Policy
At the Intersection of Health, Health Care and Policy

Cite this article as:
D Mechanic and R C Surles
Challenges in state mental health policy and administration
Health Affairs 11, no.3 (1992):34-50
doi: 10.1377/hlthaff.11.3.34

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/11/3/34.
citation

For Reprints, Links & Permissions : http://content.healthaffairs.org/1340_reprints.php

Email Alertings :
http://content.healthaffairs.org/subscriptions/etoc.dtl

Not for commercial use or unauthorized distribution
Prologue: In a federalist government, states often act as laboratories for innovation in the development of policies that can be put into place around the nation, or that can meet the unique needs of a state’s population in a way that a centralized policy cannot. In mental health, states have proved to be especially fertile ground, not only for testing new policies but for providing needed care to chronically mentally ill people. In the 1960s, this essay narrates, the federal government took on increased responsibility for providing care; that responsibility returned to the states with Ronald Reagan’s “New Federalism” in the 1980s. “The situations of states vary widely,” authors David Mechanic and Richard Surles state, “but it seems clear that the states and localities will remain providers or payers of last resort for the most seriously mentally ill.” The essay by Michael Hogan elsewhere in this volume of Health Affairs details Ohio’s approach to arranging and paying for services for its mentally ill; this essay describes in more general terms the environment for state mental health policy, the role of federal authorities, and the challenges states face in meeting the needs of their mentally ill citizens during a time of fiscal austerity. Mechanic, widely recognized for his contributions to mental health policy research, is René Dubos Professor of Behavioral Sciences and University Professor at Rutgers University. He directs the Rutgers Center for Research on the Organization and Financing of Care for the Severely Mentally Ill. A frequent contributor to Health Affairs, Mechanic is a member of the journal’s editorial board. Surles is commissioner of the New York State Office of Mental Health, a position he has held since 1987. He previously served us the chief mental health official in the city of Philadelphia and the state of Vermont. Along with several of his colleagues, he published a review of New York State’s mental health care management system in Health Affairs, Spring 1992.
State government traditionally has taken responsibility for mental health policy. Until the period after World War II, the federal role was very limited. In the 1960s federal officials took the initiative, seeking to bypass traditional systems of care and state authorities. Federal initiatives promoted a parallel system of services on a public health concept built upon a construct known as “community mental health centers” (CMHCs). Rather than working through the states, which had a long-standing responsibility and commitment to persons with the most serious mental illnesses, the National Institute of Mental Health (NIMH) formed direct alliances with nonprofit corporations at the community level and funded them directly. In most states the CMHCs embarked upon priorities that differed from those of state mental health authorities (SMHAs) and, as experience later demonstrated, contributed little to the care of large numbers of patients who were deinstitutionalized or others who in an earlier era would have been candidates for hospitalization in public mental hospitals.

In the 1980s, with President Reagan’s “New Federalism” agenda and the dismantling of NIMH as a substantial service agency, the initiative for mental health policy returned to the states. Now most federal service funds come to the states in the form of block grants, and many states have reassumed authority for setting priorities for publicly funded CMHCs, as well as for other initiatives. In the coming years, efforts will be made to consolidate and integrate health care delivery systems, and states will have to delineate their special roles carefully relative to the federal government on the one hand and to the private and nonprofit sectors on the other. The situations of states vary widely, but it seems clear that the states and localities will remain providers or payers of last resort for the most seriously mentally ill and have major responsibilities for achieving necessary integration between general medical, mental health, and social welfare services. They also will have key roles in financing, regulation, and quality assurance. In this paper we explore some differences among states and consider opportunities for strengthening the state role.

**An Integrated Mental Health Agenda**

Structure and process have little relevance without a vision of the future mental health sector and how it relates to medical, social, and welfare policies. Such a vision must be formulated in a context of considerable uncertainty, since the plight of individuals with a mental disability depends substantially on future reforms in medical insurance systems, social welfare programs, and a range of other entitlements.
Plans and strategies also must contend realistically with economic constraints on local, state, and federal capacity. As a start, mental health officials have to learn how to attain access to this large public policy arena and to become participants in the broader policy-making process.

**Case management.** In recent years many states have encouraged programs of assertive community treatment, using case managers for a range of functions varying from direct treatment to brokering services provided by a variety of community agencies. Case management as a concept applies to a wide range of structures and services and conveys little of the actual content of practice. At its best, case management programs serve as a fixed point of responsibility and authority to manage patients and assure that they get the services they need in all aspects of their lives, available twenty-four hours a day. Such programs also serve as gateways to inpatient care, linking and coordinating treatment between the community and the hospital. New York State's Intensive Case Management Program, which is directed to seriously mentally ill, high users of services, assigns a small caseload (of about ten patients) to each professional case manager (usually a master's-level social worker or nurse). The case manager receives resources for each patient to purchase necessary services beyond those already available.

Case management is now a common feature of community care for the seriously mentally ill population, but it is typically isolated from a coherent financial and organizational structure that ensures broad coverage of the population in need, continuity, and comprehensiveness. Localities have been experimenting with strategies to better accomplish these goals, including developing stronger local mental health organizations that have fiscal authority and professional accountability for public patients. Other increasingly popular initiatives include capitation experiments, new managed care arrangements, and reimbursement incentives that better target high-priority patients and link them with needed inpatient and outpatient services. The evidence remains uncertain on the effectiveness of these initiatives, but mental health officials do not have the luxury of waiting until all of the necessary evidence is available. Moreover, requirements to respond to changing need in the absence of well-tested and researched strategies make imperative the use of multifaceted strategies that can be modified based upon experience and emerging data on the effectiveness of policy initiatives.

**General hospitals.** As states have reduced the number of long-stay patients in public institutions and established stringent criteria for admission, many states have come to depend increasingly on the community general hospital for acute inpatient psychiatric care not only for the average patient but also for those more chronic and impaired. This
results in a complex and more difficult hospital case-mix and perhaps even requires new strategies for how the general hospital should carry out its psychiatric inpatient responsibilities. As state mental health authorities cede responsibility for emergency response and involuntary hospitalization to general hospitals, some states also have provided backup assistance, including the development of appropriate housing for placing difficult or homeless patients and incentives for outpatient providers to cooperate in linkage and continuity of care.\(^8\)

**State roles.** States, of course, perform many functions in the care of psychiatric patients. In respect to patients, states often are the insurer (for example, through the Medicaid program) or provider of last resort (through custodial public institutions). In dealing with institutions and professionals, a variety of state government agencies function as payers and regulators. They establish the conditions of reimbursement, define eligible recipients and providers, and set licensing standards. The state mental health agency intersects repeatedly with other state agencies, including the health department, social services, housing, vocational rehabilitation, and corrections. At the local level they may work with school systems, county boards, and a range of professional and consumer groups. States frequently negotiate the location of community facilities, which may involve acrimonious relations with neighborhood leaders and politicians. They contract with a wide range of nonprofit agencies, setting standards, setting rates, and monitoring the provision of care. The shift to a decentralized system of care for the treatment of persons with severe mental illness has dramatically changed the role and responsibilities of the state mental health director.

There are many models for managing these responsibilities but no clear guidelines, and administrative fads are common. Some states have become enthusiastic about competition and performance-contracting models, only to find that there are often few responsible competitors, and the instability introduced by these systems may create confusion regarding the roles and functions of existing systems. Moreover, what first appears to be a situation of choice becomes one in which the state becomes dependent on, even captive of, a limited number of providers.\(^9\) Alternatively, if the state distributes contracts to too many providers, this can contribute to the fragmentation of service delivery and create difficulty in ensuring an adequate level of service. The idea of local responsibility and authority seems appealing and sometimes results in outstanding performance, but local bodies are sometimes so politicized (or lacking in capacity) that local responsibility becomes a displacement of state accountability. Thus, an effective SMHA must be able to exercise flexibility and have the capacity to monitor local events. It must
have mechanisms to anticipate local response without imposing regula-
tion that stifles initiative and innovation. Here the importance of good
data becomes especially applicable.

The Role Of Medicaid And Other National Programs

By the 1980s the federal mental health block grants comprised only 2
percent of total SMHA-controlled revenues, on average. Instead, per-
sons with mental illness received far more support through services
funded with state general fund dollars and indirectly by general health
and welfare programs. NIMH reported, for example, that in 1988 eight
types of mental health organizations (including state mental hospitals,
private psychiatric hospitals, specialized psychiatric units in nonfederal
general hospitals, Department of Veterans’ Affairs [VA] mental health
services, residential treatment centers for emotionally disturbed chil-
dren, free-standing psychiatric partial care organizations and psychiatric
clinics, and multiservice mental health organizations) received more
than $23 billion from all sources. Medicaid and Medicare contributed an
estimated one-fifth of these funds. Analyses of Medicaid data from
selected states also suggest that national Medicaid expenditures for
mental health services may be seriously underestimated. Similarly, the
Supplemental Security Income (SSI) and Social Security Disability
Insurance (SSDI) programs have been major sources of subsistence for
patients residing in the community, as were a variety of other federal
programs such as food stamps. As Chris Koyanagi and Howard Goldman
have noted, considerable progress was made quietly during the 1980s to
restructure Medicare, Medicaid, SSI, and SSDI to better serve persons
with serious mental illness.

States responded differently to the opportunities available through
changes in federal programs. Four states (California, New York, Michi-
gan, and Pennsylvania) accounted for 45 percent of national Medicaid
mental health expenditures in 1988 (under Medicaid, states could
strategize to maximize federal contributions). These same four states
only accounted for 32 percent of Medicare mental health expenditures
(unlike Medicaid, Medicare offered no flexibility in designing a benefit
package). New York State alone accounted for almost one-fifth of all
Medicaid mental health expenditures in 1988, as compared with only 12
percent of such expenditures under Medicare. Since 1989 New York also
has implemented two new outpatient mental health services under
Medicaid: case management and rehabilitation. Medicaid now supports
about 25 percent of specialized psychiatric beds in 122 New York State
general hospitals, all care for children in sixteen residential treatment
centers, and care in a variety of other public and private institutions in the state. Some states now cover all community services under Medicaid, and opportunities exist for many states to build community programs by reallocating state hospital dollars for the required state match under Medicaid.

A key challenge facing states is to take the opportunity that Medicaid and other sources of funds provide to build viable and diversified systems of community mental health services. As of 1988 almost three-quarters of Medicaid funds to the eight mental health organizations studied by NIMH went to hospital psychiatric services. Similarly, 70 percent of state mental health agency funds, excluding Medicaid, went to inpatient institutions. Two-thirds of funds from all sources supported institutional care, a proportion considerably higher than in the general health care arena. Growth in expenditures for private psychiatric hospital care has been particularly large, increasing by 75 percent between 1986 and 1988. In contrast, expenditures for organizations providing outpatient care increased by approximately 25 percent, amounting to an increase of less than 10 percent in constant 1986 dollars. A major gap persists between the rhetoric of community care and the realities.

Growing need and the federally mandated Medicaid expansions have strained state budgets. State Medicaid expenditures alone grew by 18.4 percent between 1989 and 1990, and such expenditures on average exceed 14 percent of total state expenditures. Now the second-largest budget item in many state budgets, Medicaid is an area carefully scrutinized when budget reductions are needed. Significant changes in Medicaid have improved opportunities for serving individuals with a serious mental illness, including the introduction of a case management option, improved use of the rehabilitation option, and coverage of reimbursement of mental health clinics under the Medicaid clinic option. Many states have recently met matching Medicaid requirements by assessing special taxes on health providers and by accepting voluntary donations from hospitals. However, new limits imposed on such matches will make it more difficult for states to raise the necessary funds to attract federal dollars.

The remainder of this paper focuses on strategies available to state mental health agencies for reconstituting the provision of services, particularly for public patients. Most states have yet to develop the diversity of services and supports necessary for appropriate community care for patients who are seriously ill and disabled. The complexity of needs of such patients requires multifaceted, integrative strategies that address the heterogeneity of patients and the range of their needs for psychiatric care, rehabilitation, housing, and support.
The Organization Of SMHAs And The Political Process

One organizational issue concerns the location of the state department of mental health itself and its capacity to implement decisions directly on various aspects of service need. In many states the SMHA is a division within a larger umbrella human services agency, and the director (commissioner) can only gain access to key decision points through the parent department. In numerous instances directors are outside the chain of decision making on issues of vital interest to their public charges, such as licensing of service providers and rate setting for Medicaid. Mental health is rarely an area that brings great and impressive victories of the type that excite the public and reflect positively on political leaders. It is an arena that carries risk of scandal and embarrassment when one or a small number of highly publicized incidents involving a person with mental illness or a mental health facility can create a reactionary climate that negatively influences public policy.

Politicians are pragmatists, and large commitments to mental health care are unlikely to bring much political currency in the short run. Media attention focused on such problems as the homeless mentally ill may capture politicians’ interest, but it is difficult to sustain their attention. Developing coherent and effective mental health public systems is a long-term agenda, one to which politicians have generally not given extensive attention. Instead, mental health leaders, officials, and advocates have had to seek opportunities within the political process and develop integrated strategies that fit the state context and political structure. Because states vary so widely, only a general description of such strategies can be provided.

As we have suggested, formal governmental structure is important, providing differential access to the chain of decision making and opportunities to associate with and influence other important decisionmakers who control domains of importance to mental health, including Medicaid reimbursement, facility regulations, housing, social services, and income maintenance. Other factors equal, access to governors, their cabinets and staff, and important legislative leaders would be preferable for senior mental health officials. Currently, SMHA directors have varying levels of control over their priorities and departmental budgets. Access is even more variable in areas such as the relationship with the state budget office; capacity to shift dollars among budget categories; authority to deal directly with key legislative leaders; control over contracts and vendors; and even authority to hire and dismiss their own staff. While interested legislators and advocates might carefully consider need for reforms in state organizational structures over the long run,
SMHA directors must work with structures as they exist in their states. Budget making, contracting, and labor agreements all occur in the context of general state policy, and accommodation to a single state agency is seldom accorded.\(^{18}\)

In any organizational system, of course, informal links can often substitute for formal access depending on the leadership qualities and personal characteristics of officials. As people spend more time in a governmental structure, they find opportunities to get to know people, to build alliances, to trade favors, and to gain access to individuals important to their programs.\(^{19}\) Time in office permits this natural process in organizations to develop, but most mental health directors have such short tenures that these opportunities must be consciously cultivated. In addition to being a team player in one’s own institutional structure, there are at least three general approaches for doing this: cultivating important opinionmakers through mutual accommodation; working effectively with the media and related educational efforts; and building effective coalitions within government and with advocacy groups.

**Approaches To Building A Constituency**

**Personal involvement.** Mental illness, despite its high prevalence, remains a frightening and stigmatizing problem. It can also pose special problems for persons in high public positions and their families, who frequently feel at a loss in knowing how to deal with such situations when they occur. Some mental health officials make clear their accessibility in such situations, to serve as an ombudsman in ensuring that key people and their families are confidentially linked with appropriate services, and, in general, to be supportive and helpful. These small human gestures, worthwhile on their own terms, can yield enormous policy benefits. Most public officials outside the mental health sector know little about mental illness and are often uncertain in relating to this area. Demonstrating a sensitive and effective response at the personal level can elicit future interest and involvement. If one delves a bit into the background of public officials who are vigorously supportive of mental health concerns, one often finds some connection with a loved one or close friend who has a mental illness. Increasingly, some high officials have come out publicly, defining themselves as “secondary consumers.” Encouraging and supporting this process is helpful in destigmatizing mental illness and building a forceful constituency. Unfortunately, much of the public has a stereotyped view of mental illness that is unduly influenced by highly publicized atrocity stories in the media, by fictional presentations on television and in the movies, and by confront-
ing homeless persons who have a mental illness.

The press. The press is often an important key to building a policy agenda, and mental health officials whenever possible build alignments with the press within the political constraints operative in their situations. Some newspapers—for example, The New York Times, The Washington Post, and the Los Angeles Times—play a key role in framing policy questions and shaping public perceptions. Access to the press frequently poses some difficulties, since the most important newspapers are typically in large cities where mental health services problems are most difficult and where services frequently are considered inadequate. Newspapers often convey a more negative overall picture than the facts warrant and reinforce negative public stereotypes. Unlike in many other areas of public policy, it is essential for mental health leaders to work closely with the press to cultivate better understanding of the complexity of the issues, the magnitude of need, and the possibilities for developing well-functioning systems of community care.

Advocacy groups. The mental health advocacy community has grown in size and influence in recent years. Advocacy groups are themselves very diverse. They represent many different interests, are frequently fragmented, and are often in conflict. A major challenge is to support these competing groups in forming a unified agenda and realizing their political potential. There are, of course, legal and political limits and constraints on how a director can and should work with advocacy groups. It is important, however, for the state mental health agency to develop networks with advocacy groups that allow an effective flow of information and collaboration. Such efforts, linked with others, support the context for long-term initiatives and provide some of the necessary political and social bases for building a coherent mental health agenda. It is equally important to realize the dramatic difference in the role of a public official and the leadership of advocacy organizations. Each must accept his or her role, and a public official should expect to be criticized for policy positions even when mutual respect exists between government and organized advocacy.

Among the ways to develop constituencies is to convene interested advocacy groups for informational and networking purposes; involve these groups in the planning process and in the articulation of a coherent, long-term agenda; and provide contracts to selected groups for informational programs, self-help efforts, and development of consumer-run programs. Most states now have formal mechanisms for collective planning. What is frequently lacking, however, is a clear vision of the larger process involving varying governmental interests in developing an agenda for policy and system change over time. For example, the devel-
opment of federally mandated state plans, which many still view as a bureaucratic ritual, if managed well can be used to reform some of the static traditional structures that exist in many states, to realign priorities, and to build the coalitions required to develop new services across the spectrum of care.

State Information Systems, Research, And Development

An effective SMHA must have the capacity to anticipate impending issues ("intelligence"), to monitor ongoing operations, and to evaluate the cost-effectiveness of important programs and their consistency with unfolding priorities. To maintain momentum, innovation, and intellectual vitality, an SMHA must also have access or capacity to undertake research demonstrations and some generic research on high-priority and newly emerging issues.

Most states have access to vast amounts of data that are typically a by-product of program administration and reimbursement. The Mental Health Statistics Improvement Program (MHSIP), a voluntary collaboration between the federal government and states, has helped to sensitize state officials to the importance of common data elements, quality of information, and the need to link several kinds of data to answer operational questions. In addition, states have available vast amounts of data from hospital discharge abstracts (known as UB-82), Medicaid and Medicare information files, and required reports from institutions, programs, and grantees. The quality and reliability of these data vary greatly depending on the purposes for which they are collected and the incentives to report data accurately. In most states these data are difficult to obtain and extremely difficult to link.

The agencies controlling access to the data may be different from those requiring the data for program implementation. In New York, for example, the Medicaid data necessary to administer mental health programs are under control of the Department of Social Services and are not generally available for research. Jurisdictional, technical, and confidentiality issues often limit access and data linkage that could contribute to improved management. The barriers to data access also discourage state involvement of mental health services researchers who could bring new ideas, observations, and perspectives to the administration of public mental health services. There are, of course, important issues of confidentiality and deep concerns among thoughtful people about the implications of building comprehensive data banks. But such data are linked routinely in many other aspects of our commercial life and administration of business affairs, and it seems pointless to set standards for public
administration that far exceed those operative elsewhere in our society.

It is more arguable whether states should support generic research efforts, given their constrained resources. For most states it is unlikely that significant resources can be expected for generic research. Unfortunately, weak state participation in research reduces opportunities to invigorate state mental health administration and separates services research from the process of planning and delivering services and the fruitful results of such interplay. NIMH recently instituted a program of public/academic liaisons to build greater cooperation and research collaboration between service organizations and academic institutions. NIMH has also developed an ambitious national plan for research to improve services for persons with severe mental disorders, which speaks to many crucial state issues.\(^{21}\)

---

**The Need For New Approaches**

As we look toward the future, state administrators will be pressured to achieve more value for money and to establish priorities in a context of constrained, if not shrinking, resources. They must do this in an environment in which their budgets are rigidly managed, even further constrained by powerful interests and local political forces that have a stake in preserving vulnerable institutions and programs. As any SMHA director soon realizes, closing even the most redundant institution unleashes a political onslaught.

Yet control of the budget and the budget-making process is the way a department defines and clarifies its priorities. Too often, however, the budget is less under the control of administrators than of the budget process, which may be insensitive to how mental illness destroys individuals and families and creates a serious burden to communities. Moreover, the complexity of budget making for state mental health authorities is compounded by the interdependency of the discrete mental health budget with other state and federal budgets. Nevertheless, administrators need to give a high priority to the development of and advocacy for the state mental health budget, since budgets become the benchmark for implementing public policy.

Too frequently, financing drives the system, and astute administrators seek both to maximize revenue and to retain flexibility in its allocation. The history of mental health policy illustrates how changes in financing arrangements had dramatic effects on the shape of the mental health system and the flow of patients to different types of institutions in varying historical periods.\(^{22}\) A major shift again occurred in 1966 with the implementation of Medicaid and the opportunity available to the
states to substitute federal dollars for state expenditures by moving patients from state mental hospitals to nursing homes and, more recently, substituting inpatient psychiatric care in general hospitals for care in state institutions not eligible for reimbursement. A major challenge at the state level is to realign existing state funding to generate larger federal participation, a process disdainfully referred to as “cost shifting” but one that has been essential in maintaining the critical budgetary basis for mental health services for the disadvantaged.

The cost-shifting problem arises in part from a discriminatory relationship between federal policy making and the mental health arena. Medicaid, for example, does not reimburse state and county mental hospitals for psychiatric care of patients ages twenty-one to sixty-four, although comparable care provided in general and private hospitals is reimbursed. It is not difficult to appreciate the operating incentives that may inadvertently reshape the configuration of mental health services.

Given current knowledge of treatment options, the flow of Medicaid financing for psychiatric illness is irrational, encouraging disproportionate investment in inpatient care. Many patients shuttle back and forth between hospital and community, requiring the expenditure of vast resources but with little contribution to building a sound, balanced system of community care. It is imperative that we experiment with efforts to use Medicaid resources to develop systems of managed care that balance services more appropriately among varying treatment and rehabilitation modalities. This is a difficult task, given the complexity of Medicaid requirements and the magnitude of the clinical challenge. It seems clear, however, that we can use existing resources more effectively, and new approaches are gaining favor. Some states are now grappling with the question of how to develop managed care systems with proper protections for the well-being of seriously mentally ill patients. Demonstrations and innovations proceed in an uncertain economic and political environment, and it is essential to plan for the interim start-up period and to develop contingency strategies if new initiatives fail.

Capitation and other types of managed care systems involve complex matters of financing, organization, and accountability with difficult technical issues of setting appropriate rates, risk-sharing arrangements, and establishing the structure of corporate management. Considerable expertise is needed, and start-up time is typically underestimated. If federal waivers are required, negotiations and preparation of the materials necessary could be formidable. Thus, state directors must have an articulated long-term strategy with clear definition of interim phases. Moreover, as one moves from an institutionally based system to a
community-based program, some duplicate funding initially is needed to avoid chaos and to carry out an orderly transition. Older state hospitals are not closed overnight, and responsibilities to both patients and employees are not to be taken lightly. Training programs to facilitate reassignment of redundant personnel are needed, and such good-faith programs are likely to be a necessary condition for gaining cooperation of unions and others representing mental health personnel.

Given the enormous variation among states, the issue for each mental health agency is how to take advantage of the unique opportunities within its own political environment. Such considerations as centralization or decentralization, opportunities to develop and lease properties belonging to the mental health authority, and the expansiveness of the role of the mental health agency relative to other agencies of government and the private sector are all highly contingent on local conditions, legal and political organization of state government, and the current economic environment of the state. Whatever formal authority the office of mental health may or may not have, there is need to nurture a conception of mental health services beyond the elements the mental health agency is likely to control. There is a responsibility for planning carefully how one brokers the needed cooperation at the intergovernmental and agency levels. The SMHA director must become akin to a case manager at the political and administrative levels, inducing agencies to see their responsibilities in assuring appropriate treatment, management, subsistence, and rehabilitation of the seriously mentally ill.

In some states the structural weaknesses of the mental health agency may require statutory reforms to clarify relationships between mental health and other social service agencies and between state and local responsibility and authority. Such restructuring is at best a contentious and difficult task and will require strong support from influential advocacy groups and important legislative committees. Many state agencies are constrained by bureaucratic procedures and salary limitations that make it almost impossible to recruit and retain professionals with capabilities characteristic of the private sector. Innovative solutions are needed in contracting with nonprofit and sometimes private agencies to recruit appropriate professionals, reduce bureaucratic barriers, and ably staff and manage facilities. Although there has been acrimony, over the long haul the affiliation contracts between New York medical schools and New York City’s municipal hospitals have contributed a great deal to improving the quality of services available to public-sector patients. New Hampshire now contracts with the Dartmouth Medical School to manage and run its state mental hospital, and some states have developed close relationships between the medical schools’ departments of
psychiatry and the public mental health sector. The University of Maryland’s Department of Psychiatry, for example, has a long history of working with the state mental hygiene administration to recruit well-trained psychiatrists to state service and to administer well-supervised residency training programs in the state’s public mental hospitals.

It is apparent that the challenge for leadership in public mental health services is a complex and difficult one. Administrators of mental health authorities have to maintain a delicate balance between the needs of patients and the dedicated workers who provide services, political and economic considerations, and a varied range of interest groups. They must develop the necessary formal and informal networks to get the needed tasks accomplished, build an agenda and a constituency to support it, and sufficiently institutionalize change so that new structures do not collapse with turnover of key departmental personnel. Anyone observing the process becomes rapidly aware of the ingenuity and dexterity of state directors who, if they are fortunate enough to avoid the unpredictable and often unavoidable scandal, attempt to establish an agenda, organize resources, and assert leadership in an environment of great complexity and uncertainty.

**Health Care Reform: Challenges And Opportunities**

The growth of the uninsured population, rising health care costs, and difficulties in the insurance market make it inevitable that major health care system reform will occur within the next decade, if not before. Major changes are likely at both federal and state levels that will have significant implications for care for persons with mental illness. The substance of the impending changes is highly uncertain, however, and much depends on how the political situation unfolds. Mental health directors will be wise to follow these developments carefully and do what they can to ensure that reforms are sensitive to the planned configuration of mental health services in their states and the special needs of persons with serious and persistent mental illness.

Health care reform involves both risks and opportunities for the mental health arena depending on the approach taken. National or state health insurance programs are primarily financing approaches and do not necessarily address the issues of greatest concern to the mental health sector. The Bush administration’s proposals for a mandated basic minimum health insurance policy, for example, is linked with an override of existing state mandates and could result in even less coverage for the mentally ill than is currently available in many states. Similarly, national health insurance in other countries such as Canada tends to
freeze existing patterns of service and a medical orientation to psychiatric disability, and has not resulted in particularly good care for persons with severe and persistent mental illness.  

Most health insurance coverage for mental health services is narrowly conceived, based on a medical model. Such an approach fails to provide for many important needs of persons with severe and persistent mental illness, such as case management services, psychosocial rehabilitation, partial care, clubhouse arrangements such as Fountain House, and the like. In recent years available options under Medicaid have allowed an expanded range of services and reimbursable providers that contribute to developing some of the needed community mental health services. As health care reform proceeds, it is essential that new initiatives have the scope and flexibility required for appropriate care of patients with chronic disease. In major health care reform, the future of Medicaid may also become an issue. Should a more global approach encompass Medicaid, it will be essential to retain expanded concepts of services such as case management that have been achieved in the past decade.

There is considerable anxiety among policymakers and insurers about growth in demand if mental health services are made more available. Outpatient use of mental health services is more sensitive to price than is use of general medical services. One approach to rationing is to limit entitlements by diagnosis, but this alternative has serious liabilities. First, diagnosis itself is an extremely poor measure of need or resource use because it fails to capture severity, risk, disruption, or other major aspects of the patient's condition. Second, studies indicate that many patients have significant disability that impoverishes their lives but do not meet a diagnostic threshold. Focusing on diagnosis rather than disability would leave many serious needs unmet. Alternative rationing approaches include developing systems of managed care as in prepaid group practice or tying the level of cost sharing required to the type of service being provided. For example, it is difficult to imagine many people seeking case management services when they are not needed, and significant cost sharing in this case is both a disincentive to needed care and unnecessary as a rationing device. In contrast, psychotherapy is highly sensitive to price and probably requires more controls.

It is unlikely that any health care reform will cover all of the needs of the mentally ill. Thus, states and the directors of state mental health agencies must coordinate state services within the broader framework of health care entitlements. As we have argued here, the states are quite varied and must develop strategies within their own political and economic contexts. Each state Medicaid program differs in its response to various options and opportunities. Planning is necessary to link new
insurance entitlements with Medicaid and to coordinate health services with provision of disability entitlements, housing, vocational rehabilitation, and other specialized services.

It is clear that the next decade will be challenging for state mental health agencies but also will likely offer some new opportunities. With careful anticipation and planning, appropriate data systems, and an effective constituency, states could be well positioned to take a major step forward in mental health services organization within the context of more general reform of our health care arena.

The authors thank Noel Mazade, Howard Goldman, and David Shem for their useful suggestions. This research was supported in part by Grant no. MH43450 from the National Institute of Mental Health (NIMH).

NOTES


Hospital and Community Psychiatry 37 (1986): 875–878.
10. T. Lutterman and M.F. Hogan, Funding Sources and Expenditures of State Mental Health 
Agencies: Revenue/Expenditure Study Results, Fiscal Year 1987 (Alexandria, Va.: National 
Association of State Mental Health Program Directors Research Institute, April 1990).
12. G. Wright and J. Buck, “Medicaid Support of Alcohol, Drug Abuse, and Mental Health 
13. C. Koyanagi and H.H. Goldman, “The Quiet Success of the National Plan for the 
14. Sunshine et al., “Expenditures and Sources of Funds for Mental Health Organizations,” 
calculated from Table 8.
15. A.K. Blanch and J. Shepardson, “Integrating Mental Health Policy, Financing, and 
Program Development: The New York State Experience,” Administration and Policy in 
17. D. Mechanic, “Strategies for Integrating Public Mental Health Services,” Hospital and 
18. A.P. Schinnar, A.B. Rothbard, and D. Yin, “Public Choice and Organizational 
Determinants of State Mental Health Expenditure Patterns,” Administration and Policy in 
20. N.A. Mazade, C. Wurster, and T. Lutterman, guest editors, Special Issue on Utilizing 
Data for Policy and Decision Making, Administration and Policy in Mental Health (March 
21. National Institute of Mental Health, Caring for People with Severe Mental Disorders: A 
22. Grob, From Asylum to Community.
23. Mechanic and Aiken, Paying for Services.
24. L.L. Bachrach and C.C. Beels, eds., Survival Strategies in Public Psychiatry, New Direc-
tions for Mental Health Services Monograph 42 (San Francisco: Jossey-Bass, 1989).
25. D. Mechanic, “Considerations in the Design of Mental Health Benefits under National 
and Policy Issues” (Paper presented at the Twentieth Anniversary Conference of the 
Association for Canadian Studies in the United States, Boston, Massachusetts, 1991).
27. E.B. Keeler, K.B. Wells, and W.G. Manning, The Demand for Episodes of Mental Health 
Services, RAND Report no. R-3432-NIMH (Santa Monica, Calif.: The RAND Cor-
poration, October 1986).
28. C.A. Taube, E.S. Lee, and R. Forthofer, “DRGs in Psychiatry: An Empirical Evalu-
29. K.B. Wells et al., “The Functioning and Well-Being of Depressed Patients: Results from 
the Medical Outcome Study,” Journal of the American Medical Association 262 (1983): 
914–919; and J. Johnson, M.M. Weissman, and G.L. Klerman, “Service Utilization and 
Social Morbidity Associated with Depressive Symptoms in the Community,” Journal 