In the changing landscape of American domestic politics lies the opportunity for the mental health and well-being of individuals to emerge as a central element of the nation’s social agenda. To seize this opportunity, however, our nation must rethink the issues and policy priorities. Despite mental health’s relatively low position on the nation’s priority list during the past decade, much progress has been made, particularly with regard to the most disabling mental disorders. That progress represents a foundation of achievement and experience on which to build for the future.

This Commentary is a synthesis of views that have emerged from our discussions over the past five years with leading scientists and policy thinkers. Our purpose has been to develop a working model of the conceptual and strategic elements that are critical to efforts to raise the priority of mental health on the American social agenda and, ultimately, to enhance the mental well-being of individuals. Our hope is that these challenges will suggest a direction for the next decades—guideposts against which we can measure our progress.

Perspective On Mental Health

Our perspective begins with a society that places its highest value on the well-being of the individual. In our view, society’s goal should be the realization of every individual’s potential, whatever it may be; society thus should assure the conditions under which that potential is developed and expressed. The responsibility to develop human potential is shared among society and individuals. The conditions that promote the development of the individual differ from person to person, and some individuals need more help and support than others.

Inherent in this perspective is recognition of the mind as the core of...
each individual’s being. The mind plays a critical role in the way one learns, thinks, reasons, plans, and makes decisions; the way one relates to others and to the environment, responds to the challenges of living, bounces back from serious life events, and learns from life experiences; and the way one behaves toward oneself, others, and society.

Our future society would value the health of the mind at least as much as it values the health of the body, implementing policies and programs that promote healthy mental development and prevent mental illness, and that provide caring and supportive environments and competent care for individuals with mental, emotional, or behavioral disorders. This will require that society (1) recognize mental health as more than the absence of disease and mental illness as more than categorical disorders defined by standard psychiatric criteria; (2) comprehend the range of mental function and dysfunction; (3) understand mental state to be highly dynamic; and (4) accept the challenge of developing and delivering effective means for sustaining mental health and preventing and treating mental illness.

**Mental well-being as a continuum.** Defining people as either mentally healthy or mentally ill fails to account for the range of severity of mental dysfunction we routinely lump under the term “mental illness.” In reality, one’s mental well-being cannot be neatly assigned into one of two mutually exclusive categories—mentally well or mentally ill—any more than one can be described as either physically well or sick.

Just as we routinely view physical health as arrayed along a continuum from poor to excellent, we should conceive of mental health as a continuum of well-being from good health at one end to catastrophic dysfunction and suffering at the other. In between are a number of points, representing greater or lesser degrees of well-being, at which the state of an individual’s mental health is a result of the interaction between the nature of his or her disorder—either long-term or transitory—and a range of personal strengths and social or family circumstances.

This concept should not be misunderstood. It does not imply that every illness has definable stages or could be prevented if caught early enough; nor does it suggest that each definable condition or disorder has its place on a continuum of severity. Rather, we use it to portray an individual’s mental condition at a point in time, taking into account all positive and negative factors that apply in a person’s life.

Responding effectively to a continuum of mental well-being requires a continuum of intervention strategies. In the more familiar realm of physical disorders, we recognize that treatments range from “sleep, drink fluids, take two aspirin, and call me in the morning,” to heroic, life-saving therapies. Similarly, we should perceive efforts to enhance the
health of the mind as arrayed along a continuum, from programs that promote well-being and prevent pathology to crisis intervention.

**Mental well-being as dynamic.** Since society does not ordinarily categorize people as either always well or always sick, why do we stigmatize individuals with mental disorders and assume that their conditions are permanent, unchanging, and hopeless? Few people with even the most serious mental disorders are ill all of the time. Rather, many long-term conditions are episodic. A person with a severe and long-term mental illness may, with appropriate treatment and support, maintain a relative level of well-being most of the time. A person also may experience a brief but devastating bout of illness that temporarily pushes him or her to catastrophic dysfunction. Many people experience mental conditions at various times that are transitory, treatable, and compatible with a normal, productive existence.

**Interdependence of mental and physical health.** Although society has structured its health policies, programs, professions, and institutions as though there were little relationship between mental and physical health, experience and, increasingly, empirical evidence speak strongly to the contrary. We know from everyday experience that the state of the mind has a profound influence on the state of the body. That influence is deeply embedded in our explanations for ill health, from backaches to cancer. Physicians also know from their experiences that many of the physical symptoms they see in patients are manifestations of mental distress or illness. This base of experiential knowledge is slowly being substantiated by studies documenting the role of mental state in the maintenance and deterioration of good physical health, and in the treatment of and recovery from physical illness.

### Policy Implications

This perspective has significant implications for public policy. Here we discuss how this approach relates to three major policy domains: health care, research, and mental health policy itself.

**Health care policy.** One of today’s most pressing social issues is the quality, accessibility, and cost of health care. Mental health is considered a basic part of health care when costs are being discussed; otherwise, however, the two are most often treated as distinct. Conceptual and institutional barriers isolate mental health care from the mainstream of health care and sustain the myth that mental and physical health are independent states. The imperative to rein in runaway health costs impedes attempts to break down those barriers.

Mental health care represents a significant part of the overall health
care system; more than 20 percent of all hospital days are devoted to mental health care. Health policies that perceive the systems as separate and fail to take into account trends in mental health systems are likely to create perverse and costly distortions in patterns of care. For example, viewing hospitalization for mental illness as the responsibility of the state mental health system belies the reality that expenditures for care in scatter beds in general hospitals now constitute the single largest element of all hospital expenditures for mental disorders.

The health/mental health dichotomy also contradicts the reality of patterns of care. Most people with mental health symptoms—recognized as such or not—are seen first by primary health practitioners. Given the growing reliance on such practitioners for providing the first line of care and for serving as gatekeepers to specialty care, a particular challenge is to develop strategies to increase their capacity to recognize, diagnose, treat, or refer individuals with mental illness. That capacity will be greatly enhanced by diagnostic criteria that are consistent with the realities of the mental conditions that people experience and with the health care system. It also will be enhanced by the development of effective mechanisms for bringing mental health expertise to a range of health care settings. Such advances will assure greater access to competent mental health care without the need for labeling or formal referral.

An integrated approach to health and mental health care also will require that reimbursement systems eliminate the current discrimination between interventions for mental and physical conditions. Reimbursement rules that distort diagnosis and treatment options do far more than discourage recognition and appropriate treatment of mental problems. They drive up health costs—often for inappropriate care—masking them under reimbursable diagnoses. Reimbursement systems also discriminate against the use of psychosocial interventions in the treatment of physical illnesses. As we learn more about the relationship of mental state and health, psychosocial interventions proven effective in the treatment of physical conditions should be included in the armamentarium of the health care system and reimbursed accordingly.

Research policy. One’s mental, emotional, and behavioral health at a point in time is determined by a complex set of factors—individual and environmental—that interact to shape the course of human development across the entire life span. Policies capable of enhancing the mental well-being of individuals must be based on sound knowledge of these forces and the ways in which they interact. That knowledge can only derive from research with the capacity to elucidate the genetic, biological, psychological, social, and cultural determinants of health and illness, and to synthesize integrated models of their interactions.
Today's research, hobbled as it is by narrow perspectives, disciplinary boundaries, and institutional compartmentalization, lacks that capacity. The challenge for researchers is to develop intellectual frameworks and models capable of integrating the diverse factors that determine mental well-being and its relationship to physical health, and to translate new knowledge into effective interventions. The challenge for policymakers and administrators is to develop organizational structures, incentives, and funding mechanisms capable of fostering and sustaining intellectual collaboration among those researchers. The challenge for advocates is to promote the broadest, most comprehensive research agenda possible, with the understanding that there are no easy answers.

Mental health policy. Historically, the purview of public policy in mental health was limited largely to public responsibility for individuals with severe mental illness—essentially the state’s responsibility to provide institutional care. After World War II that purview was expanded, with the creation of a federal role that grew to encompass biomedical, behavioral, and social policy research; human resource development; and services aimed at prevention, treatment, and supportive living.

Critics always saw this expansion as fragmenting resources and attention, “overpromising” what mental health care could contribute to addressing society’s ills, and shortchanging basic biological research and the core issue of mental illness. And, indeed, over the past decade and more, a significant narrowing of focus has occurred; “mental health issues” increasingly mean “biomedical mental illness issues.”

Many factors joined to produce this change: perceived neglect of the social responsibility for people suffering from severe mental illness; budgetary pressures to focus on core priorities; larger political pressures to limit the federal role to research and to keep research clear of social issues; and growth and decline of various advocacy groups. The effect has been, first, to limit the perception of mental health policy to programs related to individuals with the most severe and chronic conditions, and second, to limit the federal leadership role to biomedical research.

A major accomplishment of the emphasis on severe illness has been recognition that an individual with an illness such as schizophrenia has a range of human as well as treatment needs, which fluctuate over time. While treatment for the illness is essential, such individuals also need assistance in obtaining food, shelter, general health care, and work, and in developing supportive relationships and a life structure capable of enhancing and sustaining their relative level of mental health and well-being. Similarly, the emphasis on biomedical research has yielded significant understanding of the biological components of what once was viewed as the intangible phenomenon of mental illness.
This narrowed focus also has negative consequences, particularly in the degree to which it has engendered neglect of other elements of mental well-being. Less severe forms of mental disorder and distress, however painful or disabling, have received little attention, and little effort has been devoted to protecting and sustaining mental well-being.

The time has come to refocus again. We should not repeat the mistake of overselling the power of mental health approaches to solve complex social problems or of neglecting essential concerns with research and severe illness. Nor should we be so foolish as to ignore what we learned during the more expansive era and what is now well recognized: that enhancing the mental and emotional health of children is a critical element in bringing them to school “ready to learn;” that enhancing the mental, emotional, and behavioral health of individuals in the work force is a critical element in strengthening the country’s economic productivity and competitiveness; and that enhancing positive mental health among the growing population of older Americans is an integral element of societal efforts to increase the quality, length, and productivity of life, with minimized disability and institutionalization.

An important challenge for public policy in the 1990s is to explore how mental health and disorder affect and interrelate with high-priority policy concerns, from homelessness to substance abuse to family preservation. This is not simply a matter of restoring balance to the National Institute of Mental Health (NIMH) research portfolio, so that it addresses psychological, behavioral, and social as well as biomedical processes, although this is needed. We must assure that mental health knowledge and perspectives are appropriately incorporated into the nation’s conceptualization of and response to critical social problems.

The concerns of mental health policy already extend into a wide variety of policy arenas. Medicaid and Supplemental Security Income do much more than categorical mental health funding to set directions and provide resources. State and local education and criminal justice systems reach more people with mental disorders than do state mental health systems. Policies of the National Institutes of Health (NIH) and the National Science Foundation drive the decisions that determine the viability of interdisciplinary research more than do those of NIMH.

The partition of NIMH exemplifies the end of an era in which there could be a single federal focus for mental health. With the research arm of the federal mental health agency moving into the mainstream of health research at NIH and the services arm attempting to rejuvenate itself as one element of a new Substance Abuse and Mental Health Services Administration, the danger of fragmented and competing goals is real. The challenge is to forge a comprehensive concept of mental
health capable of linking and integrating the increasingly fragmented elements of policies and programs. Particular attention is needed to assure continuing interaction and dialogue among the research, training, and services communities, to assure that knowledge moves from the laboratory to practice and policy and that questions derived from practice and policy inform research planning.

**Goals and priorities.** In a time of extreme pressure on public resources, priorities must be set. If everything is a priority, then nothing can be. However, in setting priorities, we must still recognize the reality of “lesser” needs and the implications of failing to address them. Priorities inevitably will be set through a political process involving disparate groups and interests both within and outside the mental health field.

What is needed is a common set of goals related to enhancing the mental health and well-being of our population. Common goals would provide a positive context for debating specific policy issues and public funding priorities, and a framework within which diverse elements can work to promote their specific interests. They also would point the way to strategies for transcending the barriers that now isolate mental health from health, mental health care from health care, mental health services from social services, and people with mental disorders from other people.

The views expressed in this Commentary are those of the authors, not of the organizations with which they are associated.

### NOTES


5. See L. Eisenberg, “Treating Depression and Anxiety in the Primary Care Setting,” in this volume of *Health Affairs*.