

Establishing Mental Health Priorities

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IN AN IDEAL WORLD WE WOULD CLARIFY OUR VALUES, clearly specify related priorities, and structure available funding to maximize outcomes. This model process is unlikely for numerous reasons. Major disagreements prevail, even within the mental health community, about the values and priorities that should apply. Information on the effectiveness of alternative modalities is incomplete and inadequate. Furthermore, the structure of funding and entitlements as they apply to mental health care makes comprehensive planning impossible. I begin with a brief discussion of these issues, followed by an examination of how we arrived at our present situation. In conclusion, I examine possible options for determining future priorities within existing social constraints.

Lack of Consensus on Values

Mental health is a broad concept, encompassing a wide range of needs and issues that apply to a heterogeneous population. Because resources designated for mental health are limited, different subgroups compete vigorously to achieve their priorities, often with considerable acrimony.

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The battle is enjoined as a zero-sum game, and too little consideration is given to enlarging the available resources by building creative coalitions.

Mental health constituencies are stratified along various dimensions defined by type of condition, age group, emphasis on treatment versus prevention, and support for certain types of facilities (e.g., mental hospitals) or professions (e.g., clinical psychology versus psychiatry). Separatism is evident among constituencies supporting the developmentally disabled and advocates for alcohol and drug treatment, who either seek an independent agenda to enhance their potential success or try to distance themselves from the mentally ill and the stigma attached to them. A further division occurs by age group, as advocates for children and the elderly (i.e., those concerned with Alzheimer's disease) perceive their interests as different. A major tension derives from the competing perspectives of the National Mental Health Association, which argues for a broad agenda in mental health (one that includes both preventive and treatment services), and the National Alliance for the Mentally Ill (NAMI), which prefers that public support be channeled to the severely and persistently mentally ill and is skeptical of prevention and advocacy services. These divisions at best limit the potential for effective united advocacy and at times result in destructive mutual recriminations.

The divisions among mental health constituencies are real, but they are exaggerated by the emphasis on a few seemingly intractable points of contention like the differences between advocates for the civil liberties of persons with mental illness and supporters of greater efforts to hospitalize patients involuntarily for their own safety and welfare. Mental health financing need not be a zero-sum game, and strong coalitions may offer benefits that transcend the costs of compromising on points of difference. In my experience, constituencies are unnecessarily polarized by their differences in thinking about mental health functions. Families associated with NAMI, for example, in advocating for persons with serious mental illness, often view prevention services as a less valuable investment, amounting to no more than extraneous activities like dance or art classes. These same advocates will often see the point in more central preventive activities, such as identifying children who are more vulnerable and at higher risk of disorder because they live in families with depressed or schizophrenic parents. In fighting over priorities, advocates tend to devalue unnecessarily the potential and legitimate contributions of initiatives applied to varying populations and components of mental health services.

Achieving a joint agenda is no easy process, but by consolidating forces mental health advocacy groups can better match the influence of many other disease lobbies. Agreeing to disagree, and focusing on those common elements of an agenda that all groups are able to support, can facilitate the mental health agenda. This easing of discord would not limit any particular group from advocating for its vital interests, but the process of maintaining a coalition would at least mute some of the acrimonious rhetoric that characterizes infighting among these groups. Considerable progress has been made recently in unifying advocacy groups, and some of the evident advances in presenting cogent arguments to make the case for mental health can be attributed to this new cooperation.

Limited Knowledge

The mental health field is filled with uncertainties. Knowledge is lacking on the etiology of most disorders or on definitive treatment, and characterizations of the field range wildly from the biological to the social. In the past ten years, perspectives have narrowed—for example, few would argue today that mental illness is a myth—but a rich diversity of views persists regarding the reality of many mental disorders described in the *Diagnostic and Statistical Manual*, the value of commonly used treatment approaches, and the potential for prevention. Mental health, more than most other areas of medicine, offers a very wide latitude in treatment approaches, and, in the absence of convincing research evidence, established interventions often cannot be distinguished from the latest fads. Groups with varying value commitments thus have much to fight over, and they do. Supporters of advocacy services, for example, see these as essential for client welfare and empowerment; many NAMI members, on the other hand, regard them as mischievous interference with the administration of appropriate treatment. Comparable types of conflict in the field involve such issues as the value of psychotherapy compared with more medically oriented services; the question of whether electroconvulsive therapy is an effective therapeutic option or a social control mechanism; the appropriate uses of involuntary hospitalization and treatment; and the implications of family-centered interventions based on expressed emotion and related concepts. Although in principle it might be possible to agree that investments should largely reflect cost-

effective practice, the paucity of agreement about effectiveness leads us to expect little from such discussions. In some areas, however, treatment guidelines are being developed, and there is now more consensus on the appropriate treatment of major mental disorders.

The Structure of Funding and Entitlements

Mental health services are funded in many ways: private health insurance; Medicaid and Medicare; state and local services provided either directly or through contractees; Veterans Administration hospitals and clinics; and other programs geared to special populations. In addition, the severely mentally ill depend substantially on the welfare system (Supplemental Security Income [SSI] and Social Security and Disability Insurance [SSDI]), housing subsidies, and other categorical programs. Many of the large entitlement and services programs that impact the life of seriously mentally ill persons, particularly Medicaid, SSDI, and SSI, were not developed with much concern for the needs of persons with a mental illness, and the mental health advocacy community has only learned slowly how essential these programs are to its agenda. On the one hand, they offer extraordinary opportunities; for example, Medicaid allows coverage of services such as case management and psychosocial rehabilitation, which are typically not covered under private insurance but are crucial to patients with long-term severe disorders. On the other hand, the programs have drawbacks: the structure of Medicaid as an insurance mechanism, for example, is weighted heavily toward inpatient care, which is programmatically less flexible than other directly financed state and local mental health services.

The relevance of general entitlements is particularly apparent as the nation looks toward health care reform. The future prospects for persons with psychiatric disorders are tied to the extensiveness of coverage under any major health insurance plan that materializes, the range of mental health services covered, the definition of reimbursable providers, the differentials in cost sharing, the maximum benefits for psychiatric illness compared with other types of conditions, and related issues (Mechanic 1978, 1993). National health reform will not inevitably bring improved mental health services. Some health insurance proposals for extending coverage to the uninsured by creating a more affordable basic insurance

package could reduce mental health coverage, for example, by revoking state mandates for coverage.

In short, the configuration of mental health services is a product of unrelated decisions involving coverage under health insurance, the investments of state and local mental health funds, entitlements and administrative rules under the Medicaid and Medicare programs, disability criteria under Social Security, and many more. Rarely is mental health policy conceived of or considered as an integrated whole. Perhaps the most thorough examination of the subject was prepared in the late 1970s by the U.S. Department of Health and Human Services (1980), culminating in a 1980 publication, *Toward a National Plan for the Chronically Mentally Ill*. This effort recognized the range of public programs that impacted the mentally ill and identified necessary policy changes to achieve a more integrated and effective effort. Koyanagi and Goldman (1991a) observe that, despite the failure of the Reagan administration to adopt the plan, considerable refinements in Medicaid, Medicare, SSI, and SSDI regulations were made during the 1980s, resulting in better service to persons with severe and persistent mental illness. They further identify many additional changes that would benefit the mentally ill population.

The Evolution of Current Priorities

Mental health policy has evolved in a disjointed and nonlinear fashion, reflecting the multiplicity of decision points, prevailing ideologies, emerging technologies, and financial and other incentives as they interact with the local political, economic, and organizational frameworks of care (Mechanic and Rochefort 1990). Traditionally, mental health services have been a state responsibility, and states have primarily discharged this historic responsibility by investing their resources in institutions for the most severely and persistently mentally ill.

During the century a variety of social movements sought to broaden mental health domains and to develop preventive strategies. The child guidance movement, and later the mental hygiene movement, set the stage for the renewed focus on preventive ideologies in the 1950s and 1960s. In the 1950s there was still a strong presumption that hospital and community care were important aspects of a balanced integrated care system (Grob 1991, 179), but by the 1960s hospital and community

were increasingly viewed as polarized policy choices. President Kennedy signaled a willingness to introduce important mental health legislation, but a conflict emerged between advisors who wanted to build on and improve the existing system and those who sought an entirely new public health approach that bypassed traditional state mental health authorities. The latter viewpoint prevailed, and the Community Mental Health Center's Act was launched; one result was that federal officials began to deal directly with local groups, often excluding state involvement and ignoring or belittling state priorities or traditional missions. This polarization set the stage for subsequent neglect of persons with the most serious and persistent mental illnesses during the 1960s and 1970s.

The public health approach to mental illness that prevailed in the late 1960s and in the 1970s was driven by assumptions that were ideological and untested (Mechanic 1989). The most important of these beliefs, which concerns the nature of mental disorders and the potential for primary prevention, can be described as follows:

1. Mental disorder is a continuum of distress and dysfunction rather than a disparate collection of disorders with unique characteristics, etiologies, and natural histories.
2. Early intervention can prevent the major mental disorders.

Many of the new mental health services were organized around the second premise, which had no empirical substantiation. These assumptions rationalized redirection of attention away from people with severe mental illness to individuals with more moderate dysfunctions and a variety of "problems in living." The shift in emphasis served the interests of mental health professionals who were trained primarily in the 1960s and 1970s to provide psychotherapeutic services, patterns of treatment not suited to the needs of many of the patients typically found in public mental hospitals.

Mental health services also expanded in the 1960s and 1970s because of extensions of mental health coverage under health insurance, the enactment of Medicare and Medicaid, the growth of community mental health centers (CMHCs) and clinics, and the increasing availability of clinicians. The number of mental health episodes in organized mental health settings increased from 1.7 million in 1955 to 7 million in 1983.

Klerman (1982) estimated that the use of mental health services in the 25 years subsequent to 1955 increased sixfold. The vast majority of services, however, were being extended to new types of clients who were not seriously mentally ill.

In testimony before the Congress on behalf of the CMHC program, National Institute of Mental Health (NIMH) officials suggested that the growth of CMHCs would work in tandem with deinstitutionalization. It was apparent, however, that CMHCs were not particularly receptive to deinstitutionalized patients, and subsequent studies showed little connection between patients discharged from mental hospitals and the typical clientele of CMHCs. Instead these studies showed that the implementation of Medicaid in 1966, particularly nursing-home expenditure, was linked to an increase in rates of deinstitutionalization during the subsequent period (Gronfein 1985). Medicaid provided states with strong incentives to move patients from public mental hospitals into nursing homes and to arrange for more acute inpatient care in general hospital beds.

The Carter Years and the Mental Health Systems Act

Mental health services expanded rapidly during the 1960s and 1970s, despite the hostility of the Nixon administration. By the late 1970s, however, the problem of uncontrollable medical care costs and the necessity for budgetary constraints had become evident, and whereas Carter was favorably inclined toward mental health concerns, his options were limited by the fiscal problems that plagued his term in office. In February 1977, Carter established a Presidential Commission on Mental Health and appointed Rosalyn Carter as honorary chair to review the mental health needs of the country and to make recommendations.

The commission report in 1978 addressed a wide range of issues, urging greater investment in mental health and commenting on the need to develop accessible, community-based services. It made a strong case for increased support of research and training, for attention to chronic mental illness, and for meeting the special needs of disadvantaged groups, children, adolescents, and the elderly. The obvious fiscal constraints encouraged maneuvering among the well-established mental health con-

stituencies. Seeking to avoid division, the commission's report endorsed most of the major points of view and avoided confronting the various constituencies or enunciating specific priorities. The report thus turned into an advocacy document rather than a serious blueprint for the future. It provided a great deal of information and an opportunity to trade on Rosalyn Carter's interest and influence.

One major outcome of the commission's work was the Mental Health Systems Act, which had a long and torturous legislative history. After months of haggling, a bill was first presented to Congress and was then substantially altered to satisfy contending interest groups (Foley and Sharfstein 1983). The process reflected the diverse ideologies that characterize the field and the interests of the various professional and employee groups who staff mental health facilities. Although the act became law in October 1980, it was not implemented. It was subsequently rescinded when Reagan initiated his "new federalism" after he became president.

One outcome of the commission's work was the development by the Department of Health and Human Services of an integrated federal strategy to deal with the broad needs of persons with chronic mental illness. This plan, devised to complement the Mental Health Systems Act, focused on needed changes in the Medicare, Medicaid, and the major disability programs. Because the projected substantial cost of the changes concerned senior officials and White House staff, the report was not widely circulated (Koyanagi and Goldman 1991a). Unlike the commission's report, the recommendations in the national plan were highly focused and defined for informed advocates and participants the areas of general entitlements and welfare programs with crucial implications for the well-being of persons with serious and persistent mental illness.

Koyanagi and Goldman (1991b) have reviewed the considerable progress that quietly occurred during the 1980s in amending important federal programs. For example, psychosocial rehabilitation services were expanded under Medicaid, and reimbursement of mental health clinics was required under the Medicaid clinic option. Outpatient mental health coverage under Medicare was expanded, and a new 20 percent copayment was instituted for medical management services, in contrast to the more traditional 50 percent copayment for mental health services. Release programs for persons discharged from state institutions were improved under the SSI program, and the "substantial gainful activity test" that once defined disability for people returning to work was eliminated.

The Changing Environment of the 1980s

It is relevant to examine how these important, and often costly, modifications could have been made under the hostile conditions that prevailed during the Reagan administration. Many of these changes, despite their importance and cost, involve technical modifications and thus constitute policy with a small "p." As such, they do not engage the attention of the media or the varying interest groups in the same way that highly visible policy issues do. Many persons legislating and administering the programs are sympathetic to the changes and view them as consistent with the intent of the programs in question; the policy makers who might potentially oppose such changes are not experts and thus might not be aware of the implications of these technical changes. They are also less likely to be alerted to them by the media, interest groups, or even their own staff. Some of the changes therefore occur quietly; indeed, they can "sneak" through undetected.

The safety net for persons with severe mental illness was severely curtailed in the 1980s when housing subsidies, social services, and other federal programs were cut back and Medicaid failed to keep pace with the growing numbers of poor people. Particularly traumatic was the excision of large numbers of persons with severe mental illness from disability insurance programs by the Social Security Administration (SSA) during the disability reviews of 1980 and 1981. The criteria for disenrolling the mentally ill were poorly thought out; one result was the atypical coalescing of advocacy groups. Various states that administer disability determination for the federal government refused to comply with SSA mandates, and the courts repeatedly rejected SSA decisions on appeal. The extraordinary amount of litigation, unfavorable press reports, and fierce lobbying was an important factor in forcing the government to retreat on the issue and to develop new criteria for ascertaining psychiatric disability. In trying to repair its badly tattered public image, the SSA became more conciliatory on issues affecting persons with severe mental illness.

Ironically, the social policies of the 1980s greatly contributed to refocusing attention on severe mental illness. The return of mental health service dollars in block grants to the states reestablished state mental health authorities as major players in the priority-setting process; exercising their traditional concerns for the most disabled mentally ill, the state authorities pressured community mental health centers to provide more

services to this population. The Reagan years also witnessed a direct assault on social science and socially oriented intervention efforts (Mechanic 1990). In adapting, the NIMH redirected its efforts to research programs that focused on illness rather than on health and excised many of its social and preventive intervention and research programs. New attention to biological research, to the new and exciting potentialities of the neurosciences, and to diagnostic issues shifted the emphasis to discrete disorders and away from social amelioration. Under congressional pressure the NIMH is now in the process of recreating a prevention research agenda (Mrazek and Haggerty 1994).

The Emergence of the National Alliance for the Mentally Ill

During the 1980s NAMI emerged as a major player in the mental health arena. Representing families who felt devalued by mental health professionals and were angry about priorities that shortchanged persons with severe mental illness, NAMI chapters grew rapidly at the state and local levels; the Washington office achieved a significant presence under the leadership of Laurie Flynn. NAMI supported the biological research programs and the schizophrenia plan of the NIMH and encouraged the improvement of services for severe mental illness. NAMI also involved itself in organizational matters, such as the transference of mental health research to the National Institutes of Health, the establishment of a new mental health agency (Substance Abuse and Mental Health Services Administration [SAMHSA]), and the location of specific research and demonstration programs within the NIH and SAMHSA structures. NAMI representatives continue to work actively with Congress and have developed close alliances with particular representatives and senators. Most observers concede that NAMI has become a significant force, and NIMH and state officials increasingly include NAMI representatives in national forums and on important committees.

The NAMI membership is diverse, and some of its members express strong views that are inconsistent with the priorities of other major mental health advocacy organizations. They disagree about the amount of attention to be given to persons with serious mental illness relative to other consumer groups and about functions like prevention, consultation, protection, and advocacy. The resultant lack of unity weakens the

potential for clearly formulating mental health concerns within the broader context of health care reform.

Mental Health within the Context of Health Care Reform

The stigma associated with mental illness extends beyond the general community to the health arena. Most policy makers know little about mental illness, share many of the stereotypes held by the general public, and are uncomfortable with mental health concerns. Although there may be empirical justification for discriminating between some mental health and other medical services under insurance because of their high responsiveness to price (as in psychotherapy, for example), mental health services generally are not accorded equality with other types of health benefits in most public and private insurance plans. Moreover, claims for mental health care are regarded more skeptically than those for general medical services, and policy makers demand from them a higher level of proof of effectiveness.

Even within the federal, and many state, structures, mental health offices are isolated from the useful contact with other agencies that is crucial to their constituencies. Policies important to persons with mental illness are often formulated by outsiders who have little expertise. Inter-agency committees and related mechanisms rarely overcome the isolation that characterizes the mental health field. In my experience, connections are more easily made by persons outside the government because they are not constrained by routine bureaucratic procedures and conventions. The result is that many opportunities are lost for effectively integrating services and programs. Integration is more likely to occur when senior staff in the relevant agencies encourage collaboration; advocacy groups would do well to work with agency heads in promoting their goals.

As the country ponders health care reform, the manner of defining mental health benefits will have far-reaching importance. Generic health reform, or even national health insurance, does not necessarily imply improved mental health services. Two issues are especially important. Mental health is a human service involving a broad range of health professionals, some of whom clearly can substitute for one another. Psychotherapy, for example, could be competently carried out by psychiatrists, psychologists, nurses, and social workers; the quality of the service is likely to de-

pend more on the personal characteristics of therapists than on their respective disciplines. Any health care reform has the potential either to open the range of reimbursable health care providers or to medicalize the provision of services. Similarly, the scope of the benefit package is key because persons with severe and persistent mental illness typically require a broad range of services.

The range of services needed to care for persons with serious mental illness resembles that required for a variety of patient groups with long-term chronic disease and disability; care that includes such a range of care is probably a more appropriate model for the health management of an aging population than the prevailing pattern (Mechanic 1994). Coalitions between mental health, aging, and disability groups could give impetus to the expansion of services and of reimbursable providers.

In an important sense, the changing conceptions and goals of general medical practice and the emerging challenges in patterns of disease and disability are helping to elevate mental health priorities. As medicine struggles with managing disabling illness, it looks for models that require longitudinal responsibility and the mobilization of other related services. Such models already exist for managing serious mental illness. As the medical sector focuses on outcomes and capacity to function in social roles, it can profit from lessons offered by the mental health field regarding the consequences of depression and other psychiatric morbidity for disability; medicine and mental health thus start to form ties. Increasingly, it is difficult to conceive of the nation's health without considering both physical and mental health and their interrelations. It may seem ironic that considerable progress in promoting mental health concerns and needs occurred in the 1980s during an administration that at best viewed the mental health sector with benign neglect. The challenges posed by a nonsupportive federal administration required mental health administrators and advocates to argue for their priorities and to effect technical changes in a more rigorous way, resulting in government programs that more competently served persons with serious mental illness.

With a new president and administration in place that strongly supports mental health, the opportunity to bring mental health concerns into the mainstream is enhanced. The president's proposal offers a relatively generous mental health benefit that will achieve parity with other medical services in the year 2001. It also proposes a long-term-care benefit for the disabled that would benefit the most severely impaired persons

with mental illness. Although the fate of the president's plan is uncertain, the challenge to mental health policy is not. Mental health forces must struggle with the paradox that while they insist on parity, persons with the most serious mental disorders require a substantially different mix of services than does the typical medical patient (Schlesinger and Mechanic 1993). Reconciling a desire for equality with the need for different benefits and approaches is emblematic of the challenges to our future health care system.

References

- Foley, H. A., and S. S. Sharfstein. 1983. *Madness and Government: Who Cares for the Mentally Ill?* Washington: American Psychiatric Press.
- Grob, G. 1991. *From Asylum to Community: Mental Health Policy in Modern America*. Princeton: Princeton University Press.
- Gronfein, W. 1985. Incentives and Intentions in Mental Health Policy: A Comparison of the Medicaid and Community Mental Health Programs. *Journal of Health and Social Behavior* 26:192-206.
- Klerman, G. L. 1982. The Psychiatric Revolution of the Past Twenty-five Years. In *Deviance and Mental Illness*, ed. W. R. Gove. Newbury Park, Calif.: Sage.
- Koyanagi, C., and H. H. Goldman. 1991a. The Quiet Success of the National Plan for the Chronically Mentally Ill. *Hospital and Community Psychiatry* 42:899-905.
- . 1991b. *Inching Forward: A Report on Progress Made in Federal Mental Health Policy in the 1980s*. Alexandria, Va.: National Mental Health Association.
- Mrazek, P. J., and R. J. Haggerty. (Eds.) 1994. *Reducing Risks for Mental Disorders: Frontiers for Prevention Intervention Research*. Washington: National Academy Press.
- Mechanic, D. 1978. Considerations in the Design of Mental Health Benefits under National Health Insurance. *American Journal of Public Health* 68:482-8.
- . 1989. *Mental Health and Social Policy*, 3d ed. Englewood Cliffs, N.J.: Prentice-Hall.
- . 1990. The Role of Sociology in Health Affairs. *Health Affairs* 9:85-97.
- . 1993. Mental Health Services in the Context of Health Insurance Reform. *Milbank Quarterly* 71:349-64.
- . 1994. *Inescapable Decisions: The Imperatives of Health Reform*. New Brunswick, N.J.: Transaction.

- Mechanic, D., and D. Rochefort. 1990. Deinstitutionalization: An Appraisal of Reform. *Annual Review of Sociology* 16:301-27.
- Schlesinger, M., and D. Mechanic. 1993. Challenges for Managed Competition from Chronic Illness. *Health Affairs* 12 (suppl.):123-37.
- U.S. Department of Health and Human Services. 1980. *Toward a National Plan for the Chronically Mentally Ill: Report to the Secretary*. DHHS pub. no. ADM 81-1077. Rockville, Md.

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