The Mental Health Commission Tackles Fragmented Services: An Interview With Michael Hogan

Efforts to create alignment and energy among the disparate parties involved hold promise for remedying the problems that persist.

by Robert Cunningham

PROLOGUE: The impetus behind the creation of the President’s New Freedom Commission on Mental Health came from several sources. President George W. Bush has described the personal impact of a friend’s struggle with major depression—and eventual recovery. Bush’s father signed the Americans with Disabilities Act in 1990, which created the foundation on which the commission would eventually build. The younger Bush announced his New Freedom Initiative shortly after taking office in 2001, covering a wide range of disability-related issues. In the meantime, the U.S. Supreme Court’s 1999 Olmstead decision added the force of a legal imperative to the broad movement toward increased use of home and community-based care for the disabled. The increased emphasis on deinstitutionalized, patient-centered care also resonated philosophically with the president.

The April 2002 executive order creating the commission called for a comprehensive study and recommendations that would help adults and children with serious mental and emotional disorders “to live, work, learn, and participate fully in their communities.” An interim report by the panel the following October concluded that “America’s mental health service delivery system is in shambles,” with responsibility “scattered among agencies, programs, and levels of government.” Its final report in July 2003 recommended “fundamentally transforming how mental health care is delivered” so that people are treated under a coordinated plan of care at all levels. Although the challenges to implementing the report’s recommendations are formidable, the report was well received by hard-to-please consumer advocates. “It brings us out of the dark ages,” said one.

The chair of the commission was Michael F. Hogan, director of the Ohio Department of Mental Health since 1991 who has guided the department through its own transformation from an institutionally based to a community-based system. Prior to that he had leadership positions in both the Massachusetts and Connecticut mental health systems and was Connecticut’s mental health commissioner from 1987 to 1991. Hogan holds a doctorate in special education administration from Syracuse University. Robert Cunningham is a deputy editor of Health Affairs.
ABSTRACT: Michael Hogan, chair of the President’s New Freedom Commission on Mental Health, describes the commission’s findings on the fragmentation of the public mental health services infrastructure and its effort to formulate strategies for improving the alignment of federal, state, and local policy and practice. Clinical treatment needs to be coordinated with supportive services such as housing, education, job training, and case management. State planning is crucial to harmonizing diverse revenue streams. Hogan notes the commission’s efforts to include stakeholders in its deliberations and to initiate efforts to coordinate policies among the agencies represented by its members.

Robert Cunningham: The charge in the executive order creating the President’s New Freedom Commission on Mental Health seems broad. Can you explain how you went about organizing the commission’s work?

Michael Hogan: The agenda was broad. But it was also, in some ways, very focused. It was focused, for example, on the goal of helping people to achieve significant and valued life outcomes as opposed to more narrow or proximate clinical goals. I think that is significant. It lifts the sights of mental health care beyond narrow outcomes toward helping people achieve the goals in their lives. This emphasis ties back to the administration’s New Freedom Initiative theme of greater access to opportunities for people with disabilities. So you could say that the commission is, to some extent, about civil rights as much as it is about treatment. This is because another part of the context for the commission was the Supreme Court’s decision in Olmstead, which is referenced throughout the New Freedom Initiative.

Back to your question about the mission being broad, there are some boundaries. This was to be a study of the service delivery system, not a redo of the surgeon general’s report, which was by and large a summary of the science. We interpreted that to mean that the commission’s work should stand on the shoulders of the surgeon general’s report.

We were also instructed in the executive order to focus on adults with serious mental illness and children with severe emotional disturbance—this set not a hard-and-fast boundary but a focus. The commission was not so much to be about prevention or about services for people with less significant illness or disabilities, but rather to address, as its core concern, people with the most serious disorders.

Cunningham: Was there also a reservation about getting into private insurance coverage issues?

Hogan: Yes, there was, although I would cast that in another way. When the president announced the commission in his speech in Albuquerque in April 2002, he said that there were three obstacles to people getting the care they needed: the stigma attached to mental illness, unfair limits that were related to inadequate insurance coverage, and a fragmented service delivery system.

The real headline of the speech that day was not the announcement of the commission, but the announcement of the president’s support for parity legislation—which, unfortunately, still hasn’t passed Congress. So the charge to the commission implicitly said that President Bush has made a policy determination and has taken a position on insurance coverage (that there should be parity). Therefore, the commission didn’t have to go over that ground and could focus on the fragmented service delivery system. All of this oriented the commission, not exclusively but to some degree, toward the public mental health delivery system, not the private marketplace.

A Complicated Context Of Fragmentation

Cunningham: What else do we need to keep in mind about the context for this task?

Hogan: Mental health care is unique in health care because there are state- and county-administered care systems specifically for a category of illness. In my opinion, this is a fundamental underlying problem and limitation in our approach to mental health. In my view,
until there is more universal private responsibility, until we treat mental illness in health plans the same as other illnesses, aspects of this second-class status for mental health care and aspects of stigma are going to be retained.

This problem is too big for this commission to address, because to really get at it would require the total restructuring of health care. But it’s a piece of context that I think is significant. As opposed to the rest of health care, most mental health care is paid for with public dollars, and a lot of it is publicly administered.

Another aspect of the context of mental health care can be described as a paradox or a puzzle: that the organizational responsibility for mental health care in the public sector is primarily with states (as it’s been since the founding of the state asylums in the nineteenth century). With the devolution of this responsibility, it’s also increasingly a responsibility of counties in many states.

So the fundamental responsibility rests with states and counties, but most of the money is federal money. And most of the federal money is not mental health money. That is, it is money in mainstream programs, the biggest of which are Social Security—SSI and SSDI payments—Medicaid, and Medicare. These are mainstream programs where the evidence suggests that people with a mental illness fare worse than people with other illnesses or disabilities.

This creates an extremely complicated context. The biggest dedicated federal mental health program is the mental health block grant, at $440 million annually. By comparison, annual federal Medicaid expenditures for mental health care, not including drugs, are on the order of $20 billion, and state and county Medicaid expenditures are just a little bit less than that. So the fragmentation that the president referred to is designed and hardwired into these systems of care.

**Cunningham:** Considering additional services such as housing and education, aren’t those revenue streams spread out all over and not tailored to mental health, either?

**Hogan:** Exactly right. This is one of the pictures that emerged in the commission’s review of the problem. A lot of those programs also have significant amounts of federal money, but they are administered by different entities at the state or local level, like local public housing authorities that are county- or city-based. So there is a major problem with respect to the leverage needed to change mental health.

Furthermore, if you ask people what’s the big problem with mental health, they’ll say, “Oh, it’s all those mentally ill people in jails or in prisons”; or “It’s the homeless”; or “It’s kids in child welfare”; or “It’s kids in juvenile justice”; or “It’s people stuck on disability payment.” What’s curious is that all of those “mental health” problems are outside of the mental health system and not the direct responsibility of federal, state, or county authorities that are tasked with mental health care.

This picture is dramatically different than it was twenty-five years ago. Then, establishing responsibility for mental health in these mainstream federal programs was the right and responsible thing to do. Twenty-five years ago, for example, Medicaid and Medicare had no benefit for mental health care. Changes were made over time in both programs and in Social Security, changes with major ramifications for mental health. But they were what looked like modest changes considering the programs’ huge scope, like creating a case management benefit in Medicaid, then a clinic benefit and a rehabilitation benefit. So now you’ve got $20 billion in dedicated mental health spending. The adjustments and retrofits and add-ons and modifications in these federal programs were important.

These changes have accomplished a tremendous amount of good. There’s absolutely no doubt that Medicaid payment for clinic and rehabilitation and case management services was absolutely essential to enabling a lot of people to live in communities and achieve much better outcomes.

**Progress In Coordination**

**Cunningham:** Before the acceleration of “Medicaidization,” were the states making progress in coordinating services?

**Hogan:** If you go back a generation...
health, state hospitals were the dominant service, and clinics were a secondary node. The mental health clinic node grew into community mental health centers (CMHCs), which were considered the dominant model. The community support idea articulated by people at NIMH [National Institute of Mental Health] in the late 1970s was a fundamentally different concept of mental health care that brought in social welfare concepts to what had been solely a treatment system. It attended to the necessity for housing and income support and employment supports—practical services—as key elements of care.

A dominant idea in the early 1980s in state mental health programs was this process of reframing community mental health care from clinic-based treatment to a community-support orientation, with a wide array of supports like housing and rehabilitation, relying on case management to pull all of this together. In the early 1980s many states made progress in reshaping the mental health system.

In the past two decades Medicaid has become a dominant payer for community care, so efforts within the states and counties to order the mental health system got overridden by the emerging complexity of these multiple funding streams. I should note that there's huge variability in this, because mental health care has now devolved to fifty states and hundreds and hundreds of counties and local communities. As the saying goes, if you've seen one state, you've seen one state.

Work Of The Commission

Cunningham: You've done a pretty good job of setting the stage. Let's talk about the work of the commission.

Hogan: The fifteen appointed members of the commission were a pretty diverse group: mental health professionals, family members, and consumers from all over the country. They were people whom I would describe as leaders in their own community, whether that's a geographic community or a practice community—as opposed to people who think regularly about mental health policy at the national level. That mix was leavened by the appointment of seven ex officio members, representing federal agencies with major responsibility, directly or indirectly, for mental health care. Those were SAMHSA [Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services], NIH [National Institutes of Health]—which really meant NIMH—Department of Veterans Affairs, Centers for Medicare and Medicaid Services, HUD [Department of Housing and Urban Development], Department of Labor, and Department of Education. The latter has responsibility for both special education and the vocational rehabilitation program. So the membership set up a kind of dialogue between insiders and outsiders that was hard at times but ultimately productive.

Our strategy for how to conduct the commission emerged partly out of conversations with people in the Washington mental health policy arena, some of whom had taken part in the Carter Commission of the late 1970s. These conversations suggested a need to develop a collaborative relationship with people in the Washington policy and advocacy arena, so that there might be kind of a parallel inside process (the commission) and outside process (among advocates) that would be mutually reinforcing. Another suggestion we received, an obvious but invaluable one, was to run the meetings so that there were multiple opportunities for open public comment. We ended up having a period of public comment at every meeting. Some people drove hundreds of miles just to come and talk to us for a few minutes.

Cunningham: But you're creating an environment that's inclusive and that doesn't seem to pit stakeholder against stakeholder.

Hogan: Absolutely critical. There were signifi-
cant concerns, early on, expressed by a number of people in the mental health consumer/survivor movement about whether the commission would be responsive to their concerns. One out-of-the-closet, consumer/survivor–identified member of the commission was Dan Fisher. He and I and others met and dialogued with people in the consumer movement and established, if not trust, at least an understanding about the give-and-take that we would have. That was a critical example of the kind of openness that we needed.

Another guiding concern was that a commission like this has one primary master: the president who appointed it. So the assignment was to write a report that will be acceptable and helpful to that president. On the other hand, looking at the experience following the Carter Commission’s work, part of the impact was not immediate executive action by the president but ideas that might have been reflected in subcommittee reports or working papers, picked up later by staff in federal agencies, or by advocates, or by congressional committees.

This relates to another reality of a time-limited commission. It is catalytic much more than it’s determinative. There might be a few big ideas that emerge. But the mental health system is very diffuse, which means that big ideas tend to be debated to death by diverse stakeholders. So we entered the process with the idea that the commission would have to proceed on multiple fronts at once, without knowing exactly how that would play out. The commission decided to create subcommittees, partly because members came with many diverse interests and wanted to make sure that their most significant concern was addressed—whether that was children or evidence-based practices or disparities in care for minorities. Subcommittees also allowed us to bring in consultants and advisers, who were very knowledgeable about the issues, to write papers as a basis for discussion and decision making by the subcommittees. These subcommittee reports would create a useful input for the report to the president. They could also go a little bit deeper and perhaps subsequently be published as working papers. The Carter Commission did this, and its working papers become a resource for advocacy.

**Early Accomplishments**

**Cunningham:** Were you able to get moving quickly in some areas, so that your task didn’t seem too overwhelming?

**Hogan:** Yes. In several cases, we moved relatively rapidly to having a good working product. One that comes to mind is in the area of the relationship between mental health and the criminal justice field, where there are a set of ideas about what needs to be done where consensus is starting to emerge. We had the benefit of having Hank Steadman, one of the people who has helped develop that consensus, as our adviser. He wrote a very crisp paper that summarized the issues; that paper found a lot of resonance with members of the subcommittee.

Three broad concepts emerged from the criminal justice paper that are reflected in the report to the president. First, mental health and law enforcement and the courts, in local communities, should collaborate to engage people with mental illness who may have committed criminal acts, to divert them into appropriate supervised treatment rather than incarceration. It’s likely to be better for them, because such people fare very poorly in jails and prisons. Solutions in this area include police crisis-intervention teams specially trained to work with people that are mentally ill and collaborate with local mental health providers; or mental health courts, where judges hear a docket of cases of defendants who have a mental illness and have case managers and treatment staff available and make dispositions for treatment in lieu of trial and sentencing. The second notion is that if people did commit crimes and are tried, found guilty, and incarcerated, they are entitled to get constitutionally required levels of mental health care while incarcerated. The third emerging principle is that when these folks are released, linkages to mental health care are critically important.

**Cunningham:** Are there other areas where the commission was able to make progress?

**Hogan:** One area that the commission wanted
to get into was suicide and its prevention. The surgeon general did a report on this. People on the commission were concerned about it. And a good deal of work has been going on to develop a national strategy for suicide prevention. But the fruits of that work are really not very visible outside of Washington. So we had a subcommittee on suicide and suicide prevention and were able to review and crystallize all of that work and develop a recommendation that the work that has been done on suicide prevention needs to be accelerated, supported, implemented, and enhanced.

The national strategy for suicide prevention is quite broad and has multiple elements that include access to care and focusing on improved clinical work with people who might be at risk. But its core idea draws from the quite incredible story of how the Air Force recognized suicide as a major problem among its members and essentially engaged in a strategy of community mobilization. Messages went out through the command structure that reversed an unintended but longstanding pattern that essentially said, “If you’ve got problems, don’t acknowledge them, because it’s a sign of weakness.”

Of course, in the military you have the advantage of an extremely robust command structure. Now this command structure is sending a message through the ranks that asking for help is a good idea, and that if people have problems, those in charge should make sure that they get the care they need. What had been an organizational weakness has turned into an organizational strength. There aren’t many communities out there like the Air Force, but we’re starting to see early signs of what can be done on college campuses, for example. Universities are a kind of a natural community that can organize for suicide prevention, as can high schools, businesses, or faith communities.

### Efforts Among Diverse Agencies

**Cunningham:** What about the problem of aligning the efforts of diverse agencies? Were there opportunities to make connections?  
**Hogan:** There are a number of cases where collaborations are improving. But it’s going to be an ongoing task, in part because multiple agencies are involved at multiple levels of government. One example of a critical relationship that is actually within the mental health arena has to do with the roles of NIMH and SAMHSA in developing knowledge and discerning what is truly effective with respect to treatment and services, and then finally doing what is necessary to achieve widespread adoption of effective models.

My opinion is that these two federal agencies have not been able to sustain an effective collaboration on this issue. I think there is an opportunity to build on the NIMH role, which is fundamentally a science role, as the commission calls for a stronger focus on finding out what treatment and services approaches are really effective. The commission also wants NIMH to focus its clinical and services research sights on interventions that are likely to be usable in the real world, not on arcane interventions that work well in the university clinic but could never be applied in a CMHC reliant on Medicaid funding. NIMH should work with SAMHSA on methods to get that knowledge, once developed, into the hands of practitioners.

Some commission proposals related to the use of evidence-based practice are broader than this: the notion of developing a national strategy that includes public and private collaborations to advance this agenda; and the idea of making better connections with payers like Medicaid or others, so that what is determined to be effective can actually be reimbursed.

I think we are seeing a ratcheting up of collaboration on what people are calling the “science-to-service continuum,” to some degree because of the dialogue that occurred...
during the commission process.

**Cunningham:** Are there other examples of incipient improvements in collaboration?

**Hogan:** Yes. For example, a number of us have engaged for several years in a project that tries to build on the findings of the schizophrenia PORT [Patient Outcomes Research Teams] study by Tony Lehman and his colleagues, by helping people to use interventions that are now evaluated as being demonstrably effective for adults with serious mental illness. Two examples are supported employment and assertive community treatment. One obstacle to adoption of evidence-based interventions is that the service is not efficiently reimbursed. So the commission recommends that the Centers for Medicare and Medicaid Services [CMS] issue some guidance to the field about how to use Medicaid reimbursement to fund assertive community treatment and to fund those components of supported employment that are appropriate for reimbursement in a health insurance–type program. The commission recommends that the Office of Special Education and Rehabilitation Services ought to specifically reimburse models of supported employment that are effective in helping people with mental illness get and keep a job.

**Cunningham:** What are some other examples of collaboration that have been problematic where the commission made progress?

**Hogan:** There are several broad ideas. One is bottom-up, and the other is more top-down.

The bottom-up strategy has been employed quite successfully in some so-called wraparound programs for children with multiple needs, integrating separate funding and bureaucratic silos, as they're often called. In the case of a child with emotional disturbance, there is the mental health clinic, the school, and the child welfare organization. All have different rules and requirements and formats for individual case planning, and so on.

The model that has emerged in some of these programs is having one plan negotiated at one table, where all participants come together with the individual or the family and work it all out, making it more transparent and accessible for the family, but also creating one place to coordinate essential services.

With respect to mental health care and employment, to cite another example, adults with serious mental illness may get mixed messages from their providers. Their therapist might express concern about their taking on more stress and suggest that there are treatment goals to be addressed before the person starts looking for a job. At the same time, the rehabilitation people think—correctly, I believe—that a person should go for a job first and then figure out how to accommodate these other issues. If you can create one table and one plan, maybe you can reconcile these things.

So the commission is proposing to the president—but this is as much for states, counties, and others, too—the idea that every person with serious and multiple disorders ought to have one plan, and that the various agencies and bureaucracies involved need to figure out how to come together to achieve that.

The macro, fragmentation-busting, top-down strategy is also going to take considerable work and time to evolve. This is the commission's call for a significantly upgraded state mental health plan. Right now, states have a responsibility to develop their own mental health plan. However, their efforts focus on the mental health block grant, which is only a tiny component of mental health funding and is delimited by the organizational boundaries of the state mental health agency. That means that my state's mental health plan may address what's done with its $15 million block grant, but it doesn't touch the $300 million in the Medicaid community mental health program, and it doesn't address vocational rehabilitation or special education or child welfare.

The notion is that maybe we should elevate concern about mental health in the direction of the governor's office, with a quid pro quo implied. That is, that to the extent that a state would elevate its responsibility for mental health care, it ought to achieve more flexibility with respect to those federal funding programs that would be employed to deliver on this elevated plan. This is a very big, broad concept that is going to take quite a while to play out and may require statutory changes across
multiple programs, because it may touch HHS, HUD, Education, and Social Security.

**More Flexibility, Less Fragmentation**

Cunningham: Getting more flexibility in Medicaid, for the mental health benefit and other areas, is a high priority for the Bush administration and for many states. What’s your view on this?

Hogan: My own opinion is that the administration’s current Medicaid proposal may be too broad, and there’s a question about how the numbers work for the states. But my view as state mental health director is that if somebody were to offer me a block-grant approach to our mental health benefit in Medicaid, and if the way the numbers worked was not unreasonable, I would take it in a minute. Because one of the consequences of how Medicaid is often run, given its fee-for-service orientation and categorical approach to eligibility, is that it has made community mental health care into piecework, with an emphasis by case managers and therapists on billable units of service for people who are Medicaid-eligible, as opposed to clinically necessary care for people who need that care irrespective of eligibility.

Another big idea about dealing with fragmentation comes from a conversation that we had with Rosalynn Carter, who came to one of our meetings for dinner. She said that she thought that one thing had changed most dramatically in the twenty-five years since the Carter Commission report. I was thinking to myself, what does she mean? Is it the new medications? Is it the deinstitutionalization of mentally ill people? But she said that it’s the understanding that it is possible for any person to recover. Today, we have this understanding. We did not then.

The one big idea—the headline, if you will—in the report to the president is that recovery is possible for anybody. But the system is too fragmented, and the services that are available are inadequate and not of high enough quality to allow recovery to be a realistic promise for many people. So the commission’s vision statement for future mental health care is that recovery should be expected because of the accessibility and quality of services that are provided.

If that’s the headline, the implication is that narrow reform measures aren’t up to the task of achieving such substantial change. A much more fundamental transformation in mental health care is required. There is no one thing that can be done to remedy problems in mental health. You have to do an awful lot of things, and they’ve all got to be linked.

One of the goals articulated in our report is that technology—the emerging power of computing and communications technology—be used to improve access to mental health care and information. Mental health care should be included in development of integrated electronic medical records, with appropriate protections for privacy. But we also envisioned using the Internet in more consumer- and family-friendly ways for people to get information about their condition, about services that are available, about treatments, and so on. This is certainly not something that by itself solves the problem of fragmentation. But it is a potentially powerful tool, if used right.

Cunningham: Are there ways in which, without frightening people about privacy, you can use information technology (IT) tools to tackle fragmentation of support services?

Hogan: Yes. I’ll give an example. Many agencies here in Ohio use an electronic patient questionnaire that asks about quality-of-life indicators as well as symptoms. When people come in, they sit down and go through this little questionnaire on an electronic tablet before their appointment. In some agencies the tablet, via a docking station, immediately dumps the information into a working version of this per-
son’s treatment plan and medical record, which then shows up on the therapist’s desktop. When the therapist and the patient talk about goals for treatment, this information is in front of them. I heard from a woman who said that until she filled out this questionnaire and thought about her life, she hadn’t realized how much time she’d spent battling depression, but she didn’t have a job and didn’t really have a life. She said, “I thought to myself, what would happen if I took some steps to maybe get a job or to get involved in some things? Would that be good with me? Would that help me with my depression?” And lo and behold, she did, and it did.

Next Steps In Implementation

Cunningham: What do you anticipate the process of implementation will look like? You said that a number of patient and provider groups are planning to use the commission’s report as a springboard.

Hogan: In general we stayed away from recommendations to the administration about how to organize all of this. That’s their job, not ours. But there is a recommendation that there should be point responsibility for follow-through. When the report was released, HHS Secretary Tommy Thompson designated SAMHSA Administrator Charles Curie to take the lead on follow-through for HHS.

The groups that plan to work together now that the report has come out include the National Association of State Mental Health Program Directors, the Bazelon Center, the National Alliance for the Mentally Ill, and the National Mental Health Association. Their coalition strategy is loosely based on the Campaign for Tobacco-Free Kids. The degree of collaboration among members of the advocacy crowd who tend to have, if you will, relatively sharp elbows with each other under the backboards, is a great development.

There’s a tension in any effort like this. It’s as if you’ve got these few minutes with the president. The alluring, wrong thought is: What’s the one thing you want to tell him to do to make mental health care all better? If only just a few people in Washington would make these powerful decisions. But our mental model of the commission’s work is that it also suggests a direction for states, for provider organizations, for advocacy organizations, that they might address immediately. That is, maybe this is about creating alignment and energy among the disparate parties in this so-called system. There are lots of suggestions in the report that are things people can work on at home, so to speak. Although federal leadership, and substantive change in federal programs are essential, much can be done that doesn’t necessarily require a single strong, bold, clear action by the federal government.

It will also be interesting to see the extent to which the report mobilizes us around the notion of recovery. For many people, recovery is an ongoing process of positive adjustment to life with an illness. For others, recovery might look more like freedom from symptoms and really getting better. Among consumers, families, and professionals on the front end of change, recovery has come to represent the hope that things can get better, which is, we know, a powerful, organizing force. Recovery is an emergent hope or force. If we can just give it a little boost, that alone will be a great thing.

Cunningham: Has the White House response been supportive?

Hogan: Yes. A part of a commission like this is also a subtle dialogue and understanding between the staff at the White House and the commission. That relationship has been very cordial and supportive. Staff came to a couple of meetings to observe what was going on and give us a tiny bit of guidance. I was really impressed at the White House’s openness to accepting the ideas that we were developing. There was no censorship or interference with the process. Probably some of that was due to clear direction from the get-go. Some of it was probably due to our trying to pay attention to what the rules and expectations were. But it was a collaborative endeavor, and it doesn’t always go that way.