MENTAL HEALTH POLICY IN THE UNITED STATES

The Transformed Scope of Mental Health Policy In The 20th Century

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Abstract: This lecture provides a brief overview of the transformation of the scope of mental health policy in the 20th century, during which time the concept "mental illness" expanded from serious and persistent mental illness to include conditions that previously were regarded as personal problems, strange behavior, eccentricities, character flaws, or ordinary forms of sadness, worry, or bad temper. New services emerged for this population, initially forms of psychotherapy and, later, medications such as anti-depressants and anti-anxiety agents as well. Providers proliferated including private practitioners, hospital and community-based clinics, social service providers using clinical interventions, and more. Over time, primary health care professionals provided more and more of the treatment of people with mental disorders that were not severely disabling, usually by prescribing medication. New, complex funding sources emerged, such as employer-based health insurance and Medicaid and Medicare. Managed care was introduced to control costs and assure access to medically necessary care. The role of government shifted from primarily providing service to primarily funding and regulating non-governmental providers. In addition, in the last quarter of the century, the field of "mental hygiene" fragmented into separate fields of mental health, developmental disability, cognitive impairment, and substance use. By the end of the century, the field of mental health was complex, sprawling and fragmented with responsibilities spread between the private and public sectors and across federal, state, and local governments.

This lecture, like the century of mental health policy that it describes is, I'm afraid, a little chaotic. It covers the expansion of the concept of mental illness, the proliferation of new forms of service provision, related changes in funding, and the changing roles of governments. A century that began with a relatively simple mental health system built around state hospitals and asylums ended as a remarkably complex and chaotic system, as you shall see.

The Expansion of the Concept of Mental Illness

Freud and The Concept Of Mental Illness

The concept of mental illness that emerged in the United States late in the 18th century was limited to severely disabling conditions generally referred to as "madness", "insanity", or "lunacy".[1] This view dominated what we now call "mental health" policy and practice until early in the 20th century when the concept of mental illness began to expand to cover personal problems, strange behavior, and states of mind that previously were thought of as eccentricities, character flaws, or just ordinary—if somewhat extreme—forms of sadness, worry, or bad temper.

This transformation of the concept of mental illness took place largely through **the spread of psychoanalytic theory and practice**, which had begun with Sigmund Freud's highly controversial theories of neurosis, the unconscious, psycho-sexual development, etc.

Freud made his first appearance in the United States in 1909 when he delivered a series of lectures at Clark University.[2] Fairly rapidly his ideas had tremendous impact on the fields of psychiatry, psychology, social work, education, criminal and juvenile justice, child welfare, and family service. They also became highly popular among intellectuals and had great influence on literature and the arts.

Although Freud himself distinguished between human unhappiness (which he thought was an unavoidable part of the human condition) and mental illness[*],[3] his theory that unconscious conflicts create neuroses contributed to the development of a belief that much personal distress is illness that can be alleviated with psychotherapy.

In a sense there was a shift from the belief that individuals are personally responsible for their behavior and ways of life to a belief (among progressives at least) that an individual's personality and behavior are an outgrowth of a process of development that begins at birth, is buffeted by environmental factors, and is largely outside the control of the individual. We become who we must become given the forces that mold us as we grow

[*] Near the end of his life, Freud wrote a wonderful essay ("Analysis Terminable and Interminable"), in which he criticized those of his followers who kept their patients in psychoanalytic treatment for many years.

up. We cannot change via will power alone; but psychotherapy can help us to understand and to overcome some of the unconscious drivers on our thoughts, emotions, and behavior.

What an idea! Psychotherapy—talking—can help us change by rooting out and working through unconscious conflicts between fundamental human drives—especially sex—and the demands of civilized society.

This was a stunning shift in perspective—**from the moral/religious to the psychological**,[4] from harsh and judgmental to humane and understanding**.** Punishment, penitence, and prayer were no longer seen as the only methods for making people better people. No longer was intellectually knowing thyself the source of personal improvement. A totally new form of self-knowledge had emerged.

As an aside, for the most part Freud has by now been disdainfully dismissed by clinical thinkers, practitioners, and others for his erroneous views on sexual development, women, homosexuality, the psychotherapeutic process, and more. But it is worth keeping in mind that he is the source of views that continue to hold sway today--that there are unconscious conflicts, that talk therapy is a way address emotional distress and unsatisfactory behavior, that sex is a very powerful driving force in human life, that human beings go through a developmental process, and that childhood experience informs and shapes adult behavior. Transformative ideas!

And Freud's thinking about society, particularly in *Civilization and Its Discontents*,[5] offers great insight, I think, into why social and political utopia is not possible. A discussion for another time.

Fairly rapidly after Freud invented psychoanalysis, the field began to fracture into a variety of orthodoxies. The intellectual battle between Freud and Jung is perhaps the most interesting example of that.[6] Also a discussion for another time.

Through Freud's constant re-formulation of his ideas and the imaginative alternative theories offered by his critics, a number of very important ideas emerged that have had tremendous influence. This includes the belief that changing childhood experience can change the behavior and mental state of both children and the adults they will become. (This is an idea that has returned in force with the concept of "adverse childhood experiences" (ACES).[7]

The idea also emerged that there is a continuum from neurosis to psychosis and that if neurosis is treated soon enough psychosis can be prevented. This is an idea that had vast negative influence on the development of community mental health centers, as I have noted in my discussion of the consequences of deinstitutionalization in the prior two lectures.

And very importantly, the concept of psychosexual development that ends in childhood gave way to a belief that development is lifelong, with different stages of development over time. Erik Erickson's work was particularly important to the emergence of this idea,[8] which is now generally referred to as the "life course" or "life span" perspective.

The Practice of Psychotherapy

In addition, to changing psychological thinking, Freud and his followers developed a method to alleviate mental illness. The first form of this—psychoanalysis—used a technique that required treatment 4-5 days a week. But over time other psychoanalytic thinkers developed a concept of supportive psychotherapy, which could be provided typically once a week and sometimes less while often continuing for many, many years.

In all its varieties, psychodynamic psychotherapy, as it is now known, burgeoned even though it was almost entirely limited to affluent people, who could afford four or five days a week of treatment in private practices or could afford leisurely, long-term treatment in psychiatric hospitals. (Go visit the Westchester Division of New York-Presbyterian Hospital in White Plains, New York or Sheppard-Pratt in Baltimore or others if you want to get a sense of private psychiatric hospitals in their heyday.)

The Expansion of Mental Health Providers

Over time, access to psychotherapy increased because of the advent of mental health insurance, because much training for psychiatrists took place in public hospitals where the trainers were increasingly psychoanalysts, because the switch to community mental health policy provided public funding for outpatient services, and because psychoanalytic thinking became central to social work, giving case and group work the appearance of a scientific base. As a result, child welfare and family service agencies shifted more and more to models of service in which psychotherapy was central.

Organizationally-based mental health services for people who were regarded as mentally ill but who were not psychiatrically disabled developed a service model that continues to dominate the field after nearly a century—**the clinic**.

A clinic is a place where psychotherapy and, later, other forms of therapy are provided in offices. Patients (or "clients" depending on the terminology chosen) come to the clinic, usually for scheduled visits during regular business hours.

Clinics use a combination of professional staff. Early on it was primarily psychiatrists, psychologists, and psychiatric social workers, sometimes referred to ironically as "the holy trinity". Although each of these professions provides treatment, they also have distinct special roles. Psychiatrists do diagnosis, oversee treatment plans, and do assessment of homicidal and suicidal risk. Once psychiatric medications were invented, psychiatrists became responsible for that as well. Psychologists used to do intelligence and personality testing, which is no longer a routine part of pre-treatment assessment. Social workers are the link to families and to the client's social environment.

Professionals in clinics work together as a team, using case conferences and case records to communicate among themselves.

(As an aside, despite the expectation of peaceful cooperation among the professions, there have always been public policy disputes about "scope of practice", with battles, for example, about whether psychologists can prescribe medications, whether social workers can get paid for treatment without psychiatric supervision, and whether it is really necessary for psychiatrists to sign off on treatment plans.)

The clinic model and the model of interdisciplinary teamwork continue to dominate the field nearly 100 years after they first emerged. And they are built into licensing and accreditation[†] standards with which most programs must comply to be funded by health insurance or by government.

[†] Many mental health providers are accredited as well as licensed. Accreditation is done by non-governmental organizations, such as the Joint Commission, that have been created for that purpose. But some states accept accreditation in lieu of having separate state-operated licensing processes.

Funding Changes

For the most part, psychotherapy services were originally funded privately, by the people receiving treatment or their families or by philanthropies that funded some health and social services.

But from roughly 1950 into the 1990s, various changes in funding fueled very substantial growth of psychotherapeutic services in both the private and the public sectors.

In the private sector, employer-based health insurance increasingly covered inpatient and outpatient mental health services, fueling the **growth of private psychiatric hospitals** (which increasingly served very difficult adolescents), **psychiatric units in general hospitals, and private psychotherapeutic practice.**

In addition, large employers increasingly established **employee assistance programs** (EAPs), some of which offered psychotherapy services in clinics in the workplace.

In the public sector, growth of mental health services was fueled by funding for community mental health centers and for other efforts to expand services in the community for people who might otherwise be in institutions. Much of this funding actually was used for people who were "neurotic" rather than psychotic because it was widely believed that treatment of less severe disorders would prevent the development of psychotic disorders and because most mental health professionals were trained in psychodynamic psychotherapy rather than in interventions more useful to people with serious and persistent mental illness.

In addition, the advent and growth of **Medicaid** and **Medicare** vastly expanded public **funding for inpatient and outpatient mental health services—some in hospitals, some in community agencies, some in child welfare agencies**, some in private practice, etc.

The use of Medicaid was limited by a provision little known to the general public but highly controversial among providers and advocates—the so-called "IMD exclusion". This prohibits Medicaid from paying for mental health services for adults 22-64 in "institutions for the mentally diseased" (IMDs), i.e., in state and private psychiatric hospitals.

Despite the IMD, Medicaid has grown to be the single largest source of funding for mental health services in the United States.

The availability of Medicare and Medicaid, as I said, also led to some increase of mental health services in private practice. But this was limited by the low fees, especially in Medicaid, and—in Medicare—by high co-pays, 50% rather than 20% for physical health care. This disparity between payment for physical and mental health services continued until the passage of a Federal parity law in 2008.[9] Also, some states, such as New York, created barriers to the use of private practitioners for people on Medicaid, largely to avoid scandals about "Medicaid mills".

There was also increasing public funding for mental health services in **child welfare and some other social service programs,** some of it Medicaid.

The **education system** also took on greater responsibility to provide services for emotionally disturbed children and adolescents, especially after 1976 when the Free Education for the Handicapped Act (now the Individuals with Disabilities Education Act) required schools to include students with serious emotional disturbance (SED) in mainstream classes or to provide special education and "related services", which included psychological services.[10]

Managed Care

As noted above, the availability of mental health insurance to cover inpatient treatment fueled substantial growth of psychiatric hospitals. Employers who provided health insurance voluntarily and the health insurance companies with which they contracted became more than a little dismayed about the growing cost of mental health services and about the hospitalization of kids who didn't need it. They were also distressed about being gouged by pharmaceutical companies, which could set prices for new drugs without control or even negotiation.

As a result, during the 1980s and early 90s, **behavioral managed care** was introduced into virtually all commercial insurance programs. It was called "behavioral" managed care rather than "mental health" managed care for two reasons—(1) to combine coverage of mental and substance use disorders and (2) to emphasize functional change in patients' lives.

The goal of managed care is twofold—to hold down costs and to assure

access to mental health services that were "medically necessary".

Managed care was widely despised by mental health providers, who insisted that it was just an effort to save money, that it violated professional autonomy, and that it would inevitably and disastrously restrict access to needed treatment.

Drug companies also protested various forms of cost control of medication, insisting that the choice of drugs was a private matter between doctor and patient and should not be left in the hands of bureaucrats and clerks.

But from the standpoint of funders, behavioral managed care has been a great success, **reducing unnecessary utilization of hospitals, expanding utilization of evidence-based short-term therapies, and holding down costs**.

During the 1990s, the arguable success of managed care in the private sector, inspired the development of **Medicaid managed care**.

There was a debate at the time whether behavioral managed care should be **"carved-in" or "carved-out"** of basic managed care programs. "Carved-in" meant that behavioral health services would be managed by organizations created primarily to focus on physical health. The presumed advantage was that physical and behavioral health services would be "integrated" and cost savings from better management of physical health care could be used to expand behavioral health services. The presumed advantage of "carved-out" behavioral health services was that ordinary managed care organizations (MCOs) had little idea what kinds of services people with serious, long-term mental disorders need and little ability to manage such critical services as day treatment, rehabilitation, case management, and housing.

In most states—but not all—arguments for carve-outs of services for people with serious mental illness prevailed. However, most state Medicaid programs used some form of integrated physical and mental health managed care for those with less severe or less long-term mental disorders and/or substance use disorders.

Most states also introduced "preferred drug programs" (PDPs) in which Medicaid could only be used for selected drugs unless special permission was given. This was not popular with big pharma, which fought tooth and nail

against PDPs and took "interesting" steps to win the alliance of mental health advocates and physicians.

Private behavioral managed care organizations expanded to handle Medicaid patients. Most were for-profit organizations, a few were individual not-for-profit organizations, such as the subsidiary of the Jewish Board in NYC that I helped to set up in the early 1980s, and some were networks of not-for-profit mental health providers.

Currently, Medicaid managed care is in a complex transition designed to hold down costs by making sure that people with co-occurring serious, chronic mental, substance use, and physical disorders get the treatment they need before they become critically ill and very expensive to treat.

Other Major Changes In Services For People With Non-Disabling Mental Disorders

Changes in funding are not the only important developments in the evolution of a mental health system for people with non-disabling mental disorders. Others include:

- the growth of mental health services in primary health care
- the growth of the use of medications
- the shifting role of government from provider to funder and regulator
- the separation of the fields of mental health, cognitive health (dementia care), developmental disabilities (including autism), and alcohol and drug abuse.

Mental health services in primary care and the use of medications

As the 20th century wore on, the recognized need for mental health services exceeded capacity. In addition, psychotropic medications emerged as the treatment of choice. This resulted in two major shifts. (1) Primary care physicians, relying heavily on anti-depressants, anti-anxiety agents, and anti-psychotics, became the major providers of treatment for mental disorders. And (2) a huge psycho-pharmaceutical industry emerged. By early in this century, medications consumed about 30% of mental health spending.

Some family physicians and pediatricians were psychologically minded before the middle of the 20th century, but very few. And psychotherapy

takes time, of which there is precious little in busy primary care practices. It also requires experience and skill that most primary care physicians don't have. Medication, on the other hand, seems easy to prescribe, and short visits billed as physical health care are more lucrative than long visits to provide most forms of psychotherapy.

Over time a basic expectation has emerged that primary care physicians will treat people with run of the mill mental disorders with medications and refer those with more severe or confusing disorders to mental health professionals.

Sadly, this approach does not work very well. According to the National Co-Morbidity Survey Replication (NCS-R) of 2000—the most extensive epidemiological study of mental illness—primary care physicians provide "minimally adequate" mental health services less than 15% of the time. Referrals also are problematic because about half of referrals are not pursued and of the half that result in treatment by mental health professionals, only about half of the patients get minimally adequate care.[11]

Nevertheless, reliance on primary care personnel to provide mental health services appears to be here to stay. Fortunately, there is a model of intervention known as "coordinated care management" that substantially increases the effectiveness of treatment in primary care settings.[12] Although it is not often used, as primary care practices increasingly become group practices with multiple specialties, there is hope that coordinated care management will become standard.

THE CHANGING ROLE OF GOVERNMENT

In the 19th century, public mental health services were provided directly by governmental entities, primarily in state hospitals with some services in some states provided by county or city hospitals. But over the course of the 20th century, particularly after WWII, "public" mental health services were increasingly dispersed between the public and the private sectors, with a substantial role for non-profit organizations, including general hospitals and community agencies, and for private practitioners, private psychiatric hospitals, residential schools for children and adolescents, and private rehabilitation facilities for people struggling with addiction.

Over time governments have reduced their roles as providers (the VA is a notable exception) and taken on increasing responsibility for organizing,

overseeing, funding, and assuring the quality of services provided by diverse providers.

These functions are incredibly complex involving highly detailed:

- Determinations about who and what is funded, how, and for how much
- The development and enforcement of standards for licensing professionals and organizations so as to assure reasonable quality of care
- Decisions about new services
- And much more, as I will discuss in a future lecture.

Speaking loosely, these are the "regulatory" functions of government, and those of you who will have careers in policy will undoubtedly spend a great deal of time working on these kinds of very detailed issues as regulators and as advocates.

Fragmentation Into "Silos" of Mental Health, Developmental Disabilities, Substance Abuse, and Dementia Services

Another major shift in the 20th century was the separation of mental health, developmental disabilities, substance use, and dementia in separate fields of practice and policy. This shift began as early as the 19th century with separate asylums for "lunatics" and "imbeciles". At that time and during the first half of the 20th century, people with dementia were generally grouped with people with serious mental illness in asylums for "lunatics"—later called "state hospitals". In fact, at the peak population of state hospitals in the United States, about 1/3 of the patients had one form of dementia or another.[13]

But from the standpoint of governmental management, mental illness (including dementia) and mental retardation (now called "developmental disabilities") and later alcoholism and substance abuse were usually grouped together. In New York State, for example, there was a Department of Mental Hygiene that covered mental health, "mental retardation", alcoholism, and substance abuse—four "disability areas", as they are now called.

In the mid-1970s the Department was split into four cabinet level Offices, each with its own commissioner. These were the Office of Mental Health, the Office of Mental Retardation, the Division of Alcohol Abuse, and the Division of Substance Abuse. The latter two merged into the Office of Alcohol

and Substance Abuse Services shortly thereafter. [‡]

Later, services for people with dementia, (usually called "organic brain syndromes") were moved under the umbrella of the Department of Health, which was responsible for what is now called "long-term care", including nursing homes, assisted living, home health, and medical day care.

These splits, and others like them in other states, reflected vast differences in perspective and tremendous animosity among the providers and advocates for each "disability area". What have emerged are separate fields that do little to communicate, coordinate, or cooperate. These have come to be called "silos", though I'm not at all sure what the source of the metaphor is.

Almost immediately the bureaucratic separation into silos resulted in serious problems for people with co-occurring disorders. For example, in New York about 40% of people primarily classified as developmentally disabled also have a mental illness. Many people who misuse alcohol, medications, and/or illegal substances also have a mental disorder and/or a cognitive impairment. A high proportion of people with serious and persistent mental illness also misuse substances and are at high risk for dementia. And virtually all people with cognitive impairments experience "neuropsychiatric" symptoms—depression, anxiety, psychosis, substance misuse, difficult behavior, etc.—at one time or another.[14]

Various, mostly unsuccessful, efforts have been made to coordinate care. This notably included efforts to provide integrated services for people with both mental and substance use disorders, who—at various times—have been called "mentally ill chemical abusers (MICA)", "dually diagnosed", or people with "co-occurring disorders".

Over time a concept of "behavioral health" emerged, which covers treatment of people with mental and/or substance use disorders. This took place first in commercial managed care and later in public policy. It has become increasingly common to use the term "behavioral health" instead of "mental health", and the conceptual shift has been important to recent efforts to develop very complex managed care systems to integrate services. (I discuss this in greater detail in an article entitled "Behavioral Health: What A

[‡] It is interesting that local governments in NYS, including NYC, did not follow suit. They all have departments of "community" services that cover the four disability areas.

Difference A Word Makes". [15])

One popular approach to developing integration among the service systems has been mergers of governmental departments such as the Divisions of Alcoholism and of Substance Abuse in NYS. Currently, NYS has moved to integrate the Office of Mental Health with the Office of Addiction Services and Supports.

Another strategy is consolidation of behavioral health services under the umbrella of Departments of Health.

I have great reservations about both approaches. Mental health policy, in my view, should not be a subset of health policy because it is really an amalgam of social welfare, criminal justice, and health policy. And mergers of federal, state, or local governmental departments are often, in my view, bureaucratic illusions. Usually, the merged departments are broken into two sub-parts each headed by a Deputy Commissioner or Secretary and with little gain in communication or cooperation.

Integration, in my view, needs to take place on the ground, where services are provided. The problem of fragmentation is not conceptual or governmental; it is the failure to address the overall needs of human beings.

A Very Complex "System"

- What began over 200 years ago as a rather simple mental health (really a mental illness) system for people with severe and disabling mental illness has evolved into a large and very complex (non)system. There are many types of providers in both the private and the public sector. There are providers that are explicitly mental health providers and others in primary care, child welfare, education, etc. There are not-for-profit and for-profit providers. There are multiple levels of government—federal, state, county, and municipal—involved in funding, regulation, and service provision. There are diverse sources of funding. And so forth. (I discuss this in greater detail in my article "Improving American Mental Health Policy: No Simple Answers". [16])

- I began this lecture with a discussion of mental health policy for people with behavioral health problems that are not severely disabling. But as I have explained the developments, I think it has become clear that, while the development of services for people with less severe disorders took

place in parallel to the total redesign of services for people with psychiatric disabilities, the two streams of service intertwined over time. Now, as I've said, we have a very complex, somewhat incoherent bundle of behavioral health services.

- The attached chart gives some sense of the expanse and complexity of the so-called "system".

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[2] Freud, S. (1909). *Five Lectures on Psychoanalysis.*

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[4] Rieff, P. (1966). *The Triumph of the Therapeutic*

[5] Freud, S. (1930). *Civilization and Its Discontents*

[6] Freud versus Jung: a bitter feud over the meaning of sex | Aeon Ideas

[7] Centers for Disease Control (CDC). "Fast Facts: Preventing Adverse Childhood Experiences"

[8] Erikson, E. (1950). *Childhood and Society.*

[9] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet

[10] US Department of Education Website regarding IDEA Individuals with Disabilities Education Act (IDEA)

[11] Wang, P et al (2005) Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication - PubMed (nih.gov)

[12] Coordinating Care for Better Mental, Substance-Use, and General Health - Improving the Quality of Health Care for Mental and Substance-Use Conditions - NCBI Bookshelf (nih.gov)

[13] Kramer, M. (1977). Appendix 10. *Psychiatric Services and the changing institutional scene, 1950-1985*. MLibrary.

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