

Mental Health Services in the Context of Health Insurance Reform

DAVID MECHANIC

Rutgers University

MENTAL HEALTH BENEFITS MAY SEEM DIFFICULT TO manage within the context of health insurance reform because they require that policy makers confront the complexity of relations between acute and long-term care, between medical and social services, and between services provided by physicians and those offered by other health care professionals. The temptation is to sidestep these issues by defining an acceptable minimal mental health benefit, as many employment-based group health insurance plans now do. Such coverage is typically limited to an inpatient benefit of 30 to 45 days, 20 to 40 outpatient visits, and required deductibles, coinsurance, maximum allowances, and the like. Although adhering to this pattern may be convenient, it fails to take advantage of the potential to address many of the historic inequities and perverse incentives that have turned mental health into one of the most troubled sectors in our health economy. Alternatively, the expanding discussion on health reform provides an opportunity to address constructively the historic discontinuities between the general medical sector and specialty mental health care, between public and private institutions, and between medical and psychiatric care and associated mental health services that are essential to the welfare of many patients with serious mental illness and disabilities.

The establishment of new national health policies can either contrib-

ute to reconfiguring how major health problems are managed or seal into place traditionally narrow and outmoded approaches (Rochefort 1992). In this article I will review how mental health problems are now managed within our fragmented financial and institutional structures and identify the major points of decision that policy makers must address as they go forward. This requires careful consideration of the social and medical aspects of mental disorder, the interrelations between acute and long-term-care approaches, and the relations among the varying mental health institutions and providers.

State Responsibility for the Mentally Ill

Responsibility for the mentally ill historically has been a state function, and care of the mentally ill has required significant components of state budgets (Grob 1991). Prior to the 1960s, mental health was a relatively modest sector concentrated on inpatient care in public hospitals and offering relatively little access to outpatient services for persons with less severe disorders. General physicians undoubtedly provided a great deal of care, and the small number of psychiatrists available largely served the affluent on a fee-for-service (FFS) basis. With the expansion of mental health personnel, increasing coverage of mental health needs through insurance, the development of community mental health centers and clinics, and the growing acceptability of seeking out mental health services, utilization increased sharply. Patient care episodes in specialty mental health organizations increased from 1.7 to 6.9 million between 1955 and 1983 (Mechanic 1989), and, in addition, there was a large growth of office-based providers. Klerman (1982) estimated a sixfold increase in mental health utilization in the 25 years subsequent to 1955. There was an enormous expansion in the numbers of people receiving care. Michigan researchers who surveyed the American public in 1957 and 1976 found that its use of professional help for psychological problems increased from 14 to 26 percent, unpropelled by any change in average levels of well-being in the population (Kulka, Veroff, and Douvan 1981).

Deinstitutionalization of the public mental institutions modified the state role, although most state mental health resources continue to be dedicated to maintaining mental hospitals. However, with reduced state hospital populations, and with the vast majority of patients remaining in

the community, the state role in licensing, contracting, regulating, and paying for services has greatly increased (Mechanic and Surles 1992). The introduction of Medicare and Medicaid in the mid-1960s, and their subsequent expansion in recent years, has made these programs central to state mental health systems and the configuration of services.

The availability of at least 50 percent matching funds under the Medicaid program provided inducements to the states to modify service arrangements and to develop new service strategies to maximize federal support. Because adult care in "institutions for mental disease" was not eligible for Medicaid funding, transferring care to nursing homes and increasing acute inpatient services in general hospitals allowed states to shift a considerable portion of the cost to the federal government. This has contributed to blurring the traditional demarcation between public and private mental health services (Fisher et al. 1992) as nonprofit and private providers take more responsibility for public care, and public institutions increasingly try to capture third-party reimbursements from whatever source.

The mental health sector has been shaped substantially, albeit unintentionally, by general health and welfare policies that were not designed to accommodate the mentally ill. Aggressive and clever state administrators perceived opportunities in federal programs to capitalize on federal funding, but federal restrictions on disbursement of Medicaid funds often hampered the administrators' flexibility in using these resources most cost effectively. As the Medicaid program expanded options, it also gave states the opportunity to develop their services around Medicaid, which offered broader possibilities than traditional employment-related insurance. However, it also created obstacles to the substitution of coherent outpatient systems of care for inpatient services because of its inflexible regulations regarding the interchangeability of types of services. Medicaid-managed care is the newest strategy for developing systems to allocate care more efficiently and appropriately.

Defining Need and Demand for Service

The population of users of mental health services is heterogeneous, varying by disorder, degrees of discomfort, disability, and voluntary participation. Although most users seek care willingly, the mental health sector continues to play an important role in protecting the public and the

mentally ill themselves from dangerous and disruptive behavior. Thus, some patients come to care under extreme pressure, and others are hospitalized against their wishes. The boundaries between voluntary and involuntary care are often unclear, and the status of patients often changes within a single episode of care.

As with medical care more generally, no clear standard defines when patients should seek professional help. Data from the Epidemiological Catchment Area (ECA) study found that only a small minority of persons who met the criterion of a clinical disorder had received a mental health service in the prior six months, and significant proportions of persons even with the most serious psychiatric disorders had not received any mental health care (Shapiro et al. 1985). Others with disturbing symptoms that did not meet clinical diagnostic thresholds were substantial consumers of care, but there is little reason to doubt their personal pain and disability. Studies generally show that symptoms like depression, short of a clinical diagnosis, are associated with levels of discomfort and disability comparable to many clinically defined conditions (Wells et al. 1989b). Thus, simply matching patients with artificially defined clinical definitions, such as the criteria for disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 1987), is not sufficient to differentiate appropriate users of specialized care in a responsible manner. Insurance proposals based on such artificial and arbitrary distinctions are likely to have significant limitations and would be a major departure from how we structure access to care for other illnesses.

Estimates suggest that perhaps half of mental health treatment is provided by general nonpsychiatric physicians in the course of general care (Mechanic 1990). Despite concern about potential overutilization of mental health services, stigma remains powerful in this area, and patients often resist referral to mental health specialty care. Although primary care physicians commonly fail to recognize mental disorders in their patients—for example, half of all cases of depression are missed (Wells et al. 1989a)—even when recognition occurs, physicians often have difficulty in persuading patients that their problems might be psychiatrically based or inducing them to seek mental health treatment.

Economists focus on “moral hazard,” which is an inclination to use services more when they are fully insured in contrast to use under varying copayment arrangements. Use of outpatient mental health services is more responsive to price than is use of general medical services (Frank

and McGuire 1986), leading to the belief that cost barriers are more necessary in the provision of these services. However, most evidence demonstrates that people are reluctant to use mental health specialty services and that fear of being stigmatized constrains persons with high levels of need from seeking care.

“Moral hazard” is a likely possibility in the use of psychotherapy, which is not only a form of treatment, but also an educational exercise and an approach to self-knowledge and self-actualization. Psychotherapy thus may be an attractive service to persons who are only in modest discomfort, but who have a psychological orientation and value self-exploration. There is little empirical support for the value of extended psychotherapy as a treatment relative to short-term and focused forms of counseling. Tying rates of copayment to expected moral hazard has been suggested as one approach to controlling utilization and cost (Frank, Goldman, and McGuire 1992), and many national proposals suggest higher copayment for psychotherapy than for other treatments. To the extent that FFS continues to prevail, as it probably will, such an approach seems justifiable. It would be desirable to use a lower copayment rate for initial visits to ensure that high copayment does not deter persons in need from initially contacting appropriate providers. This would dilute the payer’s potential control on utilization because copayments affect initial probability of use more than the amount used once care has begun. An escalating copayment structure, however, would protect against unnecessarily extended psychotherapy.

The Mental Health Benefits Package

With the possible exception of psychotherapy, there is no justifiable reason for treating mental health benefits differently from other medical services used by persons with chronic disease. Such services would involve inpatient hospital and physician services, outpatient care, partial hospitalization, and outpatient medication management and counseling services. Other types of residential care might be substituted for more expensive inpatient services. For example, some part of inpatient benefits might be applied on a formula basis to pay for day care in ratio to the relative costs of these services. There is no compelling reason to establish different limits for psychiatric services than for other medical services, and comparable deductibles, coinsurance, and utilization limits

could be applied. However, because standards for psychiatric inpatient care are less clear than for medical and surgical care, and because psychiatric diagnosis is a particularly poor indicator of resource need or use, careful standards must be applied in reviewing inpatient utilization patterns, and improved inpatient and outpatient care standards must be developed. Strong preadmission certification programs are essential in administering inpatient psychiatric benefits.

Given the patient's probable uncertainty about whether treatment is necessary and how much treatment is required, it is curious that there is typically so much focus on demand for care. An adequate system of care should make an initial clinical assessment highly accessible, and because so much of what follows depends on the provider's behavior and his or her influence on the patient, incentives should substantially help shape the provider's response. Health maintenance organizations (HMOs) are, of course, a case in point, and the evidence indicates that prospective budgets affect both the style of mental health care and the quantity of care provided. HMOs, compared with FFS practice, make mental health services somewhat more accessible, but limit their intensity and tend to substitute other professionals for psychiatrists and group for individual therapy. Prospective payment of hospitals also changes resource use patterns, but issues remain on how to devise supply-side cost constraints so as to reimburse fairly, minimize large winners and losers, and protect against low-quality service, issues to which I will return. We obviously require some blend between incentives affecting demand and supply (McGuire 1989).

Mental health services, perhaps more than others, typically involve long-term care, including such services as case management, psychosocial rehabilitation involving instruction in everyday living skills, and assistance with work and other material needs. In many states Medicaid covers such services, and thus the future relationship between any national health initiative and Medicaid is crucial. Typically, reference is made to dividing Medicaid into its acute- and long-term-care components, with long-term care remaining as a state-funded program. A person's medical care is not so simply divided, however, and careful articulation of responsibilities will be required if fragmentation of care is not to increase even more.

If we conceive of national health reform as providing necessary basic coverage, then the appropriate distinction is less between acute- and long-term care, and more between basic and catastrophic coverage. A

too restricted definition of basic services favors inpatient over outpatient care, and medical in contrast to alternative sociomedical services as typified by professional case management. The concept of case management has been used to represent varying functions ranging from therapy to services integration, different levels of training from minimal to professional, and different organizational roles from advocate to gatekeeper. Professional case management, as I use the term, refers to a service that takes responsibility and is accountable for the total pattern of a patient's care, that helps the patient access needed services, and that integrates care within the context of a longitudinal treatment plan. Such a service might be performed by a professionally trained individual such as a master's-level social worker or a nurse or a primary care physician or, perhaps more appropriately, by an interdisciplinary team. Professional case management, to be meaningful, must be able to access the necessary services or provide them directly, and ideally it operates in a context with incentives for careful consideration of trade-offs in various patterns of care.

At any point in the trajectory of a person's illness, both acute- and long-term-care services may be required. Rather than attempt to split such services artificially between health insurance and the state, thereby contributing to large discontinuities of care, it seems more desirable to define mental health benefits very broadly, more easily permitting some types of residential and community treatment to substitute for expensive inpatient benefits through a specified formula. The state safety net, then, comes into effect at the point when insurance benefits are exhausted and patients face catastrophic situations. This approach is consistent with the tendency of states to become more involved as payers and regulators of services than as direct providers. The state safety net thus becomes increasingly a secondary insurance system.

At first appearance, the notion of a separate long-term-care or disability-care benefit may seem appealing. In distinguishing the predicted needs of generic enrollees from those with disabling conditions, a separate benefit offers the illusion of reducing the complexity of benefit design and limiting the uncertainties in cost associated with care for persons with severe and persistent disabilities. This approach, however, has major disadvantages.

When most expenditures and attention are dedicated to the larger acute-care system, the existence of a secondary disability benefit is likely to be associated with a less valued tier of health care. The formal separation, and the association of the disability benefit with a relatively poor

and powerless constituency, will turn the disability system into a target for cost containment and may focus the public's hostility on welfare-associated services. Thus, persons with disabilities would lose the enormous political advantages of being part of the mainstream system of care. Moreover, processes of eligibility determination are likely to become extensive and contentious, taking on some of the characteristics that have typified the administrations of Social Security Disability Insurance and Social Security Insurance (Mashaw 1983).

Beyond the political and symbolic aspects, separating the acute- and long-term-care systems reduces much of the potential to substitute a range of long-term-care services for highly expensive acute care that yields limited benefits. Because the majority of care for the population will be concentrated in the acute system, the failure to integrate care for the disabled into the larger system will diminish opportunities to develop adequate systems of community services by garnering some of the funds that typically go into acute inpatient care. Much of the incentive for large insurance plans to develop alternative approaches to care for persons with disabilities would be diminished if they were not held responsible for the long-term-care aspects of health care management within the basic premium or capitation. A dual benefit structure in which everyone receives acute care, while the long-term-care needs of the disabled are covered under another payment system, limits the opportunities to balance different types of care and maintains incentives to resort too often to traditional acute care. The point to be emphasized is that long-term care is not simply custodial care in nursing homes or other residential settings. Long-term care should be a philosophy and a strategy for managing disabilities in a manner most conducive to retaining functional performance and independence in living consistent with people's goals and aspirations. As the population ages, and as household structures and living arrangements change, the challenges of maintaining people with serious illnesses and disabilities in their natural settings will require skillful organization and effort as well as appropriate funding. In order to enhance the possibilities of care in the least restrictive settings using economical means, we will need health care organizations with the resources and incentives to strike a balance between acute-care technologies and the restorative services that maintain living skills and social networks. We are left with the issue of how to develop and organize such capacities.

Capacity Development

The inclusion of persons with chronic disabling disease in a health insurance framework will require considerable capacity development if a high quality of care is to result. Although there is little systematic evidence, much anecdotal information suggests that existing office-based physicians and HMOs have limited interest, capacity, and willingness to provide the type of broad longitudinal care needed to manage complex and disabling chronic illness (Schlesinger 1986). Such patients are at risk of not receiving the needed services in the context of an increasingly competitive and pressured health care situation.

The evidence, however, is also clear that although blueprints for well-organized community care have been developed and tested, sometimes with impressive results (Stein 1992), these approaches have not been widely diffused. Major gaps in care are commonplace, and, despite significant expenditures, care for persons with chronic mental disabilities and other chronic problems remains fragmented, with little focus of responsibility or accountability (Mechanic and Aiken 1987). Much of the mental health dollar still goes for inpatient care while outpatient services struggle to maintain financial viability. Inclusion of persons with mental disabilities in a system of managed competition provides opportunities to develop incentives that increase accountability and help build the continuum of community services that have been difficult to establish under current financial arrangements.

There are three basic alternatives for developing the capacity to manage chronic disabling conditions in the general health sector. First, existing health programs can broaden their service patterns and professional staff to manage such patients more ably. To do so, they need sufficient volume to justify the development of new services and the hiring of case managers and other specialized personnel. Although HMOs have not encouraged enrollment of persons with psychiatric or other major disabilities, capitation can be designed to encourage greater receptivity to such patients (Mechanic and Aiken 1989).

Large managed-care organizations will doubtlessly develop their own systems of service to manage psychiatric disabilities, but many providers will not have a sufficient concentration of such patients to justify the start-up and maintenance costs required to accrue the needed expertise and relationships. Such organizations are likely to subcontract with men-

tal health organizations to take partial or full responsibility for specialized services, and the existing mental health specialty sector can substantially shape its activities around the goal of assuming such responsibilities. A major role will be available for existing mental health specialty organizations like community mental health centers, clinics, and psychiatric hospitals, in addition to mental health managed-care organizations that have emerged in recent years. The range of organizations and situations is likely to lead to a diversified secondary sector that may be forced into considerable competition and consolidation. To the extent that financial responsibility is centered in the basic health insurance program, some public clinics and programs will also have to compete for contracts if they are to maintain financial viability. A public system is likely to remain as a safety net for intractable cases and for those who pose issues of public safety. This is likely to be one important remaining function for the traditional public mental hospital, although the number of such beds is likely to continue to decrease. Increasingly, the distinctions between public and private will diminish and become less important.

Some subgroups of disabled patients will require such intensive mental health services that it may be most desirable for a specialized mental health HMO to act as the primary provider. Such organizations would receive the basic adjusted capitation and would be responsible for contracting for all necessary general medical services (Babigian and Marshall 1989). These entities would have to be developed to a considerable degree if they are to have a significant presence in the chronic care arena. Yet, it seems reasonable for persons whose mental health disabilities overwhelm all other areas of function to receive their primary management from organizations dedicated to providing high-quality specialized mental health services.

A specialized mental health HMO is just one of several potential specialized HMOs that might emerge to serve persons with chronic disabling diseases whose disabling condition defines the continuing focus for the care they need. Such organizations, planned on a sufficiently large population base, can bring together the types of specialized expertise and service commitment unlikely to be found in an ordinary HMO or even one with sophisticated secondary contracts. For example, organizations based on Assertive Community Treatment, as in Dane County, Wisconsin, could contract as specialized HMOs, but they would require the capacity to manage contractual arrangements for all necessary medical care. The most developed system of this kind financially is the capitation

experiment in Rochester, in which the responsible system (Integrated Mental Health) contracts for services for the highly disabled population that include "all inpatient and outpatient medical, dental and psychiatric care, medications, and other costs necessary for community living, including housing when required" (Babigian and Marshall 1989, 51). The organizational expertise necessary to develop and administer such organizations, establish the necessary contracts, and manage the required quality assurance and cost-control approaches is not easily or quickly acquired. Taking a decade to consider and plan for such developments would not be unreasonable.

As the overall health system takes more responsibility for persons with disabilities, states and localities may shift some of their investments, but this process must be carefully managed. HMOs tend to refer persons with serious mental illness to public sector services, and this kind of cost shifting is likely to continue until nonprofit providers are motivated and organized to seek the reimbursement due them. More important, it would be tragic if the public sector services eroded before the emergence of new provider organizations with the capacity to provide the necessary spectrum of services.

Risk Selection, Adjusted Capitation, and Related Uncertainties

Persons with chronic disabling illness, and especially persons with serious and persistent mental illness, are likely to have high and often unpredictable health expenditures. Small provider organizations that attract a disproportionate number of such persons could face serious financial risk if they are not protected by adjusting capitation payment or sharing risk. Methods to do this reliably are limited and uncertain, and provider organizations are likely to make efforts either to discourage enrollment or to encourage disenrollment of such patients. The latter is especially difficult to monitor and control.

Several approaches can be used to limit risk selection under a system whereby provider organizations compete to attract enrollees within prescribed rules. All competing providers should be required to offer sufficient comprehensive mental health services at a minimum level to ensure that patients with mental disorders are not discouraged from joining a plan simply because basic needed services are unavailable. The actual se-

lection process among competing plans should be handled exclusively by the regulatory authority organized to do this, whether we call it a corporation, a cooperative, or an alliance. Selection should occur in an open enrollment situation with no exclusions for preexisting illness and at a uniform community rate. Such authorities should be especially careful in monitoring access, responsiveness, and quality of care for persons with chronic disabling mental illness.

Although community rates should prevail, authorities would have to adjust capitation to take account of the risks associated with disabling chronic illness. Thus far, most approaches fail to explain more than a trivial amount of variance in resource use, although approaches that better gauge severity, disability, and risk of danger and disruptiveness may do better. Ultimately, methods of greater predictability will be devised, but, in the short run, adjustments based on prior utilization may offer the best solution. Adjustments would have to be revised frequently to account for the annual variability in resource use and expenditures. Capitation adjustments are, of course, imperfect solutions, but they provide a somewhat fairer basis for payment to providers who care for disproportionate numbers of people with disabilities. Even then, the prediction of risk is uncertain and provider organizations face an unstable situation. Reinsurance provides some backup protection (Schlesinger and Mechanic 1993).

Providers who assume responsibility for persons with disabling illness should be obligated for care only to a certain expenditure level, after which a reinsurance program should become operative to share the risk. Maintaining provider cost consciousness once the reinsurance threshold has been reached can be achieved by making the provider responsible for some portion of remaining costs beyond the threshold. Although no single mechanism is likely to correct tendencies toward risk selection, a combination of mechanisms, however imperfect, can contribute to a more level playing field.

The Fate of Medicaid

If disabling mental illness is included in emerging health reforms, Medicaid as we have known it would cease to exist. To the extent that the role of Medicaid in both acute- and long-term care is appropriately subsumed under health reform, major inequities could be diminished. Eligibility

for Medicaid, the scope of benefits, reimbursements for providers, and actual expenditures vary greatly among states, and some greater uniformity would be desirable and certainly more equitable. In making changes, however, great care must be exercised to ensure that special highly vulnerable populations that now depend on Medicaid—the seriously mentally ill, the frail elderly, and persons with developmental disabilities and AIDS—are not disadvantaged.

Several states have built their systems of care for highly vulnerable populations around Medicaid financing. Because of the options available under Medicaid, and the opportunity to broaden the range of traditional services, some Medicaid programs offer a constructive blend of medical and social services. These state systems, however, are highly fragile and cannot easily recoup if funding is withdrawn in order to facilitate the implementation of a national plan. States with traditionally rich Medicaid expenditure patterns require some formula basis for support that will allow maintenance of innovative programs that have been painstakingly developed within the context of Medicaid. Although current expenditure patterns among states are inequitable, these innovative programs serve some of the most neglected and vulnerable populations in America. Services for populations like those with severe and persistent mental illness have been chronically deficient. It would be sad to lose the little momentum that has developed in some states for the integration and improvement of the system of services.

In Conclusion

Caring appropriately for persons with severe mental illness is a long-standing problem that is not easily remedied. The current effort at health reform is simply a first iteration in an evolution that will take a decade or two to produce an appropriate capacity to meet the complex and varied needs of persons whose suffering and disabilities diminish their lives and productivity and who pose significant burdens for their loved ones and their communities. Persons with chronic disabling mental illness have long suffered neglect and discrimination. We now have an opportunity to put their care on par with others.

There is no justifiable reason to treat mental health needs and benefits differently from others, with the possible exception of psychotherapy, which enjoys a cultural cachet among certain groups. Many other

groups with disabilities share the long-term needs of persons with serious mental illness and appropriate models for their care, geared to retaining function and independence in living, are important to good health care more generally. With a changing population structure and new household arrangements, the need to focus on the social services allied to medicine will become ever more apparent and important.

Because of the character of long-term illness, it is important that health care be defined broadly and not only in terms of what physicians do. To achieve this within any reasonable cost context will require significant supply as well as demand constraints. If supply is to be restricted intelligently, however, it is imperative that we develop better standards and methods for monitoring quality and outcomes.

Reform must be sensitive to the need to preserve excellent programs while seeking to create new structures. In reviewing some of the ways in which the broad Medicaid package has shaped the development of state mental health systems, I caution against dismantling fragile structures without ensuring that they will be adequately replaced. Integrating most of the acute- and long-term-care services needed by persons with chronic illness and disabilities will provide opportunities to balance care choices more thoughtfully and efficiently and help reduce the biases that favor inpatient care.

There are formidable problems ahead. Appropriate models for assessing risk, and thus reimbursing providers fairly, are still wanting. Techniques to control risk aversion and other forms of gaming are primitive. Proposed regulatory authorities that will serve as the vehicles for individuals to exercise prudent choices have to be developed so they function in reality as they do in theory, and they must develop the means to assess the quality of care patients are receiving. Above all, the system must develop the capacity nationally to provide high-quality mental health care because entitlement without access is meaningless.

The health care system is positioned for significant change in the relatively near future. Major problems of access, quality, and cost must be addressed for the system as a whole and for a large, heterogeneous population. The complexity of health care reform is daunting in terms of the financial, organizational, and service arrangements necessary to make the system work in the varying contexts of this nation characterized by large variations in population density, racial and ethnic composition, health infrastructure, and economic circumstances. In addressing these challenges, there is a danger that the special problems and needs of sub-

groups of persons with the most serious and disabling illnesses will not be fully understood or taken into account. In the long term, the success of the health care system must be judged less on its success in serving the majority of the population, most of whom have few or simple medical care needs, and more on how effectively it addresses the problems of those with serious and persistent disabling illness, who depend on the health system for their functioning, perhaps even for their lives. To the extent that the reforms address these important issues successfully, they are likely to serve us all well.

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Address correspondence to: David Mechanic, PhD, Director, Institute for Health, Health Care Policy, and Aging Research, Rutgers University, 30 College Avenue, New Brunswick, NJ 08903.