

Sixth Edition

MENTAL HEALTH AND SOCIAL POLICY

Beyond Managed Care

DAVID MECHANIC · DONNA D. MCALPINE · DAVID A. ROCHEFORT





CSWE's Core Competencies and Practice Behavior Examples in This Text

Competency	Chapter
Professional Identity	
<i>Practice Behavior Examples...</i>	
Serve as representatives of the profession, its mission, and its core values	1, 9
Know the profession's history	1, 3, 9
Commit themselves to the profession's enhancement and to their own professional conduct and growth	9
Advocate for client access to the services of social work	9
Practice personal reflection and self-correction to assure continual professional development	9
Attend to professional roles and boundaries	8–10
Demonstrate professional demeanor in behavior, appearance, and communication	
Engage in career-long learning	
Use supervision and consultation	9
Ethical Practice	
<i>Practice Behavior Examples...</i>	
Obligation to conduct themselves ethically and engage in ethical decision-making	8, 11
Know about the value base of the profession, its ethical standards, and relevant law	1, 9, 11
Recognize and manage personal values in a way that allows professional values to guide practice	
Make ethical decisions by applying standards of the National Association of Social Workers Code of Ethics and, as applicable, of the International Federation of Social Workers/International Association of Schools of Social Work Ethics in Social Work, Statement of Principles	
Tolerate ambiguity in resolving ethical conflicts	8, 9, 11
Apply strategies of ethical reasoning to arrive at principled decisions	8, 9, 11
Critical Thinking	
<i>Practice Behavior Examples...</i>	
Know about the principles of logic, scientific inquiry, and reasoned discernment	4–6, 12
Use critical thinking augmented by creativity and curiosity	
Requires the synthesis and communication of relevant information	4–6, 12
Distinguish, appraise, and integrate multiple sources of knowledge, including research-based knowledge, and practice wisdom	4–5, 9, 12
Analyze models of assessment, prevention, intervention, and evaluation	5, 8, 10, 12
Demonstrate effective oral and written communication in working with individuals, families, groups, organizations, communities, and colleagues	



CSWE's Core Competencies and Practice Behavior Examples in This Text

Competency	Chapter
Diversity in Practice	
<i>Practice Behavior Examples...</i>	
Understand how diversity characterizes and shapes the human experience and is critical to the formation of identity	4, 6
Understand the dimensions of diversity as the intersectionality of multiple factors including age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation	4, 6
Appreciate that, as a consequence of difference, a person's life experiences may include oppression, poverty, marginalization, and alienation as well as privilege, power, and acclaim	1, 6, 10
Recognize the extent to which a culture's structures and values may oppress, marginalize, alienate, or create or enhance privilege and power	2, 3, 5
Gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups	
Recognize and communicate their understanding of the importance of difference in shaping life experiences	
View themselves as learners and engage those with whom they work as informants	
Human Rights & Justice	
<i>Practice Behavior Examples...</i>	
Understand that each person, regardless of position in society, has basic human rights, such as freedom, safety, privacy, an adequate standard of living, health care, and education	1-3, 10, 11
Recognize the global interconnections of oppression and are knowledgeable about theories of justice and strategies to promote human and civil rights	5, 11
Incorporates social justice practices in organizations, institutions, and society to ensure that these basic human rights are distributed equitably and without prejudice	1, 3, 9-11
Understand the forms and mechanisms of oppression and discrimination	3, 7, 11
Advocate for human rights and social and economic justice	9, 11
Engage in practices that advance social and economic justice	5, 7, 9-11
Research Based Practice	
<i>Practice Behavior Examples...</i>	
Use practice experience to inform research, employ evidence-based interventions, evaluate their own practice, and use research findings to improve practice, policy, and social service delivery	4-10, 12
Comprehend quantitative and qualitative research and understand scientific and ethical approaches to building knowledge	4, 6, 12
Use practice experience to inform scientific inquiry	5, 8, 9, 12
Use research evidence to inform practice	1, 4-8, 12

Competency	Chapter
Human Behavior	
<i>Practice Behavior Examples...</i>	
Know about human behavior across the life course; the range of social systems in which people live; and the ways social systems promote or deter people in maintaining or achieving health and well-being	1, 2, 4–6, 10
Apply theories and knowledge from the liberal arts to understand biological, social, cultural, psychological, and spiritual development	5
Utilize conceptual frameworks to guide the processes of assessment, intervention, and evaluation	2, 5, 6, 12
Critique and apply knowledge to understand person and environment	1, 2, 4, 5
Policy Practice	
<i>Practice Behavior Examples...</i>	
Understand that policy affects service delivery and they actively engage in policy practice	1–3, 7, 8, 10–12
Know the history and current structures of social policies and services; the role of policy in service delivery; and the role of practice in policy development	3, 6–11
Analyze, formulate, and advocate for policies that advance social well-being	1, 3, 10–12
Collaborate with colleagues and clients for effective policy action	10, 12
Practice Contexts	
<i>Practice Behavior Examples...</i>	
Keep informed, resourceful, and proactive in responding to evolving organizational, community, and societal contexts at all levels of practice	9
Recognize that the context of practice is dynamic, and use knowledge and skill to respond proactively	2, 6, 9
Continuously discover, appraise, and attend to changing locales, populations, scientific and technological developments, and emerging societal trends to provide relevant services	3, 4, 6, 9, 10
Provide leadership in promoting sustainable changes in service delivery and practice to improve the quality of social services	9, 10



CSWE's Core Competencies and Practice Behavior Examples in This Text

Competency	Chapter
Engage, Assess Intervene, Evaluate	
<i>Practice Behavior Examples...</i>	
Identify, analyze, and implement evidence-based interventions designed to achieve client goals	5–9
Use research and technological advances	5, 8, 10, 12
Evaluate program outcomes and practice effectiveness	8, 12
Develop, analyze, advocate, and provide leadership for policies and services	1, 9, 10, 12
Promote social and economic justice	1, 2, 9, 10, 11
A) ENGAGEMENT	
Substantively and effectively prepare for action with individuals, families, groups, organizations, and communities	5, 9
Use empathy and other interpersonal skills	5, 9
Develop a mutually agreed on focus of work and desired outcomes	5, 6, 9
B) ASSESSMENT	4, 7, 12
Collect, organize, and interpret client data	
Assess client strengths and limitations	5, 9, 12
Develop mutually agreed-on intervention goals and objectives	5, 9
Select appropriate intervention strategies	5, 6, 8–10, 12
C) INTERVENTION	
Initiate actions to achieve organizational goals	10, 12
Implement prevention interventions that enhance client capacities	5, 9
Help clients resolve problems	5, 9, 11
Negotiate, mediate, and advocate for clients	11
Facilitate transitions and endings	5, 9
D) EVALUATION	
Critically analyze, monitor, and evaluate interventions	8, 12

SIXTH EDITION

Mental Health and Social Policy

Beyond Managed Care

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Preface

Mental Health and Social Policy: Beyond Managed Care provides a multidisciplinary review of mental illness and its treatment. It addresses disease patterns, conceptual debates, services, financing, professional resources, legal issues, and historical and contemporary policy directions related to the field. This text should be well suited to the kind of mental health policy survey course that has become a standard part of the curriculum in undergraduate and graduate programs in social work. It is also intended for students and researchers in other fields, such as public health, human services, psychiatric nursing, psychology, sociology, political science, public policy, and public administration, who may be seeking a broad-ranging analysis of mental health policy in American society.

First published by the lead author in 1969, or more than 40 years ago, this book was written in the early era of deinstitutionalization, a decade in which public mental hospitals were rapidly reducing their patient populations; when many new social programs including Medicare and Medicaid were enacted as part of President Johnson's "War on Poverty"; and when the Vietnam War and its effects began to unravel the fabric of American society.

American psychiatry in the 1960s was still dominated and controlled by psychoanalytic and psychodynamic practitioners, largely working in office-based practice and mostly with middle-class patients having mild and moderate conditions. Meanwhile, a large number of people with serious mental illness, most of them poor, were left neglected and untreated. This was an unusual situation compared to other areas of medicine, where the worst sicknesses and disabilities generally attracted the greatest attention and expertise of the medical profession. The book's first edition had as its central theme the need to correct existing priorities by giving more attention and resources to those with the most severe and persistent mental disorders. Each subsequent edition (1980, 1989, 1999, and 2008), which were also the work of the lead author, reinforced this perspective. Fortunately, priorities have shifted over the decades and persons with serious conditions now receive more treatment than before. Yet inequalities by race, ethnicity, social class, and type of psychiatric condition persist.

Policies concerning mental health and mental health services have become increasingly complex. In developing this sixth edition, it seemed best to extend the range of expertise through collaboration. The book's two new coauthors bring not only an expanded range of knowledge and perspectives about the mental health field but also an informed sense of students' experiences with the book. Donna McAlpine is associate professor and director of the program in Public Health Administration and Policy at the University of Minnesota School of Public Health. Donna completed her Ph.D. in sociology at Rutgers in 2001 and collaborated with David Mechanic over several years on about a dozen papers and chapters on mental health services. David A. Rochefort is Arts and Sciences Distinguished Professor of Political Science at Northeastern University. He has published several books on health and social policy and has researched the mental health services field extensively in

the United States and Canada. David also completed a postdoctoral fellowship in 1986–87 at Rutgers in the mental health research training program directed by David Mechanic, and the two wrote papers together on mental health and health care reform and comparative health systems. In this way, the preparation of this sixth edition offered a welcome opportunity for the three colleagues who had benefited from and respected each other's work to come together again and focus on revising a well-established text, keeping it current with the distinctive risks and opportunities of this second decade of the twenty-first century.

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David Mechanic would like to express his sense of great fortune over the past 33 years for having the close friendship and collegueship of Gerald Grob and Allan Horwitz at Rutgers, both exemplary contributors to the mental health field. Grob is the preeminent medical historian of mental health services in America; Horwitz is a medical sociologist who has contributed to many areas including conceptions of mental illness, mental health epidemiology, and changing patterns of mental health services.

We would also like to thank Joanne Atay and Judy Teich from the Substance Abuse and Mental Health Services Administration (SAMHSA) for making available early results from *Mental Health, United States, 2010*. Over the years, these data have proved invaluable for describing changes in the U.S. mental health system. We also thank Ron Manderscheid, Executive Director of the National Association of County Behavioral Health and Developmental Disability Directors, for helping us obtain needed data. Ron spent many years at the National Institute of Mental Health and SAMHSA and was instrumental in promoting and maintaining many of the data sources used in this book.

We are all deeply indebted to Margaret (Peg) Polansky, who kept us on course, checked facts and references, and assured that we met all necessary publication requirements. Peg is more than a truly outstanding assistant, and we are very grateful to her.

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Mental Health and Mental Illness as Social Issues

Human feelings and behavior are extremely variable. The same people may be happy or sad, energetic or lethargic, anxious or calm depending on their environment and personal lives at the time. Many emotions and reactions fall within the normal range of response to everyday events. To be sad when a loved one dies and to be anxious about an important but difficult examination are normal responses because such feelings fit the situation. Feelings of sadness, depression, or anxiety by themselves do not constitute mental illness. But what does constitute mental illness remains the subject of debate.

In 1973, David Rosenhan published “On Being Sane in Insane Places,” an article reporting the results of what would go on to become one of the most famous of all social science studies. Briefly, the research involved sending pseudopatients to mental hospitals to determine what diagnoses and treatments they would receive. The main conclusion was that mental health professionals inaccurately applied diagnoses of major mental illness (usually schizophrenia in remission) while interpreting the subjects’ normal behaviors consistent with these diagnoses. In sum, Rosenhan concluded professionals could not reliably distinguish sane from insane. While the validity of this experiment subsequently became the subject of debate (e.g., Spitzer 1976), it succeeded in casting doubt on the very nature of our definitions of mental illness. The article begins with a question we continue to struggle to answer: “If sanity and insanity exist, how shall we know them?”

DEFINING MENTAL ILLNESS

Much has changed in the decades since the Rosenhan study, including our choice of words. When once to talk of sane versus insane may have seemed sensible, now we talk about mental illness, mental health, and degrees of psychiatric disability. But the central question remains equally salient today as it was in 1973. How do we know what mental illness (or health) is? This question challenges us to take an additional step, and ask: If we do not know what mental illness is, how do we develop social policies that are appropriate and effective?

The struggle to find a valid definition of mental illness continues to preoccupy researchers and policymakers. Even the practice of defining mental illnesses

as something apart—different—from physical illnesses seems foolish and has had unintended consequences. The brain is a part of the physical body. The feelings that constitute something like depression play out in the body and are experienced physically. Yet a distinction between mind and body underpins insurance models that historically have funded and delivered mental and physical health services separately. Thinking of mental health as something distinct from general physical health has led to feelings of embarrassment or shame when the designation of mental illness is applied. Similarly, we know that to write about mental illness as though it is one condition or disease is a vast oversimplification. Mental illness encompasses much diversity, from relatively minor forms of emotional distress to often debilitating disorders that substantially interfere with the ability to function over long periods of time. Using the term “mental illness” is simply a convenient communication device; it is not an adequate reflection of the heterogeneity of conditions we might think of as coming under the umbrella of the term.

One approach to defining mental illness is to conceive of it as a deviation from normal reactions or feelings given one’s life circumstance. The difficulty with such an approach is that what is normal or deviant is socially and culturally defined. Although a person from a cultural background featuring a belief system based on witchcraft might understandably be fearful of being poisoned or harmed by magic, a similar reaction from a person born and raised in Akron, Ohio, would leave us puzzled and concerned. Such an incongruity might indeed suggest mental illness. Persons with countercultural lifestyles appear bizarre to more conventional persons, but their patterns of dress and action are not necessarily discordant with their peers’ beliefs and values.

Another major way of identifying deviations from “normal” is through recognition of personal suffering that is not justified by the circumstances of an individual’s life. Although it may be normal for an unemployed person who cannot adequately provide for his or her children, or who is deprived and discriminated against, to feel anxious or depressed, we infer that a person showing a similar reaction under favorable life circumstances and in the absence of any objective provocation may be psychiatrically disordered.

Definitions of mental illness also often take into account some determination of how much the symptoms interfere with our functioning in common roles. The dominant paradigm for defining mental illness in the United States, as expressed in the *Diagnostic and Statistical Manual of Mental Disorders*, for example, specifies that a disorder must produce “clinically significant distress or impairment in social, occupational, or other important areas of functioning” (American Psychiatric Association 1994, p. 7). How one should operationalize significant distress or impairment is, however, not clear.

An important concept in the realm of mental health policy is “severe and persistent mental illness” (SPMI), although again there is no universally agreed upon definition. However, the term is usually intended to convey a history of serious acute episodes, psychiatric comorbidities, continuing residual disability, and high levels of medical and psychosocial need. Patients showing such signs typically have serious problems in many facets of daily living, including work, social relations, and family life, which necessitate special programs and resources.

The notion of “severe and persistent” speaks to the trajectory of the condition and not the diagnosis; thus, it is difficult to obtain an accurate count of this population group, although we will later review best estimates. Even though diagnoses such as schizophrenia encompass a large proportion of patients with SPMI, the diagnosis itself is not a true measure of chronicity. The course of disorder and level of function vary a great deal. Typically,

for public policy purposes, estimates of this population are based on duration of illness or treatment or disability, the latter measured by inability to work, or pronounced difficulty in carrying out activities of daily living.

Debates about what constitutes mental illness matter. At the most basic level, they identify groups of special interest in society, that is, categories of individuals considered to be deserving of public expenditures, and target populations for public policy initiatives. For example, the first national review of mental health policies in the United States took place in the late 1950s. It contended that national efforts should concentrate on the needs of people with the most severe impairments, people who at the time were likely to be housed in long-term mental hospitals:

A national mental health program should recognize that major mental illness is the core problem and unfinished business of the mental health movement, and that the intensive treatment of patients with critical and prolonged mental breakdowns should have first call on fully trained members of the mental health professions. (Joint Commission on Mental Illness and Health 1961, p. xiv)

The period following this report was marked by the large-scale movement of people out of mental hospitals into the community as well as major health initiatives, such as Medicaid, that substantially shifted many responsibilities, especially the financing of care for individuals with the most severe mental disorders, to the federal government. Yet the 1960s was also a period when the nation adopted a more comprehensive vision of community mental health care and began to create a service system devoted to a broad range of assistance for all kinds of disorders, from mild and moderate to severe.

Decades later, under the Clinton Administration, the first Surgeon General's Report on Mental Health took a broad stance on the definition of mental illness and the kinds of problems meriting attention on the national agenda:

The Nation's contemporary mental health enterprise, like the broader field of health, is rooted in a population-based public health model. The public health model is characterized by concern for the health of a population in its entirety... In years past, the mental health field often focused principally on mental illness in order to serve individuals who were most severely affected. Only as the field has matured has it begun to respond to intensifying interest and concerns about disease prevention and health promotion. (U.S. Department of Health and Human Services 1999, pp. 3-4)

Research and policy in this recent period have tended to focus more on common mental disorders such as depression, and less on disorders that are usually more severe but affect fewer people, such as schizophrenia. Although serious debate was lacking about the trade-offs of implementing policy at the population level versus addressing the needs of people with the most severe mental illnesses, most experts now agree on the benefits of strategies such as screening for mental health problems in primary care. With passage of the federal Patient Protection and Affordable Care Act (ACA) of 2010, the affirmation of its constitutional status by the U.S. Supreme Court, and its many provisions improving behavioral health services through health homes, collaborative care, and other approaches, program initiatives focusing on behavioral health within general medicine will increase.

Neither a broad nor a narrow policy approach is inherently right or wrong. Indeed, it is easy to support the notion that everyone experiencing psychological distress or emotional pain is deserving of attention. But public resources are limited. In addition, medical

treatment does not come without side-effects. Encouraging increasing numbers of people to be treated for self-limiting periods of emotional distress seemingly is wasteful and sometimes comes with its own risks. Moreover, there are opportunity costs to consider. If we devote our policies primarily to addressing the more common mental health problems such as depression and anxiety, does this divert attention and resources from much less common, but sometimes more debilitating, disorders? Balancing the needs of persons with very different types of mental health problems remains an essential policy dilemma.

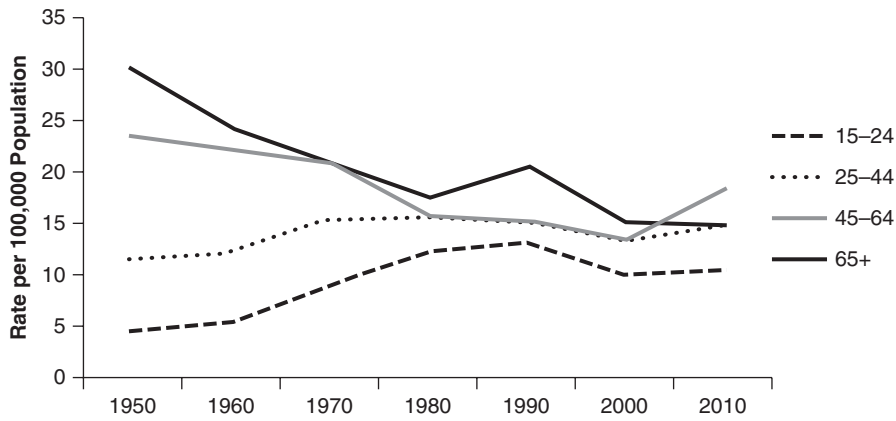
Debates about what constitutes mental illness will never be fully resolved. While there have been great steps forward in our understanding of the chemistry and structure of the brain, there is unlikely ever to be a meaningful biological test to identify depression, anxiety, schizophrenia, or the like. Although we continue to struggle with definitions, accepted practice now relies on clinical judgments based on the presence of specific constellations of symptoms judged to be indicative of disorder. Applying these formal clinical criteria to community samples, researchers have concluded that about one-half of the U.S. population will meet the criteria for one or more types of common mental illness sometime in their lifetime. Even if someone goes through life without such a problem, most people are extremely likely to know someone with a mental illness.

The experience of mental illness is most often intensely private and marked by profound suffering for the individual and his or her close family and friends. First-person narratives by those who have lived with and through this situation remind us powerfully of this reality. Novelist William Styron (1992), in his memoir *Darkness Visible*, describes his own clinical depression as “despair beyond despair.” Jay Neugeboren (1997), also a writer, provides an unforgettable account of decades of struggle during which he coped with his brother Robert’s severe mental illness. While arguing that persons with all forms of mental illness have the potential to live happy, satisfied lives, he also reminds us that “hundreds of thousands of other human beings, like Robert, despite all forms of treatment and medication, continue to live grim lives of madness, misery and despair” (1997, p. 22). Countless other biographies and autobiographies speak to the plight of individuals living with mental illness. However personal and private the predicaments may be, it is also important to recognize that the experience of mental illness can be shaped by decisions in the public arena, including social policies. Part of the responsibility of policymakers is to understand the consequences of mental illness and to configure programs and policies that may alleviate distress and neglect.

THE CONSEQUENCES OF MENTAL ILLNESS

One of the most tragic consequences of mental illness is suicide. In 2010, there were almost 38,000 deaths by suicide in the United States (Murphy, Xu, and Kochanek 2012). This figure likely vastly underestimates true prevalence because it only includes suicides listed as such on death certificates. Over the decade between 2000 and 2010, suicide ranked as either the tenth or eleventh leading cause of death (Heron et al., 2009; Murphy, Xu, and Kochanek 2012).

Risk of suicide varies significantly by age. As shown in Figure 1.1, between 1950 and 1980 suicide rates declined steeply for persons aged 45 and older, while increasing for the youngest age groups. Historically, persons 65 years and older have had the highest rates of suicide. After 2000, however, middle-aged persons took over this position. The reason for

Figure 1.1 • Suicide Rates by Age Group in the United States: 1950–2010

Source: Data from 1950–2000 from National Center for Health Statistics. *Health, United States, 2011: With Special Feature on Socioeconomic Status and Health*. Hyattsville, MD. 2012. Available online: www.cdc.gov/nchs/data/hus/11.pdf; Data for 2010 from Murphy, Xu, and Kochanek, 2012; data for age group 65+ not available, estimate based on 2008 data.

this trend is not clear, but it may be due partially to the aging of the baby boom cohort. This cohort of men had increased risk of suicide in adolescence and young adulthood compared to cohorts that came before or after them, and perhaps this risk has persisted into middle age (Phillips et al. 2010). While, in general, older persons have had higher suicide rates than those younger, much of the public's attention is riveted on younger age groups. This is not surprising, given that suicide ranks as the third leading cause of death for persons between 15 and 24 years old, accounting for almost 11 percent of all deaths in this group (Murphy, Xu, and Kochanek 2012).

There are also important race and gender differences in suicide. As shown in Table 1.1, among all racial groups, men have higher rates of completed suicide than women. White and American Indian males have particularly high rates compared to the other racial groups.

It is, of course, difficult to know what proportion of suicides is due to mental illness, although depression and other mental disorders often play a role. Some studies have attempted to make the connection through psychological autopsies that include reviews of administrative data, such as hospital records, and interviews with key informants to try to establish the circumstances of people's lives leading up to death. There is a high level of concordance between estimates of disorder based on personal clinical assessments and reports on comparable measures from a close relative or friend (Schneider et al. 2004). There is also a high level of agreement between diagnosis based on psychological autopsies and those based on information from clinicians who treated the victim (Kelly and Mann 1996). However, it is always difficult to weigh retrospective reports concerning the factors leading up to such a dramatic and shocking event as a suicide given the efforts of informants to attribute meaning to prior events. In a systematic review of studies using psychological autopsy methods, Cavanagh and colleagues (2003) examined the frequency of evidence that suicide victims had previously met the criteria for a DSM disorder.

**Table
1.1****Age-Adjusted Suicide Rates (per 100,000), 1999–2009**

Race/Ethnicity	Female	Male	Total
Hispanic/Latino	1.8	9.7	5.7
White	4.9	19.8	12.1
African American	1.7	9.5	5.3
Asian or Pacific Islander	3.3	8.4	5.7
American Indian	4.8	17.5	11.1
Total	4.4	18.3	11.0

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999–2009 on CDC WONDER Online Database, released 2012. Data for year 2009 are compiled from the Multiple Cause of Death File 2009, Series 20 No. 20, 2012, Data for year 2008 are compiled from the Multiple Cause of Death File 2008, Series 20 No. 2N, 2011, data for year 2007 are compiled from Multiple Cause of Death File 2007, Series 20 No. 2M, 2010, data for years 2005–2006 data are compiled from Multiple Cause of Death File 2005–2006, Series 20, No. 2L, 2009, and data for years 1999–2004 are compiled from the Multiple Cause of Death File 1999–2004, Series 20, No. 2J, 2007. Accessed at <http://wonder.cdc.gov/ucd-icd10.html>

They estimated as many as one-half to three-quarters of all suicides could be avoided if mental illness could be prevented, obviously a utopian possibility. Moreover, they found mental disorder to be a stronger correlate of suicide than other factors such as social isolation, physical health problems, or recent stressful life events.

Many persons who commit suicide have had contact with health services prior to their death. Perhaps as many as three-quarters of suicide victims visited a primary care physician and one-third had contact with a mental health specialist within the year prior to their suicide (Luoma, Martin, and Pearson 2002). More current data concerning contact with health providers by suicide victims in the United States are needed. However, existing research suggests potential opportunities for detection and treatment of mental illness.

A particularly promising point of intervention is hospital emergency rooms (ER), where many persons who attempt to harm themselves first appear. This group is almost six times more likely to commit suicide following hospital discharge than persons in the general population (Olfson, Marcus, and Bridge 2012). A randomized controlled study by the World Health Organization in Brazil, India, Sri Lanka, Iran, and China assessed the effects of an intervention among people who were originally seen in the ER following a suicide attempt. This intervention involving an hour-long information session combined with nine follow-up contacts by phone or in-person over 18 months reduced subsequent deaths by suicide eleven-fold (Fleischmann et al. 2008). A related nonrandomized prospective study in the UK followed for 12 weeks persons who had poisoned themselves. The researchers found that only 10 percent of those receiving psychosocial assessment and

support poisoned themselves again while 18 percent who did not receive such an assessment did so (Kapoor et al. 2002).

Olfson, Marcus, and Bridge (2012) used national Medicaid claims and other data to assess whether patients who engage in deliberate self-harm received mental health assessment and follow-up outpatient mental health care following an ER admission. Only about half such patients underwent psychological evaluation or had any follow-up within 30 days of discharge. Given the fact that suicide remains a relatively rare event, self-harm ER admissions would appear to be a strategic point for realistic suicide prevention efforts.

That persons with mental illness have greater mortality risk than the general population has been well established. One early study tracked a community sample of persons 40 years of age and older for whom detailed measures of psychiatric disorder were available (Bruce et al. 1994). Nine years after initial assessment of disorder, their survival status was recorded. Overall, depression, alcohol-use disorders, and schizophrenia increased risk for mortality. The leading causes of death for persons with mental illness were circulatory diseases and cancer-related illness, a pattern that largely paralleled the distribution of mortality for the population as a whole.

Another study examined mortality among persons served by public mental health services in eight states from 1997 to 2000 (Colton and Manderscheid 2006). Across all states, the relative risk of death for public mental health clients exceeded that for the general population, adjusted for sex and age. Overall, public mental health clients experienced 13 to 30 years premature loss of life. In general, clients with major mental illness (MMI)—schizophrenia, major depressive disorders, bipolar, delusional and psychotic disorders, and attention deficit/hyperactivity disorders—died at younger ages than clients of public mental health services with non-MMI diagnoses in the same state. For the six states where information was available, the researchers found similar patterns between the general population and persons with mental illness in regard to cause of death, with heart disease, stroke, cancer, diabetes, respiratory illness, and lung diseases topping the list.

Druss and colleagues (2011) studied a nationally representative sample of Americans, some with a diagnosis of mental illness (schizophrenia, affective disorders, substance use, and other mental disorders) and some without, followed for a period of 17 years. Unlike previous studies, these researchers controlled for socioeconomic status (SES), health system factors such as having health insurance, and baseline health status including the presence of comorbid physical conditions, obesity, and self-assessed general health status. Overall, about 27 percent of persons with a mental illness died during the follow-up period, compared to 20 percent of persons with no mental disorder. Death occurred about eight years earlier on average for those with a mental illness. As in previous studies, the causes of death for people with a mental disorder coincided with those for the general population, including cardiovascular disease (34 percent), cancer (21 percent), and pulmonary disease (14 percent). Only about 5 percent of deaths were due to suicide, homicide, or accidents. Controlling for demographics, SES, health system factors, and health status reduced the relationship between mental disorder and risk of death to nonsignificance. In particular, SES and health system factors each accounted for about one-quarter of the excess mortality among persons with mental disorder, highlighting the need to address such risks for this population.

Rates of smoking are much higher among persons with schizophrenia than the general population. The most recent meta-analysis of studies worldwide, which was based on outpatient and inpatient samples, estimated the prevalence of smoking among persons

with schizophrenia to be 62 percent (de Leon and Diaz 2005). High rates of smoking have also been observed for persons with many other types of mental illness. In population studies in the United States and Australia, current smoking rates were about twice as high for persons with a mental disorder (anxiety, affective disorders, or substance use) as for others (Lawrence, Mitrou, and Zubrick 2009). Overall, in both studies, about 30 percent of current smokers had a recent mental illness.

Our understanding of why persons with mental illness are more likely to smoke has been hampered by the tobacco industry's involvement in setting the research agenda (Hirshbein 2012). The research that grew out of a collaboration between the tobacco industry and psychiatry proposed that the link between smoking and lung cancer is not as strong for persons with severe mental illnesses as for the general population. Unfortunately, however, mentally ill smokers die of lung and other cancers much like everyone else. This research also suggested that smoking might in a way be beneficial for persons with mental illness by providing a calming effect and acting as a stress modifier. Many mental health consumers and advocacy organizations, while acknowledging the physical consequences of tobacco use, have embraced this more positive view of smoking. The "right to smoke" even became part of the empowerment movement (Hirshbein 2010). Mental health advocacy groups, for example, successfully lobbied for exempting psychiatric hospitals from smoking bans. As a result, until recently there has been little serious attention within public health circles to mental illness and smoking, while clinicians have often regarded smoking as a secondary medical concern in treating persons with mental illness. There is need for better understanding of why persons with mental illness have such strong attachment to tobacco use before we can hope to develop the necessary interventions to reduce smoking (Hirshbein 2010).

Beyond the health hazards associated with smoking, antipsychotic medications contribute to metabolic risk. The side-effects of common atypical antipsychotics, particularly clozapine and olanzapine, include elevated risk of obesity, elevated triglyceride levels, increased fasting glucose levels, high blood pressure, and other components of the metabolic syndrome that increase risk for diabetes and cardiovascular disease (Meyer and Stahl 2009; Newcomer 2007). When patients with serious mental illness receive inadequate medical care, it compounds these problems (Druss et al. 2002; Newcomer and Hennekens 2007).

The disability associated with mental illness exceeds that of many chronic illnesses. Researchers have estimated and compared the disability impacts of common chronic physical conditions (e.g., arthritis, asthma, heart disease, and cancer) with specific mental disorders (depression, anxiety, and impulse control disorders) in four areas of life: home, work, social interaction, and ability to form and maintain close relationships with others (Druss et al. 2009). Overall, having a mental illness is associated with greater impairment than physical disorder in each area of functioning. Depression and bipolar disorder feature the greatest level of impairment, exceeding that of chronic illnesses such as chronic pain syndrome and heart disease. However, disabilities in specific realms of life differ by type of disorder. While the greatest impairments for persons with mental disorder occur in the domains of social functioning and relationships, chronic physical disorders are more likely to interfere with functioning inside the home and work activities.

The aggregate amount of disability associated with mental illness is striking (Merikangas et al. 2007). Disability days are those when one is totally unable to carry out work or other day-to-day activities. On average, common chronic physical conditions account for about 7 annual disability days (arthritis) to 53 days (irritable bowel syndrome),

while mental health disorders account for between 14 disability days (specific phobias) and 28 days (major depressive disorders). Taking into consideration prevalence of disorder, mood and anxiety disorders are the second and third most disabling conditions respectively, following musculoskeletal disorders. These results generally confirm an earlier Medical Outcomes Study that found patients with depressive disorders, or even depressive symptoms short of clinical disorder, had comparable or greater disability than patients having eight other chronic conditions such as diabetes, arthritis, ulcers, and spine problems (Wells 1989).

These studies do not include assessments of the disabilities associated with schizophrenia and many other severe disorders, but we know from other research that the latter are even more disabling. Schizophrenia, for example, is perhaps the most disabling of all mental disorders and often associated with problems in living independently, finding work, maintaining social relationships, and managing activities of daily living.

Mental illness and socioeconomic disadvantage also coincide. Even when controlling for other childhood adversities, such as parental neglect or parental mental illness and low socioeconomic status, there is evidence that having an externalizing disorder, such as impulse control or substance use problems, is strongly associated with terminating school early (Breslau et al. 2008). Adults with a mental illness are less likely to be employed (Mechanic, Bilder, and McAlpine 2002). Having a severe mental illness also correlates with lower levels of income when employed (Kessler et al. 2008).

While mental illness proves to be a strong predictor of poor general health, and negative social and economic outcomes, there is much variability depending on type and stage of disorder as well as life circumstances. Behavior disorders in childhood represent one area in which we can readily appreciate the potential gravity of consequences.

CONSEQUENCES OF BEHAVIOR DISORDERS IN CHILDHOOD

Children are one of society's most vulnerable populations but also a group with tremendous future potential regarding all aspects of life. For this reason, it is apt to focus on behavior disorders during childhood as one key indicator of the impact of mental health problems.

According to longitudinal epidemiological studies, antisocial behavior during childhood often results in difficulties later in life (Odgers et al. 2008; Robins 1966, 1979a, 1979b). Resistance to authority during childhood, as reflected in delinquency, drinking, and sexual behavior, is correlated with the development of employment difficulties, problems with the law, alcoholism, drug abuse, and early death in adulthood. Children in this troubled group often begin to stand out early in their school years due to low IQ, poor reading and poor school performance in general, and truancy.

The best research that has followed people throughout their lives comes from the United Kingdom, where four major birth cohort studies (1946, 1958, 1970, and 2000) have been conducted (Richards et al. 2009). The first three of these cohort studies now have data on individuals from childhood into middle and later life. The research team did not directly assess disorders, but instead relied on early reports from teachers or parents concerning poor conduct (such as fighting, lying, and disobedience) and emotional problems