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PRESERVATION

MENTAL HEALTH CONFERENCE

CLINTON/GORE ADMINISTRATION UNVEILS NEW INITIATIVES TO ADDRESS MENTAL HEALTH AT THE FIRST-EVER WHITE HOUSE CONFERENCE ON MENTAL HEALTH
June 7, 1999

Today, at the first-ever White House Conference on Mental Health, chaired by the President's Mental Health Advisor Tipper Gore, the Clinton/Gore Administration will unveil unprecedented measures to improve mental health. "To improve the health of our nation, we must ensure that our mental health is taken as seriously as our physical health. That is why we are taking new steps to break down the myths and misperceptions of mental illness, highlighting new cutting-edge treatments, and encouraging Americans to get the help they need." said Tipper Gore. The Administration's proposals provide parity, improve treatment, bolster research, and expand community responses to help those with mental illnesses. Highlights of these initiatives include:

- **Ensuring that the Federal Employees Health Benefits Plan (FEHBP) -- the nation's largest private insurer - implements full mental health and substance abuse parity.** Today, the Office of Personnel Management is sending a letter to the 285 participating health plans informing them that starting next year they will have to offer full mental health and substance abuse parity to participate in the program. This step will provide full parity for nine million beneficiaries by next year and ensure that the Federal government leads the way to providing parity. The Department of Labor is also launching a new outreach campaign to inform Americans about their rights under the Mental Health Parity Act of 1996.

- **Accelerating progress in research.** In July, National Institute of Mental Health (NIMH) will launch a $7.3 million landmark study to determine the nature of mental illness and treatment nationwide and to help guide strategies and policy for the next century. This new study will collect information on mental illness, including the prevalence and duration of mental illness as well as the types of treatment that are most commonly used. NIMH also will announce the launch of two new clinical trials, investing a total of $61 million, to build on effective treatments for those affected by mental illness.

- **Encouraging states to offer more coordinated Medicaid services for people with mental illness.** Millions of Americans with severe mental illness rely on Medicaid to pay for their health care. To encourage states to make the most effective services available, the Health Care Financing Administration (HCFA) will advise all state Medicaid directors that: (1) Medicaid will reimburse for services provided in Assertive Community Treatment (ACT) programs targeting people with the most severe and persistent mental illness; (2) Medicaid recipients all have access to medications approved by FDA for the treatment of serious mental illnesses; and (3) states should educate Medicaid providers and beneficiaries about their ability to enter into "advance planning directives" that set out treatment guideline for people who became severely incapacitated in the future.

FINAL PRESS RELEASE

- **Launching a pilot program to help people with mental illness get the quality treatment they need to return to work.** Of the 4.7 million Americans that receive Social Security Disability Insurance (SSDI), the Social Security Administration (SSA) estimates that approximately one in nine (about 500,000) has an affective disorder (such as depression or a bipolar disorder). Research suggests that many of the people suffering with these disorders could get effective treatment and perhaps return to work. The Administration will launch a new five-year, $10 million demonstration to provide treatment for SSDI beneficiaries with affective disorders. This complements the Jeffords-Kennedy-Roth-Moynihan legislation, which allows people to buy into the Medicaid or Medicare program when they return to work.

- **Educating older Americans and their health professionals about the risks of depression.** Five million Americans over the age of 65 suffer from some form of depression, but many do not recognize their symptoms as depression and do not receive the treatment they need. NIMH and the Administration on Aging (AoA) will launch an outreach initiative to educate the elderly and their healthcare professionals about mental illness. The Department of Veteran Affairs will also launch six new study sites to test two modes of primary care for older Americans with mental health and/or substance abuse disorders.

- **Reaching out to vulnerable homeless Americans with mental illnesses.** The Department of Housing and Urban Development is launching a new initiative to encourage communities to create safe havens where homeless mentally ill Americans can get treatment and care. HHS will also launch a two-year, $4.8 million grant program to study the treatment, housing, education, training, and support services needed by homeless women and their children given to as many as 2,000 homeless mothers and their 4,000 children, many of whom suffer from mental illnesses. The Department of Veteran Affairs will double the number of "stand down" events to reach out to homeless Americans with mental illness to help them get the treatment and services they need.

- **Implementing new strategies to meet the mental health needs of crime victims.** To ensure that the federal response to community crises, like acts of terrorism or mass violence, includes a strong mental health component, the Administration is announcing a new interagency partnership between the Department of Justice's Office for Victims of Crime and the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration (SAMSHA). This partnership also will ensure that strategies are in place to address the mental health needs of victims of violent crime.

- **Developing and implementing new strategies to address mental illness in the criminal justice system.** SAMHSA and DOJ are hosting a conference later this summer to focus on how the criminal justice system can prevent crime by mentally ill people and can address the needs of offenders with mental illness. Following this conference, DOJ will launch an outreach effort to educate the criminal justice community on how to better serve people with mental health needs. This initiative will include a new partnership with the National GAINS center so that communities interested in pursuing these approaches can get technical assistance and ideas about how to implement successful strategies.

- **Implementing a new comprehensive approach to address combat stress in the military.** At least 30 percent of those who have spent time in war zones experience combat stress reaction. Today the President will direct the Department of Defense to report back within 180 days on an implementation plan for a comprehensive combat stress program throughout the military. DOD will also hold a conference this fall to develop strategies and educate military leaders and medical personnel about the need to enhance current prevention strategies.

- **Launching the expansion of the "Caring For Every Child" mental health campaign.** At least one in ten American children and adolescents may have behavioral, or mental health problems. The Administration will launch a five-year $5 million dollar campaign in targeted communities to highlight the special mental health needs of children.

- **Improving the mental health of Native American youth.** The suicide rate for Native Americans between the ages of five and 24 years old is three times higher than the rest of the U.S. population in this age group. This initiative allocates at least $5 million for a collaboration between the Departments of Interior, Justice, Education, and HHS, to go to ten Native American communities to develop effective strategies to address mental health needs of youth in settings such as the home, school, treatment centers, and the juvenile justice system.

- **The Administration Also Challenged Congress to Pass Legislation to Improve Care and Services for People with Mental Illness.** The Administration urged Congress to:
  - Pass the Jeffords-Kennedy-Roth-Moynihan-Lazio-Waxman-Bliley-Dingell legislation, which would enable people with disabilities to return to work by accessing affordable health insurance.
  - Hold hearings on the mental health parity law to review its strengths and weaknesses.
  - Fund the historic $70 million increase in the mental health grant.
  - Pass a strong enforceable patients' bill of rights which ensures that people with mental health needs obtain critical protections such as access to specialists and the continuity of care protections.
  - Pass strong comprehensive privacy and legislation to eliminate genetic discrimination.

ACCOMPLISHMENTS

Development of FEHB Mental Health and Substance Abuse Policy

Over the past years, the FEHB Program has not accepted reductions in the value of mental health benefits offered by carriers, has encouraged judicious utilization management to help compensate for modest improvements in benefits, and allowed benefit improvements to be an exception to cost-neutral benefit change requirements.

In1990 we advised carriers to consider managing care rather than reducing benefit levels if experiencing high utilization in mental health and substance abuse benefits.

In 1991, in support of the President's initiative to combat substance abuse, we required all fee-for-service plans to have a stand-alone inpatient substance abuse benefit and to increase the maximum payment by $500. We also required a mandatory case management proposal from all fee-for-service plans.

In 1992, we set the minimum lifetime maximum for mental health benefits at $50,000 and encouraged higher maximums.

In 1993, we instituted a maximum annual out-of-pocket limit on fee-for-service plans of $4,000 per person under a High Option plan and $8,000 per person under a Standard Option plan for mental health and substance abuse benefits.

In 1994, we required minimum coverage for mental health benefits of 50% of the cost of 30 inpatient days and 20 outpatient visits per calendar year. Inpatient days were permitted to be exchanged for outpatient day treatment at a rate of two day treatments per inpatient day. Health maintenance organizations that had combined mental health and substance abuse benefits were directed to offer benefits that covered 30 inpatient days and 20 outpatient visits for each category.

In 1995, prior to the Mental Heatlh Parity Act, we eliminated lifetime maximums for mental health benefits.

In 1998, OPM implemented the remaining requirements of the Mental Health Parity Act, by prohibiting annual maximums on mental health benefits. We encouraged health benefit carriers to move away from contractual day and visit limitations and high deductibles and encouraged judicious utilization management. We also encouraged the use of PPOs so that increased benefit levels could be achieved on a cost neutral basis.

For 1999, we directed that pharmacotherapy, medical visits, and testing to monitor drug treatment for mental conditions be covered as pharmaceutical disease management.

DEPARTMENT OF DEFENSE
ACCOMPLISHMENTS
IN DELIVERY OF MENTAL HEALTH CARE
DURING
PRESIDENT CLINTON'S ADMINISTRATION

May 25, 1999

In July 1993, CHAMPUS established Partial Hospitalization Programs (PHP) under the basic mental health benefit. The benefit allowed for cost-effective follow-on care for patients discharged from psychiatric hospitals or for those not meeting medical necessity criteria for such facilities.

In early 1995, the Department of Defense (DoD) conducted an analysis of mental health/ substance abuse utilization review (UR) criteria employed by managed care companies, insurance companies and government agencies. These criteria are used to determine appropriate level of care for mental health and substance abuse patients. The project resulted, in November 1995, in the development of a state-of-the-art standard for determination of level of care based on medical necessity. The criteria set was endorsed by the Veterans Administration and was made available to the States through the Substance Abuse and Mental Health Services Administration (SAMHSA).

In March 1995, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) regulation mandated comprehensive quality of care certification standards for Residential Treatment Centers (RTC) for children and adolescents, Substance Use Disorder Rehabilitation Facilities (SUDRF), as well as PHPs. This rule updated existing standards to reflect current mental health practices.

In 1995, the United States Air Force developed a pilot program at Tinker Air Force Base in which specialty behavioral healthcare is provided in primary care clinics, thus enhancing access to mental healthcare, decreasing stigma associated with seeking such care, and enhancing prevention efforts. The National Naval Medical Center in Bethesda, Maryland, has developed a similar pilot program.

In 1997, DoD developed policy and implementation guidelines which govern the conduct of mental health evaluations of active duty service members, (DoD Directive 6490.1 and DoD Instruction 6490.4). These policies serve several purposes: 1.) to define potential and imminent dangerousness; 2.) to protect individual Service members' rights by establishing criteria which must be met when a commander refers a member for psychiatric evaluation against the member's will (Whistleblower Protections); and, 3.) to protect the general public from potentially violent individuals by establishing requirements of actions healthcare providers, administrators and commanders must take to diminish the likelihood of violence.

In 1997, DoD developed policy and programs under DoD Directive 6490.2, "Joint Medical Surveillance" and DoD Instruction 6490.3, "Implementation and Application of Joint Medical Surveillance for Deployments" for mental health surveillance. The DoD collects data on mental

health status before, during and after deployment utilizing "just in time" checklists. A Service member is referred for mental health screening before deployment if he/she indicates recent or current mental health problems. The DoD also utilizes the annual Health Evaluation Assessment Review (HEAR) for mental health surveillance.

In 1998, DoD initiated a demonstration project in the TRICARE Central region of the United States to evaluate the clinical outcomes and cost-effectiveness of "wraparound" services as a significant component of mental health care for children and adolescents. Wraparound services include a full spectrum of community-based, family-integrated levels of care, including home care, intensive outpatient services, partial hospitalization, residential services and full inpatient care. Clinical outcomes resulting from program services are being evaluated by Vanderbilt University.

In 1998, the initiation of comprehensive onsite reviews for RTCs was directed by the Acting Assistant Secretary of Defense (Health Affairs). Reviews consist of: on-site inspections of the RTC facilities; interviewing staff and board members, volunteers and patients; auditing fiscal and other records that confirm compliance with CHAMPUS requirements; and examining reports of evaluations and inspections conducted by federal, state, local governments and private agencies and organizations. The directive also stated that "We must ensure that vulnerable children are protected and receive the highest quality of medical care."

Under the Department's National Quality Management Program, the DoD is piloting the evaluation of mental health treatment outcomes at selected sites: Fort Hood, TX in 1998 and Fort Belvoir, VA in 1999. An automated survey tool is employed to establish measures of patient clinical status and adaptive functioning, and is self-administered in waiting room outpatient clinics. Results of the surveys are then compared to national benchmarks and made available to patients' providers who use the information for treatment. Both patients and providers are followed up after three months to assess patient clinical outcomes from both patient and provider viewpoints. Current plans may include the use of aggregated (non-identifiable) outcome data to satisfy healthcare facility accreditation requirements of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO).

In 1999, DoD developed policy to establish Combat Stress Control Programs (DoD Directive 6490.5) within the Services as part of the Department's Force Health Protection initiative. This policy emphasizes the critical role of leadership in primary prevention of combat stress reactions. Key aspects of leadership in preventing CS includes: frequent communication with troops; fostering unit morale and cohesion; conducting pre-, during and post-deployment mental health screening; conducting critical event debriefings, as needed; and conducting realistic military training which enhances troop confidence that they will succeed in battle. The Directive requires training of all military personnel from junior enlisted to senior flag officers about symptoms and causes of CSRs, and how to prevent and treat affected individuals or units. The directive increases requirements for training and experience in CSC for medical and mental health personnel.

The Department is initiating a demonstration program to assess the feasibility of providing managed care services to its beneficiaries over age 65 (TRICARE Senior Prime). In support of this effort, DoD will provide the Health Care Finance Administration (HCFA) with various

mental health-related performance measures drawn from the Health Plan Employer Data and Information Set (HEDIS), an industry-wide managed care quality "report card."

The Department is working with the Department of Veterans Affairs (DVA) to develop clinical guidelines for the diagnosis and treatment of major depression by primary care practitioners. The DoD/DVA joint Working Group met April 26-28 to revise the DVA guidelines. The Working Group collaborated with the Quality Interagency Coordination Task Force (QuIC) to bring in additional resources from the Substance Abuse and Mental Health Services Administration, the National Institute of Mental Health and the Agency for Health Care Policy and Research. Clinicians from other Federal agencies that may use the guidelines, the Bureau of Prisons and the Indian Health Service, also participated in the conference. Work on the guidelines should be completed by late July 1999. Choosing the performance measurements is particularly important and challenging because of the current state of the art. The QuIC is planning a conference in July for the working group and national experts to assist with that and to set a research agenda for further work in the field.

For Administration Accomplishments Paper:

Department of Labor

The Administration worked closely with Congress to enact a law to provide better access to mental health benefits for American workers and their families. The enactment of the Mental Health Parity Act of 1996 (MHPA) is an important first step in providing equality in health care benefits for individuals with mental illness. The President signed the MHPA into law on September 26, 1996. The Department of Labor, working with the Department of the Treasury and the Department of Health and Human Services published interim final regulations implementing the MHPA protections on December 22, 1997. The Department of Labor has also established coordination and referral systems at the federal level with the Department of the Treasury and the Department of Health and Human Services, as well as at the State level with the National Association of Insurance Commissioners and individual State Insurance Commissioner's offices, to coordinate investigations of alleged practices by health insurance issuers and to ensure that workers and their families are not unjustly denied any protections provided under MHPA.

PRESIDENTIAL TASK FORCE ON
EMPLOYMENT OF ADULTS WITH DISABILITIES
EFFORTS TO ELIMINATE THE BARRIERS TO EMPLOYMENT

President Clinton signed Executive Order 13078 in March 1998 creating the Presidential Task Force on Employment of Adults with Disabilities. The purpose of the Task Force is to "create a coordinated and aggressive national policy to bring adults with disabilities into gainful employment at a rate that is as close as possible to that of the general adult population."

Completion of Section 2 mandates in Executive Order by August 1998.

Initial recommendations to eliminate the barriers to employment for adults with disabilities submitted to the President and adopted July 29, 1998 as follows:

1. Directed the Attorney General, the Chair of the Equal Employment Opportunity Commission and the Administrator of the Small Business Administration to expand public education on the requirements of the Americans with Disabilities Act of 1990 to employers, employees and others whose rights might be affected. President ordered that special attention be directed to small businesses and under-served communities, including racial and language minorities.

2. Directed the Secretary of Health and Human Services to take all necessary actions to inform Governors, state legislators, state Medicaid Directors, consumer organizations, employers, providers and other interested parties about Section 4733 of the Balanced Budget Act of 1997.

Section 4733 allows states to provide Medicaid coverage for working individuals with disabilities who, because of their earnings, would not qualify for Medicaid under current law.

Completion of mandate in Executive Order requiring Task Force to issue a report to the President by November 15, 1998. *Re-charting the Course*: First Report of the Presidential Task Force on Employment of Adults with Disabilities was officially presented to the Vice President of the United States on December 14, 1998.

Vice President Albert Gore endorsed two recommendations made by the Task Force on December 14, 1998 as follows:
1. Directed the Office of Personnel Management to develop a model plan to increase the representation of adults with disabilities in the federal workforce, and
2. Directed the Small Business Administration to launch a new outreach campaign to help Americans with disabilities start their own businesses.

President William J. Clinton publicly announced on January 13, 1999 full support of the remaining Task Force recommendations when the budget for FY 2000 was presented. Those recommendations are as follows: *Three-part budget initiative, which invests more than $2 billion over five years, includes:*

1. Full funding of the Work Incentives Improvement Act introduced by Senators Jeffords, Kennedy, Roth and Moynihan.
2. A new $1,000 tax credit to cover work-related costs for people with disabilities.
3. Expanded access to assistive technology for employees in the federal government and support for new and expanded state loan programs to make assistive technology more affordable for Americans with disabilities ($35 million investment).
4. Re-emphasized commitment to passage of a strong Patients Bill of Rights.
5. Proposed $50 million for the Work Incentives Grants program to help persons with disabilities find and retain jobs through One-Stops Career Center systems mandated by the Workforce Investment Act. The program would increase the employment rate of adults with disabilities by fostering interdisciplinary consortia and service integration by providers of services to adults with disabilities at the state and local level.
6. Directed Small Business Administration(SBA) to launch a new outreach campaign to educate Americans with disabilities who own or want to own businesses:
    assure the delivery of SBA programs and services to people with disabilities,
    assist small businesses in need of qualified workers, and
    work to remove barriers to entrepreneurial opportunities faced by people with disabilities.
7. The President directed Office of Personnel Management (OPM) and other appropriate agencies to explore measures aimed at eliminating the stricter standards currently applied to adults with psychiatric disabilities and to extend to these individuals opportunities currently available to individuals with mental retardation and severe physical disabilities.
8. The President directed the Social Security Administration(SSA) to increase the substantial gainful activity (SGA) amount for people receiving Supplemental Security Income and/or Social Security Disability Insurance from $500 to $700 per month. (SSA has made the change and it will be implemented this summer.)

SOCIAL SECURITY ADMINISTRATON
ACCOMPLISHMENTS RELATED TO MENTAL HEALTH

Promoting return to work

SSA has focused many of its return to work initiatives on individuals with mental disorders.

Currently, SSA is undertaking State Partnership Demonstrations in twelve States. These demonstrations, which include study cohorts targeted to individuals with mental disorders, provide funding to coordinate services among public and private organizations involved in promoting the return to work of disabled individuals.

SSA anticipates that in fiscal year 1999 reimbursements to Vocational Rehabilitation State Agencies for the successful rehabilitation of individuals with mental disorders will approximate $50 million.

Childhood Eligibility Reviews

Changes to the disability criteria for the Supplemental Security Income (SSI) childhood disability program impacted heavily on children with mental disorders. The legislation included in the Welfare Reform Law required the reevaluation of the eligibility of 288,000 children, the majority of which were eligible based on a mental disorder.

In response to concerns that the eligibility of children were being improperly ceased, SSA retrained all of its adjudicators on the application of the new standard and provided any child who lost eligibility prior to the retraining the opportunity to appeal.

In addition, SSA undertook its own targeted reviews of cases it believed may have been incorrectly adjudicated. Most of these targeted reviews were directed to children diagnosed with a mental disorder and/or mental retardation.

The net effect of this special effort for poor disabled children is that approximately 30,000 children who might have lost eligibility retained their SSI disability eligibility. Most of these children are eligible based on mental disorders.

5/27 Draft

Highlights of DOJ Mental Health-Related Accomplishments

The U.S. Department of Justice has undertaken a broad range of efforts to address issues relating to the mental health needs of people with mental illness who come in contact with the justice system:

Improving what we know. Efforts include: Bureau of Justice Statistics ongoing efforts to obtain data on mental health programs in correctional facilities and offender participation in these programs, including a soon-to-be-released special report that will provide demographic

characteristics, criminal history, and substance abuse of mentally ill offenders in prisons, jails, or on probation reporting prior treatment for a mental illness or emotional problem. A National Institute of Justice (NIJ) assessment of the Maryland Shelter Plus program, a mental health care program for dually diagnosed offenders released from jail, and an ongoing NIJ research project focusing on "The Case Management of Criminally-Involved Populations."

Continuing enforcement efforts. Efforts include: The Civil Rights Division Special Litigation Section's ongoing work to investigate allegations of inadequate care and treatment in public residential facilities (including mental retardation facilities and adult and juvenile correction facilities) under the Civil Rights of Institutionalized Persons Act. Since 1993, the Division has investigated mental health services and monitored remedial settlements to improve the mental health services in more than 300 facilities in 42 states, the District of Columbia, the Commonwealth of Puerto Rico, and the Territory of Guam. The Civil Rights Division, Disability Rights Section, also enforces the rights of individuals with disabilities, including those with mental disabilities, under the American with Disabilities Act.

Working to improve the justice system's response. Efforts include: A National Institute of Justice study of police response to emotionally disturbed persons, and a study of use of force in the arrest of persons with impaired judgement, including people with mental illness. The Community Oriented Policing Services (COPS) Problem-Solving Partnerships Project which supports a Kennebec County, ME sheriff's collaboration with a local chapter of the National Alliance of the Mentally Ill to analyze the police response in cases involving people with mental illness. The Department also has an ongoing Working Group on Mental Health and Crime, which represents DOJ components dealing with mental health-related issues. The group is examining a wide range of issues which arising for criminal justice practitioners who encounter people with mental disorders in the community, the courts, and in jails and prisons. The Bureau of Justice Assistance also supports a number of projects to improve the criminal justice system's response, including a new mental health court in King County, WA; a secure mental health treatment facility adjacent to the jail in Orange County, FL; and a project in Santa Fe, NM where police will use protective custody centers that will provide mental health and other support services to arrestees. In addition, for many years the National Institute of Corrections' (NIC) Jails Division has been conducting a Suicide Prevention Program. NIC also works in partnerhsip with the National Center for Institutions and Alternatives to publish a quarterly newsletter, *Jail Suicide/Mental Health Update*.

Supporting efforts to improve the linkages between mental health and criminal justice systems. Efforts include: Yearly National Institute of Corrections, Jails Division, regional Mental Health Workshops for jail staff and local mental health service providers to improve the linkages for providing services to inmates and/or to enhance mental health services in the larger facilities with in-house services. Joint efforts by the National Institute of Corrections, the Office of Justice Programs (including the Office of Juvenile Justice Delinquency Prevention and the Bureau of Justice Assistance), and SAMHSA's Center for Mental Health Services and the Center for Substance Abuse Treatment to fund the work of the National GAINS Center. The Center provides technical assistance to communities to integrate services for persons with co-occurring disorders in the justice system.

Addressing the mental health needs of youth. Efforts include: The Office of Juvenile Justice and Delinquency Prevention (OJJDP) support of comprehensive efforts to prevent juvenile delinquency in six jurisdictions through the SafeFutures initiative, which include providing mental health services in both community and school settings. OJJDP is also evaluating the Community Assessment Centers concept through the planning of centers in Ft. Meyers, FL and Denver, CO, and enhancement of existing centers in Orlando, FL and Jefferson County, CO. In FY 1999, OJJDP is funding a competitive grant to initiate a research and demonstration effort to substantially increase the quality of mental health services to detained and committed youth. In addition, a collaborative initiative between the Deputy Attorney General and OJJDP focuses on the needs of children exposed to violence, including on law enforcement and legislative reform, innovative programs, and raising public awareness. In FY 1997, OJJPD transferred funding to the Center for Mental Health Services (CMHS) to support training and technical assistance to the Comprehensive Children's and Families' Mental Health sites. In FY 1998, OJJDP also transferred funding to CMHS to support an additional site under CMHS's Circles of Care initiative, which supports the development of a system of care for Native American youth with mental health and substance abuse problems. In addition, the Office of Justice Program's Corrections Program Office/National Institute of Justice support of research by the California Youth Authority to evaluate an assessment tool to identify mental health problems among incarcerated youth.

Addressing the mental health needs of crime victims. Efforts include: The Office for Victims of Crime (OVC), through Victims of Crime Act (VOCA) funding, supported of over 4,000 victim assistance agencies throughout the nation in FY 1998. From 1993-1998, OVC, with federal VOCA funds and state funding, compensated victims for costs associated with mental health counseling. In addition, during 1997-98, OVC deployed ten crisis response teams to assist victims in the aftermath of several violent community incidents around the country. OVC funding also supports the development of quality training and training materials to assist a broad range of practitioners to address the mental health needs of victims. In addition, the Violence Against Women Office, through formula and discretionary funding, supports a number of state and local efforts that include components to provide menta health services to domestic violence victims and their children and victims of sexual assault.

Accomplishments of VA Mental Health Since 1993

VA mental health clinicians participated in the Clinton Health Care Reform Project, stimulated by the concept of parity in health care delivery for persons suffering from all types of disorders. VA began its own Health Care Reform, activity shortly thereafter and mental health clinicians participated in that effort as well.

In 1994 VA MH established a sophisticated accountability system that tracks services provided to over 600,000 veterans per year and includes assessments of structure, process, outcomes and costs of care system wide. This report card has been used to track major transformations in VA MH since 1993. In those years VA MH programs increased the number of patients served by 25% or 120,000 veterans/year -- from 522,000 to 649,000. Unlike other systems while VA IP use went down VA OP use went up with substantially improved continuity and intensity of OP care.

VA has built its capacity to provide state of the art services to special populations of homeless veterans, veterans with PTSD and SMI veterans. VA currently treats over 25,000 homeless veterans per year and outcomes of those treated in residential facilities have improved steadily from 1993-1999 in the areas of housing, employment and clinical status. VA treats over 50,000 vets/year in specialized PTSD programs and inpatient PTSD outcomes have improved in recent years. VA also operates one of the largest networks of Intensive case Management programs in the nation, developed since 1993, with upward if 45 teams with demonstrated effectiveness and cost savings for the most severely mentally ill veterans.

VA was a pioneer in the development of specialized treatment programs dealing with the problem of co-occurring substance abuse and other mental disorders. While this initiative began earlier, there was continued expansion of these programs during 1993 and 1994. Similarly, during these same years there was continued expansion of a previously established program of work therapy integrated into therapeutic residences for substance abuse patients. These were designed to be an integral part of the established substance abuse treatment programs.

The Center of Excellence in Substance Abuse Treatment and Education (CESATE) was developed in 1993 to provide models of care for VA's substance abuse treatment programs utilizing the latest scientifically based treatment modalities and technology. It provides program consultation, mini-residencies, assistance in the development of in-service training programs and training for professionals who wish to become proficient in the treatment of addictive disorders. Further, it has been instrumental in the development of treatment guidelines for substance abuse treatment in VA. Its basic goal has been to facilitate the provision of state-of-the-art addictions treatment to veterans.

The Women Veterans Health Division was added to VA's Congressionally –mandated National Center for PTSD in 1993 to promote the study of the sequelae of sexual trauma as well as combat related trauma in women in the military. The women's Health Division, located at the Boston VA Medical Center has worked closely with the Women Veterans Comprehensive Health Center at that facility to develop methods of integration of mental health in the medical primary care delivery setting. The National Center for PTSD established in 1989, continues its work in the implementation and promotion of PTSD education and research. Recent accomplishments include the publication in 1998 of a guidebook for clinicians and administrators entitled, "Disaster Mental Health Services". This work, created in collaboration with the American Red

Cross, is the result of experience of National Center and other VA Medical Center and Readjustment Counseling Service clinicians helping survivors of hurricanes, earthquakes and terrorist attack including the Oklahoma City bombing.

In 1997 and 1998, VA established six new Mental Illness Research, Education and Clinical Centers (MIRECCs) designed to develop basic science research in major mental illness and to promote health service delivery research on the application of scientific findings into practice. There is currently a Request for Proposals for three more MIRECCs in the field.

In 1997and 1998, VA created a new approach to psychiatric residency education the Psychiatry Residency Primary Care Education Program (PsyPCE). This program insures that resident's experience caring for the medical problems of a cohort of mental health patients as well as for their mental disorders across the years of their residency. They also address mental health disorders in medical primary care settings. Supervision is provided by both psychiatric and internist faculty. The result is a psychiatrist graduate who can care for the range of mental and medical disorders encountered in patients. Ten percent of all VA psychiatry positions are PsyPCE residents.

Highlights from our Seriously Mentally Ill/ Psychogeriatric Section Include:

June, 1993, published an updated *Mental Health Manual (M-2, Part X)* including descriptions of a new continuum of mental health programs that has been widely used. In 1994, after establishing four new types of psychosocial programs for veterans with severe mental illness at 14 VHA long-term neuropsychiatric hospitals, we published preliminary two-year follow-up findings on 1500 patients showing that intensive community case management and enhanced psychosocial rehabilitation at the hospital level, were more effective than the usual care. These programs subsequently have been adapted at other VA medical centers. In 1996, following a positive cost-effectiveness analysis by the Northeast Program Evaluation Center, we established 40 new Intensive Psychiatric Community Care programs throughout the country. By July, 1998, 39 additional programs along a similar model were established throughout VHA. In 1998, VHA began collecting functional measurements on all VHA mental health patients (Global Assessment of Functioning) for both a local and national roll-up to begin to assess outcomes for all programs.

March, 1996, published and distributed a comprehensive *Guidelines for Integrated Psychogeriatric Care* which details programs, special problems, and suggestions for treating elderly veterans with mental health problems. In 1995, we established an innovative demonstration project at 9 VA medical centers called UPBEAT (Unified Psychogeriatric Biopsychosocial Evaluation and Treatment). This six-year project involving over 2600 veterans is designed to determine whether the UPBEAT psychogeriatric intervention targeting acute medical and surgical inpatients will improve health care and reduce costs and utilization of health care resources by geriatric veteran patients in the VA system. By the fall of 1998, preliminary one-year follow-up of 882 patients revealed 5.3 days less inpatient care for the UPBEAT group compared to the usual care group, with considerable savings.

Highlights from our Health Care for Homeless Veterans Section include:

From 1993 to the present VA provides treatment to over 25,000 homeless veterans each year.
1994: VA hosted a National Summit on Homeless Veterans. Over 750 Community Service Providers and VA staff participated in this Summit.
Between 1994 to 1998 VA implemented the Homeless Providers Grant and Per Diem Program. Through 5 rounds of grant funding, VA has provided $26 million to non-VA organizations to support 127 projects in 39 states and Washington, D.C. Currently, 1000 new community-based beds are operational and another 1500 are expected to become operational in 1999 and 2000.

L. Lehmann, M.D.
5/14/99

DOE

Department of Energy laboratories have developed a device that gives doctors a "window" into how the human brain actually functions. The device takes snapshots of the brain using a technique called magnetoencephalography. Using this technique, researchers measure the tiny currents and magnetic fields that delicately charge the gray matter of the brain. This powerful tool has lead to greater insights about how the signals of the brain act or react in individuals with mental illnesses.

Earlier this year, the Energy Department gave a $10 million grant to establish the first of three National Centers for Functional Brain Imaging. The first center, named the Pete and Nancy Domenici Center for Mental Health Research is in Albuquerque. Two other colloborative centers will be established at the University of Minnesota VA Hospital and Massachusetts General Hospital-Harvard University.

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON MENTAL HEALTH ISSUES

Overview: *The Department of Health and Human Services (HHS) is dedicated to changing the way our country addresses mental illness. By working to end both discriminatory insurance practices and the stigma surrounding mental illness, HHS has drawn attention to these often disabling health problems and supported development of community-based mental health services to respond to them. In addition, HHS is funding research to better diagnose, treat and prevent mental illnesses.*

Every year, more than 51 million Americans experience diagnosable mental disorders. Of them, more than 6.5 million are disabled by severe mental illnesses, including as many as 4 million children and adolescents. Major depression, schizophrenia, bipolar illness, eating disorders, anxiety disorders, and other mental illnesses frequently impair normal daily activities such as working, sleeping and caring for oneself and others. Yet only one in four affected adults receives treatment. And only one-third of children and adolescents who need mental health services get them.

The Clinton-Gore administration is continuing its commitment to prevent and treat mental illness and has proposed $1.5 billion for mental health activities at HHS for fiscal year 2000. These funds will enable the National Institute of Mental Health (NIMH) to continue supporting critical mental health research on the origin of mental illness, ultimately improving treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) will be able to further its programs that ensure people with mental illness and their families have timely access to quality services.

Two other HHS agencies also make important contributions to mental health. The Agency for Health Care Policy and Research (AHCPR) will continue its role in setting standards for mental health treatment. And the Health Care Financing Administration (HCFA), through Medicare and Medicaid, provides access to mental health services for millions of Americans.

On June 7, 1999, Secretary Donna E. Shalala will participate in the first ever White House Conference on Mental Health. The conference will bring together mental health professionals, consumers, family members, advocates, legislators and others to discuss the successes and challenges in caring for people with mental illness.

ELIMINATING THE STIGMA ASSOCIATED WITH MENTAL ILLNESS

In addressing the mental illness issues of our society, HHS and the administration are beginning to combat a unique characteristic of mental illness -- stigma. Through various grant programs and research initiatives, HHS is helping to defeat the stigma associated with mental illness.

Combating the Mental Health Stigma. Anxiety disorders and depression are the most common mental disorders in America, yet many individuals living with these disorders keep silent, unaware of the availability of excellent treatments discovered through clinical research. NIMH currently conducts both an Anxiety Disorders Education Program and Depression Education Program to inform the public and health care professionals of effective treatments, and to combat the stigma that inhibits people from seeking treatment. NIMH also promotes the cost effectiveness of early diagnosis and treatment.

Partnering with States. SAMHSA's Mental Health Services Block Grant provides state and territorial governments with resources to support comprehensive community-based systems of care to serve people with serious mental illness and their families. These systems offer a continuum of care, including innovative treatment and rehabilitation services. To the extent possible, SAMSHA encourages the development of integrated approaches that link health, mental health, housing, education, criminal justice, social welfare and other local service systems. The President has proposed a $70 million increase for the block grant in his fiscal year 2000 budget, to $359 million.

Requiring Mental Health Parity. In December 1997, HHS issued regulations to help achieve the goal of ending discrimination in health insurance on the basis of mental illness under the Mental Health Parity Act of 1996. As of January 1998, the law began requiring health plans to provide the same annual and lifetime spending caps for mental health benefits as they do for medical and surgical benefits. The law applies to benefits received until September 30, 2001.

Supporting the Consumer's Role. The Patient's Bill of Rights drafted by HHS' Advisory Commission on Consumer Protection and Quality and supported by the President states that consumers cannot be discriminated against because of mental disability as they seek health care services. In addition to advocating federal legislation to create a Patient's Bill of Rights, HHS provides grants to develop programs that advocate for the legal rights of people with mental illness and to investigate incidents of abuse and neglect in facilities that care for such individuals.

The first Surgeon General's Report on Mental Health. Due out by early 2000, this document will distill the most current science to recommend approaches for promoting mental health, preventing mental illness, and providing state-of-the-art clinical interventions across the life cycle. To raise public awareness of the important role of mental health in our everyday lives, the report will illustrate the similarities between mental health and physical health and the value of prompt, appropriate treatment.

Meeting Special Needs of People with Living with HIV/AIDS. *HHS supports a variety of programs that address the mental health needs of those with HIV/AIDS and their families.*

Ryan White CARE Act. This law, known for its unprecedented assistance to individuals living with HIV/AIDS, supports several Health Resources and Services Administration (HRSA) programs, including those aimed to improve mental health services for individuals who are HIV positive or at high risk of becoming infected.

HIV Multiple Diagnosis Initiative. HRSA's HIV/AIDS Bureau has established the HIV Multiple Diagnosis Initiative, a collaboration with the Department of Housing and Urban Development, to

identify and respond to the personal needs of HIV infected people with housing, mental health, and substance abuse problems. Fourteen nonprofit organizations currently are funded under this initiative. Additionally, nine projects are funded under the Special Projects of National Significance (SPNS) Program to provide mental health services to individuals and families affected by HIV/AIDS.

Training health care professionals. SAMHSA has awarded grants to develop and disseminate state-of-the-art, AIDS-specific mental health education and training to both traditional and nontraditional mental health service providers. SAMHSA also evaluates the effectiveness of different approaches to providing mental health services to people affected by or living with HIV/AIDS. The agency is also overseeing a first-of-its-kind, five-year study to determine treatment adherence, health outcomes and specific costs of providing integrated mental health and substance use disorder services for individuals living with HIV/AIDS.

UTILIZING MODERN DEVELOPMENTS IN SCIENCE AND RESEARCH FOR EFFECTIVE TREATMENT OF MENTAL ILLNESS

HHS has taken a proactive approach in addressing mental health issues by sponsoring studies to advance mental health science in the following areas.

Attention Deficit Hyperactivity Disorder (ADHD). Many childhood mental illnesses escape notice, but children with ADHD often cause great concern to parents and teachers. Experts estimate that ADHD affects 3 to 5 percent of school-age children. Recent NIMH-supported research has contributed to mounting evidence that stimulant medications are more effective than behavioral therapies in controlling the core symptoms of ADHD—inattention, hyperactivity/impulsiveness, and aggression. But the addition of behavioral treatments seems to result in improved functioning in terms of better social skills and higher academic achievement.

Schizophrenia. A wide-range of treatments can be prescribed for adults with schizophrenia. Over the past seven years, AHCPR has supported the Schizophrenia Patient Outcomes Research Team (PORT) to develop a comprehensive, science-based understanding of treatment effectiveness alone in combination to improve patient outcomes. Extensive research into the use of therapy and prescribed drugs as well as family involvement and job training have led to holistic treatments that better help patients reclaim their lives.

Providing Mental Health Information. SAMSHA operates the National Mental Health Services Knowledge Exchange Network (KEN) as a user-friendly, "one-stop" gateway to a wide range of information and resources on mental health services for users of mental health services and their families, the general public, policy makers, providers and the news media. KEN can be reached at 1-800-789-2647 or via the Internet at www.mentalhealth.org.

Surgeon General's Call to Action on Suicide. In October 1998, Surgeon General David Satcher took part in a conference in Reno, Nevada which laid the foundation for developing a national suicide prevention strategy -- the first time in the United States that clinicians, researchers, survivors and activists had been gathered for this purpose. While work on a formal national strategy continues, Dr. Satcher released a list of action steps distilled from the conference that communities, individuals, health care professionals and policymakers can pursue to help prevent suicides.

Ensuring Medicaid Coverage of Mental Health Services. In October 1998, HCFA issued a state Medicaid director's letter providing guidance to all states regarding the development of Medicaid managed care programs for persons with special needs. This guidance applies to mental health service systems and further promotes recognition of mental health needs by managed care organizations serving Medicaid populations.

Providing Partial Hospitalization Benefits. HCFA is ensuring that beneficiaries with acute mental illness get quality treatment in community mental health centers (CMHCs) and that Medicare pays appropriately for those services. The evidence gathered during the Medicare anti-fraud program Operation Restore Trust, HCFA site visits, and other reviews over the past two years showed that CMHCs often bill Medicare for services that are not covered, aren't provided or aren't medically necessary. Some CMHCs have even charged for bingo and other entertainment, which Medicare does not cover, and then failed to provide basic psychiatric services legally required for Medicare payments. Implementation of a 10-point action plan has been designed to ensure that beneficiaries who need intensive psychiatric services get them from qualified providers. At the same time, it is protecting beneficiaries, taxpayers and the Medicare Trust Fund from waste, fraud and abuse of the benefit.

MYTH #1: **Mental illness is not a disease and it cannot be treated.**

FACT: Research in the last decade proves that mental illnesses are diagnosable disorders of the brain. New brain imaging technologies visually illustrate the differences in the brains of healthy people and people with serious mental disorders, such as schizophrenia. They show reductions in the overall volume of the brain and distinct differences in the way in which the brain processes information. There are also now effective treatments for mental illness that, for example, relieve symptoms for 80 percent of people with major depression; control symptoms such as hallucination or delusions for 70 percent of people with schizophrenia; and alleviate symptoms for 50 to 60 percent of people with Obsessive Compulsive Disorder.

MYTH #2: **Mental illness doesn't happen to people like me or my family.**

FACT: Mental illness affects most extended American families. One in five Americans suffer from mental illness at some point in their life. These illnesses strike all kinds of families, regardless of race, socioeconomic class, educational level or place of residence. Schizophrenia occurs at equal rates regardless of education, socioeconomic status, or culture. Depression, panic disorder and obsessive compulsive disorders are also equal opportunity illnesses. Women suffer from depression at twice the rate of men regardless of where they live, their culture, or socioeconomic status. Five million older Americans suffer from depression, and one in ten children and adolescents suffer from some type of a mental illness. Mental illness can happen to anyone. However, it is also a treatable illness.

MYTHS

MYTH #3: **Depression is a part of life that can be worked through without seeking help.**

FACT: Depression is a diagnosable, treatable illness that impacts 19 million adult Americans each year. It is a disorder of the brain that is characterized by serious and persistent symptoms such as changes in sleep, appetite, and energy; cognitive losses such as slowed thinking, and clearly discernible feelings like irritability, hopelessness, and guilt. The severity and duration of depression symptoms are clearly distinguishable from sadness and mood swings that are part of life. When untreated, depression can have serious consequences. Depression is the cause of over two-thirds of the 30,000 American suicides each year, and according to the World Health Organization, it is the leading cause of disability in the United States. However, there are effective treatments available that have proven to have 80 percent success rate for people diagnosed with depression.

MYTH #4: **Teenagers don't suffer from "real" mental illness; they are just moody.**

FACT: We now know that teenagers and even younger children, can and do suffer from mental illness. One in ten children and adolescents suffer from mental illness severe enough to cause some level of impairment, but fewer than 20 percent of these children receive treatment. Without treatment, school work may suffer, normal family and peer relationships may be disrupted, and the absence of diagnosis can potentially contribute to violent acts. In fact, depression may lead to suicide, which is the third leading cause of death among young adults. However, recent studies indicate that 60 percent of depressed teenagers will improve with modern treatments.

MYTH #5: **Depression is a part of aging.**

FACT: Depression is *not* a normal part of aging. Research using the methods of the clinical and basic neurosciences in older persons with depression have identified actual changes in brain structures. In older persons with other serious health problems (strokes, hip fractures, heart conditions) depression may delay recovery, cause refusal of treatment, and lead to excessive disability and even death. In fact, nearly 5 million of the 32 million Americans age 65 and older suffer from clinical depression. Comprising only 13 percent of the U.S. population, individuals ages 65 and older account for 20 percent of all suicide deaths, with white males being most vulnerable. However, effective mental health treatment is available for older Americans suffering from mental illness.

MYTH #6: **Talk about suicide is an idle threat that need not be taken seriously.**

FACT: People who admit to having thoughts and plans about suicide and people who have attempted suicide are at increased risk for completing suicide in the future. In a study of nearly 4,000 adults seeking psychiatric treatment, persons with a history of severe suicidal thoughts were 14 times more likely to later commit suicide within four years, compared to persons with less severe suicide ideation. Research has shown that 90 percent of all suicide victims have had a mental or substance abuse disorder.

MYTH #7: **We cannot afford to treat mental disorders.**

FACT: We cannot afford NOT to treat mental illness. Researchers estimate that mental illnesses, including indirect costs such as days lost from work, cost America tens of billions of dollars each year. However, businesses and states that have implemented new strategies to treat these disorders have not found notable increases in costs. For example, one business, Bank One, spearheaded a comprehensive effort to improve the company's ability to identify and get appropriate treatment for employees with depression in a timely manner. Between 1991 and 1995, the direct treatment costs for depressive disorders decreased by 60 percent. Moreover, Ohio implemented full mental health parity for its state employees and did not find that this increased their costs.

MYTH #8: **People with severe and persistent mental illnesses cannot be productive members of society.**

FACT: People with psychiatric disabilities have had many barriers. In fact, one study showed a 10-15 percent employment rate for individuals with severe and persistent mental illnesses. A 1995 study of the Employment Intervention Demonstration Program run by the Center for Mental Health Services assessed the effectiveness of employment strategies to assist individuals with severe mental illness get and keep employment. They found 49 percent of individuals receiving employment support services for one year were working and after two years, 55 percent were employed. Clearly, people with severe and persistent mental illnesses want to be employed and productive, and given appropriate treatment and support, they can.

MYTH #9: **A homeless person suffering from mental illness has little chance of recovery.**

FACT: There are effective treatments for the homeless with mental illness. While one-third of homeless Americans suffer from an untreated mental illness, research demonstrates a decrease in homelessness when outreach to these individuals is coupled with case management that connects them to housing and other supportive services. One study reported a 45 percent reduction in the number of days of homelessness in the first three months of this type of treatment. Over a year, clients had a 70 percent increase in the number of days worked, demonstrating that homeless persons with mental illnesses can make substantial improvements in the overall quality of their lives.

MYTH #10: **There is no hope for people with mental illness.**

FACT: These illnesses, that will affect one in five Americans in their lifetime, can be extremely debilitating. However, research proves that mental illnesses are diagnosable and treatable disorders of the brain. Eighty percent of people treated for severe depression show positive responses to treatment, and the rate of success for controlling the symptoms of schizophrenia is also high, at 70 percent, higher rates than many physical illnesses. The challenge is to assure that Americans with mental illness recognize these disorders and get the help that they need.

RADIO ADDRESS
PRESS RELEASE

PRESIDENT CLINTON AND TIPPER GORE ANNOUNCE NEW CAMPAIGN TO COMBAT THE STIGMAS SURROUNDING MENTAL ILLNESS AND ENCOURAGE PEOPLE WITH MENTAL ILLNESS TO GET HELP
June 5, 1999

Today, in a joint radio address, President Clinton and Tipper Gore announced a new national campaign to eliminate the stigmas of mental illness and encourage the millions of Americans with mental health needs to get help. The President and Mrs. Gore unveiled new information about some of the widespread myths of mental illness and some of the facts that dispel them. These myths will be discussed on Monday as part of the first-ever White House Conference on Mental Health, chaired by Mrs. Gore, the President's Mental Health Advisor. Today, the President and Mrs. Gore:

Announced National Campaign to Combat the Stigmas of Mental Illness and Encourage Americans with Mental Health Needs to Get Help. The President and Mrs. Gore announced that this fall a new nationwide campaign, with Mrs. Gore serving as the honorary chair, will be launched to dispel the myths of mental illness and encourage those with mental illness to get help. This new nationwide campaign will be a public-private partnership, led by the Surgeon General and the Ad Council, which will involve a wide range of community organizations, media, and others. This campaign will draw from many of the issues raised at the White House Conference on Mental Health.

Unveiled New Information on the Widespread Myths of Mental Illness and the Facts That Dispel Them. The President and Mrs. Gore unveiled new information that highlights many of the myths surrounding mental illness, including the following:

-- **Myth:** Mental illness is not a disease and cannot be treated.
Fact: The reality is that mental illnesses are diagnosable disorders of the brain and treatments that are effective 60 to 80 percent of time.

-- **Myth:** Mental illness doesn't happen to people like me or my family.
Fact: One in five Americans will suffer from a mental illness in their lifetime. These Americans are from all backgrounds.

-- **Myth:** Depression is a part of life that can be worked through without seeking treatment.
Fact: Depression is a diagnosable treatable illness that impacts 19 million adult Americans each year and is the leading cause of disability in the United States.

-- **Myth:** Teenagers don't suffer from "real" mental illness; they are just moody.
Fact: One in ten children and adolescents suffer from mental illness.

-- **Myth:** Depression is a part of aging.
Fact: Five million older Americans suffer from clinical depression and older people account for 13 percent of the population but 20 percent of suicides.

-- **Myth:** Talk about suicide is an idle threat that need not be taken seriously.
Fact: Research has shown that 90 percent of all suicide victims have had a mental or substance abuse disorder. People who admit to having thoughts and plans about suicide and people who have attempted suicide are at increased risk for completing suicide in the future.

-- **Myth:** We cannot afford to treat mental disorders.
Fact: States and businesses that have improved treatment of mental illness, including implementing parity, have not seen a major increase in costs.

-- **Myth:** People with severe and persistent mental illnesses cannot be productive members of society.
Fact: Studies find that 49 percent of individuals with severe mental illness were receiving employment support services for one year after working.

-- **Myth**: A homeless person suffering from mental illness has little chance of recovery.
Fact: Research demonstrates a decrease in homelessness with an effective style of case management that connects the person with treatment for their disorder, housing, and other supportive services.

-- **Myth:** There is no hope for people with mental illness.
Fact: Mental illnesses can be treated up a higher rate than many chronic illnesses.

Highlighted the First-Ever White House Conference on Mental Health. These myths and the stigma campaign will be highlighted and discussed on Monday at the first-ever White House Conference on Mental Health, that will involve tens of thousands of Americans around the country at over 1,000 cites connected to the conference in Washington.

THE CLINTON/GORE ADMINISTRATION CHALLENGES CONGRESS TO PASS LEGISLATION TO IMPROVE CARE AND SERVICES FOR PEOPLE WITH MENTAL ILLNESS
June 7, 1999

At the first-ever White House Conference on Mental Health, The Clinton-Gore Administration called on Congress to enact legislation to ensure quality care and services for Americans with mental illness. The Clinton-Gore Administration challenged Congress to pass a number of important bills to support people with mental illness including; allocating an unprecedented increase in the mental health block grant, passing a strong enforceable patients' bill of rights, and challenging Congress to hold hearings on mental health parity legislation. The proposals include:

Fund an historic increase in the mental health block grant. The Administration called on the Congress to pass the President's FY 2000 budget proposal for a $70 million increase in the mental health block grant. In addition, the Administration asked Congress to pass a 19 percent increase in funds for the Projects for Assistance in Transition from Homelessness (PATH) program. In an era of surpluses, the Administration also called on states to expand their coverage in this area.

Challenge Congress to hold hearings on mental health parity legislation. The Administration urged the Congress to hold hearings right away on the strengths and weaknesses of the current mental health parity law and to determine the feasibility of congressional legislation that would expand mental health parity for private health plans.

Pass a strong enforceable patients' bill of rights. The Administration also challenged the Congress to pass a strong enforceable patients' bill of rights that assures that consumers, including those with mental health needs, receive critical protections such as access to specialists, the continuity of care protections, and an independent appeals process to address grievances with their health plans.

Pass the Jeffords-Kennedy-Roth-Moynihan legislation to enable people with disabilities return to work. Access to affordable health insurance is the biggest barrier preventing people with disabilities from returning to work. The President and Vice President encouraged Congress to pass this legislation right away, which would help people with disabilities, including mental illnesses, buy into Medicare and Medicaid so they can return to work.

Pass strong comprehensive privacy protections and legislation to eliminate genetic discrimination. The President and Vice President also urged Congress to pass comprehensive legislation to assure medical records privacy so that information, including sensitive information about mental illness, is protected. In addition, as researchers continue to unlock the genetic code, which enhances the potential to expand treatment options, the Administration urged the Congress to pass legislation that prevents employers and health care plans from discriminating against Americans based on their genetic information.

FY2000

Increase funding for the Individuals with Disabilities Education Act. The Clinton/Gore budget includes a $50 million increase to support a Primary Education Intervention Program, for early identification and intervention with children ages 5-9 years old who are experiencing significant behavior or reading problems. Research has conclusively shown that early intervention in these areas is strongly associated with elimination or reduction of behavioral and mental health problems in adolescence and adulthood.

Establish a $1,000 tax credit for workers with disabilities. Under this proposal, workers with significant disabilities would receive an annual $1,000 tax credit to help cover the formal and informal costs that are associated with and are even prerequisites for employment, such as special transportation and technology needs.

Protect the health benefits of workers' and their families'. This proposal provides more than $2.5 million for the Pension and Welfare Benefits Administration's capabilities to interpret, investigate and provide customer service to protect American workers' and their families' rights under health laws governing job-based health benefits, which include mental health benefits under the Mental Health Parity Act.

Improve access to assistive technology. This new $35 million initiative would accelerate the development and adoption of information and communications technologies, which can improve the quality of life for people with disabilities and enhance their ability to participate in the workplace.

Enact Project Employ. Project Employ is a program initiated in 1996 by the President's Committee on Employment of People with Disabilities to expand and enhance employment opportunities for persons with cognitive disabilities. The program promotes the hiring of people with disabilities in jobs that pay higher than minimum wage, include benefits, and promotional opportunities. In the President's FY 2000 budget the President's Committee on Employment of People with Disabilities has budgeted $200,000 to develop a similar program for persons with psychiatric disability.

Expand funds for clinical and preventive programs. This proposal encourages Congress to grant a 17 percent increase for Indian Health Service (IHS), which will support oriented clinical and preventive services for Native American/Alaskan Native communities, enabling the mental health needs of 31,000 individuals are met.