NATIONAL SAFETY COUNCIL

Position/Policy Statement

Mental Health Parity

NSC supports mental health parity so that coverage, payment, and treatment for mental health conditions and substance use disorders are equal to that of other chronic and acute health conditions.

NSC supports mental health parity as designated by the Mental Health Parity and Addiction Equity Act (MHPAE), and believes that making effective care available to those suffering from mental illness and/or substance use disorder is imperative in the fight to reduce preventable death.

NSC supports language that reduces the stigma of mental health conditions and substance use disorders, and supports the implementation of clinical language that promotes better treatment.

Background

The American Psychiatric Association (APA) defines mental illness as a psychological syndrome that causes a "clinically significant disturbance" in cognition, emotion, or behavior due to an underlying psychobiological dysfunction.[1,2] 42.6 million Americans (18.1% of the adult population, 20% of children 13-18) experience some form of mental illness.[3] In the late 1980's the APA began to distinctly recognize a subset of mental illness related to alcohol and drugs, a disorder codified in the 2013 version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as "substance use disorders".[4] This disorder, commonly called "addiction" is defined by the American Society of Addiction Medicine as a "primary chronic disease of brain reward, motivation, memory, and related circuitry."[5] 20.2 million Americans (8% of the adult population, 5% of all adolescents) have a substance use disorder.[6,7]

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[1] https://www.psychologytoday.com/blog/rethinking-psychology/201307/the-new-definition-mental-disorder
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3101504/table/T2/
[3] https://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf
[4] http://caade.org/sites/default/files/dsm-5-substance-use-disorder.pdf
[5] http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/15/the-definition-of-addiction
[6] https://www.samhsa.gov/specific-populations/age-gender-based
[7] http://www.samhsa.gov/disorders

Together, mental illness and substance use disorders contribute to the deaths of thousands of Americans each year, many of which are entirely preventable. Suicide, often spurred by mental illness, claims the lives of over 42,000 Americans per year.[8] Substance use is inextricably tied to multiple leading causes of death. For example, 30% of fatal motor vehicle crashes – the leading cause of death for 1 to 24 year olds – involve people impaired by alcohol.[9] Over 50,000 Americans die each year from alcohol and drug poisoning, making it the leading cause of death for 25 to 64 year olds.[10]

Furthermore, we are seeing many of these fatal statistics trending the wrong way. After many years of consistent decline, suicide rates increased 24% from 1999-2014.[11] Similarly, alcohol-related motor vehicle fatalities increased by 3.2% from 2014 to 2015 to the highest levels in eight years.[12] Finally, substance use has become an acute national issue in recent years with the rise of the opioid epidemic. Spurred by massive increases in prescriptions of highly addictive opioid medications, the number of overdose deaths involving opioids has more than quadrupled since 1999, killing more than half a million Americans in that period.[13]

Although leaders in medicine, government, and advocacy agree that these deaths represent a pressing public health crisis, the ability of those suffering from mental illness or substance use disorders to obtain treatment and care remains low. Nearly 60% of Americans with a mental illness don't receive treatment, and 89% of those with a substance use disorder don't receive any type of specialty treatment.[14,15] More than 40% of those with a substance use disorder also suffer from a separate, co-occurring mental illness, and yet less than half will receive treatment for either. This "treatment gap"—people desperately in need of care but unable to access it—directly influences the aforementioned deaths caused by motor vehicle crashes, suicide, and overdoses.[16] Ensuring mental health and substance use treatment are equally covered in health plans is one step in increasing access to treatment, thereby improving quality of life and reducing injury-related deaths.

Legislation

According to the National Alliance on Mental Illness (NAMI), "mental health parity" describes "the equal treatment of mental health conditions and substance use disorders in insurance plans."[17] The legal recognition for mental health parity began with the 1996 passage of the Mental Health Parity Act (MHPA, Public Law 104-204), which prohibited large, employer-sponsored group health plans from placing annual or lifetime dollar limits on mental health services substantially different from those placed on other medical services. While this introduced the idea of parity into law, equal treatment of mental health conditions and substance use disorders by insurers did not occur, as the law did not mandate mental health and substance use coverage. Rather it applied only to those plans that already offered the benefit. Additionally, some plans found ways to circumvent the law by placing limits on the amount of

[8] https://www.nimh.nih.gov/health/statistics/suicide/index.shtml
[9] Injury Facts
[10] Ibid.
[11] https://www.cdc.gov/nchs/products/databriefs/db241.htm
[12] https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/812350
[13] https://www.cdc.gov/drugoverdose/epidemic/
[14] http://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf
[15] https://www.drugabuse.gov/publications/drugfacts/treatment-statistics
[16] http://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf
[17] http://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition/Understanding-Health-Insurance/What-is-Mental-Health-Parity\

care received and imposing higher cost-sharing requirements on beneficiaries.[18] Furthermore, the MHPA did not include substance use disorders in its parity requirement.

In 2008 Congress took additional action to strengthen insurance parity, passing the Mental Health Parity and Addiction Equity Act (MHPAEA) (Public Law 110-343). The law mandated that the majority of health plans (group plans, the federal employee health benefits program, Medicaid managed care plans) cover mental health and substance use disorders at the same benefit level as other medical/surgical benefits. Essential health benefits in the 2010 Patient Protection and Affordable Care Act (Public Law 111-148) furthered mental health coverage to smaller group and individual plans.

Mental Health Parity Access

Work remains to be done to ensure that those in need of mental health treatment receive it to prevent tens of thousands of unnecessary deaths. In March 2016, the White House Mental Health and Substance Use Disorder Parity Task Force was created.[19] The final report delivered recommendations on what actions need to be taken to ensure substance abuse parity.[20] This includes helping to ensure better implementation of parity; helping consumers, providers, and plans understand how parity works; and appropriate oversight and enforcement of parity protections.

Reducing Stigma

Applying the appropriate language to describe mental health and substance use disorders is a fundamental step towards changing the lens through which we view the diseases. A 2001 cross-cultural World Health Organization (WHO) study reported that substance use was the most stigmatized social condition across 14 countries.[21] Since then, government agencies and advocacy groups have worked to update terminology in an effort to remove pejorative or negatively connoted terms such as “abuse” and “dependence.” Many experts and organizations have asserted that pejorative terminology can dissuade individuals in need from seeking treatment, and contribute to a cultural stigma and misunderstanding of mental health and substance use. Perhaps even more troubling, studies have shown that doctors are susceptible to derogatory language, correlating terms like “abuse” with patient culpability.[22] By utilizing appropriate, neutral clinical language we can de-stigmatize mental illness and substance use disorders, and increase the likelihood that individuals in need seek and receive treatment.

Progress has been incremental; the language guide published in 2004 by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) specifically departed from the APA’s DSM-IV by continuing the use of the term “abuse” as a clinical diagnosis.[23] However, the aforementioned 2013 publication of the DSM-V announced a shift to superior terminology by asserting the terms “substance use disorder” and cautioning against terms such as “abuse” and “dependence”. This spurred an October 2016

[18] http://content.healthaffairs.org/content/17/3/201.full.pdf

[20] http://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf
[21] http://jan.ucc.nau.edu/rtt/pdf%20format%20pubs/Trotter%202000%20pdf%20Pubs/Cross%20Cultural%20Views%20On%20Stigma%20(Chapter%2019)%202001.pdf
[22] https://www.ncbi.nlm.nih.gov/pubmed/20005692
[23] https://www.naabt.org/documents/Languageofaddictionmedicine.pdf

announcement by the Office of National Drug Policy (ONDCP) of new draft guidance, *Changing the Language of Addiction*, which would align federal terminology with the DSM-V.[24,25]

While there is still work to be done (the American Society of Addiction Medicine notes six federal agencies that still carry the term "abuse" in their name), it is promising to see both industry and government coalescing around a common set of non-stigmatizing terms.[26] The National Safety Council supports any efforts to refine language, in an effort to reduce stigma that may perpetuate misunderstanding and deter individuals from seeking necessary treatment.

This position statement reflects the opinions of the National Safety Council but not necessarily those of each member organization.

Adopted by the National Safety Council, 2017

[24] https://www.whitehouse.gov/ondcp/changing-the-language
[25] http://journals.lww.com/journaladdictionmedicine/Pages/Instructions-and-Guidelines.aspx#languageandterminologyguidance
[26] http://www.asam.org/docs/default-source/advocacy/asam's-comments-on-changing-the-language-of-addiction.pdf?sfvrsn=2