Mental Health Parity: Past, Present and Future

by Brittany Boden, Berklee Cochand, Caroline Nelson and Renee Potter

Abstract

This article addresses the development of the Mental Health Parity Act of 1996, created to respond to the need for adequate insurance coverage for those that suffer from mental illness. Due to the problematic tendency to keep costs low, managed care organizations and insurance companies in the United States have limited the amount of mental health benefits that one may receive. This has resulted in the creation of a distinct disparity between mental health and medical benefits affecting many people today. In-depth examination of positive and negative aspects of the Mental Health Parity Act of 1996 are discussed, as well as the recently proposed Mental Health Equitable Treatment Act of 2003.

Introduction

Carla Hochalter was hospitalized with debilitating symptoms of depression after her daughter, Anne Marie, was paralyzed in the Columbine school shooting of 1999. In spite of the severity of her illness, her behavioral healthcare manager determined after 30 days of inpatient treatment that hospitalization was no longer medically necessary, forcing her into partial, outpatient treatment. One week after her release, she went to a gun shop, asked to see a pistol, loaded it, and fatally shot herself (Perina, 2002). Such an extreme story exemplifies the consequences of a savings-driven mental healthcare system that is fostered by a cultural denial of mental illness. The Mental Health Parity Act of 1996 represented a milestone piece of legislation for mental healthcare. While the act was limited in scope and application, it brought about the advent of the concept of medical parity: the spirit of equal regard and equal treatment for physical and mental illness.

The Problem

In America, the surface problem that has created a need for legislation for mental health parity is the simple fact that many people either have no insurance coverage for mental health problems, or their mental health insurance benefits are minimal in comparison to health coverage for other illnesses. Individuals who are fortunate enough to have some kind of mental health coverage are likely to have higher co-pays for these services, limits on the number of visits, limits on amounts of reimbursement for services, and lower lifetime caps as compared with those for other medical problems. All of these factors result in benefits that can run out quickly, forcing many individuals to turn to the public sector for care. Taxpayers ultimately end up footing the bill for the difference between the needed and available benefits (Hughes, 1996). Each year, the total of direct and indirect costs of mental illness is approximately $113 billion (Chordas, 2003). Therefore, people who are not utilizing mental health services may end up paying for those who can no longer afford to finance the cost of their own mental health services. It can easily be argued that providing mental health parity would ultimately benefit U.S. taxpayers (Hughes, 1996).

When conceptualizing the problem of mental health insurance disparity, one must consider the reason why mental health coverage has been separated and distinguished from medical coverage. The presence of legislation to establish parity in health insurance coverage indicates that mental illness has achieved a level of significance in the array of social problems facing our country today. A resistance to parity indicates that mental illness is viewed differently than medical illness in this country. The question arises of whether or not mental disorders are medically legitimate (Woolfolk & Doris, 2002). A lack of clarity has surrounded mental disorders for hundreds of years, and erroneous beliefs about the nature of these disorders have long existed. In the late seventeenth century, Cotton Mather, a well-known Boston minister, was known to have preached that those who were “mad” had the devil in them, yet similar statements were not made about the physically ill. Evidence suggests that the stigma which has accompanied mental illness since the colonial times, still remains today. Survey results from public opinion polls have indicated that many people feel that mental difficulties are caused by emotional weakness, and many also feel that mentally ill people choose to be ill (Fraser, 1994). It appears that mental illness is often viewed as a private trouble rather than a public issue.

Stereotypes about mental illnesses are accompanied by societal stigma associated with these problems. Some people develop stereotypes about mental illness based on one encounter with an individual exhibiting erratic behaviors or psychotic symptoms. Stereotyping of the mentally ill can also be attributed to the media. Accounts of criminals with mental illness often appear in newspapers, television and motion pictures (Hughes, 1996). One study looked at six different U.S. newspapers in the year 1999, and examined hundreds of articles that presented "mental illness" as the key subject (Wahl, Wood, & Richards, 2002). In these articles, "dangerousness" was the most common theme, and twice as many of these articles were negative as opposed to positive in nature. These articles tended to omit the names of specific psychiatric disorders, leave out descriptions of the symptoms of the disorders that they did name, and exclude the perspectives of individuals who utilize mental health services. This lack of accurate representation promotes a lack of understanding of mental illness (Wahl, Wood, & Richards, 2002). A report by the World Health Organization said that the social stigma linked to mental illness has led to insufficient attention, as well as insufficient resources, being allocated to mental health care (Woolfolk & Doris, 2002). In short, as Hughes (1996) states, "people with mental illness are some of the most underrepresented and misunderstood in our society" (p. 35).

The problem of mental health disparity affects many Americans in a variety of ways. It is important to understand that mental health consumers are diverse in age, gender, class, and income (Hughes, 1996). In one year, about 30% of adult Americans will suffer from symptoms related to a diagnosable mental disorder, and about 20% of American children will exhibit symptoms of diagnosable mental disorders (Daw Holloway, 2003). One statistic indicates that in any one month, nearly 8 million people face symptoms of depression (Abrahamson, Steele, & Abrahamson, 2003). In other words, many people may need mental health services at some point in their lives, but those who have little or no mental health coverage may be deterred from seeking help. Indeed, it is estimated that almost one half of those who suffer from a mental disorder will not seek treatment (SAMHSA, 2003). For those who do seek professional help, limitations on mental health benefits can place mental health professionals in the unfortunate position of having to tell them that their difficulties are not considered serious enough to receive coverage from their insurance company (Abrahamson, Steele, & Abrahamson, 2003) Disparity of mental health benefits can have the effect of discouraging service utilization and can also have a negative effect on the therapeutic alliance when mental health professionals become de facto representatives of the managed care system.

The problem of mental health parity exists because managed care organizations and insurance companies put restrictions on mental health benefits in order to keep costs low and to make a profit. Employers and insurers have thus managed to create a problem that impacts individuals with a mental illness. In Congress, insurance companies and managed care organizations carry heavy influence over legislators. These interests may have just as much influence, if not more, than the interests of the people who are actually affected by changes in mental health insurance coverage.

History of Mental Health Parity Policy

Mental Health Parity legislation emerged in many different incarnations throughout the 1990s. In response to a family member's serious mental illness, Senator Pete Domenici introduced the Equitable Health Care for Severe Mental Illness Act of 1993 (Geller, 2000). This was the first act directly relating to the concern of equity in mental health coverage. While great attention was paid to Clinton's 1993 Health Security Act, little progress was made to pass Domenici's act. The 1993 Health Security Act provided hope that mental health would be recognized on the same level as physical health (Geller, 2000). Unfortunately, when the Act was introduced to the public, there was no parity between mental and physical health. When the Act was taken to Congress in 1994, the Financial Committee made an enormous step forward by including parity in the discussion of what the benefits board must provide (Geller, 2000). In addition to the Health Security Act of 1993, Senator Robert Dole introduced the Dole Bill in 1994 to Congress. This bill stated that the Secretary of Health and Human Services should give priority to providing coverage for mental health and substance abuse services that is equivalent to coverage for medical services in terms of duration of treatment and cost (Gellar, 2003). After this bill was introduced, two other separate senate bills, the Mitchell Bill of August

12, 1994 and the Mainstream Proposal of 1994, also recognized the idea of true parity in regards to mental health coverage. Despite attempts at recognizing parity at the federal level, however, parity failed to be passed into actual legislation (Gellar, 2003).

Similarly, in 1995 Senator Nancy Kassebaum introduced The Health Insurance Reform Act that revisited the issue of parity in mental health coverage. Aimed at addressing issues of access to coverage, the act was amended in 1996 to include a parity provision. When the act was passed as a bill in 1996, it unfortunately failed to include parity. Senators Domenici and Paul Wellstone were determined to include parity at the federal level and introduced the Mental Health Parity Act of 1996. This act prohibited insurance companies from setting restrictions on annual/lifetime benefits for mental illness coverage (NAMI, 1999). Signed into law by President Clinton on September 26, 1996, it was then implemented in 1998.

Although this act addresses an important aspect in regards to insurance coverage, major historical social welfare issues remain. While healthcare in general has evolved over the years to be more accessible to the public, the availability of mental health parity to the public is a persisting problem. Reflected in the passage of the Mental Health Parity Act of 1996 is the notion that attitudes toward mental health are starting to change. In previous years, the stigma that mental illness carried prevented many individuals from seeking treatment and identifying their issue as a mental disorder. Today, in some circles, mental illness is beginning to be characterized as a brain disorder, which can be easily diagnosed and seen as a biologically based medical problem (Flynn, 1998). With the development of managed care, more people are seeking treatment for their illnesses and more attention is being directed toward members of this population and their needs. In 1999, almost 177 million Americans with health insurance (72 %) were enrolled in managed behavioral health organizations (Satcher, 1999). Parity at the federal level is gaining more recognition as countless attempts to establish mental health equalities have persisted. With the introduction of the Paul Wellstone Mental Health Equitable Treatment Act of 2003, various measures are being implemented at the federal level to eliminate problematic issues that exist in the Mental Health Parity Act of 1996. As a result of parity legislation, equality between medical and mental health is finally on the way to becoming a public issue.

The Policy

The Mental Health Parity Act (MHPA) of 1996 was intended to regulate discriminatory insurance practices that limit mental health coverage. The act went into effect on January 1, 1998 and it was due to sunset December 31, 2003, although the act was later extended to December 31, 2004. Employees and their dependents are the beneficiaries of this act, which prohibits employers from imposing lifetime or annual limitations on coverage for mental health benefits that have not been applied to medical benefits. This act only affects group health plans that already have mental health benefits; those that do not remain unaffected by the act. The act only applies to employers with more than 50 employees and if the cost of implementation is more than 1% of the total health plans cost, then the employer can apply for an exemption. The MHPA also allows group health plans to limit mental health services within a vague definition of what is deemed "medically necessary" (The Forums Institute, 1997).

The original amendment for the MHPA of 1996 was much broader in scope and was significantly watered down via bureaucratic compromise that originated with lobbying from the business community (Forums Institute, 1997). U.S. Senators Wellstone (D-MN) and Domenici (R-NJ), in addition to Representatives Roukema (R-NJ) and Kennedy (D-RI), continued to seek full mental health parity for the working people of this country and their dependents. However, current practices are not in the spirit of parity and maintain discriminatory access to treatment for mental illness (Killeen, 2002).

A new piece of parity legislation was introduced in 2003 - The Paul Wellstone Mental Health Equitable Treatment Act of 2003 - named in honor of the late Senator Paul Wellstone. This act will strengthen the original MHPA of 1996, as it expands upon the existing MHPA by requiring parity for the majority of illnesses found in the Diagnostic Statistical Manual, including the following mental health diagnoses: schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder, and severe anxiety disorders (Killeen, 2002). This act also prevents group health plans from imposing treatment limitations or financial requirements on the mental health coverage unless the same limitations and requirements are imposed

on medical benefits. The act defines treatment limitations as limits on the frequency of treatment, the number of visits, the number of covered hospital days or any other limits placed on the scope and duration of treatment, and it defines financial requirements to include deductibles, coinsurance, co-payments and catastrophic maximums (NAMI, 2003).

A downfall of this new act is that treatment for substance abuse is still not included. Considering that 50% of people with severe mental illness are affected by substance abuse, and 37% of alcohol abusers and 53% of drug abusers have at least one serious mental illness, how can treatment that does not address substance abuse be considered fair and equitable (NAMI, 2003)? Moreover, this omission is costly, given that approximately 73% of people with substance abuse disorders are employed, and $140 billion per year is spent on lost productivity (NMHA, 1999).

The funding mechanisms for the MHPA of 1996 are embedded within insurance plans. As such, the cost of the increased coverage for mental health benefits would have to either be paid by the insurance carriers or by whomever would pay for the insurance premiums: either employers alone in employer-sponsored health care plans, or a combination of employers and employees. Presumably, insurance carriers will not opt to absorb the costs of increased benefit coverage and so the burden of financing the benefits would fall to employers and employees. This has been one of the main arguments against parity by its opponents, along with the concern that the financial burden would result in employers dropping coverage for mental health benefits altogether or implementing other cost saving measures that would pose other limits to mental health benefits. Since the implementation of the 1996 MHPA, however, a majority of employer-sponsored plans that made MHPA-related changes did not compensate by increasing limits on other medical benefits because they expected increases in cost to be very minimal (SAMHSA, 1998).

Administration of the policy falls to the private sector via group policy changes between employers and their insurance brokerage companies or insurance carriers. These changes are then disseminated to members and beneficiaries covered by the group plan in accordance with the Employee Retirement Income Security Act (ERISA)'s Workers' Right to Health Plan Information (U.S. DOL, 2002). The MHPA of 1996 is actually an amendment to the Public Health Service Act (PHSA) and the ERISA of 1974. The Internal Revenue Code of 1986 under the Taxpayer Relief Act of 1997 was also amended by MHPA. As a result, jurisdiction over the policy's administration is shared between the Secretary of the Treasury (overseer of the Internal Revenue Code), the Secretary of Labor (overseer of ERISA) and the Secretary of Health and Human Services (overseer of the PHS Act). If someone fails to comply with the policy, they can be charged an excise tax or other civil money penalties. What these bodies actually do to enforce the laws and how severe the penalties can be is unclear. The National Partnership for Reinventing Government and others have issued criticisms of the Department of Labor's enforcement procedures and penalty structure, citing that, "[w]eak or absent penalties undermine compliance by communicating to the public (and to others in the justice system, such as U.S. Attorneys who decide which cases to prosecute) that a violation is not very serious" (NPR, 2003, para.19). The Department of Labor does, however, offer "compliance assistance guidelines" for employers and group health plans to comply with recent health care law changes (U. S. DOL, 2002).

As the policy is enacted under the umbrellas of the Department of Health and Human Services, the Department of Labor and the Department of the Treasury, it is subject to evaluation based on Executive Order 12866. This order requires government agencies to assess the economic and regulatory impacts of new legislation when the Office of Management and Budget (OMB) determines such impacts will be 'significant.' The Departments of Labor and Health and Human Services conducted an economic impact analysis on the MHPA of 1996 that was submitted to the General Accounting Office for review in 1998 (GAO, 1998). The newly introduced Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, also known as HR-953 and S-486, provides for a similar evaluation to be conducted by the GAO within two years of the act's passage into law (Bazelon, 2003).

Social workers have contributed to the grassroots campaign to support the legislation for Mental Health Parity through involvement and education by the National Association of Social Workers. The knowledge base of the MHPA of 1996 comes from the work of other national mental healthcare advocates like the National Association of Mental Illness, the National Mental Health Association (NMHA) and the Bazelon

Center for Mental Health Law. The federal government was brought into the discussion about the fractured mental healthcare system via the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH). They collaborated to produce the Report of the Surgeon General on Mental Health in 1999, a document that legitimized and federalized the effort to revamp the mental healthcare system (Satcher, 1999).

Analysis

From a social and economic viewpoint, the goals of the Mental Health Parity Act of 1996 are just and fair but remain limited. Who is covered under this act remains too narrow in scope and the act does not adequately provide benefits to those suffering from chronic or less severe forms of mental illness or chemical dependency. However, people who have access to the benefits provided by their employer as a result of the MHPA of 1996 will be able to experience more equitable treatment in mental health care coverage. From an economic perspective, the goals of working towards equality in mental health coverage compared to medical health coverage seem to be fair. While many insurance companies are fearful of the rise in cost they will encounter, it has been proven that parity is indeed affordable. For example, studies done in North Carolina, Texas, and Maryland, states that have activated parity laws, reveal that costs actually declined after parity was introduced. Also, in general, the number of users for managed care increased, with lower average expenditures per user indicating that parity can be an effective policy (Satcher, 1999).

For people with mental health issues, the goals do contribute to a better way of life for those who have access to health coverage. The ability to seek treatment in a way that does not contain discriminatory limitations allows people greater access to treatment and to knowledge about the kinds of treatment available. As more people begin to view their illness as something that can be treated, this act can contribute to restoring healthy functioning and gaining participation in the work force. A slight decrease in the stigma that has in previous generations been highly associated with mental illness, should also allow for improved access to treatment.

In addition to contributing to a better way of life for its target group, individuals afflicted with mental illness, the MHPA of 1996 is also consistent with social work values. Equality and social justice for people suffering with mental illness is something the act is strongly moving towards. Ending discrimination in terms of prohibiting annual lifetime limits reflects the growing recognition of mental illness coverage as a social problem, and strives to increase services to this population. The Mental Health Parity Act of 1996 attempts to reduce the gap between mental and physical illness that is still prominent, and shift the perspective of viewing them as two separate issues to viewing them as united. Also inherent in this act is the increasing attention directed towards self-dignity and self-worth of people who suffer from various mental illnesses. The target populations are gaining the opportunity to address their own needs and make notable changes in their lifestyles with the passage of this act.

Political Feasibility

There appears to be significant support for the new Paul Wellstone Mental Health Equitable Treatment Act of 2003. According to the National Mental Health Association, nine out of ten Americans believe that health insurance companies should provide benefits for mental illness that is more than or equal to benefits provided for physical illness or injury (NMHA, 1999). In June of 2002, more than 2,000 supporters of mental health parity assembled in Washington D.C. to urge Congress to act and end insurance discrimination against individuals with mental illness and their families. Over 1,800 members of the National Association of Mental Illness (NAMI) have called upon Congress to pass federal parity legislation. Senator Domenici has asserted that, "…illnesses of the brain are just like illnesses affecting any other organ of the body and their treatment should be covered the same way" (NAMI, 2002, para. 2).

The Paul Wellstone Mental Health Equitable Treatment Act of 2003 will be met with strong Republican opposition because it includes coverage for more than 200 mental illnesses; Republicans believe that such broad coverage would drive up the cost of employers' health coverage (Arias, 2002). Senators Pete Domenici and Edward Kennedy are diligently working to get this act passed. On November 6, 2003 they announced that the Senate would not act on the bill before Congress adjourned for 2003, saying that the Senate Majority Leader Bill Frist had assured them that this bill is a priority for 2004.

Senator Frist's assurance was able to ward off an initiative by Senator Kennedy to offer the Paul Wellstone Mental Health Equitable Treatment Act of 2003 as an amendment to the next continuing resolution. Congress has made use of continuing resolutions to allow the government to continue to function since the 2004 fiscal year started on October 1, 2003. By placing this act as an amendment on the continuing resolution, it would force the issue and keep the bill alive. Senator Kennedy may renew this initiative if the Senate does not act on the bill before the fall of 2004. Congress enacted another one-year extension of current mental health parity requirements before adjourning at the end of 2003 (Washington Bulletin, 2003). Mental health advocacy organizations are mobilizing support since the commitment to move the bill to the Senate floor early in 2004 has, as of this writing, not happened. According to the Mental Health Liaison Group, "With a shorter session this year, the Senate must act on parity soon or it will not pass in 2004" (Bazelon, 2004, Background section, para. 2).

Senate Majority Leader Bill Frist (R-TN) holds a great deal of power when it comes to passing the Paul Wellstone Mental Health Equitable Treatment Act of 2003. He has been suspected of having a hidden agenda because during his career in the Senate he has consistently championed the interests of the health care industry with its bottom-line interests conflicting with public health (Paine, 2002). Considering Frist's medical background, one cannot be surprised that doctors and other health professionals are at the top of his political contributors' list, with nearly $594,000 in contributions since 1997 (Weiss, 2002). Moreover, Frist has significant personal and financial ties to the health care industry; his father and brother founded Hospital Corporation of America (HCA), the nation's largest for-profit hospital chain. HCA's political action committee contributed more than $175,000 to federal candidates in 2002. Frist has resisted pressure to abstain from voting on legislation that could impact HCA's bottom line, claiming his investments are now in a blind trust (Weiss, 2002).

Economic Feasibility

The economic feasibility of the MHPA of 1996 and future incarnations of mental health parity legislation is substantiated by findings after several years under parity law (Levin, 1998; NMHA, 2003). Parity has been found to be feasible both by the low increase in premiums as well as the money saved by expanded access to mental health services. Parity ends up saving employers in increased productivity, reduced absenteeism and, in some cases, decreased premiums. Estimations on how much parity would increase premiums ranged from less than 1% to 1.6%, a relatively low cost, even at the highest. Some studies have shown that employers have rarely chosen to change health plan benefits in order to recoup the costs of increased parity (NMHA, 2003), but a major study by the General Accounting Office shows that a high percentage of employers have restricted mental health benefits in some other way to curtail the cost of parity benefits (Karger & Stoesz, 2002).

Studies also indicate that there is a direct correlation between medical costs and mental health care coverage. For example, psychiatric long term disability (LTD) claims are seen to increase for health plans in which access to mental health services are restricted (Salkever, 2000). A large Connecticut corporation saw a 37% increase in the use of medical care and sick leave when it cut its mental health services by 30% (Rosenheck, 1999). Whereas, when corporations increase access to mental health services, a large savings can be realized. For example, when the Kennecott Copper Corporation provided mental health counseling for its employees, the company's hospital, medical, and surgical costs decreased by a striking 48.9% (NMHA, 2003). In Minnesota, where a comprehensive state parity law has been enacted, Blue Cross/Blue Shield was able to, after one year under the law, make a 5 to 6% reduction on its insurance premiums (Levin, 1998). Therefore, future funding considerations for even more comprehensive federal parity legislation should be fully realized.

Administrative Feasibility

After the MHPA of 1996 went into effect, an evaluation conducted by the General Accounting Office revealed that 86% of employers were in compliance with the policy; however, 87% of the employers had altered their employee benefits making mental health benefits more restrictive. While some benefit plans were altered, none of the employers eliminated mental health coverage as a whole (Karger & Stoesz, 2002). Based on these results, it appears that the act has to some degree accomplished what it was intended to do

because the majority of employers are in compliance with the act. The problem is that benefits for individuals with a mental illness were reduced in an effort to offset the increased annual and lifetime caps (Satel & Humphreys, 2003). Therefore, those with a mental illness are not actually receiving coverage comparable to coverage for those with a physical illness at this time. The new act being proposed in Congress, the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, has much broader goals that would theoretically do away with this problem. However, it must be remembered that in the end, the bottom line is always cost. With this in mind, it is questionable whether the bill can truly achieve its goals.

The criticism of the proposed legislation is that full parity will result in a situation where people seeking long-term psychotherapy for marginal distress will cause inflation in the cost of mental health benefits for employers and, as a result, employers will cut back coverage across the board. If cost inflation begins occurring for employers, then managed care will likely be used to control the situation by constantly evaluating whether a minimally acceptable amount of care has been delivered and ending benefits for treatment as soon as this point is reached. As a result, the combination of managed care with full parity may actually allow for total mental health costs to go down (Satel & Humphreys, 2003). However, a consequence of this care management is that individuals with severe mental illness are treated quicker and at a minimal level in order to reduce costs, but this treatment may not truly be sufficient and they may be sent home from hospitals in poor condition. The patients may then need to be readmitted and often this will be to a state mental hospital (Satel & Humphreys, 2003). Therefore, the pairing of full parity and managed care could result in another social problem being created in which individuals with a severe mental illness do not receive the treatment that parity had intended for them to receive.

However, other views indicate that full parity would overall be beneficial to individuals and employers because full access to mental health services would cause fewer other medical services to be used and some costly medical problems could also be prevented. Research has indicated that between 50% and 70% of doctor's regular caseloads are comprised of patients whose medical problems are significantly related to psychological problems. In addition, increased availability and usage of mental health services has been associated with lower hospital and medical spending, because people receiving counseling or psychotherapy have had shorter hospital stays and less physician office visits (Abrahamson, Steele, & Abrahamson, 2003). The fact that mental health service usage may decrease the incidence of other medical problems means that money can be saved in the long run. Therefore, any increases in premiums that may occur as a result of parity will be offset.

It is possible that an alternative policy could be more effective than the policy proposed in the bill before Congress at this time. In general, a single-payer system in which mental health coverage is universal would be beneficial to everyone and would eliminate problems created by managed care involvement in mental health (Hughes, 1996). However, it is unlikely that universal mental health coverage would be instituted without general universal health care insurance in this country. Another possible way to dissolve some of the problems that managed care could create with mental health parity would be to identify and distinguish the more severe mental illnesses and guarantee parity for them (Satel & Humphreys, 2003). This would ensure that severe mental illness would receive coverage on par with medical illnesses, yet it would not benefit those with less severe, yet still disabling psychological troubles. Creating a policy that only recognizes severe mental illness would certainly not ensure equal consideration for psychological symptoms and physical symptoms, and thus would in many ways defeat the purpose of parity. A policy that provides an overall solution is difficult to attain.

In addition, there are several barriers that exist to attaining full implementation of the parity legislation. Reinforcement of this act by the federal government must be given significant importance. If the act is not strictly enforced, it is likely that employers and insurance companies will not be motivated to change their own policies. It is also necessary to consider the fact that the 1996 act is a federal law and that states have some leeway in the interpretation of this act. However, the new Paul Wellstone Act of 2003, if passed, is more specific and therefore would provide more structure in terms of state legislation. Another obstacle to the full implementation of this act is the fact that the act cannot have the effect of eliminating

the stigma that is still associated with mental illness. The public, as well as employers, need to accept mental illness as a medical problem or a problem that is not self-induced.

Despite its limitations, the MHPA of 1996 marked a significant moment in the fight for the legitimization of mental health and well-being. The stigma and denial surrounding mental illness will persist for a long time, as we even see evidence of extensive discrimination against physical ailments, such as disabilities, in our country today. Still, the stigma appears to be dissipating. It has taken the diligent work of lobbyists, educators and mental health professionals to push for the string of mental health legislation we have seen over the last decade. It was also the life experiences of Senators Peter Domenici and Paul Wellstone that carried the concept of parity into focus. Pete Domenici's daughter spiraled into symptoms of a diagnosis of schizophrenia in the late 1980s, and Paul Wellstone's older brother also suffers with symptoms of schizophrenia. Each man watched in despair as their families had to drain all of their resources to provide care for their loved ones. Though the MHPA is a watered down version of what it was originally, it is significant that it was not only extended but that the Paul Wellstone Equitable Mental Health Treatment Act of 2003 has since been introduced. The new legislation does not cover treatment for people struggling with substance abuse and it still leaves enormous segments of the population to stumble through the broken public mental healthcare system. However, parity legislation is managing to bring mental health issues up to the same level of awareness as physical health issues in incremental steps.

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The authors of this article have completed their first year in the MSW program. Brittany Boden's first-year placement was at St. Joseph Carondelet Child Care Center. Her second year placement will be with Community Counseling Centers of Chicago. Berklee Cochand completed her first-year field placement at Lincoln Park Hospital on the Physical Rehabilitation and Skilled Nursing Units. Her second-year placement will be with Metropolitan Family Services. Caroline Nelson's first-year field placement was at Youth Services of Glenview, and Renee Potter did her first-year placement at the Counseling Center of Lakeview.