

PRESENT.:
BUILDING
BRIDGES -
MENTAL
HEALTH



Field Notes

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This issue

Special

Edition

on

Stigma

**Working
for
Alaska's
Mental
Health**

Stigma is Everywhere

A mental illness is, more accurately, a brain disorder; and brain disorders -- like epilepsy -- are biologically based medical problems. The newest medical technology can take "pictures" that show differences between brains with disorders and normal brains.

In any given year, about 5 million American adults suffer from acute episodes of one of five serious brain disorders: schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder, and panic disorder. Even many of America's children -- more than 3 million-- suffer from these disorders.

Untreated, disorders of the brain profoundly disrupt a person's ability to think, feel, and relate to others and to his or her environment.

Brain disorders are shrouded in stigma and discrimination. For centuries they have been misunderstood, feared, hidden, and often ignored by science. Only in the last few decades has the first real hope for people with brain disorders surfaced, and that hope has grown from pioneering research that found both a biological basis for brain disorders and treatments that work.

Brain disorders are treatable. The current success rate for treating schizophrenia is 60 percent. The success rate for treating bipolar disorder, also known as manic depression, is 65 percent, and for major depression it is 80 percent. Mental illnesses can now be diagnosed and treated as precisely and effectively as other medical disorders. But the stigma -- and the discrimination caused by that stigma -- remains.

Stigma is an ancient evil. It still limits all aspects of life for people with brain disorders: housing, education, insurance, science, research, services, jobs, religion, and personal relationships.

By the NAMI Campaign to end discrimination against people with severe mental illness. Contact Sylvia Matthews at the Alaska Alliance for the Mentally Ill at 1-800-478-4462 or 1-907-277-1300 for more information.

Open Your Mind



REMOVING THE STIGMA OF MENTAL ILLNESS



Former Mental Patients Talk About Stigma

Example A

Ten years ago I was a professional actress in Los Angeles, and one day I came offstage and had a breakdown. The doctor told my parents that I was chronic and would be hospitalized all my life. Eventually, I found respite, became a resident, and I have been without hospitalization for 8 years. Since leaving respite, I have used it as a crisis center whenever I have had a problem. I worked my way back to the point where I could finish my college education and hold a job as a teacher.

At this point, I am unemployed and looking for work. But I have come to realize that I must rely on the technique of "the cover-up." I will do everything I can to conceal the fact that I was once diagnosed as chronic, that I was hospitalized, and that I once lived in a halfway house. If I am asked by an employer if I have ever had a nervous breakdown, I will answer, "No." If I am asked why there was a gap in my employment, I will say, "I traveled." If they notice my hands are trembling because of my medication, I will say, "It's due to my thyroid." I must do all of this because there is a stigma attached to anyone who has had mental illness.

I hope that, in my lifetime, the ignorance of emotional illness turns to understanding; that fear turns to security; and that the cover-up will no longer be necessary.

Example B

The great stigma that is attached to people who have been or who are mentally ill often results in open discrimination. I have had some difficulty with both my resident manager and with the Federal agency where I was seeking employment. The fact that I was being prejudged was upsetting and annoying.

Only recently questions about an individual's history of nervous breakdowns were eliminated from the official form required for all applications for Federal jobs. The equal employment opportunity law, as amended, now includes prohibitions on discriminating against the physically and mentally handicapped. Because of the existence of these rights, I have more self-confidence. By supporting myself, I am proving that I am a responsible individual.

We need these kinds of changes in the law to protect our rights as individuals. Specifically, we truly need anonymity in order to cope with a difficult life, without carrying forever the label of "mentally ill." I like to use the expression: "Everyone is different; therefore, we should be treated the same."



Let's Talk About Mental Illness

Attitudes of Stigmatized Persons

How do stigmatized persons feel about being stigmatized? What do they do about it? Erving Goffman has written about these feelings and actions.

Stigmatized individuals hold the same beliefs about their identity as we do. Their deepest feelings are that they are normal human beings like anyone else, persons who deserve a fair chance and a fair break. Yet they perceive, quite correctly, that, whatever others may profess, they are not really accepted.

Shame becomes a central possibility, arising from stigmatized persons' perceptions that one of their attributes is a defiling thing and one that they can see themselves as not possessing.

The primary feature of a stigmatized individual's situation in life is a question of acceptance. Those who have dealings with them fail to accord them respect and regard.

How do stigmatized persons respond to this situation?

In some cases they make a direct attempt to correct the failing, as when a physically deformed person undergoes plastic surgery or an illiterate person undertakes remedial education. Ironically, when such repair is possible,

what often results is not the acquisition of a fully normal status but merely the transformation into someone who has had a blemish corrected.

Another approach that stigmatized persons use is to devote great effort to the mastery of areas that are usually closed to people with their shortcomings. The lame person learns to swim, ride, play tennis; the blind person becomes expert at skiing and mountain climbing.

Finally, persons with differences which causes them shame can break with what is called reality and obstinately attempt to employ an unconventional interpretation of the character of their social identities.

Stigmatized individuals may use their stigma for "secondary gains," as an excuse for failures that have really come about for other reasons. Or stigmatized individuals may see the trials they have suffered as a blessing in disguise, especially because they feel that suffering can teach them about life and other people. Or they may reassess the limitations of normal people and believe that they can be of special help to normals.

When "Normal" and Stigmatized Persons Meet

A crucial question, especially for the mentally ill, is what happens when normals and the stigmatized are in the same social situation. Goffman has analyzed these "mixed contacts."

The very anticipation of contacts with each other can lead normals and the stigmatized to arrange life so as to avoid them. This will have greater consequences for the stigmatized, since more arranging will usually be necessary on their part.

All too often the stigmatized person withdraws from social contacts and becomes a social isolate. Lacking the salutary feedback of social intercourse, a self-isolate can become suspicious, depressed, hostile, anxious, and bewildered.

When normals and stigmatized do in fact enter one another's immediate presence, especially when they attempt to sustain a conversation, the causes and effects of stigma must be directly confronted on both sides.

The stigmatized individuals may feel unsure of how normals will identify and receive them. They feel that they do not know what others are really thinking about them. Further, stigmatized persons are likely to feel that they are "on," having to be self-conscious and calculating about the impressions they are making--to a degree not required of others.

Also they are likely to feel that the usual interpretations of everyday events have been changed. Minor accomplishments may be assessed as signs of remarkable and noteworthy capabilities. For example, a criminal or a mentally ill person who reads the "classics" may be complimented profusely.

At the same time, minor failings or incidental impropriety may, they feel, be interpreted as a direct expression of their stigmatized differentness. Former mental patients are sometimes afraid to engage in a sharp interchange with spouse, employer, or friends, for fear of what a show of emotion might

be taken as a sign of.

Given what stigmatized individuals face when entering a mixed social situation, they may respond with defensive cowering. Or they may attempt to approach such contacts with hostile bravado which can induce its own troublesome reciprocations. Stigmatized persons sometimes vacillate between cowering and bravado, racing from one to the other, thus demonstrating how ordinary face-to-face interaction can run wild. Here again, the mentally ill person's understandable reaction to a social situation can result in behavior that reinforces an opinion that the person is indeed mentally ill.

With what both the stigmatized and "normals" introduce into mixed social situations, it is understandable that not all will go smoothly. We "normals" often try to carry on as if the stigmatized persons fit naturally into the situation, thus treating them as people who are better or people who are worse than we really believe them to be. If that doesn't work, we often act as if they're not even present, giving them only ritual notice. Stigmatized persons are likely to go along with these strategies, at least initially.

Even when no explicit reference is made to the handicap, the interaction often is articulated too exclusively in terms of it--the unspoken evidence felt in under-lying awkwardness, self-consciousness, and heightened awareness. The familiar signs of discomfort and stickiness emerge--guarded references, common words suddenly made taboo, a fixed stare elsewhere, artificial levity, compulsive talking, awkward solemnity.

Stigmatized individuals, because they frequently are exposed to such sticky uneasiness, become more adept at managing awkward situations than we "normals" do.

The Mentally Ill – and the Stereotype of Dangerousness

A person who is found to be mentally ill and dangerous can be involuntarily committed to a mental institution. Saleem Shah, a psychologist specializing in studies of crime and delinquency at the National Institute of Mental Health, has pointed out serious issues in preventive detention and the prediction of dangerousness

Typically, an individual cannot be involuntarily confined to a mental institution simply because of anticipated--or even demonstrated--dangerousness. First, there has to be a finding of mental illness and then of an associated propensity of predicted likelihood for engaging in dangerous behavior.

Since involuntary civil commitment represents an exercise of State power that may deprive individuals of their liberty and also compel them to undergo psychiatric treatment, it raises a fundamental question: What potential harms to society or to the individual are sufficiently serious to justify resorting to coercive confinement?

The question involves public policy, sociopolitical and legal issues, not medical, psychiatric, psychological, or mental health issues. In the existing situation, however, public policy and legal issues are confounded with psychiatric and mental health concerns.

It is difficult to discern how the link between mental illness and dangerous behavior came about and why it continues to be maintained with such enduring zeal.

Several studies have examined the arrest records of patients discharged from mental hospitals. These studies do not support the stereotype of the mentally ill as highly dangerous and unpredictable. Although persons diagnosed as seriously mentally ill (those likely to be hospitalized) are not any less dangerous than persons not so diagnosed, the evidence also points to the conclusion that the mentally ill do not constitute one of the most dangerous groups in our society.

It should be noted that some of the most predictably and demonstrably dangerous persons are not preventively detained or handled with greater concern for public safety. For example, numerous studies have shown that about 50 percent of all fatal auto accidents involve drunken drivers. Our society demonstrates a truly astonishing tolerance for this group of dangerous persons.

Given the numerous court proceedings in which the dangerousness of a mentally ill person is at issue and grave decisions affecting life and liberty must be made, one might assume that some reasonable accurate means of predicting dangerous behavior are available. This assumption is false. No instrument has been developed that can predict violent and other dangerous behavior accurately or satisfactorily. In fact, no test has been developed that can adequately identify such behavior retrospectively--let alone predict it.

Stigma and the Violation of Rights

The stigma of mental illness has been reflected in many laws that restrict the freedom of mentally ill persons to make their own choices. Robert Plotkin, a lawyer formerly with the Mental Health Law Project, has summarized some of these restrictions.

Certain groups of Americans are "protected" by law from enjoying the freedom to make their own choices. The chief "beneficiaries" of the State-sponsored paternalism are the mentally different, those who are thought to be incompetent to make rational choices. The result is a double-track system: one law for "normal" people and another for the mentally different.

Voting: Virtually half the States have statutory language flatly forbidding mentally handicapped persons to vote. The range of exclusions runs from "idiots" to "insane persons" to "persons under guardianship." These laws bar mentally handicapped persons from participation in the political process, without regard for individual ability to exercise this right rationally.

Marriage: Many States have statutory bans which prevent the "feeble-minded," incompetent, or those under guardianship from marrying. If such marriages occur, they can be annulled or speedily ended by no-fault divorce. Given the problems of some so-called normal people--rising divorce rate, high incidence of child abuse, and sexual maladjustment--it is puzzling that the mentally disabled are singled out.

Adoption: In more than half the States children can be adopted without the consent of mentally disabled parents. There may be situations where parents cannot care for children and adoption is in everyone's best interest, but requirements that protect the rights of "normal" parents are forgotten when a child's parents are mentally different.

Sterilization: Some States have statutes allowing involuntary sterilization of the incompetent. Other statutes allow sterilization in "voluntary" situations, without addressing the question of how an "incompetent" decides to consent "voluntarily" to sterilization. In some States there is no judicial inquiry into the sterilization if the person's parent or guardian gives "consent."

Guardianship: Guardians have the authority to admit persons "voluntarily" into institutions, to have them sterilized or experimented upon, to invest their money and manage their affairs. Generally, a guardian sincerely believes that he or she is honestly protecting the interests of an incompetent person, and usually this is so. But there have been instances of overzealous or unscrupulous persons acting as guardians, and the law should provide greater protection to the person being "guarded."

If the law has any obligation to the mentally handicapped, it is to increase their options and to expand their opportunities, not to limit their choices and physically and legally segregate them.



Using Mental Health Advocacy to Reduce Stigma

Mental health advocacy is a recent and fruitful attempt to provide better care for the mentally ill and to decrease their stigma. Louis E. Kopolow, Chief of the Patients Rights and Advocacy Program at the National Institute of Mental Health, outlines the elements of a comprehensive advocacy program.

Mental health advocacy provides a unique mechanism by which psychiatry can respond constructively and effectively to the dilemma of delivery of mental health care in a system increasingly influenced by legal requirements and consumer demands. Advocacy is a method by which psychiatrists, lawyers, and patients' representatives can work cooperatively in meeting the patients' wishes, needs, and rights.

A comprehensive advocacy program consists of a tripartite system:

The primary element is the patient's representative, who is concerned with screening patients for such matters as the appropriateness of commitment or guardianship, of forced medication and other forms of treatment, and of transfer or release to large institutions. The patient's representative also devotes his or her efforts to preserving "the right to noninstitutionalization" and to arranging transfer of patients to other mental health programs in the community.

The second element of the program involves the legal advocates. They are necessary in handling the multitudinous legal problems, especially

those of an indigent and deprived population. In carrying out the role, the legal advocate uses all the skills of the legal profession, bringing court action on behalf of the patient against the institution, filing class action suits, and lodging complaints regarding specific violation of patients' rights in order to secure redress. The active involvement of mental health staff in assisting attorneys to represent their clients' wishes goes a long way toward assuring that alternative clinical regimens have been explored. The attorney's main task, however, is to be available as a last resort for serious problems which the patients' representative has failed to solve through less formal adjustment mechanisms.

The ombudsman is the third element in a comprehensive advocacy program and is especially relevant for a mental health system undergoing rapid change. The ombudsman addresses problems throughout the entire mental health system.

This model for patient advocacy is helpful in preventing the unfortunate situation of patients being caught in a tug of war between two opposing forces--the psychiatric and the legal professions--battling for their custody. Such a comprehensive advocacy program can become an important and lasting alternative to litigation and can help to create a mediated flexible system of care for the mentally ill.



A Bill of Rights for Mentally Ill Patients

Title V, Section 501 of the Mental Health Systems Act, 42 U.S.C. 9501, for the first time defines in United States law a Bill of Rights for mentally ill patients.

A person admitted to a program of facility for the purpose of receiving mental health services should be accorded the following:

The right to treatment and services under conditions that support the person's personal liberty and restrict such liberty only as necessary to comply with treatment needs, law, and judicial orders.

The right to an individualized, written, treatment or service plan (to be developed promptly after admission), treatment based on the plan, periodic review and reassessment of needs, and appropriate revisions of the plan, including a description of services that may be needed after discharge.

The right to ongoing participation in the planning of services to be provided and in the development and periodic revision of the treatment plan, and the right to be provided with a reasonable explanation of all aspects of one's own condition and treatment.

The right to refuse treatment, except during an emergency situation, or as permitted under law in the case of a person committed by a court for treatment.

The right not to participate in experimentation in the absence of the patient's informed, voluntary, written consent; the right to appropriate protections associated with such participation; the right and opportunity to

revoke such consent.

The right to freedom from restraint or seclusion, other than during an emergency situation.

The right to a humane treatment environment that affords reasonable protection from harm and appropriate privacy.

The right to confidentiality of records.

The right to access, upon request, to one's own mental health care records.

The right (in residential or inpatient care) to converse with others privately and to have access to the telephone and mails, unless denial of access is documented as necessary for treatment.

The right to be informed promptly, in appropriate language and terms, of the rights described in this section.

The right to assert grievances with respect to infringement of this Bill of Rights, including the right to have such grievances considered in a fair, timely, and impartial procedure.

The right of access to a protection service and a qualified advocate in order to understand, exercise, and protect one's rights.

The right to exercise the rights described in this section without reprisal--including reprisal in the form of denial of any appropriate, available treatment.

The right to referral, as appropriate, to other providers of mental health services upon discharge.

Mental Health Association in Alaska

Membership Application

Please count me among the
"People Helping People"

Date: _____

Name _____ Phone _____

Street _____ City/State _____ Zip Code _____

Memberships:

Student/Senior

Sustaining

Contributing

Patron

Corporate

\$10.00

\$25.00

\$50 - 100

\$100 - 500

\$1,000 and UP

I would like more information about the Association

I would be willing to devote time to the efforts of the Association

(Your membership contribution is tax deductible and includes a subscription to COPING Magazine.)

Method of Payment

Charge to MasterCard VISA American Express

Credit Card No.

Signature _____ Exp. Date _____ Amount _____

Check Enclosed

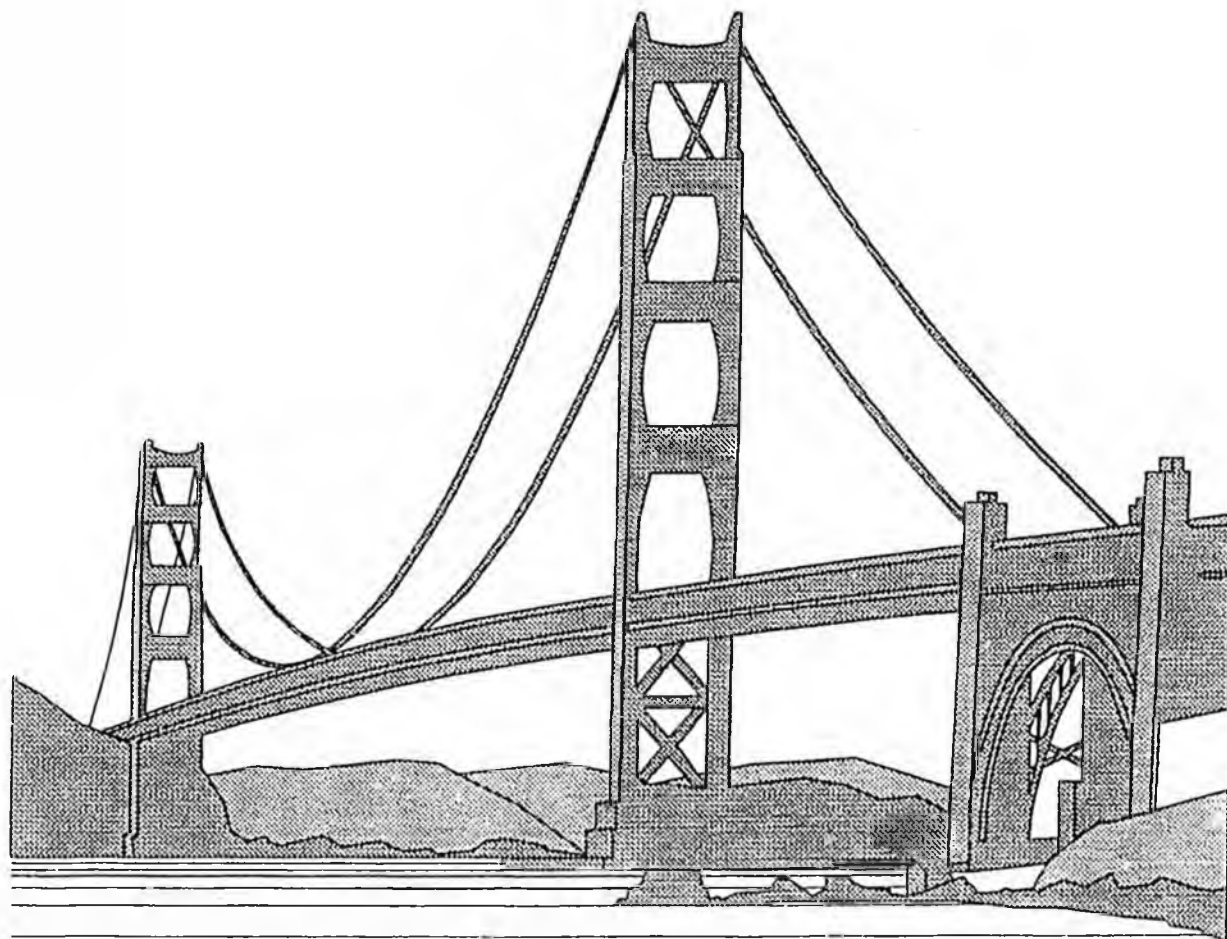
Please Join & Support the Mental Health Association

Mental Health Association in Alaska
4050 Lake Otis Parkway, Suite 202
Anchorage, Alaska 99508

Advocating to Reduce Stigma

Mental Health Parity

Resource Kit



Update on Mental Health Parity Laws

Seven States Pass Laws, Four Others Vote To Study Proposals

In October 1996, the American Managed Behavioral Healthcare Association (AMBHA) updated the status of behavioral health parity laws that have been passed or are proposed in 11 states. Five states passed laws requiring health plans to offer mental illness treatment equal to the treatment offered for physical illness. The states are: Maine, Maryland (parity for coverage of mental illness and substance abuse), Minnesota, New Hampshire, and Rhode Island. Maryland and Minnesota require parity coverage for all mental disorders. Maine, New Hampshire and Rhode Island require parity coverage for certain enumerated serious mental illnesses.

In other states, North Carolina and Texas have passed parity laws that require health plans to offer state and local government employees mental illness treatment equal to the treatment offered for physical illness. North Carolina also offers chemical dependency treatment. Louisiana, North Dakota, Oklahoma, and Virginia adopted resolutions to study parity and make recommendations to their legislatures on whether a parity law should be introduced and enacted in those states.

Following is a summary of the states' parity laws and resolutions.

Maine

Definition of mental illness covered by the law

The law requires that health care policies provide coverage for treatment of the following mental illnesses:

- ▶ schizophrenia;
- ▶ bipolar disorder;
- ▶ pervasive development disorder, or autism;
- ▶ paranoia
- ▶ panic disorder
- ▶ obsessive-compulsive disorder; and
- ▶ major depressive disorder.

The act defines "a person suffering from a mental or nervous condition" as "a person whose psychobiological processes are impaired severely enough to manifest problems in...social, psychological or biological functioning."

Scope of parity provision

The law requires that all contracts provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than benefits provided for medical treatment. The act's provisions exclude coverage for the treatment of alcoholism or drug dependencies through the diagnosis of a mental illness.

Effective date: July 1, 1996

Maryland

Definition of mental illness covered by the law

The law does not define "mental illness" or "mental health" and therefore, requires parity coverage for all mental illnesses. Note: the law also prohibits discrimination in health care coverage against any person with a drug or alcohol abuse disorder.

Scope of parity provision

The act provides that each contract providing coverage for health care 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 for treatment of physical illness. The law requires companies with 50 or more employees to provide inpatient coverage for mental health and substance abuse treatment on par with physical illnesses.

Effective date: July 1, 1994

Minnesota

Definition of mental illness covered by the law

The law does not define "mental illness" or "mental health" and therefore, requires parity coverage for all mental illnesses.

Scope of parity provision

The law requires that cost-sharing requirements and benefit or service limitations for inpatient and outpatient mental health and chemical dependency services must not place a greater financial burden on the insured or enrollees, or be more restrictive than those requirements and limitations for outpatient and inpatient medical services.

Effective date: August 1, 1995

New Hampshire

Definition of mental illness covered by the law

The law defines "mental illness" as "a clinically significant or psychological syndrome or pattern that occurs in a person and that is associated with present distress, a painful symptom or disability, impairment in one or more important areas of functioning, or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom." The following mental illnesses are covered by the law:

- ▶ schizophrenia;
- ▶ schizoaffective disorder;
- ▶ major depressive disorder;
- ▶ bipolar disorder;
- ▶ paranoia & other psychotic disorders;
- ▶ obsessive-compulsive disorder;
- ▶ panic disorder;
- ▶ pervasive developmental disorder, or autism.

Scope of parity provision

The law requires that health plans must "provide benefits for treatment and diagnosis of certain biologically-based mental illnesses under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.

Effective date: January 1, 1995

Rhode Island

Definition of mental illness covered by the law

The law defines "serious mental illness" as "any mental disorder

that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the illness." The term includes, but is not limited to:

- ▶ schizophrenia;
- ▶ schizoaffective disorder;
- ▶ delusional disorder;
- ▶ bipolar affective disorder;
- ▶ major depression; and
- ▶ obsessive-compulsive disorder.

Scope of parity provision

The law applies to inpatient hospitalization and outpatient medication visits. The law also requires that insurance coverage include the same durational limits, amount limits, deductibles, and co-insurance factors for serious mental illness as for other illnesses.

Effective date: January 1, 1995

Texas

Definition of mental illness and/or chemical dependency covered by the law

The law applies to "biologically based mental illness" which is defined as "a serious mental illness that current medical science affirms is caused by a physiological disorder of the brain and that substantially limits the life activities of the person afflicted with the illness." The term includes:

- ▶ schizophrenia;
- ▶ paranoid and other psychotic disorders;
- ▶ bipolar disorders (manic-depressive disorders);
- ▶ major depressive disorders; and
- ▶ schizo-affective disorders.

Scope of parity provision

The law applies to state and local government employees.

Effective date: September 1, 1991

North Carolina

Definition of mental illness and/or chemical dependency covered by the law

The law applies to health care coverage for mental illness and chemical dependency. The law defines "mental illness" as:

1. For adults, "an illness which so lessens the capacity of an individual to use self-control, judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control"; and
2. For minors, "a mental condition, other than mental retardation alone that so impairs the youth's capacity to exercise age adequate self-control, or judgment in the conduct of his activities and social relationships so that he is in need of treatment."

Scope of parity provision

The law applies to state government employees.

Effective date: January 1, 1996

Louisiana

Purpose of the study

The Louisiana legislature created the Louisiana Study

Commission on Parity and Nondiscrimination in Health Care For Serious Mental Illnesses to study the feasibility of enacting legislation to prohibit discrimination in health insurance policies against persons with severe mental disorders.

Action to be taken by those studying parity

The commission is charged with providing the governor, the speaker of the House of Representatives, and the president of the Senate with a report of its findings and recommendations on enacting parity legislation no later than February 25, 1997.

Date adopted: June 10, 1996

North Dakota

Purpose of the study

The resolution directs the Legislative Council to study the feasibility and desirability of implementing recommendations made by the North Dakota Health Task Force. The task force recommended that a standard health care benefit plan provide coverage for mental illness and chemical addiction equal to the coverage provided for physical illness.

Action to be taken by those studying parity

The legislative council is to study the feasibility and desirability of implementing the recommendations and also monitor the rate of health care cost increases, review the impact of newly enacted programs to improve the health status of state residents and address unmet medical needs in rural areas.

Date adopted: March 20, 1995

Oklahoma

Purpose of the study

The resolution creates a Legislative Task Force on Parity for Mental Illness Insurance Coverage to study the issue of health insurance coverage for mental illness resulting from biologically based chemical disorders, including the cost of such coverage with special emphasis on parity of cost with that of other health care insurance, the extent of such coverage, the savings to society as a result of such coverage, and other pertinent issues.

Action to be taken by those studying parity

The task force is directed to file a written report of its findings and recommendations with the president of the Senate and the speaker of the House by January 7, 1997.

Date adopted: May 31, 1996

Virginia

Purpose of the study

The resolution directs the Parity Task Force, established by the Special Advisory Commission on Mandated Health Insurance Benefits, to attempt to reach consensus on what constitutes adequate mental health and substance health insurance benefits.

Action to be taken by those studying parity

The resolution directs that the task force is to complete its work and submit its findings to the special Advisory Commission on Mandated Health Insurance Benefits. The commission is directed to report the task force findings to the governor and the 1996 session of the General Assembly.

For more information, call E. Clarke Ross, Executive Director, American Managed Behavioral Healthcare Association, 700 Thirteenth Street, Washington, D.C. 20005, 202-434-4565, fax: 202-434-4564.

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MENTAL HEALTH STATISTICS

PREVALENCE

More than 51 million Americans have a mental disorder in a single year. (NIMH & CHMS, 1994)

During the course of any given year, while more than 40 million adult Americans are affected by one or more mental disorders, 5.5 million Americans are disabled by severe mental illnesses. (NIMH, 1990)

Preliminary studies indicate that 1 in 5 children/adolescents (20 percent) may have a diagnosable disorder. Estimates of the number of children who have mental disorders range from 7.7 million to 12.8 million. (CMHS, 1993). These youth are estimated to have severe emotional or behavioral problems that significantly interfere with their daily functioning.

Less than one-third of the children under age 18 with a serious emotional disturbance receive mental health services. Often, the services are inappropriate. (Children's Defense Fund) (CMHS-Mental Health, U.S., 1994)

An estimated 19.9 million Americans--8.8 percent of the population--experience phobias. About 9.1 million--5.1 percent--live with major depression. Some 3.9 million have obsessive compulsive disorder; 2.0 million have schizophrenia; 2.4 million have panic disorder; and 2.0 million experience bipolar disorders. (NMHA, 1993), (Mental Health, U.S., 1994)

At least two thirds of elderly nursing home residents have a diagnosis of a mental disorder such as major depression. (NIM, 1990)

Up to 25 percent of the population with AIDS will develop AIDS-related cognitive dysfunction. Two-thirds of all people with AIDS will develop neuropsychiatric problems. (Mental Health Liaison Group, 1993)

A majority of the 29,000 Americans who commit suicide each year are believed to have a mental disorder. Suicide is the eighth leading cause of death in the U.S. and the third leading cause of death among people aged 15 to 24. (NIMH, 1994)

Source: For further information on these statistics, contact: Office of External Liaison, Center for Mental Health Services, 5600 Fishers Lane, Room 13-103, Rockville, MD 20857

Nearly one-third of the nation's estimated 600,000 homeless individuals are believed to be severely mentally ill adults. (CMHS, 1992)

More than 1 in 14 jail inmates has a mental illness. Twenty-nine percent of the nation's jails routinely hold people with mental illnesses without any criminal charges. (National Alliance for the Mentally Ill and Public Citizens Health Research Group, 1992)

ECONOMIC COSTS

Mental illnesses impose a multibillion dollar burden on the economy each year. Total economic costs amounted to \$147.8 billion in 1990. More than 31 percent of those costs--\$46.6 billion--are for anxiety disorders. (The Economic Burden of Affective Disorders, Dorothy P. Rice, Sc.D., and Leonard S. Miller, Ph.D., 1993)

Direct costs--expenditures for professional health care for persons suffering from mental disorders, including care in mental specialty institutions, hospitals and nursing homes, physician and other professional services and prescription drugs--accounted for \$67 billion, or 11.4 percent of all personal health care expenditures in 1990. (Rice and Miller, 1993)

Three independent studies between 1971 and 1985 found that mental health costs remained relatively constant during the past 20 years, ranging from 9 to 11 percent of direct treatment costs for health care (Bazelon Center for Mental Health Law, 1993)

Direct treatment and support costs comprise 45.3 percent of the total economic costs of mental disorders. The value of reduced or lost productivity comprise 42.7 percent of the total economic costs of mental disorders. Mortality costs comprise 8 percent and other related costs, including expenditure for criminal justice, the value of lost time due to incarceration and an imputed value for caregiver services, comprise 4 percent. (Rice and Miller, 1993)

Morbidity costs--the value of goods and services not produced because of mental disorders--amounted to \$63.1 billion for all mental disorders in 1990. Morbidity costs for anxiety disorders account for \$34.2 billion; for schizophrenia, \$10.7 billion. The morbidity costs for anxiety disorders reflect their prevalence in the population and the high rate of lost productivity. (Rice and Miller, 1993)

Mortality costs--the current value of lifetime earnings lost by all who died in 1990 because of mental disorders--amounted to 11.8 billion in 1990. (Rice and Miller, 1993)

Other related costs--the costs indirectly related to the treatment and lost productivity of people with mental disorders--amounted to \$6 billion in 1990. (Rice and Miller, 1993)

FUNDING

The mental health system relies on a high proportion of funds from public sources rather than private insurance and out-of-pocket payments. In 1990, 28 percent of funds for mental health care came from state and local governments. In general health care, the comparable figure was 14 percent. Medicare, Medicaid, VA and other Federal programs accounted for an additional 26 percent. (National Advisory Mental Health Council)

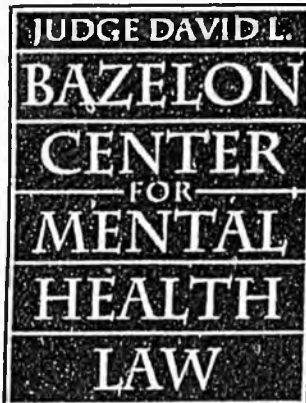
Parity in Benefit Design: Existing Law

Below are the parity requirements used in 7 states (ME, MD, MN, NC, NH, RI, TX) and the recent national government mandate (DW: Domenici/Wellstone amendment).

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5. MH coverage must use the same durational limits, amount limits, deductibles, and coinsurance as physical illness coverage:
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6. Requirements apply only to the application of lifetime and annual financial caps:
1: DW
7. Policies must not place a greater financial burden on the uninsured person or enrollee:
1: MN
8. Medical necessity criteria must be the same for mental illness and physical illness:
1: ME
9. Medical necessity criteria may be collected to determine whether they are consistent with other illnesses:
1: RI
10. Requirements apply to addictions disorders:
2: MD, NC

Information provided by the American Managed Behavioral Healthcare Association.
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1101 Fifteenth Street N.W., Suite 1212, Washington, DC 20005-5002\
Phone: (202) 467-5730



Civil Rights and Human Dignity

PAYING FOR PARITY

*A Review of Costs in Two States with
Health Insurance Laws Mandating
Equal Coverage of Mental Health Care*

May 1996

1101 Fifteenth Street N.W.
Suite 1212
Washington D.C. 20005-5002
202/467-5730

THE BAZELON CENTER

The Bazelon Center is a national nonprofit organization formed in 1972. As the leading national legal advocate for people with mental illness or mental retardation, the Bazelon Center has successfully challenged many of the barriers to dignity and choice that confront adults and children with disabilities. Our precedent-setting litigation has outlawed abuse, won protections against arbitrary confinement and opened up public schools, workplaces, housing and other opportunities for community life. Now, as all low-income people face loss of federal assistance, we work for access by children, adults and elders with mental disabilities to health and mental health care and other needed services and supports.

PAYING FOR PARITY was written by Chris Koyanagi with assistance by Lee Carty as part of the Bazelon Center's campaign for equity and fairness in health coverage for people with mental illness. Permission is hereby granted to quote from or reproduce this document with attribution to the Bazelon Center for Mental Health Law.

For additional information, contact Chris Koyanagi or Lee Carty at the bazelon Center.

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PAYING FOR PARITY

A Review of Costs in Two States with Health Insurance Laws Mandating Equal Coverage of Mental Health Care

A review of two states' experience with laws requiring coverage for mental health services on a par with coverage for physical health care contradicts arguments by opponents of a similar mandate in the Health Insurance Reform Act approved 100-0 by the Senate on April 23, 1996.

The Bazelon Center for Mental Health Law has examined preliminary outcomes in Minnesota and Maryland, the only two states with such a requirement of equal coverage for all mental illnesses, to learn if the "parity" mandate would, as its opponents assert, escalate insurers' and employers' costs and thus make all health coverage unaffordable for hundreds of thousands of employees and their families. The Bazelon Center's review found just the opposite—that ending discriminatory treatment of mental illness by private health insurers is not only fair, it's cost-effective.

This report compares the Minnesota and Maryland statutes with the statutory language of the national parity amendment as approved by the Senate and summarizes data from the two states highlighting the minimal cost-impact of such a requirement.

The Domenici-Wellstone Amendment

The Senate's parity amendment to the House-passed insurance-reform act (HR 3103) was sponsored by Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN) and passed the Senate by a roll-call vote of 68-30. It states:

- an employee health benefit plan, or a health plan issuer offering a group health plan or an individual health plan, shall not impose treatment limitations or financial requirements on the coverage of mental health

services if similar limitations or requirements are not imposed on coverage for services for other conditions. —Nothing in (this section) shall be construed as prohibiting an employee health benefit plan, or a health plan issuer offering a group health plan or an individual health plan, from requiring preadmission screening prior to the authorization of services covered under the plan or from applying other limitations that restrict coverage for mental health services to those services that are medically necessary.

The impact of the Senate amendment would be:

- to eliminate arbitrary day and visit limits for mental health services when similar arbitrary limits are not imposed on other health care;
- to eliminate the common practice of requiring individuals with mental illness to pay higher out-of-pocket costs, in the form of co-payments and deductibles, than people who have other health conditions;
- to eliminate separate (usually very much lower) lifetime limits on payments for mental health treatment than the lifetime limit for all other health care;
- to continue health plans' use of managed care techniques that, over the past five years, have proven very effective in controlling the utilization and cost of mental health services.

The amendment does not specify that substance abuse or chemical dependency services would be included under the term "mental health services," though it could be interpreted that such services are included.

The Minnesota Statute

In August 1995, a Minnesota law took effect prohibiting greater financial burden or more restrictive coverage for individuals needing mental health or chemical dependency services.

The Minnesota statute is similar to the Senate-approved amendment. It prohibits cost-sharing and service limitations

for inpatient and outpatient mental health and chemical dependency services from being more restrictive or placing a greater financial burden on the enrollee than is the case for inpatient and outpatient medical services.

The Minnesota statute would therefore have a very similar impact to the Domenici-Wellstone amendment. Both eliminate the common practice of having lower visit and day limits on mental health services than on other forms of care and the equally common practice of charging individuals more in out-of-pocket costs when they need mental health care. Both also prohibit lower lifetime caps on mental health care.

The differences between the Minnesota law and the Senate amendment are:

- the Minnesota law specifically includes chemical dependency, while the Senate-approved provision is not explicit on this issue;
- the Minnesota law does not specifically allow for the use of managed care, though it also does not in any way inhibit it.

Accordingly, the Minnesota law is, if anything, more generous than the Senate-approved amendment.

The impact of the Minnesota law:

Because the Minnesota statute only took effect in August 1995, specific studies of its impact have not yet been conducted. However, health plans' response to the mandate yield consistent and very interesting information:

- Allina Health System, a large managed care organization in Minnesota, reported that the mandate on mental health and chemical dependency would add 26 cents per member per month for the 460,000 persons enrolled in Allina plans.
- After nearly a year's experience under the Minnesota parity law, Blue Cross/Blue Shield announced a premium *reduction* of 5%-6% in the plans it writes for small businesses in the state. Blue Cross/Blue Shield uses managed care techniques to control inappropriate utilization. While there is no indication that this reduction is related to the parity provisions, it makes clear that parity did not drive up costs.

- The state runs a high-risk re-insurance pool for people who are uninsurable (the Minnesota Comprehensive Health Association), which also must adhere to the parity mandate. Recently, this plan was able to *raise* its lifetime cap and provide greater protection to all its enrollees. Again, while there is no evidence that the parity law caused this improvement, the mandate clearly did not impede it.
- The Minnesota Department of Employee Relations, Employee Insurance Division, reported in a fiscal note that the cost of this mandate on the health insurance plans for all state employees would be an added 1%-2% premium increase.
- In implementing this mandate for state employees, two companies that offer plans to state workers handled the mandate in distinct ways. One (Allina) absorbed the increase and made no increase in individual cost-sharing requirements. The other (Health Partners) redistributed the cost across all users of health services by requiring a new \$10 per doctor visit co-payment for all health services.

It is also noteworthy that in the recent legislative session no attempt was made either to repeal the Minnesota parity statute or to weaken it through amendment.

Accordingly, while data are preliminary, all evidence suggests that the Minnesota law requiring parity for all mental illnesses, including chemical dependency, has a minimal impact on the cost of health insurance. This is particularly true when health plans use managed care.

The Maryland Experience

On July 1, 1994, a new law prohibiting discrimination against persons with mental illness in health care contracts went into effect in Maryland. This law covers companies with 50 or more employees.

The Maryland law is also similar to the Domenici-Wellstone amendment. It provides that each contract in the state (including health maintenance organizations) that provides coverage

for health care may not discriminate against any person with a mental illness, emotional disorder or 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 for treatment of physical illness. The law applies to companies with 50 or more employees.

Like the Senate-approved amendment, the Maryland law prohibits arbitrary and lower day and visit limits for mental health care than for other health care services. For inpatient services, the law requires parity in terms of out-of-pocket costs; for outpatient services it permits varying co-payments (80% coverage for the first five visits; 65% for visits 6-30; 50% for more than 30 visits per year). Partial hospitalization (day-long treatment) is also a required service. As in Minnesota, substance abuse services are specifically included.

The most important difference between the Maryland law and the Senate-passed amendment is in the outpatient cost-sharing.

The Maryland law went into effect in July 1994, but for the first year, inpatient benefits could be capped at 60 days per year. In July 1995, full parity was implemented.

The impact of the Maryland law:

The Maryland law built upon a substantial mental health benefit that was already in place, which required coverage of 30 days inpatient care and unlimited outpatient services (with variable co-payments). However, the parity bill greatly expanded inpatient services.

Data are now available on the first year's impact of the Maryland parity law on inpatient utilization. Data on outpatient services are not available because such information is not comprehensively collected in the state.

According to a recent study from the Maryland Health Resources Planning Commission, prior to passage of this law, inpatient stays in Maryland hospitals were declining each year. Blue Cross, other insurance, HMOs, Medicare and Medicaid and other payers all experienced a year-by-year decrease in the length of inpatient stays in psychiatric units of general hospi-

tals. For example, the number of people staying longer than 20 days in private psychiatric hospitals in 1993 was about 24%. In 1995, the year after the law's enactment, it was less than 18%. Over the same period, the number of people staying 10 days or less went from 50.4% to 61.44%.

With a requirement of parity for inpatient mental health treatment, hospital stays continued their decline for all but one payer (in the "other" category) of stays in private psychiatric hospitals. There has been no dramatic increase in utilization of the most expensive mental health service as a result of this law; in fact, cost savings have continued to accrue with respect to inpatient care.

The data from general hospital psychiatric care are even more positive. In general hospital acute care, HMO and private insurance inpatient stays longer than 30 days accounted for less than 0.4% of admissions in 1995, the first full year of the parity requirement. Only 11 people were hospitalized for more than 60 days in 1995, compared with 21 in 1993. The parity amendment was important in offering these few people a guarantee of appropriate continuing care.

As in Minnesota, the Maryland legislature has made no attempt to repeal or amend this law, suggesting that insurers and employers have not had much difficulty meeting the requirements.

In another similarity with Minnesota, Maryland has seen enormous growth in the use of managed care, first under its mental health mandate law and now under its parity amendment.

The overall data on utilization of hospital services reported here indicate that in Maryland, as in Minnesota, requiring an equitable mental health benefit that is essentially the same as the benefit for other health care does *not* result in overutilization of services and therefore would not drive up health care costs significantly.

Conclusion

The disparity between mental illness and other conditions in health insurance coverage is unfair, outdated and unreasonable. There is solid documentation of the high cost to the American economy of mental health disorders: over \$130 billion a year in lost productivity, absenteeism, disability and early death. Yet opponents continue to predict high utilization rates and soaring premium costs as outcomes of a parity mandate. The experience to date of the two states with legislation much like the Domenici-Wellstone parity amendment clearly indicates that their predictions grossly distort what actually occurs.

National mental health policy should be based not on hyperbole but on available evidence—and now evidence *is* available about the impact of mental health parity. Congress, insurers and businesses would do well to look more closely at Minnesota and Maryland to understand how mental health care can be covered for all Americans without the unjustified discrimination in most current health insurance plans.

Resources in Maryland: Paul Gentile, Maryland Health Resources Planning Commission
410/764-3255

Linda Raines, Mental Health Association of Maryland
410/235-1178

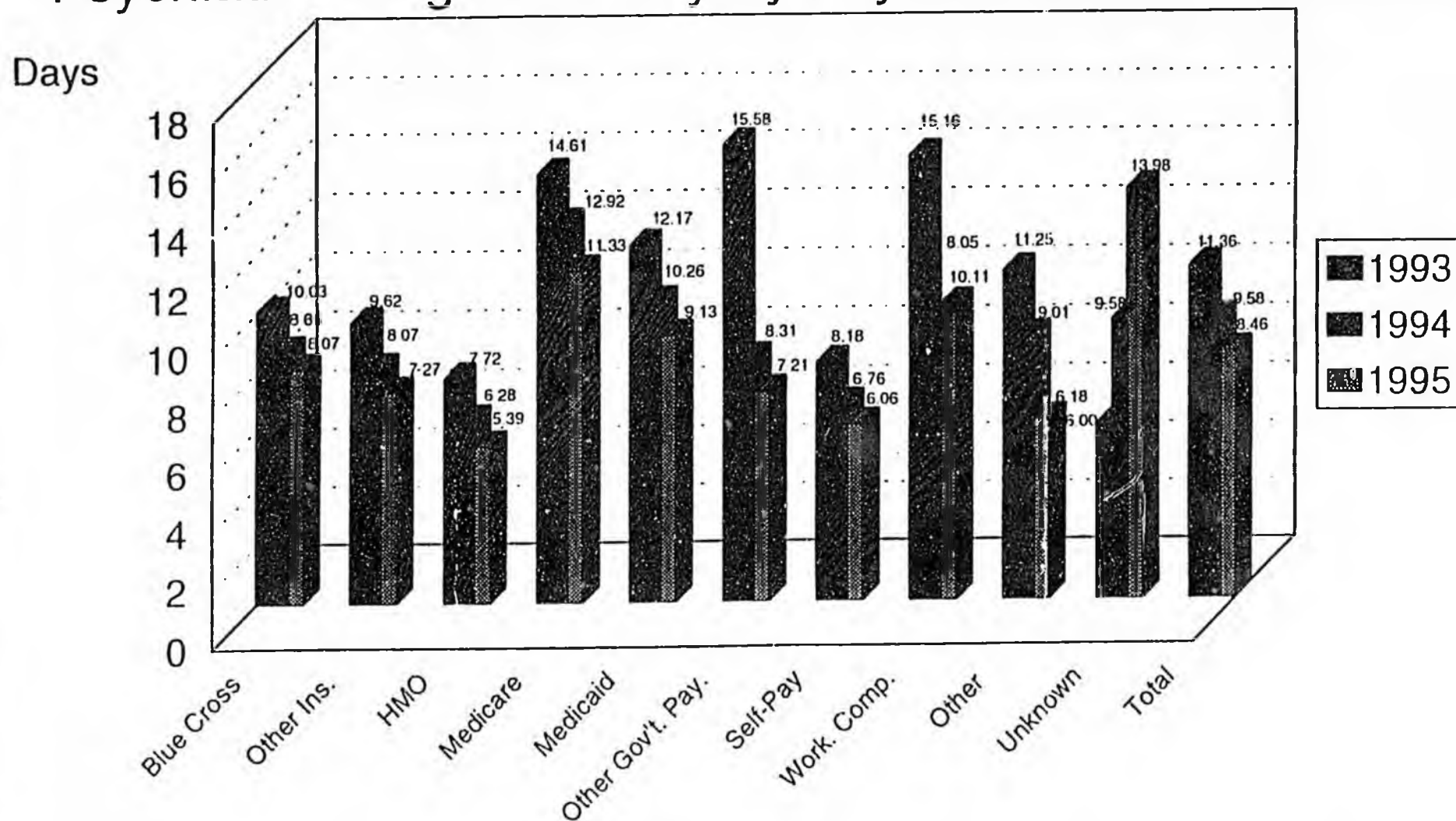
Resources in Minnesota: Ron Brand, Minnesota Association of Community Mental Health Programs
612/642-1903

Kathy Kelso, Mental Health Association of Minnesota
612/331-6840

For more information: Chris Koyanagi or Lee Carty
Bazelon Center for Mental Health Law
1101 15th Street NW, Suite 1212
202/467-5730 or bazelon@nicom.com

Maryland Acute General Hospital Psychiatric Units

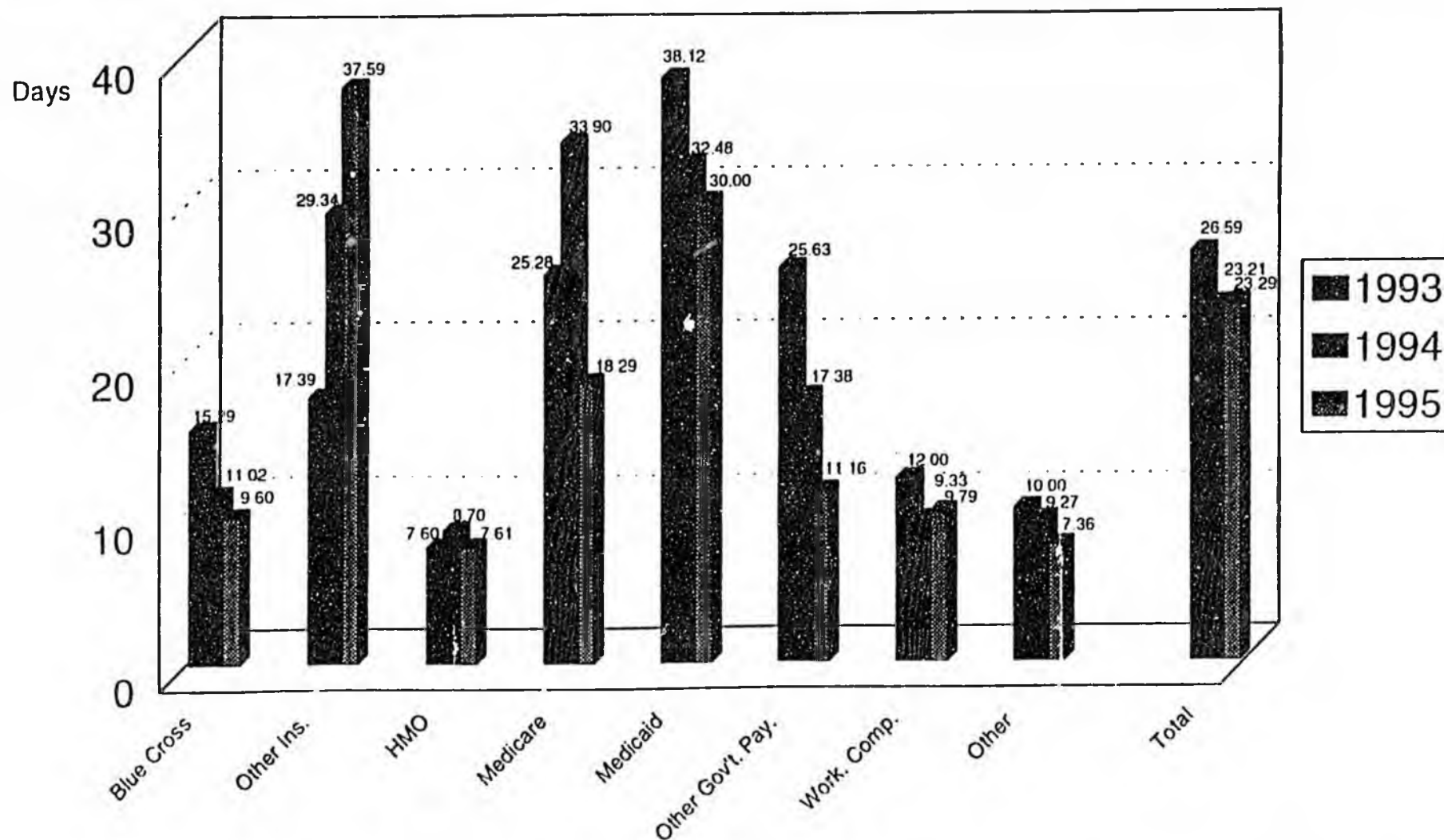
Psychiatric Lengths of Stay By Payor Source CY 1993-1995



Source: Paul Gentile, Maryland Health Resources Planning Commission, May, 1996

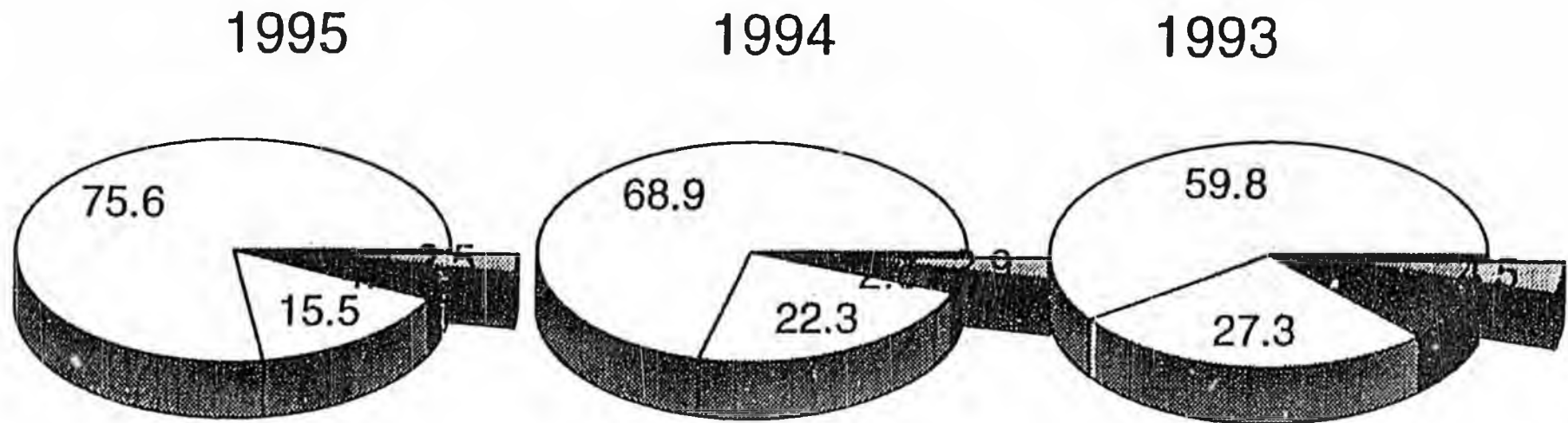
Maryland Private Psychiatric Hospitals

Average Length of Stay By Payor Source CY 1993-CY 1995



Source: Paul Gentile, Maryland Health Resources Planning Commission, May 1996

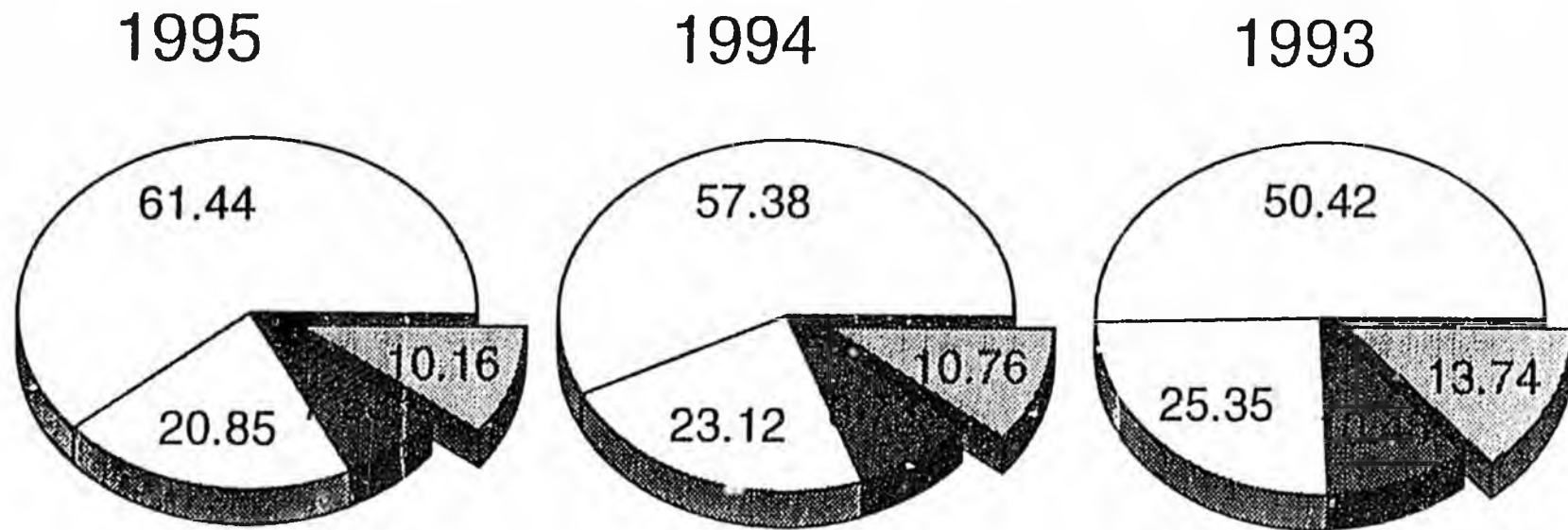
Maryland Acute General Hospitals Psychiatric Discharges
 Frequency Distribution Percentage By Length of Stay,
 1993-1995



<10 Days
 11-20 Days
 21-30 Days
 >31 Days

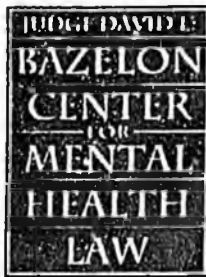
Source: Paul Gentile, Maryland Health Resources Planning Commission

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Source: Paul Gentile, Maryland Health Resources Planning Commission



EQUAL TREATMENT OF MENTAL HEALTH SERVICES IN HEALTH PLANS

Facts About the Domenici-Wellstone Amendment to Senate Bill S.1028

What the Senate's Amendment Says

- The Senate amendment simply prohibits insurers from limiting coverage because a person needs mental health services.
- It requires health plans to cover mental health services without any arbitrary treatment limitations or financial requirements that are not imposed on coverage for services to treat other health conditions.
- It allows plans to restrict all coverage to medically necessary services.

What the Amendment Does Not Say

- It does *not* mandate any specific benefits.
- It does *not* dictate how insurers should achieve parity between coverage for mental and physical conditions.

Fair Coverage of Mental Illness Is Cost-Effective and Long Overdue.

- Eliminating discriminatory limits on mental health care that do not apply to physical health care encourages treatment based entirely on medical necessity and appropriateness.
- It corrects current inefficiencies in service delivery that are driven by benefit design (such as overutilization of hospital care) and promotes delivery of the best available care.
- Mental health disorders cost the American economy over \$130 billion a year in lost productivity, absenteeism, disability and early death.¹ The Senate amendment can cut these losses by enabling many employees to receive services they need through private coverage, instead of being forced to quit their jobs so they can qualify for public benefits.
- Opponents are misinformed about mental illness and the treatments now available—vastly improved in the last two decades. The efficacy of treatment for mental illness is now as well established as treatments for many physical disorders, and the costs as easily controlled.

Parity in Mental Health Coverage Is Affordable

- The Congressional Budget Office (CBO) estimates the cost of mental health parity as a mere 1.6% increase in employer premium costs. CBO and others also estimate that the amendment will lower public health program costs, including Medicaid.
- Many large employers, managed care organizations and public programs (e.g., Medicaid) have already switched from arbitrary caps on mental health treatment to individualized services, ensuring that those who need care can receive it—and receive it in the most effective and often least costly setting—without providing unlimited care to all who seek it.
- Managed care controls the potential for abuse of mental health benefits without the enormous pain of arbitrary ceilings. In 1995, 69% of firms with 1,000 or more employees had a managed mental health program. Of small firms, 28% had managed mental health care.
- Companies and states using a managed care approach have saved 40-50% in claims costs after removing day and visit limits.² These firms actively encourage employees to seek treatment as soon as possible because it makes good economic sense.
- Without arbitrary limits, people can continue using less expensive mental health services, often avoiding costly hospitalization. Sterling-Winthrop, for example, reports a 50% increase in utilization rates due to expanded mental health outpatient care, but an overall drop in costs for mental health claims.

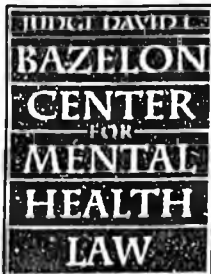
Parity in Mental Health Coverage Is Supported by Voters

- The American public overwhelmingly agrees with the amendment's purpose. A 1994 national poll by Mellman-Lazarus-Lake and Research Strategy Management, Inc. found that 78% of voters believe it is important to cover mental health problems to the same extent as physical problems. A majority oppose arbitrary limits on either outpatient care (53%) or hospital care (63%).
- In an October 1993 survey for *Parade Magazine*, 87% of respondents said medical plans should provide the same coverage for seeing a psychiatrist as for seeing other doctors.

Members of Congress should support the Senate amendment to S.1028 requiring that health plans treat mental illness no differently than other health care.

1. Rice et al., *The Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985*. U. S. Department of Health and Human Services, Alcohol, Drug Abuse and Mental Health Administration (1990).

2. Frank et al., "Risk Contracts in Managed Mental Health Care," *Health Affairs* (Fall 1995).



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National
Mental Health
Association

WORKING TOGETHER FOR NONDISCRIMINATORY HEALTH INSURANCE

Drafting State Legislation on Nondiscriminatory Coverage of Mental Health and Substance Abuse in Insurance Policies and Health Plans

This fact sheet has been developed by the Judge David L. Bazelon Center for Mental Health Law and the National Mental Health Association to assist state advocates in developing an appropriate legislative proposal to eliminate discriminatory provisions in health insurance policies and health plans regulated by the state.

FIRST STEP: ASSESS EXISTING LAWS

Federal legislation enacted in 1996 will shortly go into effect, protecting individuals in group health plans against certain arbitrary and discriminatory practices with respect to mental health coverage. Under Public Law 104-204,¹ if a group health plan does not include an aggregate lifetime limit on other benefits, the plan may not impose lifetime limits on mental health benefits, and if the plan does have a lifetime limit on other coverage, it must either apply the same limit to mental health coverage or combine mental health and other medical and surgical benefits under a single lifetime limit. The same requirements are also made with respect to annual reimbursement limits for covered mental health services.

This law thus addresses the problem of discriminatory policies with respect to overall lifetime limits and annual reimbursement limits, such as limits of \$1,000 with respect to payment for outpatient visits. Since federal law already addresses those issues, it is not necessary for state legislation to do so.

Secondly, states should focus on improving their existing schemes. Legislation prohibiting discrimination in insurance should build upon current state laws. Some states have enacted laws requiring health plans to include mental health and/or substance abuse coverage and require that

¹ Known as the Kennedy-Kassebaum health reform law, this legislation is codified at 42 USC § 300gg-5; 110 STAT 2947-2950. PL 104-204 amended Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (ERISA).

individuals be offered a plan that includes a specific mental health and/or substance abuse benefit. These laws lay the groundwork for a nondiscrimination legislation.

DRAFTING THE LEGISLATION

1) Scope of Proposal

States have the authority to regulate individual and group health insurance plans and health benefits of certain entities operating within the state, such as health maintenance organizations. States do not have the authority to regulate the health benefits offered by companies that self-insure. This authority has been pre-empted by the federal government under ERISA.

Legislation to prohibit discrimination against mental health and substance abuse coverage in health plans should be constructed so as to protect as many state residents as possible. The exact language for such coverage will vary, depending on terms used with the state and the structure of the state's regulatory system.

In drafting language to define the scope of the legislation, states should, at a minimum, cover all group or blanket health insurance and accident insurance plans and health maintenance organizations and other managed care plans in the state. Coverage for individual as well as group health plans should also be considered, since this will significantly increase the scope and effectiveness of the state legislation.

Examples of language from other laws can provide guidance to legislative drafters of state reforms.

a) Maryland's parity law covers a wide range of group and individual plans and the state's statutory definition includes:

hospital or major medical contracts or certificates delivered or issued for delivery in the State by insurers, nonprofit health service plans or health maintenance organizations on a group or individual basis and which provides coverage for health care...(MD)

b) The federal legislation is limited to group plans and plans that are offered in connection with such plans, such as under COBRA:

group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits...(Federal)

c) A more simple approach is taken in Minnesota and New Hampshire:

All health plans, as defined in section (of state law), that provide coverage for mental health or chemical dependency services...(MN)

any policy of group or blanket accident or health insurance and each hospital service corporation, medical service corporation and health maintenance organization providing benefits for disease or sickness...(NH)

2) Requirements on Plans

Given that the federal law (see above) protects against lifetime caps and annual reimbursement limits in group plans, state laws need not duplicate these protections. States can therefore focus on protecting individuals from annual day and visit limits and financial obligations, such as deductibles, co-payments and out-of-network charges.

Language to prohibit discrimination with respect to *day and visit limits* should be explicit.

a) Minnesota has broad language with respect to benefits, and could be edited (as shown in parentheses) so as to address day and visit limits specifically:

(annual day and visit) service limitations for (mental health and substance abuse) services...must not...be more restrictive than those requirements and limitations for...medical services.

b) Maryland law addresses the problem that plans may also have limitations on some medical services, however, its wording is not as clear in other respects as the Minnesota law. Maryland requires that plans:

may not discriminate against any person with a mental illness by failing to provide benefits for treatment and diagnosis of mental illness under the same terms and conditions that apply to the majority of comparable benefits available under the contract or certificate or any other type of health care.

Language with respect to discriminatory *cost-sharing* should be comprehensive:

a) The Minnesota statute is clear:

cost-sharing requirements...for... mental health and chemical dependency services...must not place a greater financial burden on the insured or enrollee...than those requirements for...medical services.

b) Another approach is to require the same terms and conditions apply to mental health services as apply with respect to other health benefits Maryland addressed the issue by requiring (material in parentheses is added for clarity):

benefits for illnesses covered by this section and the benefits for physical illnesses covered under a contract or policy shall have the same terms and conditions (with respect to deductibles, co-payments and out-of-network charges)

3) Covered Services

States that have already addressed the need for health plans to include mental health and/or substance abuse treatment through mandatory coverage laws should reference those statutes.

Although these laws do not require the full array of mental health and substance abuse services typically provided through the public sector and essential to those with the most serious disorders, they do provide a minimum package of services. Typically such laws require coverage of inpatient hospital care, outpatient treatment and partial hospitalization, reflecting the standard service array used by a working population. Other state systems will, of course, still be necessary to provide the more comprehensive array of services needed by adults with serious mental illness and children with serious emotional disorders.

States with laws *mandating* coverage, states with laws mandating the *offering* of policies with coverage and states with *no such laws* will need to address the issue of covered services differently.

In states with mandated minimum benefit laws, the state's nondiscrimination legislation should refer specifically to the services that are mandated to be covered under current state law. In this manner, the specific services (i.e. inpatient hospitalization, partial hospitalization, outpatient services, etc.) will continue to be required in all health plans, but now there will also be prohibitions on arbitrary limits in covered days/visits or financial requirements for mental health and/or substance abuse services.

In states with laws mandating the offering of mental health and/or substance abuse services, the nondiscrimination legislation should refer specifically to the services that are required to be offered. Thus, individuals will be given the option to purchase coverage that protects them for mental health and substance treatment costs and that includes at least a minimum range of services. Without this reference, plans might design insurance options that cover, for example, only inpatient hospital services and physician services and argue that this represents nondiscriminatory benefits because other services, such as partial hospitalization or services of other mental health professionals, are not furnished with respect to other illnesses.

In states with no legislation concerning minimum mental health and/or substance benefit packages, states should include a requirement that a defined minimum array of services be at least offered to state residents by the health plans operating in the state. Without this language, plans in these states will be able to avoid the nondiscrimination provisions entirely, simply by dropping their mental health coverage.

December 1996

Parity in Benefit Design: Existing Law

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Information provided by the American Managed Behavioral Healthcare Association.

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Mental Health - - address*

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1776 Massachusetts Ave., NW, Ste. 100
Washington, DC 20036
(202) 296-6443 or Fax: (202) 296-8850

MEMORANDUM

Date: February 20, 1997
To: Richard Warrington--Alaska Head Injury Foundation
From: Cheryl Norman *Cheryl*
Subject: TBI Act!!

Attached is a copy of the TBI Act. As you will see, any funds appropriated under the act by the Federal Government are disbursed to state governments. No funds are provided directly to the Brain Injury Association or any of its state affiliate. The U.S. Department of Health and Human Services will Publish a notice in the Federal Register describing how state governments can apply for the money. When the notice appears, BIA will send a copy to you. BIA is working to fill the staff position which handles all legislative matters. When that person is hired, an announcement will appear in the Staff Memo which is mailed to you at the end of every month.

TRAUMATIC BRAIN INJURY ACT BECAME LAW IN 1996

Congress Passes Traumatic Brain Injury Act

On July 12, 1996, the Senate passed language identical to the House passed version of the Traumatic Brain Injury Act. The House of Representatives had passed the bill on July 9. The TBI Act authorizes the federal government to spend \$24.5 million over the next three years on:

- Grants to states to develop model treatment programs.
- Funds for the Centers for Disease Control and Prevention to study the incidence of brain injury.
- Funds for agencies in the Department of Health and Human Services to research into prevention, treatment and rehabilitation of brain injury.
- Funds for the National Institutes of Health to host a national conference, gathering all the experts in the field of brain injury.

After a 5 -year process, not a single legislator voted against the Traumatic Brain Injury Act in 1996. In fact, a number of legislators were instrumental in passing the TBI Act. Jim Greenwood of Pennsylvania ushered this legislation through the House and consistently worked with the Senate to keep that chamber on track. Other legislators who played pivotal roles include Senators Orrin Hatch of Utah and Ted Kennedy of Massachusetts, and Congressman Frank Pallone of New Jersey.

President Hosts Signing Ceremony For The Traumatic Brain Injury Act

On July 29, President Clinton hosted a signing ceremony, recognizing the importance of people with brain injury and their families. By passing and signing this legislation, the federal government has taken proactive efforts to resolve problems associated with brain injury. Christopher Reeve, Gary Busey, Jim Brady and Frank Gifford made phone calls to the White House to convince the President that this signing ceremony was important to millions of Americans -- individuals with brain injury and their family members. In addition to BIA President Dr. George Zitnay, Vice Chairman Jim Brady and Chairman Martin Foil, top federal agency officials and ranking members of Congress were present at the ceremony.

Congress Appropriates Funds for the Traumatic Brain Injury Act

On September 30, 1996, Congress appropriated funds to support the Traumatic Brain Injury Act for fiscal year 1997:

- \$2,600,000 for the Centers for Disease Control to study the incidence of brain injury and fund education/prevention initiatives
- \$2,857,000 for the Health Resources and Services Administration to implement model demonstration projects at the state level
- A directive to the National Institutes of Health to organize a national consensus conference and produce a white paper on brain injury in the United States

Public Law 104-166
104th Congress

An Act

To amend the Public Health Service Act to provide for the conduct of expanded studies and the establishment of innovative programs with respect to traumatic brain injury, and for other purposes.

July 29, 1996
[H.R. 248]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PROGRAMS OF CENTERS FOR DISEASE CONTROL AND PREVENTION.

Part J of title III of the Public Health Service Act (42 U.S.C. 280b et seq.) is amended by inserting after section 393 the following section:

“PREVENTION OF TRAUMATIC BRAIN INJURY

“SEC. 393A. (a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may carry out projects to reduce the incidence of traumatic brain injury. Such projects may be carried out by the Secretary directly or through awards of grants or contracts to public or nonprofit private entities. The Secretary may directly or through such awards provide technical assistance with respect to the planning, development, and operation of such projects. 42 USC 280b-1b.

“(b) CERTAIN ACTIVITIES.—Activities under subsection (a) may include—

“(1) the conduct of research into identifying effective strategies for the prevention of traumatic brain injury; and

“(2) the implementation of public information and education programs for the prevention of such injury and for broadening the awareness of the public concerning the public health consequences of such injury.

“(c) COORDINATION OF ACTIVITIES.—The Secretary shall ensure that activities under this section are coordinated as appropriate with other agencies of the Public Health Service that carry out activities regarding traumatic brain injury.

“(d) DEFINITION.—For purposes of this section, the term ‘traumatic brain injury’ means an acquired injury to the brain. Such term does not include brain dysfunction caused by congenital or degenerative disorders, nor birth trauma, but may include brain injuries caused by anoxia due to near drowning. The Secretary may revise the definition of such term as the Secretary determines necessary.”

SEC. 2. PROGRAMS OF NATIONAL INSTITUTES OF HEALTH.

Section 1251 of the Public Health Service Act (42 U.S.C. 300d-61) is amended—

(1) in subsection (d)—

(A) in paragraph (2), by striking "and" after the semicolon at the end;

(B) in paragraph (3), by striking the period and inserting "; and"; and

(C) by adding at the end the following paragraph:
 "(4) the authority to make awards of grants or contracts to public or nonprofit private entities for the conduct of basic and applied research regarding traumatic brain injury, which research may include—

"(A) the development of new methods and modalities for the more effective diagnosis, measurement of degree of injury, post-injury monitoring and prognostic assessment of head injury for acute, subacute and later phases of care;

"(B) the development, modification and evaluation of therapies that retard, prevent or reverse brain damage after acute head injury, that arrest further deterioration following injury and that provide the restitution of function for individuals with long-term injuries;

"(C) the development of research on a continuum of care from acute care through rehabilitation, designed, to the extent practicable, to integrate rehabilitation and long-term outcome evaluation with acute care research; and

"(D) the development of programs that increase the participation of academic centers of excellence in head injury treatment and rehabilitation research and training.";

and

(2) in subsection (h), by adding at the end the following paragraph:

"(4) The term 'traumatic brain injury' means an acquired injury to the brain. Such term does not include brain dysfunction caused by congenital or degenerative disorders, nor birth trauma, but may include brain injuries caused by anoxia due to near drowning. The Secretary may revise the definition of such term as the Secretary determines necessary."

SEC. 3. PROGRAMS OF HEALTH RESOURCES AND SERVICES ADMINISTRATION.

Part E of title XII of the Public Health Service Act (42 U.S.C. 300d-51 et seq.) is amended by adding at the end the following section:

42 USC 300d-52. *SEC. 1252. STATE GRANTS FOR DEMONSTRATION PROJECTS REGARDING TRAUMATIC BRAIN INJURY.

"(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to States for the purpose of carrying out demonstration projects to improve access to health and other services regarding traumatic brain injury.

"(b) STATE ADVISORY BOARD.—

"(1) IN GENERAL.—The Secretary may make a grant under subsection (a) only if the State involved agrees to establish an advisory board within the appropriate health department of the State or within another department as designated by the chief executive officer of the State.

"(2) FUNCTIONS.—An advisory board established under paragraph (1) shall advise and make recommendations to the

State on ways to improve services coordination regarding traumatic brain injury. Such advisory boards shall encourage citizen participation through the establishment of public hearings and other types of community outreach programs. In developing recommendations under this paragraph, such boards shall consult with Federal, State, and local governmental agencies and with citizens groups and other private entities.

"13. COMPOSITION.—An advisory board established under paragraph (1) shall be composed of—

"A representatives of—

- "(i) the corresponding State agencies involved;
- "(ii) public and nonprofit private health related organizations;
- "(iii) other disability advisory or planning groups within the State;
- "(iv) members of an organization or foundation representing traumatic brain injury survivors in that State; and
- "(v) injury control programs at the State or local level if such programs exist; and

"B a substantial number of individuals who are survivors of traumatic brain injury, or the family members of such individuals.

"(c) MATCHING FUNDS.—

"(1) IN GENERAL.—With respect to the costs to be incurred by a State in carrying out the purpose described in subsection (a), the Secretary may make a grant under such subsection only if the State agrees to make available, in cash, non-Federal contributions toward such costs in an amount that is not less than \$1 for each \$2 of Federal funds provided under the grant.

"(2) DETERMINATION OF AMOUNT CONTRIBUTED.—In determining the amount of non-Federal contributions in cash that a State has provided pursuant to paragraph (1), the Secretary may not include any amounts provided to the State by the Federal Government.

"(d) APPLICATION FOR GRANT.—The Secretary may make a grant under subsection (a) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

"(e) COORDINATION OF ACTIVITIES.—The Secretary shall ensure that activities under this section are coordinated as appropriate with other agencies of the Public Health Service that carry out activities regarding traumatic brain injury.

"(f) REPORT.—Not later than 2 years after the date of the enactment of this section, the Secretary shall submit to the Committee on Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report describing the findings and results of the programs established under this section, including measures of outcomes and consumer and surrogate satisfaction.

"3. DEFINITION.—For purposes of this section, the term 'traumatic brain injury' means an acquired injury to the brain. Such term does not include brain dysfunction caused by congenital or degenerative disorders, nor birth trauma, but may include brain injuries caused by anoxia due to near drowning. The Secretary

(b) **CONSENSUS CONFERENCE.**—The Secretary, acting through the Director of the National Center for Medical Rehabilitation Research within the National Institute for Child Health and Human Development, shall conduct a national consensus conference on managing traumatic brain injury and related rehabilitation concerns.

(c) **DEFINITION.**—For purposes of this section, the term “traumatic brain injury” means an acquired injury to the brain. Such term does not include brain dysfunction caused by congenital or degenerative disorders, nor birth trauma, but may include brain injuries caused by anoxia due to near drowning. The Secretary may revise the definition of such term as the Secretary determines necessary.

(d) **AUTHORIZATIONS OF APPROPRIATIONS.**—For the purpose of carrying out subsection (a)(1)(A), there is authorized to be appropriated \$3,000,000 for each of the fiscal years 1997 through 1999. For the purpose of carrying out the other provisions of this section, there is authorized to be appropriated an aggregate \$500,000 for the fiscal years 1997 through 1999. Amounts appropriated for such other provisions remain available until expended.

SEC. 5. TECHNICAL AMENDMENTS.

Title XXVI of the Public Health Service Act (42 U.S.C. 300ff-11 et seq.), as amended by Public Law 104-146 (the Ryan White CARE Act Amendments of 1996), is amended—

(1) in section 2626—

(A) in subsection (d), in the first sentence, by striking “(1) through (5)” and inserting “(1) through (4)”; and

(B) in subsection (f), in the matter preceding paragraph (1), by striking “(1) through (5)” and inserting “(1) through (4)”; and

(2) in section 2692—

(A) in subsection (a)(1)(A)—

(i) by striking “title XXVI programs” and inserting “programs under this title”; and

(ii) by striking “infection and”; and

(B) by striking subsection (c) and all that follows and inserting the following:

Ante, p. 1369.

Ante, p. 1363.

"(c) AUTHORIZATION OF APPROPRIATIONS.—

"(1) SCHOOLS; CENTERS.—For the purpose of grants under subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1996 through 2000.

"(2) DENTAL SCHOOLS.—For the purpose of grants under subsection (b), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1996 through 2000."

Approved July 29, 1996.

LEGISLATIVE HISTORY—H.R. 248:

HOUSE REPORTS: No. 104-652 (Comm. on Commerce).

CONGRESSIONAL RECORD, Vol. 142 (1996):

July 9, considered and passed House.

July 12, considered and passed Senate.

○

TRAUMATIC BRAIN INJURY FACTS AND FIGURES

The Traumatic Brain Injury Model Systems National Data Center

April, 1996

Introduction

In 1987, the U.S. Department of Education, National Institute on Disability and Rehabilitation Research (NIDRR) provided funding to establish the Traumatic Brain Injury (TBI) Model Systems of Care. These research and demonstration projects focus primarily on: 1) developing and demonstrating a model system of care for persons with TBI, stressing continuity and comprehensiveness of care; and 2) maintaining a standardized national database for innovative analyses of TBI treatment and outcomes.

The TBI Model Systems (TBIMS) Project is a prospective, longitudinal multi-center study which examines the course of recovery and outcomes following TBI. Each center provides a coordinated system of emergency care, acute neurotrauma management, comprehensive inpatient rehabilitation and long-term interdisciplinary follow-up services.

Currently there are four TBIMS centers funded through 1997: Medical College of Virginia (Richmond), Wayne State University/Rehabilitation Institute of Michigan (Detroit), The Institute for Rehabilitation and Research (Houston), and Santa Clara Valley Medical Center (San Jose). Wayne State University/Rehabilitation Institute of Michigan is the current site of the TBIMS National Data Center.

The June, 1993 issue of the *Journal of Head Trauma Rehabilitation* was dedicated to a description of the TBIMS and initial research findings from the National Database. The TBIMS National Database Syllabus contains detailed information about the database and is available through the TBIMS National Data Center.

Variables originally included in the database were selected to address six major research and demonstration issues: 1) demographic characteristics of the population; 2) causes of injury; 3) nature of diagnoses including the severity of injury, impairment and disability; 4) the types of services/treatments provided; 5) the "costs" of treatment; and 6) measurement and prediction of outcomes including impairment, disability and handicap. The TBIMS National Database includes key variables to reflect these characteristics, including a set of measures designed to assess impairment, disability and handicap.

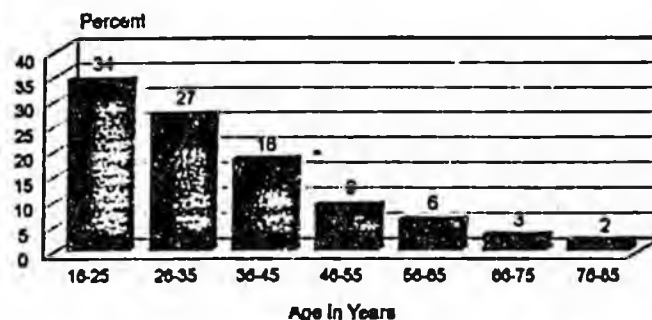
TBI is defined as damage to brain tissue caused by an external mechanical force as evidenced by: loss of consciousness due to brain trauma, post traumatic amnesia, skull fracture, or objective neurological findings that can be reasonably attributed to TBI on physical examination or mental status examination. Subjects included in the study, in addition, must: 1) be at least 16 years of age; 2) arrive at the acute care hospital emergency department within 24 hours of injury; 3) receive both acute hospital care and inpatient rehabilitation within the defined Model System; and 4) give informed consent.

Information contained in the database is collected continuously during initial hospitalization, including acute care and inpatient rehabilitation. In addition, information is collected annually thereafter, on the anniversary of injury, reflecting patient status at that time, as well as during the preceding year. The database currently contains approximately 370 variables to describe the initial hospitalization period, and approximately 240 variables relevant to the follow-up period.

Results

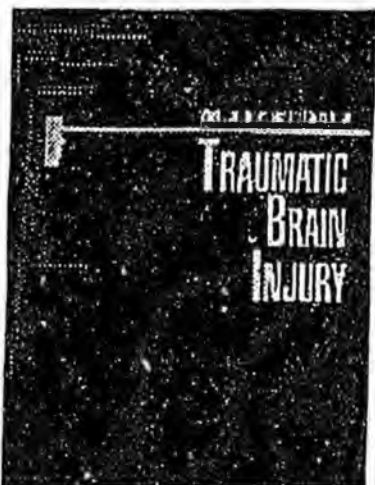
The database currently contains information on 660 individuals discharged from the four active TBIMS between March, 1989 and September, 1995; with annual follow-up information extending, thus far, to six years post-injury on the earliest cases. The majority of individuals were between the ages of 16 and 35 years at the time of injury (61%), with an average age of 35 years and a range of 16 to 92 years (Fig. 1).

Figure 1 - Age at Injury



Approximately three-fourths (77%) of the cases are males. More than half (51%) are White, 38% are African American, and 11% are of other races. Most were single at the time of injury (57%); 23% were married, 13% were divorced, 4% were separated and 3% were widowed.

At the time of injury, only half (50%) of the individuals were employed, 30% were unemployed, 11% were students, and 10% were either retired, homemakers or other. Of those individuals who were employed at the time of injury, half were in precision production/craft/repair occupations (24%) or machine operator/fabricator/laborer occupations (26%); and 12% were in managerial/professional specialty occupations (Fig. 2).



What Legislators Need To know About Traumatic Brain Injury

Executive Summary

© National Conference of State Legislatures

Each year, 2 million Americans sustain traumatic brain injuries from automobile crashes, falls, recreation injuries, assaults and violence. These injuries are the leading cause of death and disability in children and young adults in the United States. Of those who suffer traumatic brain injuries, 75,000 to 100,000 will die, and 70,000 to 90,000 must live the remainder of their lives with severe disabilities. The highest rate of injury is suffered by young males.

Brain injury has dramatic repercussions for the injured and their families. People with brain injuries have trouble with short-term memory, concentration, judgment and organization. Many have substance abuse problems that may have existed before the injury or were acquired afterwards as a way to escape the difficulties of their lives. Divorce is common among married people who sustain brain injuries, and many lose their friends. People with serious brain injuries may need constant supervision and help in managing money, doing household chores, and sometimes bathing and dressing. Because the injuries are not always visible, people with brain injuries may have trouble qualifying for federal and state programs.

Families provide the majority of care for people with brain injuries. Many exhaust their family resources or have to give up jobs to care for a family member full time. The psychological and financial stress is overwhelming as families struggle to provide care with little or no help from existing state service systems.

Today, more and more people survive brain injuries, thanks to advances in medicine and trauma care. The for-profit brain injury rehabilitation industry has grown rapidly in the last 10 years until it is now generating an estimated \$10 billion a year in gross revenues.

However, state services have lagged far behind for people with brain injuries who are not insured, have exhausted their benefits, or have left the rehabilitation centers to live with their families or in the community. Today, only one in 20 people with traumatic brain injuries receives the rehabilitation services needed.

People with brain injuries, like everyone else, want good relationships with friends and family, respect and dignity, opportunities to develop and exercise competence, and opportunities to contribute to community life and make choices about their futures. The growing advocacy movement is demanding that people with traumatic brain injuries be able to control their lives and the services they receive. Increasingly, legislators will be asked to set policies based on these values and create cost-effective systems of care.

Though some forward-looking states are providing services targeted at the special needs of people with brain injuries, in other states services are fragmented and inefficient. Many state bureaucracies

have no central home for people with traumatic brain injuries. Services are spread over many departments, including health, mental health, education and social services, to name a few. This causes problems for the people with brain injuries and their families who have to go from department to department, trying to patch together services. It also causes problems for states as they look to developing policies that would more appropriately meet the needs of people with traumatic brain injuries.

States are trying to improve service delivery by establishing state councils, creating a lead agency for people with traumatic brain injuries, and offering case management to control costs by ensuring that people get the most appropriate services. States are paying for services through traditional sources of financing such as Medicaid, vocational rehabilitation funds and state general revenues. States are also making use of more innovative financing ideas, such as dedicated funding streams drawn from fees on motor vehicle violations, including speeding, drunk driving and seat belt violations. Other states are writing Medicaid home- and community-based waivers targeted at people with traumatic brain injuries.

States can reduce the catastrophic costs of brain injury through prevention programs. Brain injury, unlike other illnesses, can be prevented in many instances. States can help prevent the incidence and severity of brain injury by passing and rigorously enforcing laws requiring seat belts, child restraints and helmets for motorcycle riders. States and localities can also launch educational campaigns to increase the use of helmets by bicycle riders and in other sports.

This publication is intended to provide legislators with the background information to help them make informed public policy decisions about systems of care for people with traumatic brain injuries in their states. The booklet is in a question and answer format and is organized as follows:

- The first two questions define traumatic brain injury and its impact on people with brain injuries and their families. They raise issues of interest to legislators, including the high cost to society, the high cost of inappropriate care, the inability of existing service systems to meet the needs, aging caregivers, the growth of advocacy movements, federal legislation that will elevate brain injury to the national agenda, and the availability of data.
- Questions 3 and 4 outline services needed by people with brain injuries and available federal assistance.
- Questions 5 and 6 look at private insurance coverage for people with traumatic brain injuries and public/private options that might be used to support services, including publicly subsidized health insurance, state-financed catastrophic health insurance, catastrophic riders to insurance policies, preferred provider organizations targeted at people with disabilities, state high-risk pools and self-sufficiency trusts.
- Questions 7 and 8 look at state service delivery and financing of services for people with traumatic brain injuries.
- Prevention efforts are addressed in Question 9, including mandatory seat belt laws, mandatory helmet laws for motorcycle riders and other strategies.
- Question 10 presents innovative approaches by state and nonprofit agencies, including statewide programs, home- and community-based services, housing, jobs education, and central registries.

FACTS ABOUT TRAUMATIC BRAIN INJURY

- * A Conservative estimate puts the number of traumatic brain injuries over 2 million per year, with 500,000 severe enough to require hospital admission.
- * Every 16 seconds someone receives a head injury in the U.S.; every five minutes, one of these people will die and another will become permanently disabled.
- * Traumatic Brain Injury (TBI) is the leader killer and cause of disability in children and young adults.
- * Each year 75,000 to 100,000 Americans will die as a result of a TBI. Most deaths occur at time of injury or within the first two hours of hospitalization.
- * Of those who survive, each year approximately 70,000 to 90,000 will endure lifelong debilitating loss of function. An additional 2,000 will exist in a persistent vegetative state.
- * Young men between ages of 15 to 35 have the highest rate of injury. Males are more likely to suffer serious head injuries than females.

CAUSES

- * Motor vehicle accidents causes over-half of all traumatic brain injuries; Assaults and violence accounting for 30%; falls account for 10%, sports and recreation is 4%.
- * Child abuse accounts for 64% of infant head injuries.
- * Each year in the U.S. 50,000 children sustain bicycle related head injuries, and of these over 400 die.

CONSEQUENCES

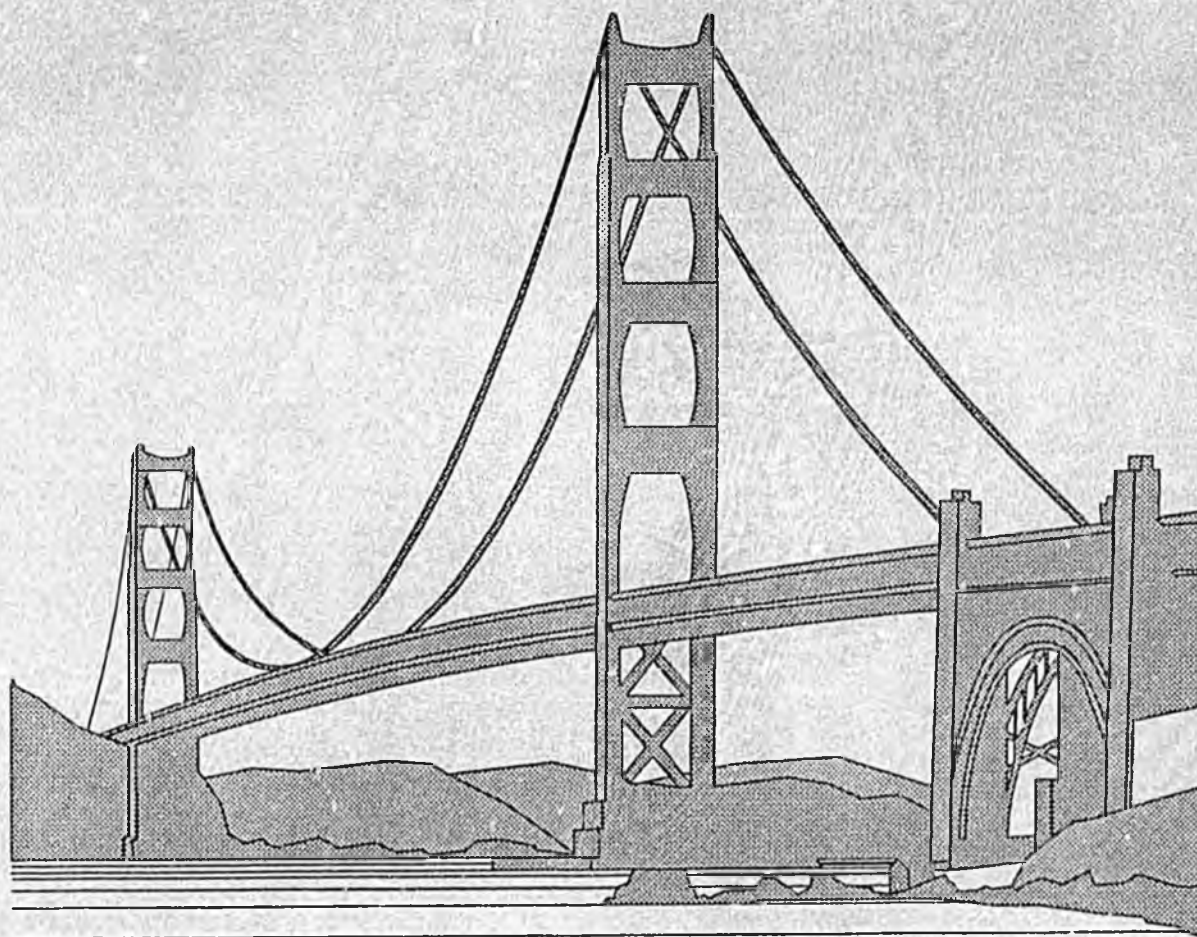
- * Physical: impairments of speech, vision and hearing loss, headaches, muscle spasticity, paralysis, and seizure disorders.
- * Cognitive: Memory deficits (short and long term), limited concentration, impaired perception and communication, difficulties with reading, writing, planning and judgement.
- * Psycho-Social-Behavioral-Emotional impairments: Fatigue, mood swings, denial, anxiety, depression, lowered self-esteem, sexual dysfunction, lack of motivation, problems with interpersonal skills, inability to self-monitor, difficulty with emotional control, inability to cope, agitation, excessive laughing or crying and difficulty in relating to others.

COSTS

- * The economic cost alone approach \$25 billion per year.
- * A survivor of a severe brain injury typically faces 5 to 10 years of intensive services; estimated lifetime cost can exceed \$4 million.

SOURCE: Interagency Head Injury Task Force Reports, National Institute of Neurological Disorders and Stroke, National Institutes of Health, Bethesda, MD.

Building Bridges Campaign for Mental Health



FY98 Legislative Priorities

MISSION STATEMENT OF THE BUILDING BRIDGES CAMPAIGN FOR MENTAL HEALTH

- ★ Empower mental health consumers, their families, providers and advocates.
- ★ Turn awareness into action for Alaska's mentally ill and emotionally disturbed citizens.
- ★ Increase state funding for community based services and programs serving persons experiencing mental and emotional illnesses.
- ★ Facilitate a grass roots effort to positively affect the legislative and other public policy decision making processes.
- ★ Increase cohesiveness within Alaska's mental health community.
- ★ Advance principles of Life Domains and coordinate with other advocacy efforts in Alaska.

BRIDGES c/o MHA in Alaska ● 4050 Lake Otis Parkway, Suite 202
Anchorage, Alaska 99508-5221
Tel 907-563-0880 ● Fax 907-563-0881 ● Toll Free 1-800-478-0880
Email mhaa@alaska.net



Dear

The Building Bridges Campaign is pleased to present to you a copy of our FY98 legislative priorities.

Building Bridges signifies the need of people with mental and emotional illnesses to have bridges to their families and communities. Lack of treatment and support results in isolation and dysfunction. With bridges of treatment and support, full community participation, contribution, and responsibility are possible.

On March 18th, 19th and 20th, the Building Bridges group (family members, consumers, service providers, and friends) will come together in Juneau. The purpose is raising public, legislative, and administrative awareness regarding mental health and the needs of those who experience mental and emotional illnesses.

We appreciate the support the Alaska legislature has provided for development of a mental health service system over the past several years. Through your support we have made significant progress in establishing services for some of the groups who suffer mental illness. Unfortunately, our system is still lacking critical elements.

We ask for your support. We must stabilize the service system that is already in place in our communities. Also, ways must be found to continue the development of necessary services. The Building Bridges Campaign endorses the Alaska Mental Health Board's Shared Vision Plan and FY98 Funding Recommendations for Alaska's Comprehensive Mental Health program. The portions of the Board's recommendations which were prioritized by Building Bridges are presented to you in this booklet.

We thank you for your time and for the opportunity to meet with you and your staff.

Respectfully,

Building Bridges

Building Bridges Campaign



Who are we?

The Building Bridges Campaign is a rural and urban group of consumers, family members, and providers. We suffer from and/or provide services for people who experience mental and emotional illnesses. The people we are advocating for have inadequate resources to obtain adequate mental health care.

What do we want?

The Building Bridges Campaign wants mental health care which is:



Affordable



Accessible



Within our Community



High Quality

What is my stake in this?

The pain and loss for our children, family, friends, and neighbors is real and **unrelenting**. We have come forward to share our experiences with you.

What am I asking from you?

I need **your help and your leadership to ensure adequate mental health care** for Alaskans.

Specifically, we ask your support for:



A fully developed system of mental health care



Community mental health program grants



Medicaid program funding

Building Bridges Campaign

When people are unable to receive adequate community mental health care, the results are felt in other areas of the community.

When Community Care is not available to:

Care is Provided by:

People who are in crisis

*Emergency Rooms
Hospitals*

People with mental illness

*Alaska Psychiatric Hospital
Correctional Facilities
Private Hospitals*

Children with Emotional Disturbance

*Private Hospitals
Public Institutions*

People with Alzheimer's and Related Disorders, or Seniors with Mental Illness

*Public Institutions
Private Hospitals
Nursing Homes*

Adults with Emotional Problems

*Physicians
Correctional Facilities*

The results of inadequate community mental health services are inappropriate and more expensive treatment.

Legislative Concerns

Education Regarding Mental Illness



People are not mentally ill or emotionally troubled by choice.



Treatment for mental illness and emotional disturbance works.



Community treatment works better and costs less and is preferred by the people receiving service.

FY98 Budget

The primary support for mental health services to people without enough money to pay their own way comes from state grants and Medicaid. Both sources are necessary to continue successful community treatment.



FY98 Budget Priorities

Building Bridges endorses the following budget recommendations for protection of base budget and for budget increments.

The increments proposed are taken from the Alaska Mental Health Board's FY98 Budget Recommendations, dated July 31, 1996.



**The Building Bridges group supports
the following levels of priority:**

The *first* level is for no cuts to the mental health system
in either grants or Medicaid budgets.

The *second* level is for increases of service capacity.

**FY98 Priorities
Summary by Budget Request Unit**

DMHDD Mental Health Services Grants

First Level = No Cuts

Funding at Base Budget Levels \$26,689.1

General Community
Mental Health \$ 888.4

Psychiatric
Emergency Services \$6,777.4

Chronically Mentally
III \$10,918.7

Seriously Emotionally
Disturbed Youth \$ 5,789.8

Native Assoc. BRU's \$ 2,267.0



Second Level

**FY98 Alaska Mental Health
Board's Recommended
Proposed Increments \$8,736.3**

Supporters of the BUILDING BRIDGES Campaign for Mental Health

Northern Region

Copper River Mental Health Center
Fairbanks Community Mental Health Center
Family Centered Services of Alaska
Four Rivers Counseling Center
Maniilaq Counseling Services
North Slope Borough Community Counseling Center
Norton Sound Community Mental Health Center
Railbelt Mental Health & Addictions Program
Tanana Chiefs Conference Mental Health & Alcohol Program
Tok Area Mental Health Center
Yukon Flats Care Center
Yukon-Koyukuk Mental Health & Alcohol Program
Yukon-Tanana Community Mental Health & Substance Abuse Program

Southeast Region

COHO Mental Health Services, Inc.
Community Connections
Gateway Center for Human Services
Islands Counseling Services
Juneau Alliance for the Mentally Ill
Juneau Community Mental Health Center
Juneau Youth Services, Inc.
Lyn Canal Counseling Center
Petersburg Mental Health Services, Inc.
SEARCH-Behavioral Health Services Division
Sound Alternatives
Wrangell Mental Health Services, Inc.

Southcentral Region

Aleutians East Health Department
Alaska Specialized Education & Training Services
Anchorage Center for Families
Bethel Community Services
Bristol Bay Area Health Corporation
Central Peninsula Counseling Services
Kodiak Island Borough Mental Health Center
Life Quest
Seward Life Action Council
South Peninsula Community Mental Health Center
Southcentral Foundation
Southcentral Counseling Center
The ARC of Anchorage
Yukon Kuskokwim Health Corporation
Community Mental Health Center
Valdez Counseling Center

Statewide Advocacy Organizations

Alaska Alliance for the Mentally Ill
Mental Health Association in Alaska
Mental Health Consumers of Alaska
Disability Law Center of Alaska