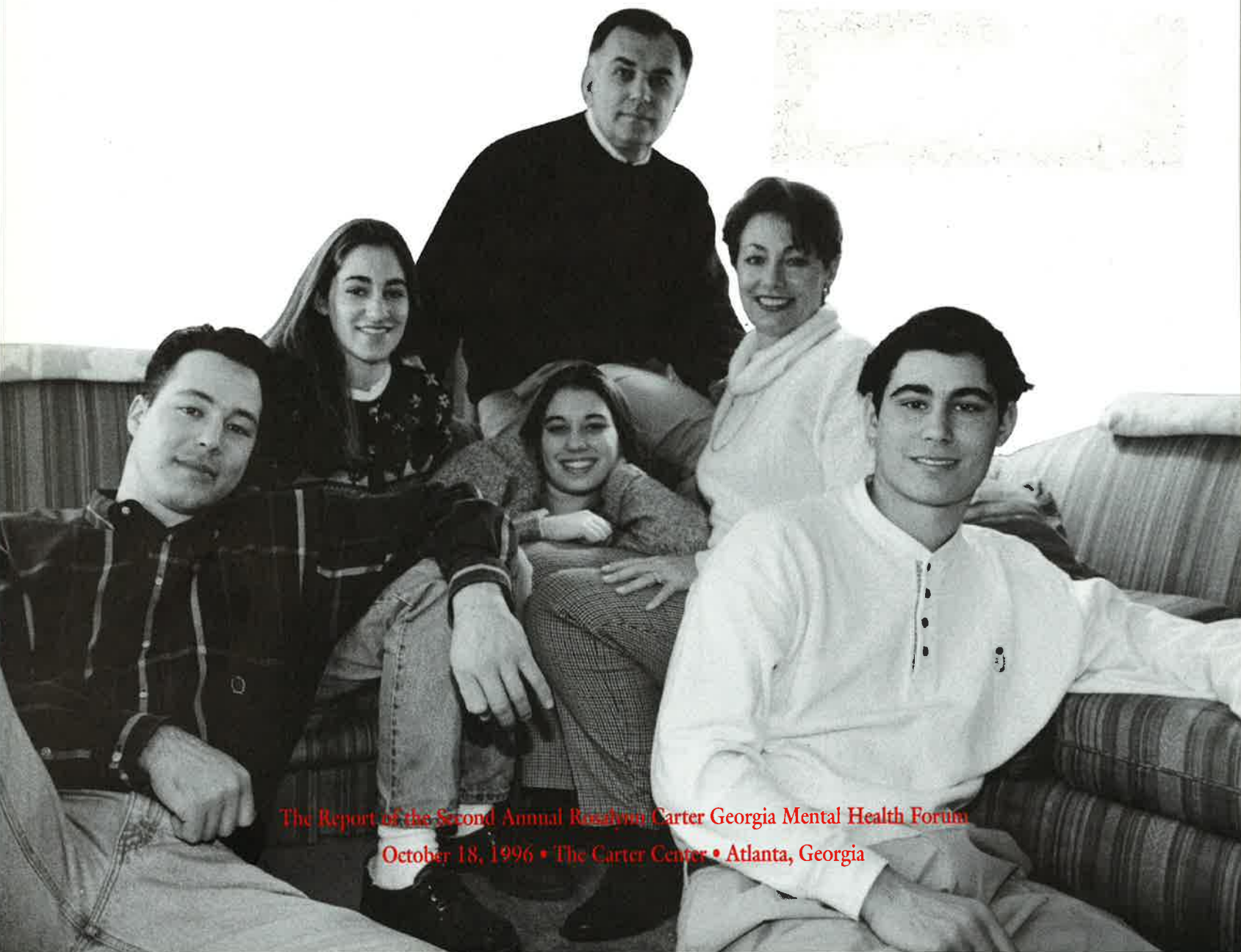# Improving Access for Georgians

The national evolution of health care brings a renewed emphasis on advocacy at state and local levels to stop needless suffering due to stigma, inaccessible treatment or cost

The Report of the Second Annual Rosalynn Carter Georgia Mental Health Forum

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Improving Access For Georgians

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"Life doesn't stop just because you have a sick child. It's just terribly painful, and very hard."

—Melanie Suggs

Hopeful Signs, Challenging Tasks

*With public attitudes about mental illness changing, we face our best
opportunity to improve conditions for those who suffer as a result of mental illness*

By Rosalynn Carter

Chair, The Carter Center Mental Health Task Force

As health care delivery evolves throughout the country, advocacy at state and local levels becomes increasingly important. This is particularly true with regard to access to quality mental health care.

Needless suffering will continue if people are afraid to seek help either because of the stigma attached to mental illness or because of the costs or the inaccessibility of treatment, and this suffering could be avoided.

In recent years we have made tremendous progress in our understanding of the nature and causes of mental illnesses and in developing effective treatments. Even so, we must continue to advocate for improved access to quality care. There are still far too many people in need of treatment who, for one reason or another, are not getting help.

The Georgia Forum is an opportunity for people around our state to explore issues related to mental health care. This year's conference focuses on "access." Our goal is to identify barriers to care and to develop strategies to overcome these barriers.

Our efforts can build upon recent developments in the nation's capital. In September, Congress passed legislation to regulate some of the discriminatory insurance practices that have historically limited mental health coverage. The legislation prohibits imposing caps on annual or lifetime mental health benefits that are lower than those for medical/surgical benefits.

Unfortunately, the amendment did not address other issues we are concerned about, such as higher co-payments for the treatment of mental illnesses, or the possibility that mental health benefits might not be offered at all.

However, this legislation is an important first step—a small victory to remind us that our message is having an impact.

And while Congress has been enacting progressive legislation, attitudes about mental illness seem to be changing in the populace. Consider these findings of a recent survey by the University of Georgia Research Center, released for the first time

Remarks opening
The Second Annual Rosalynn Carter Georgia Mental Health Forum:
The State of Mental Health Care: Improving Access for Georgians

at this meeting:

• *95 percent of Georgians believe that people with mental illness can be helped through treatment.*

Not long ago, the prevailing belief was that mental illness was a weakness or a sin or was caused by bad parenting. After years of advocacy and education, people are beginning to understand that mental illnesses are diagnosable and treatable. This is a significant shift in attitude which represents tremendous progress for mental health advocates.

• *90 percent of survey respondents believe that health insurance policies should provide the same coverage for mental illnesses as they provide for physical illnesses.*

We understand that there may have to be limits. All we ask is that mental illnesses not be treated differently than physical illnesses. If you are sick, you are sick. It is encouraging to see the number of Georgians who support this belief.

• *Almost 90 percent of survey respondents indicated that treatment for a mental illness would not prevent them from employing or recommending someone for a job.*

• *More than 80 percent of respondents would support a candidate for public office, even if he or she had been treated for a mental illness.* As an indication of the shift in public attitude, remember that in 1968, Senator Thomas Eagleton, a vice presidential candidate, acknowledged publicly that he had been treated for depression. Because of the stigma and public attitude about mental illness, Eagleton was forced to resign from the campaign.

• *Almost 50 percent said if they had mental illness and were seeking treatment they would not want their employer to know.*

Despite the enlightened responses from other survey questions, people still fear for their job if treatment for a mental illness is revealed. This is a reminder that we must continue to work with the business community to educate about the treatability of mental illness and about how mental health issues should be addressed in the work place.

The survey also asked respondents what they thought were the biggest barriers facing people who have a mental illness and need treatment. *Georgians responded overwhelmingly that the two biggest barriers are: (1) lack of insurance or ability to pay for treatment* and *(2) social stigma.*

Other barriers they mentioned included the fear of losing one's job and the lack of awareness of the symptoms of the illness.

We need to work more closely with media, schools, and the business community to teach people about mental illness because it is much better to treat these illnesses in the early stages. We also need to educate teachers, parents, employers and employees about the signs of mental illness and about what a concerned person can do.

More than ever, this survey is telling us that opinion is changing in Georgia and we have a real opportunity to move our agenda forward. Mental health is no longer a "fringe" issue. Americans are responding to the fact that mental illness touches many of us in one way or another. Treatment is available, but we must improve access to that treatment and the public understanding of the differences that will result from increased access.

Once Again, Behold the Stars

A Pulitzer Prize-winning author shares a view that is the pit of depression and urges an end to the stigma that keeps victims from the help that could save them

By William Styron

I was startled recently to read in the *New York Times* an article describing the prevalence of depression throughout the world, as monitored by the World Health Organization. Although I've always been aware of the widespread nature of depression, I hadn't realized that even now the illness is ranked number four in the world in terms of its dysfunctional quality.

Despite great strides being made in the treatment of depression, the disease itself seems immovably embedded in the nature of the human animal.

William Styron, a native of Newport News, Va., is a Pulitzer Prize-winning novelist whose works include *Darkness Visible, Sophie's Choice* and *The Confessions of Nat Turner.* He is a survivor of depression.

Twenty-five years from now, the World Health Organization predicts, depression will rise to number two in this category. Right behind ischemic heart disease, which is the leader now. This, to me, is an amazing statistic in as much as it demonstrates how—despite great strides being made in the psychiatric and pharmaceutical treatment of depression, despite Prozac and Zoloft and other medications and strategies—the disease itself seems immovably embedded in the nature of the human animal, and is likely to be with us as long as human beings, with their fragile brains, remain the complex organisms they are.

It is to be devoutly hoped by the year 2020 or there about, at least one impediment to the treatment of depression will be removed or at least greatly diminished. That is the sense of stigma and disgrace that presently surrounds the illness in all too many cases. For the stigma—the mysterious, sinister nature that depression has acquired—still remains the greatest barrier to acceptance and a humane understanding of this devastating illness.

Although it does not kill in the direct nature of most fatal diseases, of course it does kill: Vincent Foster, President Bill Clinton's associate who committed suicide in 1993, is a case in point.

Foster almost perfectly represents a person who might have survived had he not been the victim of the ignorance, superstition, and irrational fear surrounding depression—an illness whose pain is all but indescribable, and therefore to everyone but the sufferer, almost meaningless.

Thus, the person who is ill begins to regard all others—the healthy and the normal—as living in parallel but separate worlds. The inability to communicate one's sense of the mortal havoc in one's brain is a cruel frustration. Sylvia Plaths' *The Bell Jar* is an apt metaphor to the isolation one feels—walled off from people who, though visible and audible, are essentially disconnected from one's own hermetically sealed self.

Several years ago, there was an orgy of speculation in the press about the circumstances surrounding the death of Vincent Foster. What has been forgotten is that there were clear signs in the months leading up

to his suicide that he was suffering from a major depression. He had reportedly lost his appetite, and his weight had dropped by 15 pounds. He had developed insomnia. He had spoken of feeling worthless. He had felt his concentration diminish—all signs of a serious affective illness.

His closest friends seemed to be aware of his despondency, and were mystified by it. The pattern of each person's depression is different, but there are also marked similarities. The psychic torment of depression is, quite simply, albeit mysteriously and defying analysis and explanation, as exquisite as any imaginable physical pain.

I recall telling my daughter with desperate seriousness, while in the depths of my own illness, I would greatly prefer to undergo the amputation of a limb, and I meant it.

It was reported that Foster, during the weekend before the Tuesday that he killed himself, visited friends in Maryland, where he jogged, learned to crack crabs, and talked sports. To nearly everyone, this conjures up an image of summertime pleasure, but to those who themselves have confronted the horror, there is the almost certain knowledge that the jogging session was beset by demonic imaginings, the cracking of crabs was accompanied by thoughts of doom, and the sports talk became a conversational mask, hiding a frantic inner quest for oblivion.

A close friend of Foster's confided to me that though he was clearly depressed, he never mentioned suicide. This tells us little. Like many men and particularly certain highly successful and proudly independent men, Vincent Foster may have shunned psychiatry because, already demoralized, he felt it would be a final capitulation of his selfhood—to lay bare his existential wounding in front of another fallible human being.

When my own depression engulfed me, I had to overcome a lifelong skepticism and mistrust of the psychiatric profession to seek help. A Southerner like Foster, I attended the same college (before I went to

Duke) that he graduated from: Davidson in North Carolina, a small, Presbyterian institution of outstanding academic quality.

The college's venerable Calvinism, although liberalized in recent decades, has inculcated in its students the belief that hard work, material success, civic virtue, and creative achievement are the real guarantors of mental health. There is little doubt that Davidson's values left their mark.

There remains only the need to ask why Vincent Foster became one among the legions of men and women who have suffered this shipwreck of the soul.

The South, including Arkansas, is not fertile ground for psychiatry. Lawyers and writers who have been brought up in the tradition of southern Presbyterianism are often, if not usually, reluctant candidates for therapy. It has been said that Foster had been given the names of two psychiatrists, whom he never contacted.

Among the most troubling details in this wretched chronicle is the one concerning his consultation by telephone, only the day before his death, with his family physician back in Little Rock, who prescribed an anti-depressant. This long-distance procedure would seem to be appallingly insufficient— and not only because of the absurd insufficiency of anti-depressant medication at that critical moment.

Foster was near the brink. He needed to see a skilled practitioner, who most likely would have insisted that he go to a hospital where he would be safe from himself. There, after relief from the fierce pounding of the partly real, but mostly imagined, inflictions he had endured, he would have eventually recovered, as the vast majority of people do.

Far from destroying him, his breakdown would have been a deliverance. In a Washington he had learned to hate, the failure to survive his career in government would have been seen after time as of no

consequence.

There remains only the need to ask why Vincent Foster became one among the legions of men and women who have suffered this shipwreck of the soul.

One of the hallmarks of depression is the way it causes its victims to magnify troubles out of all proportion to their true measure. Paranoia reigns, harmless murmurs are freighted with menace. Shadows become monsters. Such harassments as Foster endured in Washington could not have been entirely negligible, and they plainly triggered his collapse.

One can understand why he felt betrayed and maligned, why his sense of self-worth may have been compromised. Countless stories have been written since the insinuating *Wall Street Journal* editorials about Foster. The articles claim that he must have feared exposure for some misconduct, probably connected to the Whitewater affair.

Even an anxiety like this rarely leads to thoughts of drastic solutions in the normal mind. Only in

One of the hallmarks of depression is the way it causes its victims to magnify troubles out of all proportion to their true measure. Shadows become monsters.

someone vulnerable to depression would such worries give rise to the dementia that leads to self-murder. Foster may well have been at risk since infancy. If, as in many such cases, he had a genetic predisposition toward depression, he would always harbor the potential for chaotic behavior in the case of crisis. This is no defect of character, but one symptom of a complex and mysterious illness.

The fact that Foster's destruction took place in Washington rather than Little Rock could have also been, in the end, a mere quirk of geography. Though it is unlikely that, in the placid landscape of Arkansas, he would have met the pressures and anxieties that so bedeviled him, it is not inconceivable. A home town scandal, some sudden fiasco—any of these might have

caused Foster the same devastation.

One thing in any event that is certain: It is not Washington that became the real proscenium for Vincent Foster's tragedy. It was the stage inside the mind upon which men and women enact life's loneliest agony.

And Foster then, alas, was a loser. I mean that in the sense that he lost the battle against this dreadful illness, and it's especially tragic because most people, after treatment, and even without treatment, eventually win the battle.

This, to me, is the most significant fact about the devastating illness of depression. There is always hope, even though depression certainly is an illness in which hopelessness reigns supreme.

But most people do get well, and that is the most important message that can be uttered about depression.

Near the end of an early film of Ingmar Bergman, *Through a Glass Darkly*, a young woman, experiencing the embrace of what appears to be profound psychotic depression, has a terrifying hallucination. Anticipating the arrival of some transcendental and saving glimpse of God, she sees instead the quivering shape of a monstrous spider that is attempting to violate her sexually. It is an instant of horror and scalding truth. Yet even in this vision of Bergman, who has suffered cruelly from depression himself, there is a sense that all of his accomplished artistry has somehow fallen short of a true rendition of the drowned mind's appalling phantasy megrim.

Since antiquity, in the tortured lament of Job and the choruses of Sophocles and Aeschylus, chroniclers of the human spirit have been wrestling with a vocabulary that might give proper expression to the desolation of melancholia.

Through the course of literature and art, the theme of depression has run like a durable thread of woe from Hamlet's soliloquy to verses of Emily Dickinson and Gerard Manley Hopkins, from John Donne to Hawthorne and Poe and Virginia Woolf. In

many of Albrecht Dürer's engravings there are harrowing depictions of his own melancholia.

The demonic wheeling stars of Van Gogh are the precursors of the artist's plunge into dementia and the extinction of self. It is suffering that often tinges the music of Beethoven, of Chopin and Mahler, and permeates the darker cantatas of Bach. The vast metaphor which most faithfully represents this fathomless ordeal, however, is that of Dante and his all too familiar lines still arrest the imagination with their augury of the unknowable, the black struggle to come. "In the middle of the journey of life, I found myself in a dark wood, for I had lost the right path."

One can be sure that these words have been more than once employed to conjure the ravages of melancholia, but their somber foreboding has often overshadowed the last lines of the best-known part of that poem, with their evocation of hope.

To most of those who have experienced it, the horror of depression is so overwhelming as to be quite beyond expression. Hence the frustrated sense of inadequacy found in the work of even the greatest artist. But in science and art, the search will doubtless go on for clear representation of its meaning—which sometimes, for whose who have known it, is a simulacrum of all the evil of our world: of our every-day discord and chaos, our irrationality, warfare and crime, torture and violence, our impulse toward death

and our flight from it held in the intolerable equipoise of history. If our lives had no other configuration but this we should want, and perhaps deserve, to perish. If depression had no termination, then suicide would indeed be the only remedy.

Men and women who have recovered from the disease—and they are countless—bear witness to probably its only saving grace. It is conquerable.

But one need not sound the false or inspirational note to stress the truth that depression is not the soul's annihilation. Men and women who have recovered from the disease—and they are countless— bear witness to what is probably its only saving grace. It is conquerable. For those who have dwelt in depression's dark wood and known its inexplicable agony, their return from the abyss is not unlike the ascent of the poet, trudging upward and upward out of hell's black depths, and at last emerging into what they saw as the shining world.

There, whoever has been restored to health has almost always been restored to the capacity for serenity and joy, and this may be indemnity enough for having endured the despair beyond despair. Or, in the words of Dante: "And so we came forth and once again beheld the stars."

"There are hundreds of children and families who need help. There are hundreds of parents who need guidance. Loneliness and frustration can be helped by people like you." —*Melanie Suggs*

A Family's Struggle to Save a Son

Frank and Melanie Suggs searched everywhere for help for their son, Taylor, with little luck; they persevered, determined to save the bright, talented child manacled by an unnamed foe

We have lived our lives finding ways to keep our son, Taylor, happy. Trying to answer our questions on why Taylor was so difficult was impossible. Pediatricians scratched their heads, preschool teachers dreaded him coming and, most of all, our family struggled for peace.

Taylor's first hospitalization was when he was seven, at the University of North Carolina at Chapel Hill, two and half hours from our home. We begged for a name for Taylor's illness. That seemed important then, and, after all, when a seven-year-old is as emotionally and mentally disturbed as our child was, there has to be a name. There has to be a cure, like there is for leukemia.

But there wasn't.

Four and a half months later—countless medications, double-blind studies, normal EEGs, abnormal EEGs, words like autism, epilepsy, learning disability, behavior modification therapies, family therapy, individual therapy—we still knew nothing. We brought Taylor home and continued our fight.

Taylor was emotionally and physically abusive to most people, especially to Whitney, his younger sister. Her life was hell, and ours was right behind. Our frustrations continued daily, trying to function in day-to-day activity. Life doesn't stop just because you have a sick child. It's just terribly painful, and very hard. When Taylor was in fourth grade, he was put in a self-contained behavioral disorder classroom. His school life was interesting. His I.Q. was high. But when he was acting out, when he was frustrated or overstimulated, learning was impossible.

Teaching him was impossible, being his friend was impossible, parenting him was very difficult—but loving him was easy. We continued looking for answers. We continued therapies, medications. Anyone who had an idea on what to do was our new best friend.

As Taylor grew—fast and big—it became increasingly difficult to control him when he was raging. He tortured and killed animals. He experimented with explosives, guns, and knives.

During his eighth-grade year, a miracle happened; everyone noticed—everyone at school—that is. He turned into someone that we knew he could be: wonderful. He was named the Turner Broadcast System Student of the Year. All the teachers unanimously voted for him.

But then, it went downhill again and the fight continued, literally. The violence was incredibly bad. Our 5-foot, ll-inch son, who weighed 200 pounds, was dangerous. He experimented with marijuana, which affected his medications. He was obsessed with guns. The police were regular visitors at our home. But they never arrested Taylor, even after he stabbed Frank with the screwdriver and put a gun to my head.

We cried out for help everywhere. Crisis intervention came to our home. They promised the next time they came they would take him, they would give us a respite, and help. They came, but they didn't take him. We began to think that it might take one of our family going out in a body bag for someone to listen and to know we were in trouble and needed help.

Part I: Melanie's Story

Taylor's and Frank's stories are found on pages 21 and 29.

We finally admitted Taylor to a psychiatric hospital, but with insurance putting such limitations on stays, all we were allowed was 27 days. We were required at the end of that time to have a family session before they would let Taylor leave. We coerced Whitney, our daughter, into coming. During that session, Taylor jumped across the room and attacked her. He beat her furiously. But insurance

We're hopeful. We no longer look to name Taylor's illness; that doesn't seem to matter anymore. We know Taylor. We want him to come home.

dictated that he be discharged in two days, and he was.

For two weeks, we lived in hell, we lived in fear. Taylor had control. He knew it, we knew it.

I called anyone I could who might help us help Taylor. We were constantly discouraged by the numbers of children on waiting lists. Taylor would cry and beg for help. He didn't understand why these things would happen. Finally, Scottish Rite Hospital admitted Taylor, and for 34 more days he was examined and medicated by a group of wonderful people.

But there were still no answers. They didn't know what to do because we couldn't pay for the care we needed. We did manage to gain more confidence in our knowledge of mental health and what our child needed.

We explored a very, very expensive facility in Texas. After more searching, the Village of St. Joseph opened its doors, and we found an answer to our prayers. Taylor made progress, but nine months later, his illness took over. He needed more intense treatment; we had to find a place and we had to find a way. We spent hours readying the psychiatric hospital to take Taylor. We didn't know if he would be violent on this admission.

We went to the Village of St. Joseph and picked up Taylor. He wasn't violent; he was sad. He wanted to be well.

We went to the hospital, and the director of admissions said, "Mr. and Mrs. Suggs, I'm sorry, but your child can't come in. The insurance company has withdrawn its pre-approval. They say your child needs to be in jail."

After four and a half hours of phone calls, threats, and tears, they finally admitted him. We spent the next two weeks searching to place Taylor in an intensive treatment facility. Unfortunately, it takes longer than two weeks and we had to rely on the state psychiatric facility to house Taylor until we could find appropriate placement.

I can't put into words the feelings I had leaving Taylor in that facility. I had been assured it was a good place, with good people. But my heart and brain

didn't agree. During the 30 days Taylor was there, we became friends with people throughout the state. They helped us. We were guided through the process of obtaining state funding necessary to place Taylor in a facility he desperately needed. We found wonderful, caring people. We found information in Next Steps, in the Georgia Parent Support Network. We found a home.

Taylor has been at Inner Harbour Hospital now for nine months. We're hopeful. We no longer look to name his illness; that doesn't seem to matter anymore. We know Taylor. We know he's wonderful. We know he can be productive. He needed help, and he needed time. We want him to come home.

But we also want you to know that we need communication. People shouldn't have to go through this confusion and this pain and struggle. We need agencies to communicate with each other; we need physicians to communicate with the agencies.

We've come a long way in our 17 years. We've met many wonderful people; we've become very aware of the lack of knowledge. There are hundreds of children and families who need help. There are hundreds of parents who need guidance. Loneliness and frustration can be helped by people like you, who are willing to give of themselves.

Georgia: A Sociological Perspective

Understanding Georgia—and Georgians—is imperative to understanding public policy about mental health; here is a look at how we became who we are, and the forces shaping our future

By Douglas Bachtel, Ph.D.

Before you can understand mental health, physical health, and public policy, you have to know the environment in which you are working. First, we are getting older. For example, in 1900, 50 percent of the U.S. population was under 19. Today, only one-third is under 19.

During the 1980s, many states lost population because of shakeups in their economies, but Georgia grew. Between 1980 and 1990, Georgia was the fourth-fastest growing state in the nation, on a numeric basis, and the eighth-fastest growing on a percentage basis. Atlanta is the second-fastest growing metro area in the country, behind Las Vegas.

Georgia's growth has been steady: In 1930, 2.9 million people; in 1980, 5.4 million; in 1990, 6.4 million people; and currently, 7.2 million.

In addition to people moving from other states, there is international immigration. The new America is coming from Mexico, China, the Philippines, Vietnam, the Soviet Union, the Dominican Republic, India, and Poland. Basically, the people who are moving to the U.S. are people of color.

Georgia is the fourth-fastest growing state in the nation. Sixty percent of that growth is from people moving here from elsewhere, many from overseas.

During the '90s, almost 60 percent of Georgia's growth has come from people moving in. They are coming because of our wonderfully diversified economy. We have the military, Hartsfield International Airport, agriculture, agribusiness, pecans and pulp wood. We have I-75. One of every four cars in America travels up and down I-75 in a given year, and they need gasoline and motels and food.

About 65 percent of our population is urban; there has been a tremendous decline in the rural farm population. There are now more private security guards in Georgia than farmers, certainly an indication of changing priorities.

There used to be about a quarter of a million farms in Georgia; it is now down to about 40,000.

Total Population
Georgia

Year	Population
2000 Proj.	7,637,000
1995 Est.	7,201,000
1990	6,478,149
1980	5,463,105
1970	4,589,575
1960	3,943,116
1950	3,444,578
1940	3,123,723
1930	2,908,506

Projected growth
1990-2000
17.9%
U.S. Bureau of the Census

Douglas Bachtel is a professor in the Department of Housing and Consumer Economics at the University of Georgia.
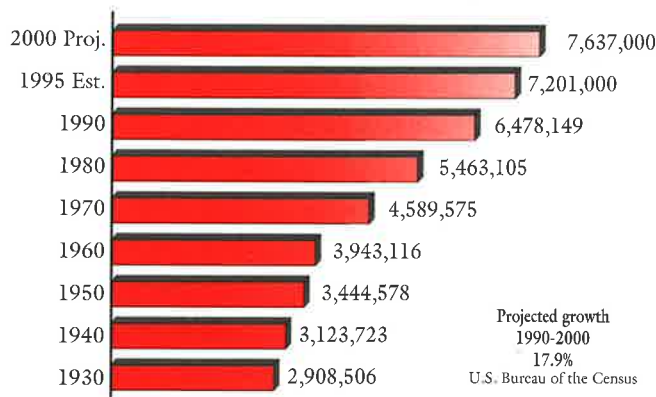
Per Capita Income:
1989-1994

Georgia · Southeast · U.S.

SE=$19,598
US=$21,696

1994 PCI
GA=20,212
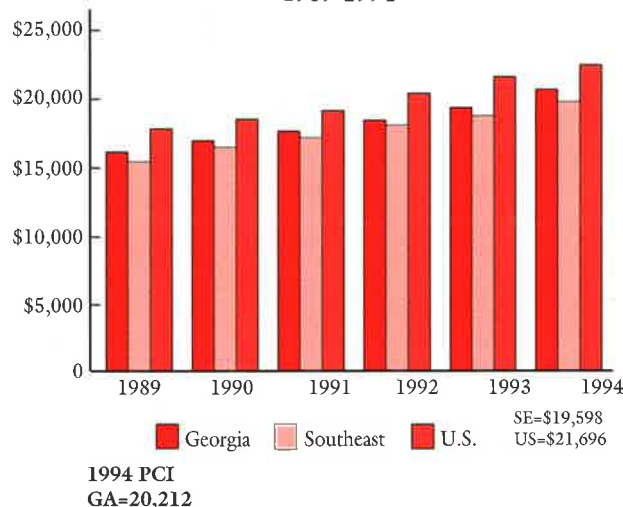
There has been a tremendous migration of the African-American population out of agriculture. There are more female-owned farms in Georgia than black-owned. Nationwide, there are less than 20,000 black farmers and their average age is about 63. In two to four years, black agriculture will essentially be over.

Georgia used to be a sleepy rural state. No more. More international telecommunication trunk lines come into Atlanta than New York City.

One solid metropolitan area is spreading across the northern half of Georgia. Anniston, Ala., is com-

Georgia has a large poverty-stricken population. More than a million Georgians live in poverty—and it's increasing, and getting more inter-generational.

ing to Atlanta, Athens is only one county away from Anderson, S.C., Macon and Chattanooga are about to hook up.

With that growth comes problems such as traffic and neighbors not knowing neighbors; Grandma does not live with us anymore. We left her up north, or in Alabama, or Mississippi. As a result, our houshold size is shrinking.

A hallmark of a rural area is a lack of affordable housing. In 1990, 11.6 percent of all Georgia's households were in mobile homes. In some counties, it is 29 to 55 percent. This is important. Mobile homes do not generate as much taxes as traditional houses and people who live in mobile homes tend to

have more children than people who live in traditional houses. We have to understand our tax base in rural and suburban areas to know how to economically support services we see as necessary.

In 1994, 40 percent of Georgians lived inside a city limit. In south Georgia, 45 percent of the population live within city limits. If you want to reach people in Georgia through government, you reach them through city government in south Georgia, county government in north Georgia. This is an important distinction for those who wish to impact public policy.

In 1995, 41 counties had a population less than 10,000. This is critical for politics. If you live in a small county, you know half the people and you may be related to some of them. As a result, if you run for the Legislature, you are going to get elected, and re-elected, and re-elected, until you get seniority. So, despite the fact that Georgia is becoming a Republican state, many rural legislators with seniority actually run the committees. This is why we will continue to have a rural flavor in the state house well into the next century.

In 1930, there were 4.4 persons per household. By 1990, it had declined to 2.6. That is mom, dad and .6 kids. Or Mom and 1.6 kids. We are living in small, isolated households with kinfolk and friends left behind. When there are problems, we often do not have anybody to turn to.

More houses, fewer and fewer people in those households—this translates into Wal-Marts all over the place. All these folks need to buy shower curtains

Population by Race

1994 Estimate
Georgia

Other 1.7%

Hispanic 2.0%

White
70.4%

Black
27.9%
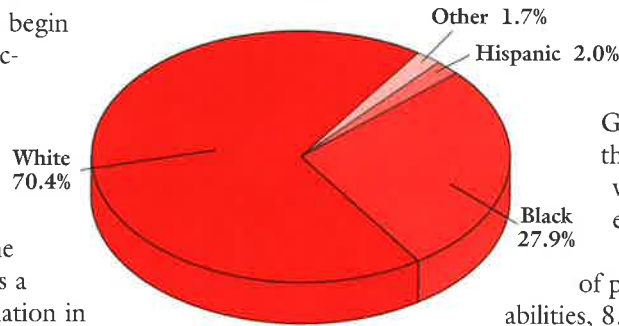
and draperies. Retailers have long understood this trend. Mental health professionals need to begin to understand it, and plan accordingly.

Per capita income is also rising; in 1989 Georgia's surpassed the average for the Southeast. But Georgia is still below the average nationwide. There is a large poverty-stricken population in Georgia. More than a million people in Georgia live below the poverty level, and it is increasing. It is getting more thorny to deal with because it is becoming more inter-generational.

In 1994, per capita income was $21,696 in the Atlanta metropolitan area. Some of the most affluent counties in the U.S. are around Atlanta. But 63 counties had per capita income below Mississippi's—at $15,828, the lowest in the nation. How are you going to fund a school system in these counties? How are you going to develop adequate governmental programs if you have a third of your housing in mobile homes, if you have steadily lost population?

Look at Georgia employers. Five percent of all firms in Georgia are in manufacturing; a small number of firms employ a lot of people and pay good wages. Then, there is the service economy, where many firms do not employ many people in relationship to their size, and they pay minimum wage.

We make more stuff in America than ever, but we are making it with robots and laser beams and computers. You do not want to lose a $17 per hour job in the manufacturing sector to work in a $4.50 per hour job in the service sector. There are tremendous psychological problems associated with downsizing and automation.

We are in the "Age of Information." Last year, we made more money from the sale of movies and TV reruns than we did from steel—incredibly, we made

more money selling *Laverne and Shirley* reruns to the Europeans than we did by making steel.

Unemployment in Georgia tends to be below the national average because we have a diversified economy.

Georgia has a large number of people reporting work disabilities, 8.6 percent of the total population in 1990. Most are in counties that rely on agriculture, pulp wood, and mining. These are dangerous occupations. Some of these counties have more than 12 percent of their total labor force with a work disability. How are you going to fund a government program if you have 30 percent of your housing units in mobile homes, you are losing population, you have a per capita income below Mississippi, and you have more than 12 percent of your work force with a work disability, plus you have a population of less than 10,000? It is going to be very, very difficult for some

In Georgia, we have a younger African-American population and older white population. The two groups have different needs, different attitudes.

rural communities to develop the economic base for publicly funded services their population requires.

In 1990, 71 percent of Georgians were white, 1.6 percent were "other"— Asians, Eskimos, Aleuts, and Pacific Islanders—and 27 percent were African-American. Georgia has the fifth-highest number, fourth-highest percentage, of African-Americans of any state; the U.S. average is only 13 percent. (Hispanic folks are not tallied because they are an ethnic group, not a racial one. You can be a white Hispanic, a black Hispanic, or an "other" Hispanic, according

to the Census Bureau. Realistically, Georgia's Hispanic population is three to five percent of the total.)

In 1880, 47 percent of the state population was African-American. The percentage declined every decade for 90 years, until the '70s, when it increased by one percentage point. Basically, that meant African-Americans were no longer leaving Georgia. Also, black women have a higher birth rate than white women, so Georgia's African-American population has been increasing on a percentage basis across the state. In one area, called the "black belt," counties are 35 percent to 80 percent African-American. This is cotton plantation country that required a large slave labor force. So, to this day, a significant number of African-Americans reside in this area.

On the other hand, where there was never a need for a large slave labor force (for example, in counties north of the Okeefonokee Swamp), there was never a large African-American population; that remains true today.

The northern section of the state is primarily white, because it was based on subsistence agricul-

Educational Attainment Levels: 1990
Percent of Persons 25 Yrs. of Age & Older
Georgia

9-12 Yrs./No Diploma
17.1%

0-8 Yrs.
12%

Grad/prof Degree
6.4%

H.S. Graduate
29.6%

Bachelor's Degree
12.9%

Some College
22.0%

ture. People there could not use or afford slave labor. Currently, 51 percent of Georgia's black population lives in seven counties: Fulton, Bibb, Muscogee, Chatham, Dekalb, Richmond, and Dougherty. It takes about 17 counties to reach 51 percent of the state's white population.

Hispanics show up in surprising places. Many reside in south Georgia. Why? Onions. Many Hispanics found work picking, chopping and toting those onions. Camden County is military-based and therefore one of the most culturally diverse counties in the state. Dade County, in the north, has a large percentage of Hispanics working in the carpet industry. A school district in Dade County is 20 percent Hispanic.

The median age for the total population in Georgia is about 31; whites at 34, blacks at 27. That is a big difference. Whites live longer, black women have a higher birth rate, so what we have is a predominantly younger African-American population and predominantly older white population. The two groups have different needs, different attitudes. A minority black population can produce a majority black school system. In rural areas, older white land owners living on a fixed income may not be willing to vote for a tax increase for a predominantly black school system.

Age is one of our most important variables. North Georgia tends to be older because it is primarily white. Metropolitan areas tend to be young because of all those people moving in. Remember: 60 percent of our growth is from immigrants, who tend to be younger, better educated, and have higher incomes than the population into which they move. I am referring to the working-age couples, raising children, who are moving to Georgia.

In 1940, more than 80 percent of Georgians did not have a high school education. By 1990, 29 percent did not.

More than 12 percent of Georgia's population dropped out of high school. Some just want to get a
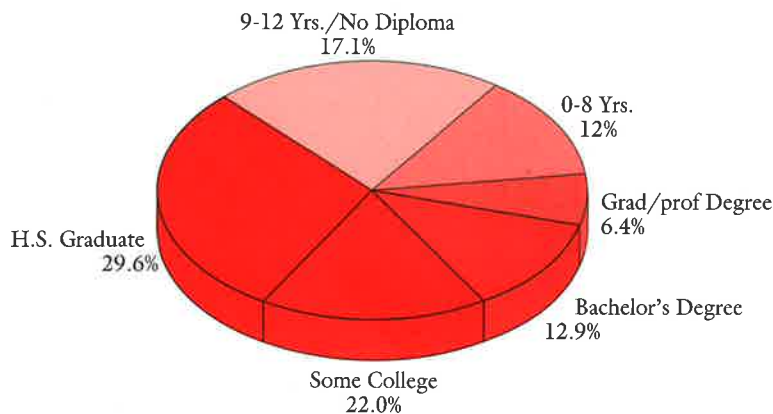
Camaro or a job. Others, because of the development of disability, mental illness, or a family situation.

In 1990, 16.8 percent of Georgia's households made less than $10,000 a year. This is what we refer to as the "working poor," who often do not have adequate insurance.

The marriage rate has increased. Marriage often provides a more stable environment. White folks marry more, and divorce more, than black folks. The birth rate has increased for both races, but African-American women continue to have a higher birth rate that white women. It is directly related to education and income.

Georgia has a tremendous problem with infant mortality, the death of a child under one year of age. Georgia has a higher infant death rate than Singapore, Korea, Hong Kong, Taiwan, Spain, and Cuba. A black baby stands twice the chance of dying as a white baby.

African-American women have a significantly higher birth-to-unwed mother rate than do white women. Black women also have a higher abortion rate than do white women. In 1994, 67.8 percent of all the births in the African-American community were to unwed mothers. The figure for white women was 18 percent. So black women have a higher rate and they have a much higher percentage.

A school superintendent in rural Georgia once told me his biggest problem as an educator was finding a room for the girls to nurse their babies. Most of the births to teenage mothers are to older teens, 18 or 19 years old.

For every 100,000 Georgians, 11.9 percent commit suicide. The suicide rates for whites is 13.9; for blacks, 6.8. Mental health professionals should be aware of the growing prevalence of suicide.

For every 100,000 Georgians, 11.5 are murdered. The murder rate for whites is 5.1; for blacks, the rate is 26.1. One of every 30 black males in American society is murdered. It is a national tragedy.

In 1994, 5,641 crimes were committed per 100,000 people in Georgia.

It costs $52 a day to keep a man or women in prison. It costs $100 a day to keep a kid in a detention center. We pay $25 a day to educate a child. Clearly, there are tremendous problems hidden in those statistics.

Georgia has a very low voter participation level. It has been more than 127 years since a majority of Georgians voted for president. In 1994, only 30 percent of the population bothered to turn out to vote.

Here is an overview of metropolitan Georgia. It is where the bulk of the population is, where many of the jobs are, where the money is, where the traffic is. But primarily, the people who live in metropolitan areas are poor. They are African-American, with a high number of births to unwed mothers. Metro areas also have very high crime rates and unemployment rates.

Then, there is suburban Georgia, the bedroom communities surrounding the metropolitan areas—counties like Henry, Paulding, Douglas, Effingham, Bryan, Jones, Harris, Oconee. Suburban Georgia is primarily white, affluent and well-educated. It has a high crime rate, but for property crime, not person crime.

It costs $52 a day to incarcerate a felon, $100 a day to keep a kid in a detention center. But $25 a day to educate a kid—what's wrong with this picture?

Next is middle Georgia. It is growing because of its scenic beauty—mountains and coast. It has a military base or a major city like Valdosta or Dublin. It has job opportunities.

Finally, there is rural Georgia—which is declining in population. Here, there is a pretty high concentration of African- Americans, relatively low education levels, problems with economic diversity, and decades of out-migration.

Georgia is too dynamic, too large, to apply just one scenario to any area, but this is the data you need to begin to assess how current and future demographic trends should impact planning for mental health services.

Issues of Access

Availability, accessibility, awareness, affordability and appropriateness are the measures of access

By Howard Goldman, M.D., M.P.H., Ph.D.

Access has several important dimensions and is best understood with reference to other attributes of the healthcare system such as cost and quality. Access is the means of entry into services: for example, through a health care provider or through voluntary admittance at a public hospital or institution.

> *It is important to distinguish between access related to the supply of services and those related to demand.*

Demographic trends may affect access in many ways. One of the most dire is the percentage of the population living in poverty. Also inhibiting access are a lack of education and minority status. The youthfulness of Georgia's population may also inhibit access; fewer young people have healthcare insurance.

It is important to distinguish between aspects of access related to the *supply* of services and those related to *demand* for services. Five "A" words characterize the multidimensional nature of access:

■ *Availability*. Do providers exist in the community? Does everyone have a choice? Rural areas and areas with rapidly expanding population may not have any, or enough, services available.

■ *Accessibility*. Can everyone get the needed care and treatment? Geographic distance, special needs for accommodation, and cultural differences may make services available, but not accessible. Transportation barriers impede access, as does the lack of providers who can communicate with those who are hearing-impaired or speak a foreign language, or who can relate to diverse individuals from many cultures. Rural areas, and urban areas with inadequate public transportation, have difficulties with this.

■ *Awareness*. A service may be available and accessible, but no one will use it if the public does not know what, when, and where it is. For example, does the single point of entry in the regional board organization of services in Georgia facilitate access?

■ *Affordability*. What is the price of the service, and can those who need the service afford it? Insurance reform, in particular the efforts at achieving "parity" in the recent Congress, can improve access through this route. Still, this has been a limited success and is only a first step.

Parity legislation is a rhetorical victory, recognizing the lack of "fairness" in coverage. But while the recent bill may offer protections against financial loss for those who would incur the largest losses because previously they would have exhausted their lifetime or annual dollar limit, it does nothing to improve "first dollar" coverage or reduce differential co-payments or deductibles. It could lead to the loss of mental health coverage for some policyholders—it pertains only to businesses with more than 50 employees—and the benefit is limited to 1 percent of premium in costs to insurers. These limitations are significant barriers to care.

■ *Appropriateness*. The service provided in response to consumer demand should be the right match of a cost-effective service to the client's need. Professional skill is needed to appropriately make this link. This will occur where concerns about quality and cost meet concerns about access.

Howard Goldman is a professor of psychiatry, University of Maryland, School of Medicine and the director of Mental Health Policy Studies.

Key Questions to Improving Access

There must be enough providers, in the right places, providing fair access to high-quality treatment

By Darrell Kirch, M.D.

Improving access to mental health care in Georgia hinges on the answers to four major questions: Are there enough providers? Are providers accessible? Do providers offer high-quality treatment? Who pays for the services? If more people are to get the help that they need, it is imperative that we develop satisfactory answers to all four questions.

■ *Are there enough psychiatrists?* Most studies indicate that there are enough nationwide, but this is more of a question in Georgia, where some counties have no doctor, of any type. Georgia ranks 37th in the nation in the number of physicians per capita.

■ *Are they accessible?* Many counties have no psychiatrist, and even fewer have a specialist in child psychiatry. This problem is acute in rural Georgia, especially in the southern half of the state. It is no accident that a significant percentage of the state's Medicaid budget is earmarked for patient transportation.

Care also must be accessible despite racial and demographic diversity. People must feel comfortable seeking help, and they must be able to understand how the provider wants to work with them.

We also must topple the barrier of stigma. To avoid stigma, people with severe mental disorders will seek help from non-professional counselors. Studies find that people are more willing to take medication for colds and headaches than for depression and anxiety.

■ *Is the treatment of a high quality?* Psychiatry in part created this problem for itself with past neglect of its scientific base. Professionals focused upon psychoanalytic theory and treatment and neglected the biological bases of disorders and pharmocological treat-

ments. We must be more than good psychotherapists. We must understand the biology of mental illness.

Another impediment to high-quality treatment is the ongoing conflict between different mental health disciplines over issues such as hospital admission and prescribing privileges. Nationally, we are plagued by fragmentation of delivery systems, and the gaps between public and private systems of care. Both systems have tried to reinvent themselves in recent years, under the influence of managed care.

■ *Who pays?* Despite recent federal legislation, a lack of parity is still common. Another reason for the battle over financial responsibility is inefficiency—another barrier we helped build. Public systems were created around monolithic hospitals that often were expensive, inefficient and not patient-centered.

There is also the barrier of blame. We consume too much energy in the rivalry between disciplines, in the tensions among providers, patients, and their families. We must challenge old assumptions upon which the current system is based. First is that medical disorders are "biological," and mental disorders are "psychological." They are not separate.

We tend to educate students in isolation—medical students do not work with nursing students, for example. This does not foster a team-based approach to care.

Telemedicine, or "electronic house calls," means a doctor's physical presence is no longer required for treatment. This helps ease the barrier of geography.

Finally, there is the idea that health care reform is best left to the marketplace. Will a system that evolves this way meet the needs of everyone?

Darrell Kirch is dean of the schools of medicine and graduate studies at the Medical College of Georgia in Augusta.
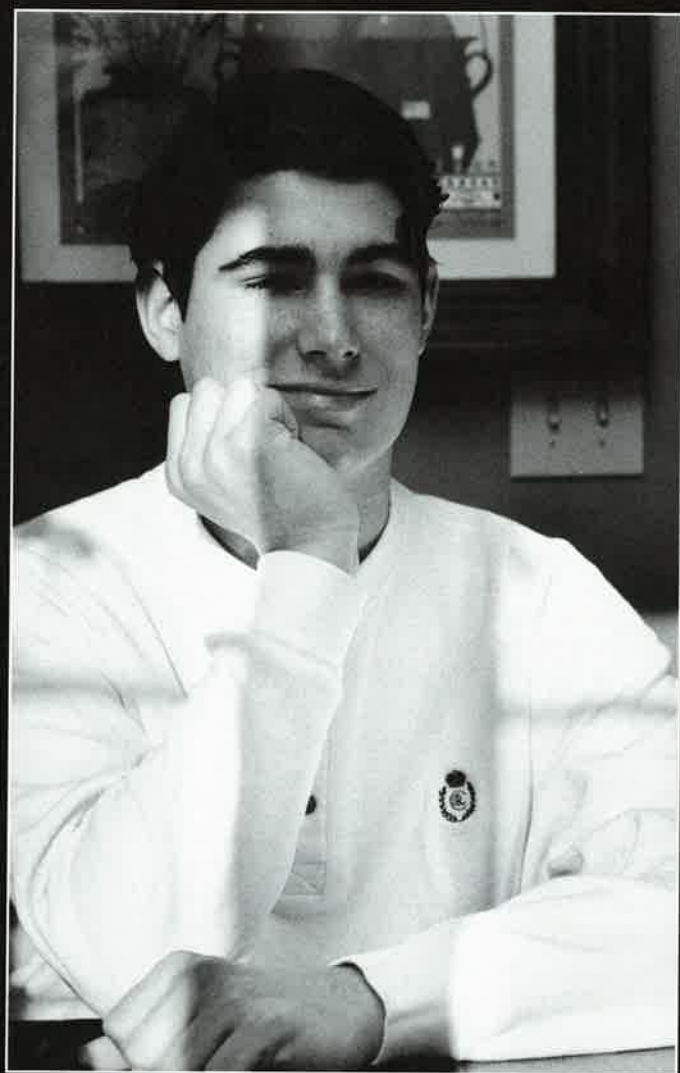
"A month ago, I learned I could not become a pilot because of the medications I'm on. A lot of kids have dreams, and they're not going to be able to make them happen."

—*Taylor Suggs*

A Family's Struggle to Save a Son

Taylor Suggs describes the good and the bad of his treatment; and shares an "impossible" dream

In my 17 years of life, I've been in seven different treatment centers. There are many good and bad things about treatment centers—like the staff.

Most of the staff are dedicated to helping young adults, and would do almost anything for the patients.

They seem to be super-human, because for as little pay as they get, they can take almost anything that the patients can dish out. They take the frustrations, the crap, the hell that we put them through, and yet they will come right back and be your friend and help you the next day.

I know this, because it has happened to me in every single treatment center.

But I've seen horror stories and have heard horror stories about what goes on behind closed doors. A staff member shook me after I spit on him when I was eight years old. I saw a patient thrown down, dragged into his room and struck. These incidences are rare, but they need to be looked at.

Also, I feel that lock-key facilities don't work. They make patients feel like they are in prison, and that they are criminals. Inner Harbour, my present facility, has an outside program which helps a lot. It allows you to be free and be outside a lot, which pleases me.

It pleases all the other patients there, as well.

I also like places with a small staff-to-patient ratio. It gives you more attention. I like places that give you a chance to go home.

One last thing that I'd like to share is a dream that I have; it is about what I'd like for myself and it tells you how my life and my future have been affected by my medications and my mental health.

My dream, ever since I was little, was to become a pilot. About a month ago I was interested in becoming a bush pilot. I decided that was going to be my career.

A bush pilot flies into remote areas and drops off equipment. It's a great job. I would love to do that. It would be outside, which I love.

A month ago, I learned I could not become a pilot because of the medications I'm on. The FAA does not even recognize Ritalin. That disappoints me.

A lot of kids have dreams, and they're not going to be able to make them happen.

Part II: Taylor's Story

Melanie's and Frank's stories are found on pages 11 and 29.

Strategies to Overcome Barriers

Experts in fields ranging from newspaper reporting to psychiatry discuss ways to improve communication about, and treatment of, mental illness

Andy Miller discusses ways to educate reporters about mental health issues

Basically, reporters are all looking for stories of human interest, no matter what the subject. We are looking for stories of conflict, of injustice, of heroism. Believe it or not, we look for good news.

What we would like to know in covering mental health issues is: What legislation is working? Are there new treatments and therapies that are treating more people successfully? Are there individuals who are doing a great job? Are there companies with progressive benefits plans that treat mental health equally with physical health?

We want to know about those stories so we can put them in the paper. Is stigma still holding people back from getting services? Is there not enough funding for services? Is there a lack of practitioners in rural areas? Are people being denied services? Are there companies who are not covering mental health at all? Are practitioners doing fraudulent things?

That last question is a double-edged sword. On one hand, it drags the whole profession down. On the other hand, when we bring the media stick to bear, we may discourage others from doing similar things.

Are there public figures who are going to come to the table and talk about their families or themselves? That is happening now more than ever before. William Styron speaks out. U.S. House Speaker Newt Gingrich has talked about his family members.

How can we compare Georgia to the rest of the country in terms of the mental health system? I think the advocacy community in this state is terrific. There is a lot more to be done, but Georgia is a progressive state. We need to tell that story, too.

How do you contact us? Sometimes, it is not easy. We are on the phone—that's what we do for a living—or we are out of the office.

Here are some guidelines: If you have an important story, send me a fax or letter about it, followed by a phone call. I'd much rather take calls from consumer advocates than corporate executives.

When you do make a call and get through to the right reporter, make sure you can target your message in a short amount of time—maybe 10 or 15 minutes. Be persistent. If a reporter doesn't get to it tomorrow, do not worry about it. It may come on down the line. There have been stories I could not get to for six months, but I remember it if the person has been persistent and polite.

Try to get us in the morning. It is almost impossible to call a reporter after about 3 o'clock. Do not call before 9 either, especially after the Braves play. Take us to breakfast, take us to lunch, come to the paper, come to the TV station. We get a lot of information, a lot of phone calls, but we still like the personal touch and we always read personal letters.

How can you help us? Try to keep it as simple as you can. Some reporters do not know the difference between Medicaid and Medicare. Try to find out how much the reporter knows. There is a lot of jar-

Andy Miller is a staff writer for the *Atlanta Journal and Constitution.* For the past four years, he has covered business, with an emphasis on healthcare issues.

gon in health care; keep things simple.

A lot of different funding streams flow into mental health. It is very confusing. Bring numbers. If one in 20 Americans suffers depression, bring that number. If the Medicaid budget is being cut, by how much? What does this mean for your field? If you are talking about an illness, bring information about it— not 50 pages; five will do. Bring phone numbers of people we can talk to: professors, political officials, consumer advocates, psychologists, psychiatrists.

It is very important for us to talk with people who have the problem. This is difficult, but try to get them to come forward. We need to talk to actual people who are being affected.

We need to be telling stories about the barriers to care. If there are 1.3 million Georgians without insurance, that is a tremendous barrier. We have more people in the state, fewer Medicaid dollars, more managed care, more population growth. What do all these numbers mean?

Ron Finch discusses what employers want and expect from mental health care.

L et's frame this in terms of data many employers use. Their main concern is to balance the cost of protecting human capital while controlling expenses. Employers know that approximately 20 percent of the population will, at one time or another, suffer from depression, and that one of every 10 adults will suffer from chemical dependency. For example, 17 percent of the women and 11 percent of the men at Westinghouse were diagnosed with depression. Eleven percent of all work days lost are due to depression. Employers also know that productivity is diminished to less than one half of normal because of mental health problems, and that tardiness, acci-

dents, and employee conflict are generated from mental health problems.

Employers know they must do something to protect their human capital; most invest significantly in training and retention programs that keep good employees on the job. As far back as the 1930s, employers started employee assistance programs that primarily addressed chemical dependency, primarily. Now, more than 90 percent of the large employers

In the Washington Business Group on Health survey, 91 percent of the employers found mental health benefits an absolute necessity in their offerings.

have these programs. In the 1970s and early 1980s, we saw hardly any difference between mental health care benefits and medical surgical benefits.

But mental health care outpaced medical-surgical in its escalation in cost. In 1989, members of the Washington Business Group on Health issued a research report on the increase in cost for medium and small employers for mental health benefits: a 47 percent increase in 1989, followed by 27 percent the next year. There was no corresponding increase in good outcomes.

Those increases forced employers to take a look at how to manage the costs of mental health benefits. At Xerox Corporation, for example, mental health benefits have grown to be 25 percent of all health care costs.

When I was at BellSouth, 23 percent of all hospital days paid for were for mental health care. The problem was the design of our insurance, which had barriers to out patient care, such as a co-pay of about 50 percent. The combination of insurance design, patient demand for care, and the provider community all produced the increase in costs.

Our challenge is to control the cost of care while increasing the access to care, helping people get the care they need early.

Now, 98 percent of full-time employees have

Ron Finch, Ed.D., is director of Counseling and Educational Services for Coopers and Lybrand, an accounting and consulting firm.

access to mental health benefits. However, only 14 percent have benefits equal to their surgical benefits.

In the Washington Business Group on Health survey, 91 percent of the employers found mental

I understand about containing costs. But if I have a patient whom I can only see for six to eight sessions, what happens to establishing rapport?

health benefits an absolute necessity in their offerings. Ninety-four percent of all the HMOs, while not re-quired to do so, offer mental health benefits.

We need to recognize the importance of mental health care benefits. Some employers simply do not want to face the issue and do not offer benefits.

Another problem is that mental health benefits could get lost in the discussion because they are a very small part of our total health care expense. In 1995, it was $45 billion out of a trillion dollars. Thanks to advocacy groups, we are continuing to keep it in the forefront.

Another problem is the fighting among profes-sionals—psychiatrists, psychologists, social workers, counselors—about who can do the best job. This confuses employers.

Employers don't care who gives the care as long as they get good outcomes. That fight has got to stop, so the best interests of consumers can be addressed.

Sherry Ramey, Ph.D., is a clinical psy-chologist, president of the Mental Health Asso-ciation of Metropolitan Atlanta, and a member of the Georgia Psy-chological Association.

Sherry Ramey discusses some of barriers psychologists must overcome to treat patients

Some of the barriers the Suggs family talks about are barriers I deal with every day. As a practicing psychologist, one of the problems is getting authorization for treatment. Patients may have insur-ance, they may have benefits, but can you get through? Just getting through on the telephone for authoriza-tion is a big deal. Sometimes, it seems to takes forever.

Once you get through, you have to convince someone that the person needs treatment. You have to paint a picture that is just unbelievable. If you do not say the right buzz words, you may not get help.

Once you get the initial approval, you have to call back for further or additional approvals. What is happening with that patient in the meantime?

Then, there are limits to the number of ses-sions. I understand about containing costs. But if I have a patient whom I can only see for six to eight sessions, what happens to establishing rapport? If you take the first session or two to establish rapport, you have maybe four sessions to treat a person, and then maybe two to terminate. What is the quality of care?

Outpatients we are seeing are sicker than they were three or four years ago, but hospitalization is very difficult to get. Many patients we are treating would have been hospitalized three or four years ago. Some still need hospitalization.

Care/cost restrictions force us to start termina-tion at the time a patient walks in the door. If you can resolve a patient's problem in four sessions, was it medically necessary in the first place?

The maze of paperwork is unbelievable. Each carrier, each facility wants something different. It is a full-time job to keep track. More confusion results from each company having its own guidelines and rules.

Then, there is the bickering among profession-als. Many managed-care companies have a total disre-gard for the fact that, as a clinical psychologist, you have to go to school five to seven years beyond col-lege, you have to go through a year's internship and, in Georgia, you have to go through the grueling process of licensing, which includes 2,000 hours of post-doctorate work.

All this is done to protect the public. Once we

go through the process, we are still forced to ask for services to patients by calling a 1-800 line to talk to someone with less training than us, who has never seen the patient—only to say, "Sorry, we cannot approve that." We deal with people in crisis.

I recently had a suicidal patient. I could not get her in the hospital; the reviewer said, "Well, has she done anything lately?"

Most companies will not qualify psychological testing. If you went to a medical doctor, complaining of a pain, would you be satisfied to talk to her/him for a few minutes and take some pills? How many people would trust that approach to treatment?

Finally, there is the issue of confidentiality. Many patients do not realize that when they sign up for managed care, they waive their confidentiality. The information is on computer, and anybody with access to that computer has their information. Again, who is protecting the public? What about the quality of care?

My concern is with the quality of care. What are we doing *to* the public? What are we doing *for* the public?

Stephen Preas discusses how mental health professionals can reach the people who need help

I f private practice or private enterprise has an ounce of courage or a lick of sense, we are going to come get you. William Styron's book is *Darkness Visible*. We have to go into the darkness and find you in order to lead you out. The problem with mental illness is that the organ that is supposed to tell you that something is wrong is the organ that is sick.

So, *we* have to come find *you*. Access is *our* problem; it is not *your* problem. *We* have to overcome the barriers and aggressively go after *you*. Companies like Transitional Family Services are already using *existing* funding to do psychotherapy for children in

the home. They may get 40 or 50 hours approved, then spend 15 of those hours in the first week doing individual and family care. That saves hospital costs, and the costs of a possible foster out-placement.

Companies like the SPEC—Strategic Prevention Education Compliance Group, Inc.—are demonstrating the drug-free work place is not only good mental health, but effective and profitable.

The biggest club in the world, Alcoholics Anonymous, has some pretty high admission dues, but it has provided the best access to care for addiction in 50 years. Nobody has improved on it. If we identify addicts and alcoholics *early* enough, we can deal with short in-patient and out-patient detoxification—but we have to find people early.

Pharmaceutical companies are sponsoring talks to the public on issues of mental illness, sleep disorders, manic depression—they helped sponsor this

I recently had a suicidal patient. I couldn't get her admitted to the hospital; the insurance company reviewer said, "Well, has she done anything lately?"

conference. Private enterprise is trying to find *you*.

Telemedicine is an exciting area. Private enterprise has to seize on video psychiatry and come to you. I can sit in my office and relate to a master's-level or Ph.D.-level worker in the field, and help her or him with the evaluation. Technologically, we can do that now. It can save costs drastically.

Stigma is an important barrier. We all have to proclaim that we practice mental hygiene every day. That we practice defensiveness every day. That we all have some degree of mental illness; it is just a matter of degree. We need to put the issue of stigma to bed once and for all.

Last, I have to revisit the issue that Andy Miller brought up. As treating professionals, we cannot tell your story; it is unethical. Only *you* can tell your story in an ethical way.

Stephen Preas, M.D., is a medical doctor in private practice. He chairs the Public Affairs Committee of the Georgia Psychiatric Physicians Association.

Jim Mimbs, M.D., is a medical doctor, director of Clinical Services at Central State Hospital, and an associate professor of psychiatry at Mercer University School of Medicine.

We need *you* to call all of the media and get on a waiting list to tell your story. We need *you* to call the legislators that represent you and get on a waiting list, if you have to, to tell your story.

We are coming to get *you*. We are going to find a way to get to *you* and lead *you* out of the darkness, and then we need *you* to lead the rest of the world.

Jim Mimbs discusses concerns over the differences between public and private services

We hear so much about virtual realities these days that I thought I would tell a story about a virtual airline named *Clients-R-Us*. The engines which drive our jet have names like *community service boards, Behavioral Health Planning Unit, regional boards*, etc. These jets are both sources of energy and steering devices. They are not all perfectly aligned, but certainly make for an interesting flight.

Where we land is another story. Privatized companies symbolically are airports, ranging from full privatization to managed-care organizations, from a managed-service environment to third-party administrators. In the center of the airports, imagine a bulldozer, ready to push the state hospitals and mental clinics into a large landfill.

It's hard, isn't it, to know where our airplane will next land? And what conditions await?

In Georgia, we are undergoing radical changes; in fact, a revolution. It's exciting. One of my concerns, though, is that we've heard how the trends of mental illness and substance abuse are rather equal across the nation, across cultural lines. But is treatment equal?

Recently, I referred a friend with insurance to a private psychiatrist at a private hospital. I visited him, and was struck by the difference between these clients and the clients my public hospital serves. I went home and reviewed 150 consecutive admission files to look at the needs and traits of the people who look to us as caregivers. Nearly 60 percent of our clients have dual diagnoses of mental illness and substance abuse. Most do not have insurance coverage, and a number are homeless.

We frequently hear that 41 million to 45 million people in this country do not have health care insurance. The number without behavioral health care is probably closer to 65 million. For these people, the reality of limited access to care is terrifying.

My specific concern and anxiety is that we will wake up in two or three years, and we will not have a safety net for these people who are the most seriously ill. Therefore, I suggest:

■ Methodical downsizing of hospitals, with an emphasis upon methodical;

■ Preserving a real safety net, including possibly changing the function of some hospitals and closing others;

■ Reducing the number of regional boards;

■ Developing meaningful collaborations between medical schools and state public health agencies; and

■ Seeking merger and integration between hospitals, community clinics, and teams for client-needed services rather than competitive encounters.

As we go from concept to implementation, we need to plan carefully while pursuing our course quickly.

Bobbie Jean Bennett is commissioner of the Georgia State Merit System.

Bobbie Jean Bennett talks about the importance of balance among cost, care, and geographic access

We at the state merit system are concerned that the expense of our major benefit plan will be in the neighborhood of $1 billion in 1998. But we operate that plan to be responsive to what our members need.

Our objective is to treat the whole person. We made a major change in our health benefit plan in 1995—we did go with a managed care program, yet people do have an opportunity to go outside of the network with reduced benefits.

Number one, we wanted broad access. Prior to this time, we had not offered coverage and reimbursement for care delivered by anyone other than psychiatrists and psychologists, and we did not offer the full spectrum of care. We did have outpatient and inpatient care, but we did not offer outpatient partial hospitalizations. Today, we have more than 2,000 individual providers who offer that service.

Quality of care is important, in terms of the requirements for credentials. What are our providers' specialities? How is their network managed?

Administrative systems are important, too. If you cannot get a claim paid, or you cannot get through the telephone system, then your systems are not working.

The clinical guidelines used in monitoring care are important. I am not a mental health professional, but I want to look at how a provider company chooses its protocols.

Reporting, and monitoring the ability to report, must also be considered.

The state health benefit plan will not have to make any changes to comply with the federal law on parity between mental and medical coverage. We have a good, balanced program.

Balance is important, in terms of costs, care, and geographic availability. We do not feel that any of the state suffers a severe lack of access, even though some areas have less access than others.

We are one of the big purchasers of medical and psychiatric services in the state. We want you to monitor how we are doing, and let us know of problems you see.

Dewitt Alfred summarizes the panel's discussion and points to future improvements in care

This distinguished panel has not provided us with answers, but with a lot of food for thought. We heard from a journalist, who reminded us that it is the job of the mental health advocates and mental health professionals to reach

Even if we have good access to mental health care, if you can't get a claim paid, or you can't get through on the telephone, then the system isn't working well.

out to the media, to tell the story. We heard from an executive in managed care, who addressed the issues of parity between mental health services and medical and surgical services, and also the issue of cost efficiency.

We've heard from private practitioners, a psychologist and a psychiatrist, who addressed a number of important issues. If you are not a provider, you just cannot imagine the burden of obtaining authorization and dealing with paperwork while remaining focused on providing good clinical care.

We also had the privilege of hearing from two individuals who play important roles in the public sector. From the director of clinical services of a large public psychiatric hospital, we were challenged to examine the changes in Georgia, and to consider how the safety net will be preserved. From the "purchaser" perspective, we heard the need for balance of cost, care, and geographic availability of services.

Our panelists have helped refine our understanding of barriers to care, and have identified a number of strategies to improve access. The rest of the work will be up to each of us.

Panel moderator Dewitt Alfred, M.D., is the chairman of the department of psychiatry at the Morehouse School of Medicine, and chief psychiatrist for Morehouse Medical Associates.

"**W**e need to
educate the public,
to make this easier
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and accept. It took me
15 years to realize
there was a mental illness
in our family." —*Frank Suggs*
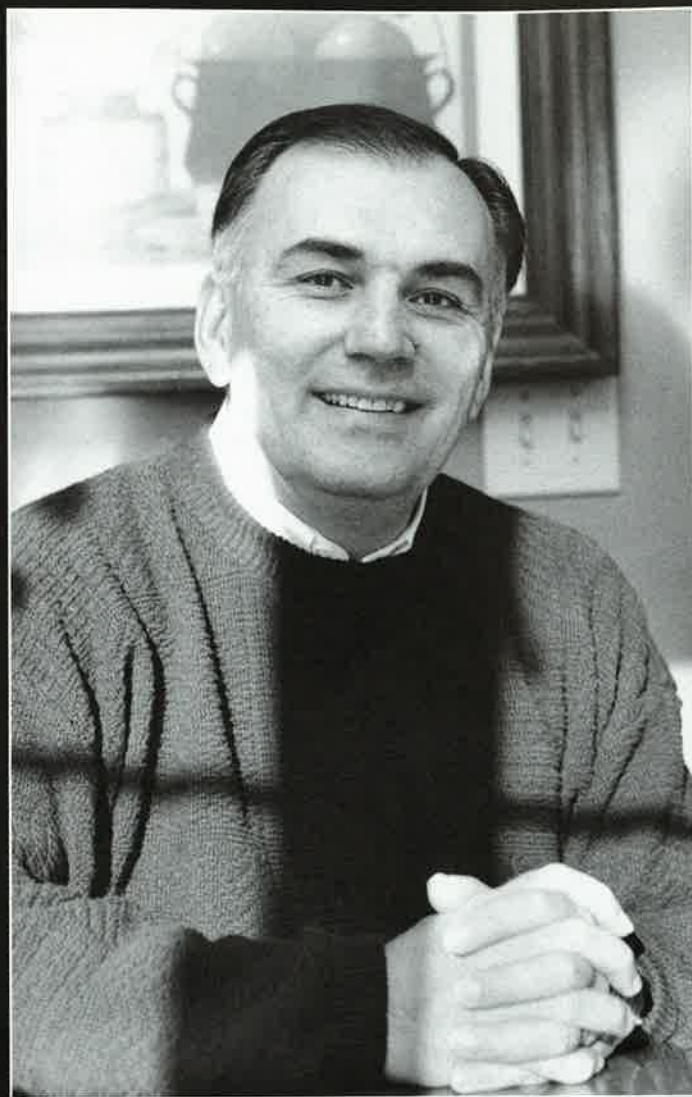
A Family's Struggle to Save a Son

Frank Suggs promises on behalf of his family to continue to lobby for those with mental illness.

Where do we go from here? Celebrities like Mr. Styron, Rod Steiger and Margot Kidder need to continue to tell their stories. Mrs. Carter needs to continue her wonderful work.

We need to educate the public, to make this easier for them to understand and accept. Words like bipolar instead of manic depressive—chemical imbalance—will make it easier. It took me 15 years to realize there was a mental illness in our family.

Melanie shared with you a story about when the recommendation was made for Taylor not to enter the hospital, but to go to jail. That decision was made by a clinical assistant in Salt Lake City, Utah. Our son had no reason to be in jail, and certainly, the decision should not have been made by someone in Salt Lake City.

We had to justify each and every day that Taylor was in the hospital. The doctor, the nurse and I were on the phone constantly, trying to show the insurance company why he still needed to be there. In the meantime, we worked diligently to find a place for Taylor.

We did meet a lot of great people along the way: The Georgia Parent Support Network, Next Steps, both on the local level and on the state level. We decided that we needed to give back. We have attempted to help other families through educating them or putting them in touch with the proper people. We want to help those who are college-bound and have a chemical imbalance to find the proper colleges and universities.

We began this challenge by contacting government agencies. They helped us get more information about certain illnesses. They told us where we might get a scholarship or grant, but were unable to give us any information on specific colleges and universities. One gentlemen told us that if we were able to find the answer, we would become the experts.

We do not want to be experts. We just want to help the next person.

Why are we here today? I hope, at least, to learn. We need to share ideas. We need to communicate with each other on every level. We must continue to educate the public.

I pledge to you that the Suggs, from our oldest son, Patrick, who is in Tennessee, to our oldest daughter, Lindsey, who is in a small school in North Carolina, to Melanie, to Taylor, to Whitney—we will make a difference.

Part III: Frank's Story

Melanie's and Taylor's stories are found on pages 11 and 21.

In Summary: The Average Georgian Cares

A survey of a cross-section of Georgians shows they share many of the same concerns with professional mental health caregivers, including that neither group wants others to know they have a mental illness

By Beth Finnerty

Beth Finnerty chaired the Second Annual Rosalynn Carter Georgia Mental Health Forum. She is executive director of the George West Mental Health Foundation, and on the board of directors of the Mental Health Association of Georgia.

We have been studying accessibility: its characteristics, its relation to supply and demand, how it is affected by change in social, economic, and demographic trends. We have seen that barriers to appropriate mental health care exist, and explored realistic, feasible strategies to overcome them. Mrs. Carter reported on a survey that indicates Georgians are concerned about mental health issues, and think mental health care should be accessible to all.

In a parallel survey of those at this year's Georgia Forum, the group—more strongly than the average Georgian—agreed that health insurance policies should provide equal coverage for mental and physical illnesses. Attendees also more strongly agreed that people with mental illness can be helped with treatment.

The average Georgian believes the biggest barriers facing people with mental illness are ability to pay and stigma. Forum participants agreed, with one difference: No Georgia respondents said lack of proven treatments was a barrier; 14 percent of Forum attendees said it was. These results show that Georgia has undergone a significant attitude change towards people with mental illness.

Despite this, misconceptions still abound with regard to treatment, symptoms and legal ramifications in the mental health arena. Almost 50 percent of Georgians would not want their employers to know they were seeking treatment for their mental illness, and 30 percent would not want their neighbors to know. Interestingly, 67 percent of Forum participants indi-

cated they would not want their employers to know, and over half indicated they would not want their neighbors to know. Both groups said fear of job loss was a significant barrier.

We need to improve the public's knowledge about mental health in order to fight discrimination and stigma. Our challenge is to articulate the barriers to care, implement strategies to overcome these barriers, and remember who we should address when discussing these issues.

We will continue to be confronted by a large rural population, often isolated from treatment due to a lack of transportation. Georgia will continue to have a substantial uneducated and low-income population, also isolated from care. Unless we take action to remedy them, these trends will worsen.

Major barriers to mental health care include a lack of adequate insurance, and stigma resulting from public misperception. Other barriers are availability and quality of services. Yet another barrier is the lack of a combination of properly trained professionals in conjunction with self-help and consumer-run services. Available services must be apropriate for, and acceptable to the consumer.

The challenges brought by managed care—access, confidentiality, and quality, as well as of geography, distance, and transportation—will continue to trouble those working in mental health fields.

The dollars for mental health care are limited. And managed care is here to stay, in some form, al-

though many have found the managed care industry is too driven by cost containment, without regard to quality. Monitoring managed care will continue to be an important task for caregivers.

Now, our challenge is to implement locally based strategies that confront and battle the stigma so inherent in mental health care and treatment. We can only do this by continuing to communicate a clear message. To the general public, we must clear up misunderstandings and use facts to confront the stigma issue head-on:

■ Research on the brain has shown that major mental illnesses are, in fact, biologically based.

■ Over 5 million Americans suffer with disabling mental illnesses, and scientists believe that these disorders are linked to functional abnormalities in the brain.

■ The right combination of modern medications, therapy, and support systems have a major, positive effect on those diagnosed with mental illnesses.

What message do we want the *media*, the *business community*, and our *elected officials* to hear? That not only are mental illnesses definable and treatable, but that the cost of not treating them can be catastrophic. We want them to hear that improved access to appropriate treatment results in healthier employees, which in turn can benefit employers. The payoff to employers is often not recognized early or easily, but can be seen in increased productivity, decreased absenteeism, and a decline in substance abuse issues.

Mental health costs are a small part of our total health care costs. Nevertheless, the sums can be staggering. In 1990, the total economic costs of mental illnesses amounted to $148 billion. The value of reduced or lost productivity comprised 43 percent of this total economic cost. The value of goods and services not produced because of mental disorders amounted to $63 billion. Mortality costs, defined as the current value of lifetime earnings lost by all who died because of mental disorders, was $12 billion.

This demonstrates that employers must become more enlightened—mental health treatment protects their biggest investments, their employees.

Elected officials are most likely to respond to pleas from families and consumers, like the Suggs. When our legislators hear personal stories, we may be closer to establishing parity for mental health.

The media can be an excellent tool for advocates to use in getting out the message to improve the public's understanding and perception of mental illness. It is our job to get to know the media and learn how to most effectively communicate with them.

In terms of treatment issues, we must continue to strategize about the appropriate distribution of services in a large, rural state. We must devise plans to make quality services more available. Challenges confront us in the transition to more private-sector involvement and regionalization of services.

Innovative treatment approaches in the emerging field of telemedicine may be one way to overcome the geographic barriers. We must also remember the

The media, the business community, and elected officials need to hear that not only are mental illnesses definable and treatable, but also that the cost of not treating them can be catastrophic.

value of empowerment and self help, as well as the importance of compassion in the healing process.

In his book, *Darkness Visible,* William Styron laments that he had thought psychiatry had advanced beyond the point where stigma was attached to any aspect of mental illness. Unfortunately, that stigma is still present in many aspects of mental illness. But we are making strides in our advocacy and education efforts, and our message is beginning to be heard.

Future progress and improving access to mental health care for Georgians can, and should, follow many paths. In the fight for improved access to mental health care, our success will be measured by our own persistence and tenacity.

Appendix: Mental Health Survey

To avoid stigma, people with severe mental disorders will seek help from non-professional counselors.

The following mental health questionnaire was administered September 6-19, 1996, by the University of Georgia. Using random-digit dialing, 404 households were selected for a telephone interview. This method produced a sample which is representative of the state of Georgia. The sampling error is no greater than plus or minus 4.9 percent, with a 95 percent level of confidence.

Instructions

Individuals contacted for the survey were told: *We would like to ask you a few questions about your attitudes toward mental health and mental illness issues in Georgia. For the purposes of this survey, mental illnesses are those which cause significant impairment in an individual's ability to function. They include major depression, schizophrenia, obsessive-compulsive disorder, and panic disorder.*

Questions and Responses

1. Do you know anyone in your community who has been diagnosed with a mental illness?

1. Yes, quite well 27.3%
2. Yes I know them, but only as an acquaintance ... 9.8%
3. Yes I know of them, but not personally 3.0%
4. No, not at all 60.0%

2. If you had a mental illness and were seeking treatment, which of the following would you NOT want to know you were seeking treatment. Please check all that apply:

1. your family 12.3%
2. your friends 15.8%
3. your neighbors 22.9%
4. your employer 48.9%

3. People with a mental illness can be helped through treatment.

1. strongly agree 31.2%
2. agree 63.6%
3. undecided 1.7%
4. disagree 0.5%
5. strongly disagree 3.0%

4. Health insurance policies should provide the same coverage for mental illnesses as for physical illnesses.

1. strongly agree 35.9%
2. agree 54.9%
3. undecided 5.7%
4. disagree 0.2%
5. strongly disagree 3.2%

5. I would support a candidate for elected office that made it known he/she had been treated for mental illness if I believed he/she was the best person for the position.

1. strongly agree 14.2%
2. agree 68.2%
3. undecided 10.0%
4. disagree 0.7%
5. strongly disagree 7.0%

6. From the following list, what do you think are the two biggest barriers facing people who have a mental illness and need treatment?

First biggest problem:

1. lack of insurance coverage/inability to pay .. 42.6%
2. social stigma/embarrassment 22.8%
3. lack of adequate treatment facilities 6.6%
4. lack of trained professionals 3.7%
5. lack of proven treatments 0.0%
6. fear of losing job 10.6%
7. lack of awareness of symptoms 11.4%
8. lack of transportation to treatment facilities ... 2.4%

Second biggest problem:
1. lack of insurance coverage/inability to pay ... 22.1%
2. social stigma/embarrassment 24.0%
3. lack of adequate treatment facilities 10.6%
4. lack of trained professionals 6.3%
5. lack of proven treatments 0.0%
6. fear of losing job 16.9%
7. lack of awareness of symptoms 14.7%
8. lack of transportation to treatment facilities5.4%

Discussion

Judy Fitzgerald, M.S.W. and John Gates, Ph. D.

This survey revealed some very encouraging trends regarding Georgians' attitudes toward mental health. Former First Lady Rosalynn Carter and other advocates have long emphasized that mental illnesses are real, they are diagnosable, and they can be successfully treated. According to this survey, Georgians agree.

Almost 95% of respondents indicated that they believe that people with mental illness can be helped through treatment. In addition, when survey respondents were asked to identify barriers to care, none selected "lack of proven treatments" as a barrier to care. These responses indicate a giant leap from a not-too-distant past when mental illnesses were viewed as a weakness, a sin, or caused by bad parenting. Public understanding that mental illnesses are indeed illnesses has improved dramatically.

Improving public awareness of the treatability of mental illness has strengthened the public debate regarding health insurance coverage for people with mental illness. Advocates around the country coalesced for the common goal of ending the historic discrimination in insurance coverage for mental illness. For far too long, mental illnesses have been subjected to restrictions and limitations in insurance coverage not imposed upon physical illnesses.

The 1996 parity debate, which resulted in the first national legislation to address these inequities, has raised public consciousness of these issues. Our survey indicated that 90% of respondents in Georgia believe that health insurance policies should provide the same coverage for mental illnesses as for physical illnesses. This is not to say that there should be no limitations in insurance coverage, but rather to indicate that there is no justification for treating mental illnesses differently from physical illnesses. The degree to which Georgians supported this notion was a surprising, but encouraging, response.

The survey yielded surprising responses related to the functional capacity of individuals with mental illness. More than 80% of respondents indicated that they would support a candidate for elected office if he/she had been treated for a mental illness. Almost 90% said they would employ, or recommend, someone who had been treated for a mental illness.

These results represent a clear shift in public attitude. It was just 1968 when then-vice presidential candidate Sen. Thomas Eagleton dropped out of the race when his history of treatment for depression was revealed. It appears that the advocacy and education efforts of the past 20 years are having a positive impact on public perception.

However, much work remains to be done. Survey respondents frequently identified barriers to treatment as lack of insurance coverage (or inability to pay) and stigma (social embarrassment). Lack of awareness of the symptoms of an illness and fear of losing one's job were also significant barriers. Almost 50% of those surveyed indicated that they would not want their employer to know they were seeking treatment for a mental illness. A pervasive fear exists that an individual might lose his/her job or be perceived differently in the work place.

Still, there is a recognition that stigma exists and that insurance plans still do not provide equitable coverage for mental illness. The push for parity must continue. We must reach out to the business community, the media, and educators. We must remain vigilant in our efforts to overcome these barriers to improve public understanding, improve access to treatments that work, and to ultimately improve the quality of life for people with mental illness.

We are undergoing radical changes; in fact, a revolution. It's exciting. But how are we to ensure that treatment remains equal in mental health?

Personal Steps

Three things I might do to improve access to quality mental health care in Georgia and reduce the stigma surrounding mental illness:

1.

2.

3.

Forum Sponsors

The Carter Center
Mental Health Program

Former First Lady Rosalynn Carter has been the driving force behind the development of The Carter Center Mental Health Program. Her long career in public service as an advocate for mental health began when President Carter was Governor of Georgia and continued with her appointment as active honorary chair of the Presidential Commission on Mental Health 1977-1978. In collaboration with the Emory University Department of Psychiatry, Mrs. Carter spearheaded the creation of the Annual Rosalynn Carter Symposium on Mental Health Policy, convening the leaders of national mental health organizations representing consumers, advocates, professionals, and policymakers to focus upon issues of common concern. In 1991, The Task Force was created to provide continuity between the annual Symposia.

Task Force priorities include:

- reducing stigma and discrimination against people with mental illness by improving public awareness, understanding, and communication about mental illness;
- fostering the development of services for young children and families which are focused upon prevention, early intervention, and the promotion of mental health;

- promoting fair and non-discriminatory access to quality mental health care; and
- improving awareness of mental health and mental illness in regions around the world and to stimulate activity to improve the status of mental health in all regions.

The Georgia Alliance
for the Mentally Ill

The Georgia Alliance for the Mentally Ill (GAMI) is a family-based, grassroots, self-help support and advocacy organization whose purpose is to eradicate mental illness and improve the quality of life for people with severe and persistent neurobiological brain disorders.

The Georgia Mental Health
Consumer Network

The Georgia Mental Health Consumer Network, a non-profit mental health advocacy organization was founded by consumers from around the state in 1990. The membership has grown to some 3000 members and the annual conference is the largest state meeting in the country. At the conference the consumers vote for the top 5 priorities—of which, jobs are always the

number one priority. For more information or to be a sponsor, write: Consumer Network, 246 Sycamore Street, Suite 100, Decatur, GA 30030.

The Georgia Parent
Support Network, Inc.

The Georgia Parent Support Network, Inc. is a statewide support system for families of disturbed children, assisting parents by providing support, telephone information and referrals, advocacy training, group organizing assistance, and linkage with other parents across Georgia. The common element among members is that our children present behaviors at home, school, and other environments that are puzzling and often difficult to handle.

The Mental Health
Association of Georgia

The Mental Health Association of Georgia is a private, non-profit organization working for Georgia's mental health and victory over mental illness. The Association is a nationally recognized leader in public policy, advocacy, an education. The Mental Health Association is affiliated with the National Mental Health Association.

Planning Committee

Chair: Beth Finnerty, *George West Mental Health Foundation*
Suzanne Baker, *Mental Health Association of Metropolitan Atlanta*
Judy Fitzgerald, *The Carter Center Mental Health Program*
John Gates, *The Carter Center Mental Health Program*
Flo Giltman, *Georgia Alliance for the Mentally Ill*

Claire Griffin-Francell, *Georgia Alliance for the Mentally Ill*
Vanessa Jackson, *Social Work, p.r.n.*
Lasa Joiner, *Department of Human Resources Board*
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Shelby Torbert, *Georgia Alliance for the Mentally Ill*
Cynthia Wainscott, *Mental Health Association of Georgia*
Chuck Waldron, *Mental Health Association of Metropolitan Atlanta*
John Wolfe, *Georgia Division of Mental Health, Mental Retardation and Substance Abuse*

"The survey makes it clear—Georgians' attitudes toward mental illness are changing. We are sometimes frustrated by the pace of change, but there is progress. The leadership of Rosalynn Carter, the courage of the Suggs, the eloquence of William Styron, and the hard work of thousands of Georgians ensure that progress will continue"

— John Gates, Ph.D.
Director of The Carter Center Mental Health Program

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