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MENTAL HEALTH AND SOCIAL POLICY: INITIATIVES FOR THE 1980s

by David Mechanic

Prologue: At a time when health care resources are tight and the competing claims for their use are intensifying, mental health policy issues constitute a serious challenge to society. In this paper, David Mechanic, university professor and former dean of the Faculty of Arts and Sciences at Rutgers University, describes the changing nature of the mental health delivery system and asks what can be done to improve it. Mechanic is a wide-ranging medical sociologist who has focused his penetrating but practical eye on health policy issues for two decades. An active member of the National Academy of Sciences’s Institute of Medicine, Mechanic has authored two previous essays in Health Affairs on “Disease, Mortality, and the Promotion of Health” and “The Transformation of Health Providers.” In this paper, Mechanic points out that the provision of mental health services has been complicated by the fragmentation of funding, the unintended but perverse effects of health legislation and regulations primarily developed with other disabled populations in mind, and cost-shifting among varying Levels of government. Exacerbating the process is the absence of a clearly defined forum for bringing coherence to the wide array of facilities and funding streams that impact the welfare of chronic patients. While residence patterns for the chronically ill mental patient have shifted dramatically, most state funding continues to be concentrated in public mental hospitals that serve only a minority of this disadvantaged population. Part of the problem is an underfinancing of care for the chronic mentally ill, but significant resistance to closing obsolete institutions and moving funds to community care comes, according to Mechanic, from employees, unions, and communities for whom mental hospitals provide an important economic base.
Mental disorders are a major source of suffering and disability, cause havoc in families and the community, and account for a large load on medical care institutions, social agencies, and sheltered facilities. In 1980, mental illness was the third most expensive class of disorders accounting for more than 20 billion dollars of health care expenditures. Only the circulatory disorders including heart disease, stroke and hypertension, and all disorders of the digestive system, were more costly in the aggregate. Moreover, much of medical care utilization associated with mental disorder is not included in the above calculations since many of these problems are expressed somatically or are associated with disorders classified under a variety of other diagnostic entities.

Problems of depression, phobias, and substance abuse are most common. However, the image of mental illness in the public mind is shaped most substantially by the highly visible chronically mentally ill who suffer from significant impairments, compose a large part of the homeless, and are often upsetting or even frightening to the public who encounter them. While the population of chronically mentally ill is estimated to be no more than 1 percent of the total population, these persons constitute an enormous burden on the community and a serious challenge to social policy.

A variety of forces dramatically reshaped the mental health services system and the location of care in the past thirty years. These included the growing burden on state mental health budgets of institutionalizing the chronically mentally ill; the widespread use of psychotropic drugs that alleviated some of the most troublesome symptoms of schizophrenic patients; the professional attack on the large public mental hospital and its role in the development of secondary disabilities associated with institutional tenure; and a vigorous civil liberties movement on behalf of the rights of the mentally ill. These influences encouraged the release of many long-term patients from public mental hospitals and shorter periods of stay for newly admitted patients. But most chronic mental patients are highly disabled and unable to support themselves. The introduction of Medicare and Medicaid in 1966 and the growth of Social Security Disability Insurance and Supplemental Security Income allowed the retention of patients in community settings or alternative institutions such as nursing homes that expanded rapidly with federal support.

The major thrust in deinstitutionalization did not occur until the mid-1960s when these welfare programs were first initiated or expanded. From 1955 to 1965, inpatient populations of the mentally ill showed an average annual decrease of 1.5 percent. Between 1965 and 1980 the average was more than 6 percent per year. Federal programs allowed states to shift part of their mounting financial burden for chronic care to the federal government by moving patients from state institutions. The num-

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ber of mental patients in, public hospitals was reduced from a peak of 560,000 in 1955 to approximately 125,000 at present. But three-quarters of a million elderly and other chronic patients, having either a primary or secondary mental illness diagnosis, are now housed in nursing homes. It is widely appreciated that many demented elderly patients reside in nursing homes, but the significant number of younger impaired mental patients in these institutions are relatively invisible. It remains unclear whether the typical care of younger chronic patients in nursing homes even approximates the quality of care, admittedly poor, typical of many of the large state and county mental hospitals prior to deinstitutionalization. Patients in nursing homes are commonly overmedicated to ease management and spend much of their time doing nothing. It has been repeatedly demonstrated, however, that inactivity is extraordinarily harmful, typically resulting in additional disabilities and poor functioning.

The numbers of patients residing in mental hospitals and total hospital days for psychiatric care have significantly declined in the United States from 168 million days in 1969 to 95 million days in 1978. However, the number of admissions to psychiatric beds has substantially increased, with a large growth of admissions in the general hospital sector. Inpatient days for psychiatric care in general hospitals approximately doubled between 1969 and 1978, increasing from approximately 1 percent of total psychiatric days in 1969 to one-fifth of the total in 1978.

The aggregate data on hospital days combine two very different populations, the insured and the noninsured. Those having insurance commonly receive their care in general hospitals and, increasingly, in private psychiatric beds, the fastest growing component of inpatient psychiatric care. Average length-of-stay is relatively brief and costs are comparable to other medical sectors. Patients without insurance, or those who have exhausted coverage, are invariably referred to public institutions that retain only the most seriously impaired. Other chronics are returned to community settings as soon as feasible, often without necessary services or adequate followup. Many of these patients suffer from repeated exacerbations of their disorders, have multiple rehospitalizations, and com-
monly shuttle between the public mental health system and the correctional system. They may live with family members, in supervised settings or in private housing, or alternate among these alternatives depending on availability, their clinical status, and their success in maintaining relationships with others. Many refuse psychiatric care and cannot be hospitalized as a consequence of stricter criteria for civil commitment that now prevail. Increasing numbers of chronics appear to be homeless, although reliable information is difficult to obtain.

The above oversimplifies trends given our decentralized system, variations among community health services systems, the varying diagnoses and personal histories of patients, and economic conditions and medical and social welfare entitlements that differ from one community to another. Patterns of care also depend on the culture of ethnic enclaves in which the mentally ill are embedded, patients’ definitions of the nature of mental illness and the psychiatric system, and community tolerance and understanding. Professionals in touch with young chronics report that a growing number of these patients are aggressive, have antipsychiatric ideologies, and are demanding and uncooperative. Whether there is a significant change in the composition of the younger chronic group as compared with earlier cohorts, or whether a subgroup of particularly difficult patients in community settings influence the perception of such patients overall remains unclear. Whatever the case, and it may differ significantly in large urban areas, the fact remains that many chronic mental patients pose formidable problems of care, rehabilitation, and social control that require vigorous and effectively coordinated programs that have medical, psychosocial, and educational dimensions. Such programs exist as isolated models but have not been adopted widely.

Much of the difficulty is in the intractable nature of schizophrenia and the vigorous and sustained efforts necessary for relatively modest achievements with these patients. But providing appropriate services has been very much complicated by the fragmentation of funding, the unintended but perverse effects of health legislation and regulations primarily developed with other disabled populations in mind, and cost-shifting among varying levels of government. Despite the enormity of mental health policy issues, there is no clearly defined arena or forum for bringing coherence to the wide array of facilities and funding streams that impact the welfare of chronic patients.

As compared with other disease-oriented interest groups, the mentally ill, and particularly chronic patients, are significantly disadvantaged in the political processes affecting the composition of health budgets and other programs relevant to the sustained research, demonstration, and practice efforts necessary. These difficulties include: (1) The mentally ill, particularly those suffering from psychiatric and other chronic and severe disorders, lack the skills, capacities, and social standing to effectively rep-
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resent their own interests in the public arena. (2) Mental illness retains considerable social stigma in comparison to other disease categories deterring influential former patients, patients, and families from engaging in “personal public advocacy.” (3) There is much fragmentation and lack of cooperation among voluntary groups representing subsets of the mentally ill in the public arena due in part to contrasting philosophies and varying definitions of the problem. Thus, advocates of the mentally ill, alcoholics, substance abusers, and the developmentally disabled almost never form a united front. (4) Both public and private insurance treat mental illness benefits differently from other disorders in terms of coverage, maximum benefits, coinsurance, and deductibles. This reflects historic conceptions of the special nature of mental illness and apprehension about costs. Such practices reinforce existing prejudices. (5) The subspecialty of psychiatry and other mental health professions do not stand high among influentials in the health arena. (6) Mentally ill patients are commonly blamed for their plight and the diagnosis of mental illness often results in attributions that challenge the capacity of the mentally ill to function reliably or make sound judgments in areas unrelated to their illnesses. (7) Much of the financial support for the treatment and rehabilitation of the mentally ill is embedded in medical insurance and federal entitlement programs conceptualized and organized in terms of illnesses and disabilities of a nonpsychiatric kind. Administrative procedures and decisions are often prejudicial or detrimental to persons with chronic psychiatric conditions. (8) Policymakers and administrators responsible for major programs affecting the mentally ill, such as Medicare and Medicaid, are often inadequately informed about the special character of mental illness and the unique needs of these patients.

Needed Initiatives

Residence patterns for the chronic patient have shifted dramatically, but most state funding continues to be concentrated in public mental hospitals that serve only a minority of this disadvantaged population. There is little doubt that the reduction of hospital patient populations has facilitated more and better inpatient care for those who remain,
transforming many custodial institutions into active treatment settings. But there remains a significant imbalance between expenditures for inpatients and many patients who in earlier periods would have been confined to public institutions and who clearly need assistance despite their outpatient status. While part of the problem is surely the underfinancing of care for the chronically mentally ill, significant resistance to closing redundant institutions and moving funds to community care comes from employees, unions, and communities for whom mental hospitals provide an important economic base.

There has been much merit in the conversion of custodial institutions to more active treatment contexts, and no one seeks to lose these gains. There also is impressive evidence that most chronic mental patients, among whom schizophrenics constitute a majority, can do relatively well with appropriate care that monitors medical need and promotes social functioning in the community at a cost comparable to or less than prevalent patterns of care which lack coherent organization. Achievement of a more coordinated and effective pattern of care will require redirection of reimbursement patterns so as to allow appropriate choices and tradeoffs between traditional medical and hospital services and more broad sociomedical services in community contexts. Given the realities of funding constraints it becomes even more essential to make cost-effective decisions on behalf of the chronic population.

**Experimental and other innovative demonstrations.** Planning for care of the chronically mentally ill has not suffered for lack of innovative programmatic ideas. Careful experimental evaluation has been less common, and little effort has been made to facilitate transferring successful programs or their components from one context to another given the complexity of organizational arrangements, financing, and professionals’ definitions of their appropriate roles.

An early community care experiment in California by Fairweather and his colleagues established a community group living situation for chronic post-hospital patients that included the organization of a janitorial service. As compared with traditional hospital care, patients in the program had greater work productivity and less psychosocial maladjustment. And even during periods of maximum supervision, the experimental program was less expensive than customary services. The experiment was a success, but the program was not widely adopted. As Fairweather saw it: “The reason clearly was that to accept it demanded rather extensive social role and status changes among professional people. They had to become problem solvers and had in fact, in the final analysis, to become consultants rather than supervisors and, indirectly, to phase themselves out of the patients’ society in order to give first-class citizenship to ex-mental patients. It was this role that was so difficult for professionals to accept.”

Other innovative community service programs have been developed
in which hospitalization is avoided and problems are dealt with through home visits and systems intervention. During periods of crisis, or when no adequate permanent home is available, patients are placed in carefully selected “foster families” supported by clinical supervision, instruction of caretakers, and clinical home visits. Families taking such patients receive a daily payment for room, board, and client care. Other programs train and use community members to assist chronic patients in daily life activities. Some communities have established patient apartment complexes, clubs and recreation centers, and a variety of sheltered work situations for the chronically disabled.

One important experiment in Wisconsin involved a training program in community living for chronic patients. This study compared an educational coping model with a progressive hospital care unit. An unselected group of patients referred for admission to a mental hospital was randomly assigned to experimental and control groups. The control group received good hospital treatment, linked with a progressive program of community after-care services. The experimental group was assisted in developing an independent living situation in the community, given social support, and taught simple living skills such as budgeting, job seeking, and use of public transportation. Patients in both groups were evaluated at various intervals by independent researchers. The findings showed that it was possible for highly impaired patients to be cared for almost exclusively in the community. Compared with control patients, patients in the experimental group made a more adequate community adjustment as measured by higher earnings from work, involvement in more social activities, more contact with friends, and more satisfaction with their life situation. Experimental patients at follow-up had fewer symptoms than the controls. This experiment illustrated that a logically organized and aggressive community program can effectively manage even highly impaired patients in the community, with minimal use of hospitals.

Such successful community programs are not without costs. A careful economic cost-benefit analysis of the above experiment, taking into account a wide range of hidden, as well as explicit costs, such as welfare payments and supervised residency costs, suggests that while such programs yield net benefit, they are not necessarily less expensive in economic terms than more conventional approaches. Moreover, there are social costs in maintaining patients in the community, as compared with hospital care during the more acute phases of disorder, as measured by law violations and assaultive behavior. The prevalence of such behavior was low, but not inconsequential. We still need careful study of the best mix of community care and short-term and prudent use of hospital facilities. Gudeman and Shore, on the basis of their experiences at the Massachusetts Mental Health Center, estimate that 6 percent of their chronic population, such as assaultive and highly disruptive patients, would be better served in
specialized facilities than in the community. Projected to the population of Massachusetts, this would require 861 psychiatric beds. While proponents and opponents of mental hospital care may argue about appropriate criteria, it seems apparent that some small component of the chronic population would be better cared for in an appropriate but humane institution.

The visibility of the homeless in large cities, many of whom are chronic mental patients, focuses disproportionate attention on a group that apparently has no or very limited family supports. In contrast, many chronic mental patients continue to live in family settings or relate to relatives actively involved with their welfare. Much is gained by supporting natural groups when they are available and assisting them to cope with the problems and burdens of caring for a seriously impaired relative. Fortunately, there have been some exciting developments in understanding better how to assist family members to cope successfully with a schizophrenic patient.

As early as 1962, Brown and his associates in London reported that schizophrenic patients with relatives who showed high expressed emotion in a family interview deteriorated more frequently than patients living in a low emotional involvement environment. This observation was replicated in a variety of research settings in various countries. Emotional involvement in the case of schizophrenic patients largely denotes excessive involvement, negative emotions, and criticisms. While the effects on the patients’ symptoms are attenuated to a considerable degree when patients are maintained on psychotropic medications, emotional involvement affects medicated patients as well. It seems that schizophrenics cannot tolerate high levels of stress, and that psychotropic drugs in part blunt the effects of stress. Patients who have less face-to-face contact with over-involved relatives are also less likely to relapse. Negative emotions of relatives is also related to family tolerance and expectations, which in turn relates to the patient’s retention outside the hospital.

In a recent controlled social intervention trial in London, schizophrenic patients having intense contact with relatives demonstrating high expressed emotion were randomly assigned to either routine outpatient care or an intervention program for patients and their families emphasizing education about schizophrenia and the role of expressed emotion. The intervention also included family sessions in the home and relatives’ groups. All patients were maintained on psychotropic drugs. After nine months, half of the twenty-four control patients relapsed but only 9 percent in the experimental group. There were no relapses in the 73 percent of the experimental families where the aims of the intervention were achieved.

A similar experimental trial was carried out in California where family members of schizophrenics were taught about the condition, were instructed in problem-solving techniques, and efforts were made to reduce family
Follow-up at nine months found that patients in families receiving such interventions had a much lower rate of exacerbations than those in a control group receiving clinic-based individual supportive care. Only one patient in the intervention group (6 percent) was judged to have a relapse, in contrast to eight (44 percent) in the control group.

**Long-Term Impacts**

A discouraging aspect of care for chronic patients is that even the successful programs require continuing efforts over many years. Long-term studies of programs for chronic patients, whether in the hospital or the community, indicate that improvements in patient functioning and performance require persistence and continuity. Wing and Brown, in a study of three British mental hospitals in the period 1960 to 1968, found that with changes in these hospitals, patients benefitted in the early years, but over time some of the progress was lost. These data reflect how difficult it is to maintain progress with chronically impaired patients over long periods of time. Comparable findings characterize community care. The progress achieved by the community care program described by Stein and Test was lost once the program ended and patients returned to traditional care. A five-year follow-up of the patients studied by Pasamanick and associates also found deterioration of patient functioning following the termination of the experiment.

These studies suggest, comparable to other studies involving interventions to change health behaviors, that while short-term improvements can be achieved, long-term progress is a more formidable goal for both patients and those responsible for their care. It is not clear to what extent initial progress is in part assisted by the hope, enthusiasm, and novelty associated with innovative efforts or new programs. The results suggest, however, the importance of renewing periodically the energies, interest, and commitment of the treatment staff. In many instances, failure results primarily from the loss of stable funding. Once we make the commitment to the need for longitudinal responsibility for chronic patients, identifying means to maintain efforts over time and insure stable funding are continuing challenges.

**Appropriate mix of health personnel.** Psychiatry is one of the few medical specialties anticipated to be in relatively short supply in the future. In recent years we have seen less interest in psychiatry among medical students and residents, and those choosing psychiatric careers are more oriented to biological psychiatry than to community care or rehabilitation. Few psychiatrists seem enthusiastic about working with the chronically mentally ill. Sophisticated drug management is essential for appropriate care of most psychiatric illness and to avoid the dangers of serious side-effects associated with psychotropic drugs, but psychiatrists might more
realistically function in this area as consultants to practitioners organizing chronic care than as primary caretakers. There clearly seems to be an appropriate role for a new nursing specialty, the psychiatric nurse practitioner.

Psychiatric nurse practitioners can be an invaluable resource in staffing a variety of institutional facilities, outpatient services, and community care programs for the mentally ill. While psychologists and social workers also have essential roles to play, the appropriately trained nurse practitioner is potentially in a strategic position. They bring to this role a long tradition in socioemotional and supportive aspects of care and some familiarity with medication monitoring and pharmacological issues. Also, nurses are increasingly conversant with behavior modification techniques and supportive group therapies. The close association between nursing and medicine insures credibility with physicians and patients in the area of medication administration and monitoring, and psychiatric nurse practitioners can also serve as effective “boundary practitioners” for many patients who resist treatment within the psychiatric sector but more readily accept general medical and nursing assistance. A major problem even among chronic patients is their resistance to psychiatric conceptualizations of their distress and behavior. Nurses with enhanced mental health capabilities could play an important leadership role. Since nurse practitioners and nurse specialists have comparable roles in other areas of patient care, the necessary adjustments and role transitions would not be insurmountable.

In reality, nurses and other nonpsychiatric personnel have provided most of the available care for chronic patients. However, their formal training has not fully prepared them for the tasks they perform. The psychiatric nurse practitioner, for example, should receive more intensive training in psychopharmacology and, with improved training, would prescribe a limited range of psychotropic drugs using approved protocols. While this would require legislative changes, nurse practitioners in other areas already have such responsibility and authority, for example pediatric nurse practitioners. Also, more intensive training should include a broader understanding of the complex range of social programs and financial entitlements that are central to maintaining mental patients in the community. Such nurses, in short, must learn to be effective case managers as part of their role.

Key Policy Issues

The care of the chronic mental patient is a formidable task requiring a coordinated strategy, cooperation among varying levels of government, a clear definition of responsibility, and a longitudinal perspective and approach. Private psychiatric beds have been expanding rapidly to serve insured populations with less incapacitating disorders, but it is an illusion
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to anticipate that the interests of these difficult and uninsured patients will require anything less than sustained state responsibility. Even with more generous reimbursement, contractors in the private sector are likely to have little interest in these highly impaired patients. While most of the mentally ill can be managed reasonably within the context of our larger health care system, the chronic patient requires central public policy attention. It is inevitable that these patients will require special efforts by specially trained and motivated professionals functioning within a coherent and integrated system of financing and service delivery.

Chronic mental patients in community settings face formidable problems in coping, including acquisition of appropriate medical care and mental health services, housing, nutrition, recreation, and sustained social contact. These patients are repeatedly brought to emergency rooms, hospitals, and jails during periods of extreme stress and psychotic disorganization, and consume enormous medical and other community resources that are used ineffectively. While in the community they are often isolated, neglected, and out of touch with an established system of services that is organized to respond realistically to their needs. A well-organized community program based on the care principles discussed in the review of experimental programs could prevent much needless and expensive hospitalization and imprisonment, monitor medical and mental health status more closely, and promote higher levels of functioning and activity.

Similar conceptions of community care served as the basis for the Community Support Program, a major national plan for the chronically ill prior to the decentralization of federal mental health programs. Responsibility for these patients now almost exclusively rests with local and state authorities. A single authority at the local level funded to assume responsibility for the total array of hospital and community services for the chronic population is needed. While no fully integrated system exists including all sources of funding, Wisconsin’s formula for mental health and social services holds counties responsible for the entire spectrum of necessary care providing an incentive for careful choices among alternatives. In one county, 83 percent of expenditures for chronic patients are in the form of community services as contrasted with hospital care.
By funding an identifiable program with broad responsibilities, incentives are developed for carefully considered tradeoffs between inpatient and community care alternatives. Following the logic of a health maintenance organization (HMO), such organizations have incentives to avoid unnecessary expensive care and alternatively invest these resources in building and supporting a more appropriate spectrum of community services. Such systems also induce responsibility for monitoring patients appropriately since failure to do so wastes scarce resources essential to support community services and employ appropriate professional personnel.

While the concept of county responsibility, as developed in Wisconsin, serves as an excellent beginning framework, the larger ideal would be to integrate responsibility and funding for the total array of medical, mental health, social services, and social welfare funding for this population. The multiplicity of funding authorities and sources of finance make full integration unlikely, but even partial integration of selected categorical programs, each with its own eligibility criteria and regulatory limitations, would contribute immensely to better organized and effective care. Achieving this requires complex negotiations, agreement on waivers, and considerable technical expertise. It should be possible to fund at least the medical, mental health, and social services care of chronic patients on a capitated basis, but achieving this in more than an isolated instance will require our very best and sustained efforts.

With the decentralization of mental health services, and funding complexities, a formidable problem is diffusing effective approaches from one setting to another. Barriers to replication of successful programs include resistance to redirection of reimbursement from hospital to community, required changes in professional roles and relationships, lack of local leadership, financial incentives to persist with traditional approaches, and entrenched interest groups that benefit from the current organization of services.\footnote{27}

While the political barriers are substantial, much of the problem is also evident in the poor flow of practical information, the lack of confidence many mental health professionals have in changing course, and the difficulty of gaining the administrative, managerial, organizational, and technical mental health experience that allows successful techniques to be transferred and fitted to varying local circumstances. We could do more to transfer effective approaches by bringing teams of appropriate officials and professionals to sites where they could learn directly from those involved in new programs, and to share clinical and organizational experiences. Such “teams” might include individuals having the financial, administrative, and professional authority and expertise necessary to implement their goals once they return to their own communities.

In summary, we face an extraordinary challenge in caring for the chronic mentally ill, particularly in light of cost-containment pressures on the health
care system as a whole and in a context of tightening eligibility within many programs on which the chronic patient depends. It seems unlikely in this context that much new funding will become available for this population, making it even more critical that existing budgets be used wisely and to best effect. Patterns of care continue to be fragmented and poorly organized, and the range and complexity of existing entitlements requires ingenuity and energy to negotiate. The single most important contribution to patient care we could make in coming years is to consolidate funding sources at the local level allowing rational calculations and decision making among alternatives. The trick is to get there from our present starting point.

NOTES

5. W. Gronfein, “Rhetoric and Reality in Mental Health Policy: The Case of the State Hospitals” (Rutgers-Princeton Program in Mental Health Research, 1984).


22. Stein and Test, “Alternatives to Mental Hospital Treatment I.”


