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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.

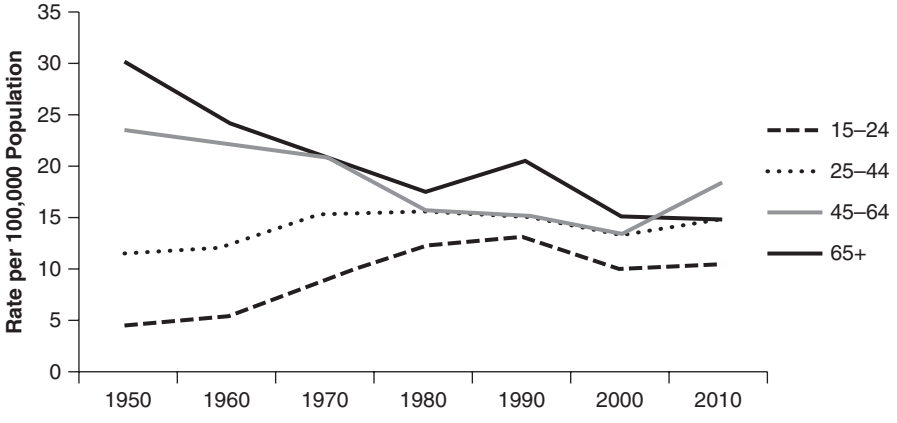
The experience of mental illness is most often intensely private and marked by profound suffering for the individual and his or her close family and friends. First-person narratives by those who have lived with and through this situation remind us powerfully of this reality. Novelist William Styron (1992), 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/hus11.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 (Kapur 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

(such as fearfulness, worries, and solitariness). Results indicate that behavioral problems in childhood have much stronger repercussions into adulthood than emotional problems. Having a severe, or even mild, conduct disorder in childhood or adolescence goes along with a range of negative outcomes over time, such as lower educational attainment and earnings, greater risk of teenage parenthood, disengagement from economic activity, and problems with the law. Moreover, these risks do not appear to be explained by SES in childhood or psychological variables like early cognitive ability or hyperactivity.

What emerges from many studies is the sad trajectory followed by so many of these children, one in which problems exacerbate with age and have disastrous outcomes for both the affected individuals and society. Although a violent and aggressive childhood does not necessarily ensure such patterns in adulthood, such behavior is unlikely to develop subsequently if it was absent at an earlier age. Social deprivation, low social status, and adverse cultural environments can be overcome. Children living in well-functioning homes under such conditions still do well in adult life. Poor social and economic conditions, however, are conducive to family pathology, child abuse, alienation, and lack of encouragement for achievement, which all increase the probability that children growing up under such conditions will have difficulties. Social deprivation, broken homes, parental deviance, child abuse, and little parental supervision or interest in the child are often interrelated, making it difficult to isolate the central causal factors contributing to the child's maladjustment.

Childhood dysfunction does not thwart all possibility of productivity and fulfillment in adulthood. Children with conduct problems, school difficulties, and poorly developed skills can overcome these issues, but the risk of adult difficulties after such a vexed start in life is considerable. The 40-year follow-up of children from the 1946 British birth cohort found that, while having a conduct disorder during adolescence was associated with lower educational attainment, still 35 percent in this group whose problems were classified as severe managed to achieve educational qualifications (Colman et al. 2009). A major challenge for mental health workers—and for policymakers—is to intervene effectively when children enter into circumstances with poor prognoses so as to maximize their life chances and well-being (Mrazek and Haggerty 1994; O'Connell, Boat, and Warner 2009).

THE IMPORTANCE OF MENTAL HEALTH PROFESSIONS

Mental health care is an intensive form of human service typically delivered on the basis of one-to-one contact between a patient (or consumer) and a specially trained clinical practitioner. For this reason, a critical resource in operation of the mental health system is the supply of mental health professionals within different disciplinary specializations. Changes in the organizational location of professionals, their assigned responsibilities, and the nature of their interaction with each other have often been a focus for mental health program and policy innovations. Just as significant, however, much of the conflict over administrative control and payment practices inside the mental health field has had to do with determining appropriate roles for professional personnel.

According to one classic definition, a profession may be distinguished from other areas of work by its standing in the social structure and the division of labor (Freidson 1988).

A profession possesses control over its work in a specialized domain and is sanctioned by society to exercise this control. Often, though not always, certain attributes go along with this special status, such as superior skill, a theoretical knowledge base, and an ethical code on the part of members of the professional group.

Conceived in this way, no mental health professions existed prior to the founding of mental hospitals. Within the field of medicine, a professional specialty of psychiatry was born out of the asylum system of the 1800s, and its originating concepts and practices were largely a by-product of this setting (Grob 1973). While psychiatrists sought to root their work in science and medical knowledge, they also emerged as a specialty distinctly concerned with questions of institutional management and social control. A key element in this story was formation of the Association of Medical Superintendents of American Institutions for the Insane in 1844 with Dr. Samuel B. Woodward, superintendent of Worcester State Lunatic Hospital in Massachusetts, as its first president. Although the professionalization of psychiatry and mental hospitalization were wedded together as social processes by the early twentieth century, psychiatrists began to forsake public institutions as desirable places for conducting their professional practice, capitalizing on their M.D. status to move to private practice.

As mental hospitals grew rapidly in size, women were recruited to attend female hospital patients. Psychiatric nursing developed out of the need for this group of workers, and many training programs were situated at the asylums (Boling 2003). It was not unusual for psychiatrists and nurses to live nearby the patients on the hospital grounds, so enveloping was the mental institution as a social environment. One leading figure in the development of psychiatric nursing in the United States was Hildegard E. Peplau, who founded the first graduate-level program for clinical nurse specialists in psychiatric nursing at Rutgers University in 1954 (Neeb 2001). As the education of psychiatric nurses became more sophisticated and particular competencies were elaborated, it provided the means for mental health nursing personnel to go beyond the role of handmaiden to psychiatrists and to assume their own significant responsibilities in patient care and administration of services.

The origins of clinical psychology as a profession can be dated a short time after psychiatric nursing, or close to the end of the nineteenth century (Benjamin 2005). These practitioners were university-trained specialists in a new academic field that originally grew out of, and then separated from, philosophy. At first, psychologists were primarily devoted to testing and research, and they were tied to mental hospitals to carry out these activities. Later, when the United States entered World War I, the skills of this group were needed in constructing instruments for selecting recruits into different military occupations and for intellectual assessment of inductees. Psychologists also became involved in diagnosing cases of "shell shock," or what is now called posttraumatic stress disorder. In 1917, the American Association of Clinical Psychologists was established. It would take several more decades, however, and overcoming opposition from psychiatrists, before counseling and psychotherapy were consolidated as main areas of education and practice for psychology and the profession achieved the dominance it enjoys in this sphere today.

By contrast, a community orientation was inherent in the ideology of social work when the specialty of psychiatric social work took shape in the early decades of the twentieth century (Grob 1983; Stuart 1997). In 1907, social work services were added to the neurological clinic at Massachusetts General Hospital. By 1920, Mary C. Jarrett, who earlier had been Chief of Social Service at the Boston Psychopathic Hospital, formed a Psychiatric Social Workers Club that was forerunner to a psychiatric section within

the National Association of Social Workers. Social workers became essential personnel in the delivery of aftercare services for discharged psychiatric patients. Soon, their role expanded through participation in a variety of Progressive-era mental health programs, including outpatient mental health services, child guidance clinics, and the promotion of "mental hygiene." Parallel to the rivalry between psychiatrists and psychologists, psychiatric social workers were not always well supported by other practitioners in their quest for professional status and autonomy in the mental health field. Over the decades, however, psychiatric social workers honed a valuable perspective based on clinical expertise combined with sensitivity to the patient's social environment and knowledge of the functioning of community agencies and institutions. This outlook proved indispensable when the community mental health movement arrived (Silverman 1985). Still today, the evolving practice of case management imitates, in some respects, the activities and objectives of the early psychiatric social workers (Stuart 1997).

In mental health care there are other professionals and paraprofessionals—marital therapists, mental health counselors, rehabilitation specialists, and more—as well as subspecialties within categories, such as geriatric and forensic psychiatry and dual-diagnosis practitioners. But the four main groups of psychiatrists, psychiatric nurses, clinical psychologists, and psychiatric social workers define the core mental health professions, and these are the ones we will examine later in this book when reviewing mental health personnel trends and issues.

The state of mental health personnel has been recognized as a serious issue from the time when officials first began formulating mental health policy on the national level. The National Mental Health Act of 1946 included fellowships for individuals and institutional grants for professional training as one of three new areas of federal funding. Nonetheless, by the late 1950s, one systematic review of mental health personnel trends in the United States described a serious mismatch between the public's need for services and the availability of clinical professionals, a situation it characterized as no less than "desperate" and likely to persist for decades to come (Albee and Dickey 1957). Much growth in personnel has occurred since this time, but not so much that concerns about the shortage have abated. In 2009, in order to examine supply issues, researchers grouped mental health professionals into two categories, nonprescribing and prescribing personnel (Thomas et al. 2009). Nationwide, nearly one in five counties had unmet need for nonprescribers, while unmet need for prescribers was nearly universal. The situation is particularly severe for certain specialties. According to one estimate, the number of practicing child psychiatrists satisfies about only one-fifth of national requirements (Huang et al. 2004; Thomas and Holzer 2006). Long waiting lists prevail.

For reasons pragmatic and ideological, the shift to community care in the 1960s inspired development of a team approach among mental health professionals (Burns 2007). The logic was inescapable. If comprehensive mental health care depended on an array of psychological, medical, and social services, attention must be given to organizing and coordinating this multifaceted effort. Community Mental Health Centers pioneered the use of multidisciplinary treatment teams, including, at times, the participation of consumers. Currently, the Assertive Community Treatment program is the most well-known model for providing mental health care in the community by creative utilization of a variety of personnel in management and service delivery roles focused on supporting patients on a long-term basis. Yet teamwork can sometimes produce confusion as well as role strain (Cirpili and Shoemaker 2010; Mancini et al. 2009). As traditional lines of professional

functioning become blurred and overlap, new questions of authority, responsibility, and equitable compensation present themselves.

Other forms of professional tension also enliven the contemporary mental health scene. With the spread of managed care, providers have generally not taken kindly to attempts by health insurance gatekeepers to assert themselves as supervisors for clinical decision making. Psychologists continue to battle for prescribing privileges. And some psychiatrists question the progressive narrowing of their role, which has become increasingly devoted to brief medical consultations and less concerned with intimate engagement of patients through in-depth counseling (Harris 2011).

SOCIETAL BURDENS AND POLICY DILEMMAS

The disability, morbidity, and mortality associated with mental illnesses not only have consequences for individuals and their families, they also create a major societal burden. The costs of health care, lost earnings, and disability payments for persons with mental illness exceeded $300 billion in the United States in 2002 (Insel 2008). The World Economic Forum recently estimated the global costs of mental illness (including medical costs and indirect costs such as income loss due to morbidity and mortality) at about $2.5 trillion in 2010, with about 33 percent of this attributable to medical care. Meanwhile, the costs related to lost economic output (which includes lost capital and labor) approximate $16 trillion, a figure higher than similar costs associated with diabetes, cardiovascular disease, respiratory diseases, or cancer (Bloom et al. 2011).

Such calculations are, at best, rough estimates, but they do support the case that mental illnesses produce an immense social burden, one equaling or surpassing most other types of illnesses. Indeed, such estimates are probably conservative because they do not take into account many indirect costs like crime and incarceration, the effects of family disruption on children, special education and social welfare programs, family caregiving for members with mental illness, and homelessness. We do not have good estimates of these amounts, but they are substantial and they represent appropriate subjects of concern within the public policy process.

Sociologist C. Wright Mills (1959) made a classic distinction between personal troubles and public issues. The former has to do with concerns considered to be individual, private, and outside the sphere of government and politics. The latter refers to problems whose breadth and character are such that they impact the functioning of society, they reflect the structure and operation of social institutions, and they cannot be addressed meaningfully without public policy action. Recognition of mental health problems as a public issue goes back to the earliest days of American society when seriously disordered individuals lacking proper supervision were perceived to be a menace to the community and themselves. As we will see, it is a concern still perplexing to American courts in the twenty-first century. Over time, however, a specialized system of organizations, services, and funding gradually sprung up to provide not just custody but also care of those with mental health problems of all types. Today, that effort involves multiple levels of government and a spectrum of professional groups and bureaucratic agencies financed with public dollars. Whether mental illness is a public issue or not has long ago been settled. Yet this does not mean there is agreement on the priority to be given to mental health care versus other social commitments, nor

does consensus exist concerning the appropriate content and organization of mental health programs.

Definitions of mental illness shape the scope and purpose of mental health policies. Over the past two decades, the battle over parity insurance coverage for mental health and physical health problems resulted in passage of many pieces of regulatory legislation on the state and federal levels. But the question remains: Which mental illnesses should fall under the umbrella of parity rules and protections? This is a quandary that has stimulated persistent debate among policymakers, and many laws set boundaries by means of definitional approaches such as excluding substance abuse problems or applying the law only to a list of "brain diseases" or "biologically-based disorders." Similarly, when eligibility guidelines for disability programs specify which types of persons and mental health disorders qualify for benefits, it is a means of relegating others to a marginal status for income support initiatives of this kind. The Americans with Disabilities Act (ADA) of 1990 has so far had small effect on persons with mental illness due to narrow court interpretations of the law's applicability. Recent revisions to the ADA taking effect in 2011 could begin to correct this limitation, but it is far too soon to say for sure. One of the most enduring issues within U.S. mental health policy, previously noted, has been the choice between distributing resources across all levels of impairment and targeting assistance according to illness severity (Grob and Goldman 2006). The fact that diagnosis is not a reliable gauge of this latter characteristic only adds confusion to the controversy.

U.S. mental health policy reflects a delicate act of balancing responsibilities among local, state, and federal governments. Prior to the 1950s, states played the lead role, but the impetus shifted to the federal level with such reforms as the Community Mental Health Centers Act and Medicaid and Medicare. Nonetheless, some of the most innovative recent programs, such as assertive case management and the fashioning of community support systems, have emerged at the subnational level. It seems the pendulum of influence and control in mental health policy is always in motion. Over the past few years, economic recession has strained state budgets, diverting resources away from people with mental illnesses. At the same time, the federal Patient Protection and Affordable Care Act (ACA) of 2010 holds promise of greatly augmenting the ability of individuals with mental disorder to access treatment and care. In a mental health policy system like in the United States, however, almost nothing is uniform, and it will be essential to track the way key coverage issues are decided from one part of the country to another. At various places in this book, we will discuss the strengths and weaknesses of general health reform legislation when considered from the vantage point of mental health care issues.

Recent decades have seen the rise of powerful groups vying for decision-making control and resources within the mental health system. Providers, drug manufacturers, insurance companies, and managed care organizations all have a substantial stake in how mental health services are delivered and financed. Sometimes their interests converge with those of consumers, yielding positive results. For example, the profit motive of pharmaceutical companies has been partially responsible for new classes of drugs that have proved effective and lifesaving for many patients. At other times, stakeholder interests may diverge and lead to potentially perverse outcomes, such as when pharmaceutical companies, exploiting their market power, charge so much for their products that some needy consumers are excluded from the benefits.

In general, consumers of mental health services have been a weak political constituency in our society, with sporadic policy influence. This fact is a reflection of the particular forms

of disability produced by severe mental illness, inadequate organization and resources, and the difficulties of building a public advocacy movement centering on socially stigmatized conditions. Change is taking place so that an increasing number of mental health advocacy groups have come to the fore. Such interests now have much more say in policy matters than in previous eras, with the greatest gains in recent years being scored by the family movement and by the consumer/survivor movement (Tomes 2006). One drawback, however, is that groups seeking to represent or work on behalf of people with mental illnesses sometimes disagree among themselves. Divisions have been noted not just between families and consumers but within the growing constellation of consumer/survivor groups. Such fracturing disadvantages all parties in a competitive political arena.

Mental health policies have evolved in many ways over time. The first national review of the state of mental health and mental health services in the United States occurred under authority of the Mental Health Study Act of 1955. A Joint Commission on Mental Illness and Health set about the task of describing the existing system as well as formulating recommendations for change. In 1961, the commission issued its report, *Action for Mental Health*, whose preamble acknowledged the gap between rhetoric and reform in past consideration of this issue:

> It would seem futile to content ourselves with restating the problem of the unmet needs of the untreated or poorly treated mentally ill. Such a statement of *what*, as an aftermath of the millions and millions of words which have been written and spoken on the subject in the last fifteen years, would seem useless without at the same time seeking the more important explanation of *why* the words have not moved us. We are prone to boast of progress in mental health, and some has been made, but measured against the over-all dimensions of mental illness, our gains are pitifully small. (Joint Commission on Mental Illness and Health 1961, p. 4)

The report catalyzed important new directions within the mental health system, but not all turned out as planned. Public mental hospitals lost their dominant position in mental health care, but the difficulties of establishing a truly comprehensive and effective array of alternative services were largely unanticipated. The millions of words highlighting unmet needs continued to multiply, often landing on deaf ears.

In 2002, or more than 40 years after the Joint Commission's work made news, President George W. Bush convened the New Freedom Commission on Mental Health. The objective was much the same as with previous such efforts, including President Carter's Commission on Mental Health in the late 1970s and the first Surgeon General's Report on Mental Health in 1999. This was to refocus the national spotlight on the subject of mental health and illness and to compile the best available knowledge on the scope of the problem, its causes, treatments, and recommended services. In its letter to the president introducing the final report, his task force stated:

> Today's mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities. . . . The time has long passed for yet another piecemeal approach to mental health reform. (New Freedom Commission on Mental Health 2003, p. 1)

The point was not that the period between the first Joint Commission and the New Freedom Commission was one of inaction or constant backsliding. A person with severe

mental illness in 2012 is almost certain to have a very different experience, or at least a greater range of options, than one who fell ill in 1961. Much of the information presented in this book will document this reality and the expansion of evidence-based treatments, model programs, and insurance options. Popular television shows feature characters with mental health problems, and celebrities openly discuss their own personal struggles with mental illness in an unprecedented way. All these developments were unimaginable 50 years ago. Yet, as the commission bluntly stated, despite these and other favorable currents, the mental health care system remains deficient and disorganized. Many people with mental illnesses have bleak stories to tell that advertise its failures.

We see the shortcomings of mental health policy in the number of persons with mental illness who are homeless, in the large numbers of people in our jail and prison populations who have mental health problems (mostly untreated), and in the plight of consumers and their families who continue to struggle in navigating a system that seems at best illogical and at worst impossible. The fact is most people who meet the criteria for a mental health problem still do not receive treatment. Quality of care varies widely. Model programs have long waiting lines. Gaps in the system tend to be particularly pronounced within minority racial and ethnic communities, where those diagnostic and treatment services that are available often do poorly in recognizing and responding to cultural diversity.

CONCLUSION

A central question asked throughout this book is why psychiatry and mental health services have not reached a point of greater maturity, confidence, and public support and why mental health care often seems to stand apart from the progress and purposefulness one finds in other major disease sectors. To a great extent, the answer must be sought in our public policy choices, both the approaches we have adopted and those we have rejected or ignored. Debates surrounding mental health care are vital and consequential, not just academic abstractions. Mental illness is real, and so is the suffering of people with mental illnesses and their families and friends. Most persons with a mental illness want what everyone wants—a sense of mattering to others and of being worthwhile, having close relationships, finding something productive to do to occupy one's time and fulfilling one's talents. This book will look at how social policies have made these tasks easier or harder.

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