHIS Mental Health (NHIS-MH) interviews were completed for 113,231 persons, or 96.8 percent of those interviewed on the basic questionnaire. The overall response rate for the NHIS-MH was 91.9 percent (the product of the response rates for the basic and mental health questionnaires).

Sampling errors

Because estimates shown in this report are based on a sample of the population rather than on the entire population, they are subject to sampling error. When an estimate or the numerator or denominator of a percent is small, the sampling error may be relatively high. In addition, the complex sample design of NHIS has the effect of making sampling errors larger than they would be had a simple random sample of equal size been used. Estimates and figures based on estimates that do not meet the reliability criteria of 30 percent relative standard error are marked on the tables.

Approximate standard errors of the estimated numbers (x) in the tables (except for age, sex, and race for all persons when the standard error is assumed to be 0.0) may be calculated using the formula

$$SE(x) = \sqrt{.0000307(x)^2 + 3640(x)}$$

For example, it is estimated that 3,264,000 adults had a SMI in the last 12 months (table 1). Using this formula, the standard error for the estimated number is

$$SE(3{,}264{,}000) = \sqrt{.0000307(3{,}264{,}000)^2 + 3640(3{,}264{,}000)}$$

$$= 110{,}490$$

Approximate standard errors of the estimated percents in the tables may be calculated using the formula

$$SE(p) = \sqrt{\frac{3640(p)(100-p)}{y}}$$

where p is the percent of persons and y is the base population from which the percent is calculated.

For example, it is estimated that 78.8 percent of adults with SMI have one or more specific limitations resulting from the SMI (table 1). Using this formula, the standard error for the estimated percent is

$$SE(78.8) = \sqrt{\frac{3640(78.8)(100-78.8)}{3{,}264{,}000}}$$

$$= 1.86$$

If x_1 and x_2 are two estimates, then the approximate standard error of the difference $(x_1 - x_2)$ can be computed as follows:

$$SE(x_1)^2 + SE(x_2)^2 - 2r\,SE(x_1)SE(x_2)$$

where $SE(x_1)$ and $SE(x_2)$ are computed using the appropriate formulas previously presented in this section and r is the correlation coefficient between x_1 and x_2. Assuming $r = 0.0$ will result in an accurate standard error if the two estimates are actually uncorrelated. If they are correlated, the standard error of the difference will be underestimated or overestimated. These calculations can also be performed for differences in percents using the appropriate standard error formulas for percents.

In this report, unless otherwise noted, a difference was considered statistically significant at the 5-percent level if the difference $(x_1 - x_2)$ was at least twice as large as its standard error. Further information on how the standard error parameters are constructed is available in "Current Estimates From the National Health Interview Survey: 1989" (9).

Related documentation

More detailed discussion of the sample design, estimating procedures, procedures for estimating standard errors, nonsampling errors, and definitions of other sociodemographic terms used in this report have been published in *Vital and Health Statistics*, Series 1, no 18; Series 2, no 110; Series 10, nos 160 (16–18) and 176 (9).

A public use data file based on the 1989 Mental Health Survey questionnaire was released in April 1991. Information regarding the purchase of the public use data tape may be obtained by writing the National Center for Health Statistics, Division of Health Interview Statistics, 6525 Belcrest Road, Hyattsville, Maryland, 20782.

Table 1

Analysis of Mental Health Costs

Adult Population Base: 202807

1997	202807
1990	184000
1980	159000

	Prevalence Rate % Pop	Inpatient Services Only	Treatment Rates (% with Prevalence Receiving Treatment in 1 Year Period)						
			Any Mental or Addictive Service	Specialty Mental Addictive	General Medical	Health Systems Subtotal	Human Services	Any Professional Subtotal	Volunteer Support Network
Inpatient Services w/ O/P			0.007	0.007		0.007		0.007	
Inpatient Only			0.002	0.002		0.002		0.002	
Any DIS ADM Disorder	0.281	0.025	0.285	0.127	0.127	0.219	0.059	0.247	0.089
Any DIS Disorder (exc Alcohol or Drug)	0.221	0.029	0.319	0.145	0.142	0.249	0.068	0.279	0.094
Any Mental Disorder w/ comorbid SA	0.033	0.067	0.374	0.206	0.163	0.294	0.077	0.327	0.114
Any SA Disorder	0.095	0.029	0.236	0.112	0.099	0.175	0.044	0.196	0.084
Any Alcohol Disorder	0.074	0.028	0.220	0.109	0.098	0.168	0.038	0.188	0.080
Any Drug Disorder	0.031	0.038	0.298	0.142	0.116	0.215	0.060	0.244	0.089
Schizophrenic Disorders	0.011	0.169	0.643	0.460	0.290	0.600	0.137	0.629	0.070
Affective Disorders	0.095	0.047	0.457	0.231	0.219	0.378	0.094	0.413	0.128
Any Bipolar	0.012	0.076	0.609	0.324	0.335	0.541	0.100	0.589	0.096
Unipolar Major Depression	0.050	0.058	0.539	0.278	0.253	0.450	0.116	0.490	0.166
Dysthmia	0.054	0.05	0.421	0.193	0.212	0.347	0.083	0.378	0.097
Anxiety Disorders	0.126	0.032	0.327	0.149	0.148	0.257	0.067	0.286	0.093
Phobia	0.109	0.033	0.311	0.139	0.149	0.249	0.062	0.273	0.089
Panic Disorder	0.013	0.084	0.588	0.336	0.297	0.518	0.126	0.544	0.131
Obsessive-Compulsive Disorder	0.021	0.074	0.451	0.253	0.183	0.364	0.103	0.413	0.108
Somatization Disorder	0.002	0.104	0.697	0.425	0.494	0.634	0.153	0.672	0.153
Antisocial personality Disorder	0.015	0.061	0.311	0.175	0.110	0.229	0.076	0.256	0.106
Cognitive Impairment (Severe)	0.027	0.029	0.170	0.069	0.072	0.129	0.029	0.145	0.042
All SMI	0.028			0.436	0.326	0.624			
Schizopheria	0.015			0.456	0.337	0.645			
Manic Depressive	0.010			0.398	0.406	0.654			
Major Depression	0.011			0.645	0.342	0.791			
Panic	0.004			0.550	0.505	0.798			
Obsessive Compulsive	0.006			0.390	0.281	0.541			
Sub-threshhold Cases			0.093	0.032	0.039	0.066	0.019	0.078	0.023

Table 2

Analysis of Mental Health Costs

Adult Population Base: 202807
1997 202807
1990 184000
1980 159000

	Prevalence # (1000s)	Inpatient Services Only	% of Population Any Service	# (1000s) Treated in 1 Year Period, In/p or O/P: Any Mental or Addictive Service	% of Population Any Service	Health System Services: Specialty Mental Addictive	% of Population SMA	General Medical	Health Systems Subtotal	% of Population HS	Other Assistance: Human Services	Any Professional Subtotal	Volunteer Support Network
Inpatient Services/w O/P	202807	1419.649	0.7%	1419.649	0.7%	1419.649	0.7%		1419.649	0.7%		1419.649	
Inpatient Only	202807	405.614	0.2%	405.614	0.2%	405.614	0.2%		405.614	0.2%		405.614	
Any DIS ADM Disorder	56989	1425	0.7%	16242	8.0%	7238	3.6%	7238	12481	6.2%	3362	14076	5072
Any DIS Disorder (exc Alcohol or Drug)	44820	1300	0.6%	14298	7.0%	6499	3.2%	6364	11160	5.5%	3048	12505	4213
Any Mental Disorder w/ comorbid SA	6693	448	0.2%	2503	1.2%	1379	0.7%	1091	1968	1.0%	515	2188	763
Any SA Disorder	19267	559	0.3%	4547	2.2%	2158	1.1%	1907	3372	1.7%	848	3815	1618
Any Alcohol Disorder	15008	420	0.2%	3302	1.6%	1636	0.8%	1471	2521	1.2%	570	2821	1201
Any Drug Disorder	6287	239	0.1%	1874	0.9%	893	0.4%	729	1352	0.7%	377	1534	560
Schizophrenic Disorders	2231	377	0.2%	1434	0.7%	1026	0.5%	647	1339	0.7%	308	1403	156
Affective Disorders	19267	906	0.4%	8805	4.3%	4451	2.2%	4219	7283	3.6%	1811	7957	2466
Any Bipolar	2434	185	0.1%	1482	0.7%	789	0.4%	815	1317	0.6%	243	1433	234
Unipolar Major Depression	10140	588	0.3%	5466	2.7%	2819	1.4%	2566	4563	2.3%	1176	4969	1683
Dysthmia	10952	548	0.3%	4611	2.3%	2114	1.0%	2322	3800	1.9%	909	4140	1062
Anxiety Disorders	25554	818	0.4%	8356	4.1%	3807	1.9%	3782	6567	3.2%	1712	7308	2376
Phobia	22106	729	0.4%	6875	3.4%	3073	1.5%	3294	5504	2.7%	1371	6035	1967
Panic Disorder	2636	221	0.1%	1550	0.8%	886	0.4%	783	1366	0.7%	332	1434	345
Obsessive-Compulsive Disorder	4259	315	0.2%	1921	0.9%	1078	0.5%	779	1550	0.8%	439	1759	460
Somatization Disorder	406	42	0.0%	283	0.1%	172	0.1%	200	257	0.1%	62	273	62
Antisocial personality Disorder	3042	186	0.1%	946	0.5%	532	0.3%	335	697	0.3%	231	779	322
Cognitive Impairment (Severe)	5476	159	0.1%	931	0.5%	378	0.2%	394	706	0.3%	159	794	230
All SMI	5679	1215	0.6%	5679	2.8%	2476	1.2%	1851	3543	1.7%			
Schizopheria	3042	681	0.3%	3042	1.5%	1387	0.7%	1025	1962	1.0%			
Manic Depressive	2028	396	0.2%	2028	1.0%	807	0.4%	823	1326	0.7%			
Major Depression	2231	706	0.3%	2231	1.1%	1439	0.7%	763	1765	0.9%			
Panic	811	219	0.1%	811	0.4%	446	0.2%	410	647	0.3%			
Obsessive Compulsive	1217	233	0.1%	1217	0.6%	475	0.2%	342	658	0.3%			
Sub-threshhold Cases	145818			13561	6.7%	4666	2.3%	5687	9624	4.7%	2771	11374	3354
Threshhold & Treatment	56989			16242	8.0%	7238	3.6%	7238	12481	6.2%	3362	14076	5072
Total All Persons	202807			29803	14.7%	11904	5.9%	12924	22105	10.9%	6133	25450	8426
Sub-Thresh % of Population				6.7%		2.3%		2.8%	4.7%		1.4%	5.6%	1.7%
Threshhold % of Population				8.0%		3.6%		3.6%	6.2%		1.7%	6.9%	2.5%
% Pop Receiving Treatment				14.7%		5.9%		6.4%	10.9%		3.0%	12.5%	4.2%

Distribution of Employer Benefit Plan Coverage for Mental Health by Maximum Dollar Benefits

Behavioral Health Plan Dollar Maximums	% of Plans
$0 - 24,999	7.0%
$25,000	14.0%
$25 - 49,999	12.0%
$50,000	40.0%
$50 - 999,999	16.0%
$1,000,000	9.0%
More then $1M	2.0%

Based upon a Mercer Survey of Large Employers