Progress in mental health services has been made incrementally in a sequence of policy steps. In recent years, in spite of political conservatism, progressive changes have advanced new principles of service delivery. Reports from the surgeon general and the President’s New Freedom Commission on Mental Health advanced these principles, including recovery and evidence-based practices. Both of these high-level reports were influenced by the findings of the Schizophrenia Patient Outcomes Research Team (PORT). The Schizophrenia PORT established the effectiveness of mental health treatments and supports, which provided a scientific foundation for the optimistic focus on recovery and its expectation of improved outcomes for individuals with severe mental disorders. The PORT study also established the gap between treatment recommendations and actual services. Concern about this gap has motivated efforts to transform services by implementing evidence-based practices. Advances in broad mental health and social policy, coupled with continued advances in science, have the potential to improve the care of individuals who experience severe mental disorders, such as schizophrenia.

Key words: mental health policy/mental health services

In 1978 Schizophrenia Bulletin published a seminal article on “community support,” a new concept for mental health services for individuals with severe and persistent mental disorders. The concept of community support broadened the view of the service needs of individuals with disabling mental disorders beyond traditional medication and office-based psychosocial treatments to encompass an array of rehabilitation and support services, including employment and housing. Dissatisfaction with standard treatment in the mental health system, particularly in community mental health centers, prompted this reform. The National Institute of Mental Health (NIMH) spearheaded this reform movement, and leaders at NIMH chose Schizophrenia Bulletin as the vehicle to announce this new service concept to the mental health field and the scientific community. Almost twenty years later, when the Schizophrenia Patient Outcome Research Team (PORT) identified further service delivery and quality problems, Schizophrenia Bulletin published the key papers.

These publications were encouraged by the NIMH, then the publishers of Schizophrenia Bulletin, presumably to keep the scientific audience abreast of important service delivery and policy issues that were relevant to them and to the patients and families whom their investigations were intended to help. In the decade since the publication of the findings and recommendations of the Schizophrenia PORT, there have been further important events and changes in policy that are of interest to the readers of Schizophrenia Bulletin. Among them was the release of Mental Health: A Report of the Surgeon General (1999) and Achieving the Promise: Transforming Mental Health Care in America (2003), the final report of the President’s New Freedom Commission on Mental Health.

This article reports on some key historical events and policy directions for the future. It begins by introducing a conceptual framework for thinking about progressive changes in mental health services. It refers to concepts such as “recovery,” “sequentialism,” “evidence-based practices,” and “transformation,” placing them in the context of contemporary mental health policy. It continues with a history of progress over the past 25 years and concludes with a discussion of the implications for mental health care—for administrators, clinicians, service users, and their families.

Conceptual Framework

In spite of the rise of increasingly conservative social policies in the United States and many other countries, there are signs of progressive changes in mental health policy. These progressive reforms have emerged in conservative times in the past quarter century. (By “conservative policies” I mean policies that favor limited government intervention, reduced public spending on health and social programs, and reliance on market forces, also called...
“fiscal conservatism.”) These reforms have favored community integration and social inclusion—what we call “recovery”—and these progressive changes have occurred one step at a time. They can be explained (in part) by a process of incremental social reform guided by a clear vision of a better quality of life for individuals with severe mental illness.

Two theoretical concepts are useful for thinking about mental health policy. One framing concept is the idea that policy has moved in a series of cycles of reform. Reforms began with the asylum movement of the early nineteenth century and moved through the mental hygiene movement of the early twentieth century to the community mental health and community support reforms of our current era. The second of these concepts is sequentialism—the idea that policy may advance more progressively in a series of incremental steps if advocates or policymakers have direction, guided by a blueprint or vision. Policy can then proceed by a series of sequential steps toward a goal rather than meander as undirected incrementalism.

Where Do We Stand Now?

At the present time one cannot declare victory, and go on to other endeavors. The interim report of the President’s New Freedom Commission in 2002 recorded many current deficiencies and serious problems. In a forthcoming monograph Richard Frank and Sherry Glied conclude that although the conditions for individuals who experience a mental illness are better now than 25 or 50 years ago, there are many problems left to address. Individuals with the most severe and persistent mental disorders are still profoundly disadvantaged. They have poorer health outcomes than the general population and those with less severe mental disorders. They also have poorer school and work outcomes and are more likely to end up homeless. Furthermore, although there are effective treatment and rehabilitation services potentially available, the supply does not meet the need for such services because of limits on financing and organizational barriers. With the progressive move away from centralized institutions toward community care, stewardship became decentralized, fragmented, and often diffused among many human service agencies and policymakers.

Although the field has developed several important blueprints for change over the past quarter century, it may need a roadmap more than a blueprint to be more successful in improving the lives of people with severe mental illness. The implication is that a more action-oriented agenda is needed to get from current problems and a vision of the future to effective solutions.

Where the blueprint has been effective, there has been a confluence of forces that moved policy forward in incremental steps. One such example is the case of the implementation of the National Plan for the Chronically Mentally Ill (NP/CMI) during the 1980s. In 1978 the mental health commission appointed by President Jimmy Carter called for legislation and for a “plan” that would review all of the rules and regulations that affected the lives of individuals with chronic mental illness. The NP/CMI was completed in 1980 in the midst of the presidential election and was embargoed from release until after the election. During the ensuing years under Presidents Ronald Reagan and George H. W. Bush, the NP/CMI had no place in official administration policy. Yet, advocates worked with lawmakers to turn the blueprint of the national plan into a road-map. By 1990, a decade after its tentative release, most of the important recommendations of the NP/CMI had become law with supporting regulations. The advocates had used the plan as a blueprint for incremental change, moving in a consistent direction in behalf of the population.

The observation of the advances of mental health policy in the 1980s, in spite of the apparent opposition of the Reagan and first Bush administrations to mental health reform, gave rise to the idea of “sequentialism.” That work and those observations also influenced the thinking of the recent President’s New Freedom Commission through its director, Michael Hogan, whose strategy for the commission was modeled after the “quiet success” of the NP/CMI (personal communication 2003).

Historical Background

The idea that changes occur incrementally in health policy is not new. In a chapter in Eli Ginzberg’s book on American health reform, David Mechanic writes, “Experience throughout the world indicates that no health system achieves its full potential in a single leap. Rather, they evolve through iterative stages that reflect accommodations … and an appreciation of the need to fine-tune various financial and organizational features. To the extent that we view health reform as an evolving process, we will have better opportunities to achieve reasonable solutions built around widely shared principles” (p. 51). In the same volume health policy analyst Lawrence D. Brown contrasts “fundamental,” “comprehensive,” and “systemic” change models with the model of incrementalism and its concerns for the institutional and bureaucratic “details” that he concludes make all of the difference. Commenting on mental health reform in yet a third chapter in the same book, Goldman, Frank, and McGuire describe the “phased-in” approach for including mental health benefits in the Bill Clinton administration plan. Administrative and political obstacles to more comprehensive reform necessitated this explicitly sequential approach to major reform. The “phased-in” reform plan recommended a basic mental health benefit that was better than typical private insurance benefits for the first
stage of health reform—to be followed by a more comprehensive benefit package if costs could be controlled.

Tipper Gore, the wife of Vice President Al Gore, had cochaired the Working Group on Health Care Reform that proposed the phased-in benefits for mental disorders. She had strongly preferred the more comprehensive approach and was disappointed in the negative responses she received to the broader reform proposals. Perhaps most shocking to her were the dismissal of the “reality” of mental disorders and serious doubts about the effectiveness of treatment and services expressed by opponents of expanded insurance benefits. Even when bolstered with evidence from research on mental illness, the comprehensive proposals were rejected by the leaders of health care reform. Research documents from professional associations and the NIMH were dismissed as “advocacy” documents (Tipper Gore, personal communication, 1993).

After attending the release of a report of the surgeon general on physical activity and health at the 1996 Olympic Games, Tipper Gore was impressed with the value of the imprimatur of the nation’s leading health officer. Immediately, she began the process within the administration that led to the writing of a report of the surgeon general on mental health,4 released in 1999 (Tipper Gore, personal communication, 1999). Although the report did not include specific policy recommendations, it outlined a vision for the future and 8 “courses of action” to improve mental health in the United States. The following 8 courses of action were derived from the scientific review by the surgeon general: (1) continue to build the science base; (2) overcome stigma; (3) improve public awareness of effective treatment; (4) ensure the supply of mental health services and providers; (5) ensure state-of-the-art treatments; (6) tailor treatment to age, gender, race, and culture; (7) facilitate entry into treatment; and (8) reduce financial barriers to treatment.4

The report of the surgeon general6 laid the scientific foundation for reform, and its courses of action suggested a set of directions for the policy recommendations that were to emerge from the President’s New Freedom Commission on Mental Health. The commission was formed in April 2002 and worked for 1 year to develop an interim (2002)5 and a final report (2003).5

**Where Do We Go from Here? What Does the Future Hold?**

The final report of the President’s New Freedom Commission on Mental Health lays out a series of goals and recommendations for “transforming” the mental health system.5 It is directed toward improving the chances and opportunities for recovery for individuals with severe mental disorders to permit them to live and work in their communities. The report emphasizes the importance of reducing fragmentation and implementing evidence-based practices for achieving the goals of the commission. The goals are for a consumer-driven system, where mental health is viewed as fundamental to health and where disparities based on race and region are eliminated. The report envisions a mental health service system where early screening, assessment, and evidence-based treatment are the rule, where research is accelerated, and where information technology becomes commonplace.

Underlying the cycles of reform concept is the idea that new technologies for treatment and rehabilitation might permit progressive change. Each previous cycle of reform was built on the idea that some new approach to treatment—moral therapy in asylums, mental hygiene in psychopathic clinics, community mental health in centers—would prevent chronicity through early treatment of acute mental illness. The Achilles’ heel of these reforms was the lack of effective treatment technology to accomplish the fundamental objective. New places for treatment were developed, but mental disability was not prevented. The community support reforms of a quarter century ago uncoupled reform from prevention and instead offered the idea of mainstream community supports to improve the quality of life of individuals with severe mental impairments. At first, the objective of community support was meeting the basic humane support needs of disabled individuals. Then, the aspirations and expectations of reformers grew into the hope for community integration, social inclusion, and recovery. The rehabilitation technology to achieve these goals is only slowly developing, but unlike earlier reforms there is a technology to sustain the reform. The report of the U.S. surgeon general4 and the initiatives on evidence-based practices that followed16,17 including the President’s New Freedom Commission on Mental Health,5 all affirmed the scientific advances in effective interventions to support recovery.

In July 2005 the federal government released an “action agenda” to guide the would-be transformation of mental health care in America, the objective of the Bush commission.18 It was a step in the right direction, but it did not call for much in the way of new expenditures that many feel are needed to advance evidence-based treatments. In the same month a coalition of mental health advocacy organizations, called the Campaign for Mental Health Reform, issued a “roadmap” of their own to recommend policy changes consistent with the goals of the president’s commission.19

Even without adding new resources the report has implications for mental health practice: We can all set “recovery” as a goal for individuals who experience a mental disorder. Optimism about chances for community participation is more likely to bear fruit than the pessimism that pervaded the thinking and practices of previous generations of service providers. That optimism will be even more warranted, if we continue to guide practice with scientific evidence. Implementing evidence-based
practices is difficult, but it is imperative. It is also critical to continue to build the science base with more research on treatment and related service interventions. We can all embrace the broader vision of community participation in a system of community support. According to that vision, mental health services should assist service users to gain employment and improve their housing status, as well as provide treatment to relieve distress and improve functioning. More than ever, mental health policy flows in the mainstream of broader social policies, affected by and affecting policy and practice in education, employment, housing, criminal justice, child welfare, and juvenile justice.

Conclusion

What is needed now is the political will to close the gap between what the science tells us works and what we make available to those in need. The goals and recommendations of the commission report are lofty and can only be achieved in a conservative era of incremental change if advocates press for the reforms recommended in blueprint or roadmap documents such as the commission’s final report. People with severe mental disabilities need better treatments and rehabilitation services and more supports, such as housing and employment opportunities. They need less stigma and discrimination and more support from the general population. To accomplish these goals we need to provide financing and organizational reforms to stimulate better services, to implement evidence-based practices, to disseminate treatment guidelines, and to improve the quality of services and supports. Recent history suggests that making progress requires reformers to make strategic choices of incremental steps to achieve their goals. They are more likely to succeed by following a vision embodied in a high-level report from a trusted source to serve as a roadmap for change and progress on achieving shared objectives.

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