Systematic Failure: Mental Health Policy in the U.S.

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ABSTRACT

The United States spends only 5.6 percent of its health care spending on mental health, and the associated problems tend to receive national attention primarily in the wake of mass shooting events. This policy aspect of mental health treatment appears to have faded from view in a relative way, and has devolved into a top-down and bottom-up failure. Government policy has been bifurcated between (a) paying private-sector actors such as pharmaceutical companies and hospitals to render outpatient treatment and (b) transferring de facto management of the mentally ill to prisons and municipal authorities. This paper contends that the ultimate reason for this devolution in mental health policy has been the successive failure of both institutionalization and deinstitutionalization, which in turn has reduced the policy scope that government can apply to the problem of mental health treatment. The reduction is best understood not as a single, simple reflection of either public opinion or political orientation, but as the result of a systematic, decades-long failure of two distinct policy approaches.

MENTAL HEALTH POLICY IN THE UNITED STATES

In the span from 1985 to 2006, the largest component of mental health spending in the United States evolved from expenditures on hospitals to retail prescription drugs. From 2007 onwards, this trend has accelerated, such that, as of 2015, retail prescription drugs represented roughly 33% of all mental health care spending in the United States. Figure 1 below demonstrates how rapidly the gap between hospital spending and prescription drug spending was closed in the critical 1985 to 2006 period:

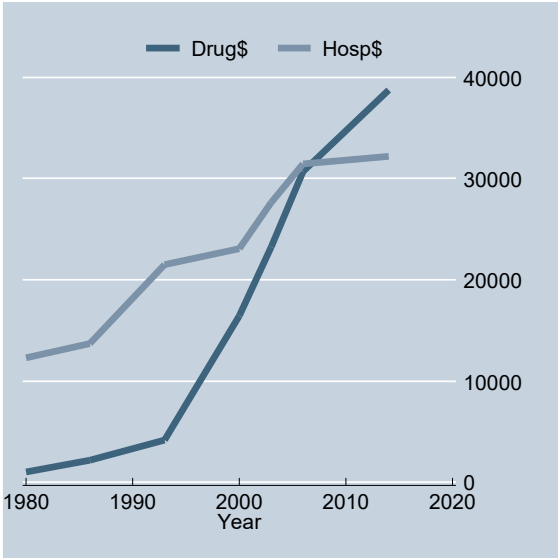

Figure 1. Change in American Mental Health Spending, in Millions of $. Original figure based on tabular data collected by the United States Department of Health and Human Services (DHHS 2014).

When these data are disaggregated, they demonstrate that, as early as 2003, pharmaceutical spending had become the largest category of spending in American mental health care.

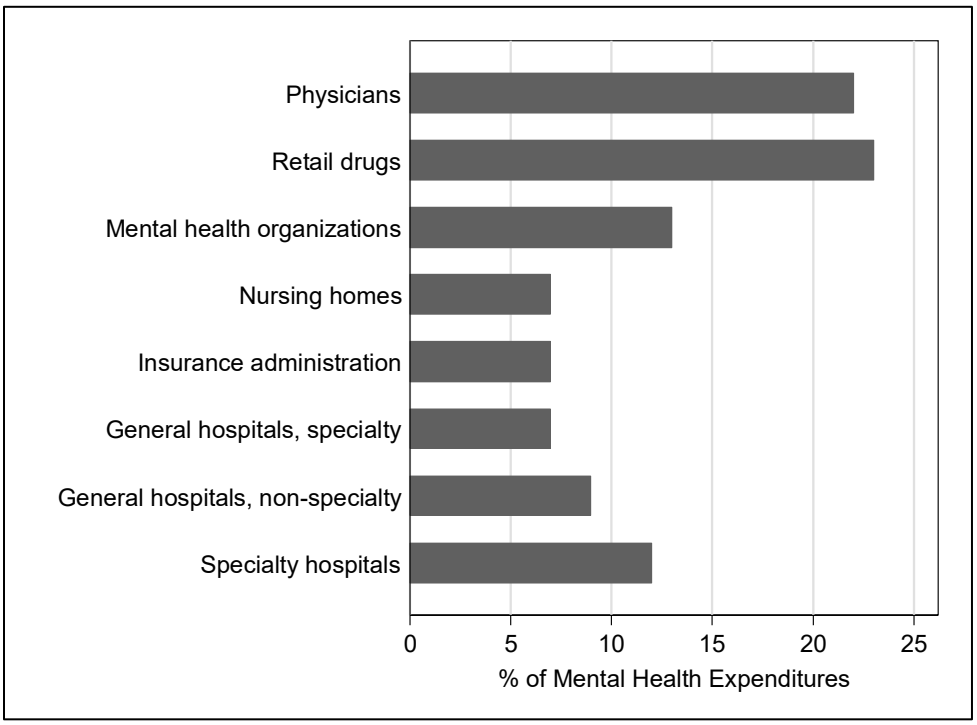

Figure 2. Distribution of Mental Health Expenditures by Service, 2003. Original figure based on tabular data collected by the United States Department of Health and Human Services (DHHS 2014).

At the same time that the structure of American mental health care spending has changed radically, it seems that (a) American healthcare spending is also growing more rapidly than healthcare spending in comparable countries and (b) American mental health patients are not receiving adequate levels of treatment. With respect to treatment satisfaction, there is broad consensus among scholars that the American mental health system is not performing well, especially in comparison to mental health systems in other OECD countries. The United States spends only 5.6 percent of its national health care spending on mental health, and the Bureau of Labor Statistics estimates that 89.3 million Americans still live in federally-designated Mental Health Professional Shortage Areas (BLS 2016). At the state level, there are many specific indicators of the quality breakdown in American mental health policy. For example, the New York State Office of Mental Health disclosed that roughly one-fourth of all patients remained symptomatic. In Alaska, a survey found that 38% of mental health outpatients reported low to non-existing access to needed services in 2011.

There is a consensus in the literature on mental health that, in the current setting, much of the American approach to mental health has been reduced to disseminating pharmaceuticals combined with superficial approaches to therapy. Some proof of the dominance of pharmaceutical approaches to mental health policy can be found by consulting Figure 1, which shows roughly 1500% growth in prescription drug spending over the same period of time that hospital spending grew by less than 250%. In other words, over the time period covered in Figure 1, American spending on pharmaceutical solutions to mental illness grew six times faster than spending on actual hospitals. Despite this shift in spending, the data show that American mental health patients are dissatisfied, and that mental health problems are growing.

The epidemiological and empirical data on mental health dissatisfaction suggest that the pharmaceutically centered, outpatient-based mental health delivery paradigm in the United States has some important limitations. With this background in mind, the main purpose of this research paper is to attempt to explain the observable shift in mental health care spending policy—away from hospitals and towards drugs—in terms of two policy failures, institutionalization and deinstitutionalization. It will be argued that the dominance of drugs in American mental health care treatment settings and paradigms represents the entry of the market into a policy realm from which government—first, as custodian of the hospital and later as custodian of the community mental health care center—has steadily distanced itself. The purpose of the paper is thus to suggest ways in which the drug-centric nature of American mental health treatment policy is likely to be related to the favor of government policies and the subsequent creation of a space for market entities to play a greater role in policy.

In terms of policy theory, the main thesis defended in the paper is that the current approach to mental health in the United States—an approach that can be described as *laissez faire* in terms of allowing the pharmaceutical and medical industries to drive paradigms of treatment—is the natural end result of what Kingdon (1984) described as the rise and fall of publically recognized problems:

> Problems not only rise on governmental agendas, but they also fade from view. Why do they fade? First, government may address the problem, or fail to address it. In both cases, attention turns to something else, either because something has been done or because people are frustrated by failure and refuse to invest more of their time in a losing cause.

Figure 3 below is a visual overview of the arguments encapsulated in the paper. Note that, over the course of some decades, important components of American society rejected both asylums and asylum alternatives:

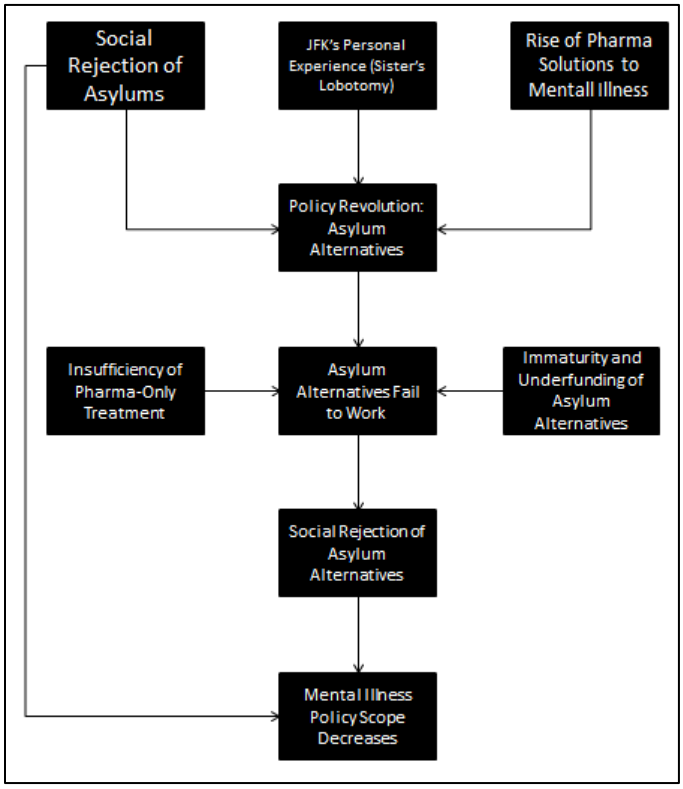

Figure 3. Visual Overview of Arguments. Original figure.

Simply put, two successive policy approaches to mental illness—namely (a) institutionalization and (b) deinstitutionalization—were both rejected, with the rejection of institutionalization resulting from advances in science and the development of more egalitarian views vis-à-vis the mentally ill and the rejection of deinstitutionalization resulting from widespread social disgust at the idea of mentally ill people leaving controlled environments and instead living in highly visible urban spaces. Understood from the viewpoint of Kingdon's theory, the failure of both institutionalization and deinstitutionalization has resulted in a fading of the issue of mental illness as a specific public health policy issue; the slack has been taken up by the private sector (particularly, the pharmaceutical industry) and by different branches of the public sector (such as prisons, which, functioning somewhat like contemporary asylums, house a vast population of the mentally ill).

Methodologically, the research paper aligns closely with Fernand Braudel's idea of a *longue duree,* in which historical events that might appear abrupt or unexplained can in fact be explained with reference to long-germinating trends and shifts. This kind of methodology has a great deal of explanatory power, especially given the paucity of primary sources. In the context of American mental health policy, for example, there are few primary sources in which Presidents, Senators, and other decision-makers offer reflections on how and why they entered into certain kinds of policy decisions, and market entities such as drug manufacturers do not disclose how and why they try to manipulate policy. However, there are many secondary sources that support inferences about how American mental health policy evolved, over the *longue duree*, in response to particular social, economic, and political forces. These inferences are subject to their own methodological weaknesses. In the case of 1960s-era deinstitutionalization, for example, there is no smoking gun to establish a relationship between the state's closure of mental hospitals, the economic incentives for the state to do so, and the convenience of new pharmacological treatments to provide a clinical reason for deinstitutionalization. Rather, inference, inductive methods, and persuasive argument have to be marshaled to make the case for the relationship between these variables. As such, the arguments advanced in this research paper are vulnerable to critique and alternative forms of interpretation. These limitations will be acknowledged in the concluding section of the paper.

With this background in mind, the paper has been structured as follows. The second section contains a brief historical overview and an examination of social pressures that, in response to the perceived inefficiency and inhumanity of mental hospitals, created a groundswell of support for the Community Mental Health Centers Act of 1963 and related legislation. The third section contains an overview of pharmacological developments that informed legislation designed to transition the mentally ill away from hospitals. The fourth section contains a discussion of the Reagan-era influences on mental health policy, particularly in terms of blocked or sabotaged legislation, and also discussions of developments in post-Reagan-era mental health policy in the United States. The fourth section also includes an empirical analysis of policy, lobbying, and spending outcomes related to mental health policy. The fifth and final section contains a summary and synthesis of the arguments of the study, as well as speculations and reflections on both the past and future of American mental health policy, based on the evidence presented and also on a subjective assessment of the current social and political climate in the country.

HISTORICAL OVERVIEW

The idea of a mental hospital dates from the 17th century, when, according to the French historian/philosopher Michel Foucault, there was a paradigm shift in the understanding of mental illness itself. This paradigm shift was closely related to the evolution of policy. As modern nation-states evolved, they began to regulate states and concepts—including mental illness—that had once been untouched by law. In this context, the evolution of policies relating to mental illness are inextricably intertwined with policies addressing homelessness, as both mental illness and homelessness threatened states' powers of control.

Foucault was among the first scholars to call attention to the cultural construction of mental illness. This process unfolded in Europe over several centuries, as elites came to understand that the mentally ill were potential civil threats and had to be brought under social control. In fact, the whole notion of mental illness came about in the early modern era. As Foucault argued of conceptions of mental illness during this time, mental illness *per se* did not exist. Mentally ill individuals were considered to be either touched by God or demonically possessed.

Interestingly, Henry VIII was the initiator of the modern era of mental illness. "Prior to the establishment of the Court of Wards and Liveries by Henry VIII...the jurisdiction over Idiots and Lunatics was entrusted to the Lord Chancellor...[they were] afterwards transferred to the...*Secretary of Lunatics*" . This transfer of power was the beginning of the era of institutional approaches to controlling mental illness. In the early eighteenth century, the first asylums opened in England, shortly to be followed by asylums in the United States.

DOCUMENTING SHIFTS IN AMERICAN MENTAL HEALTH POLICY

Unfortunately, mental hospitals of the eighteenth, nineteenth, and much of the twentieth centuries were little better than prisons for the mentally ill. In fact, some scholars have characterized what went on in such institutions as torture. Mentally ill people in institutions were routinely lobotomized, punished, and otherwise tormented. Such conditions were unforgettably dramatized in Ken Kesey's *One Flew Over the Cuckoo's Nest*, a 1962 novel whose central incident is the lobotomy of a man in a mental hospital. Many Americans had, by this time, come into contact with the mental health system, either through their own institutionalization or through the institutionalization of friends or relatives, and they had formed overwhelmingly negative impressions of such institutions, which, as depicted by Kesey, were often inhumane.

At around the same time that Kesey published his famous work, the academics Erving Goffman and Thomas Szasz, among others, were chipping away at the legitimacy of the idea of involuntary mental hospitalization through scholarly publications. Finally, President Kennedy had been active in mental health policy, partly because his sister, Rosemary, had been lobotomized and institutionalized at the age of 23, at the behest of Joseph P. Kennedy, Sr. Shortly after his election, Kennedy had appointed the President's Panel on Mental Retardation, whose findings were part of the background of the Mental Retardation Planning Amendments of 1963.

Mental health policy in the United States has undergone profound changes over the past several decades. One illustration of this change is the transition of mental health patients from inpatient to outpatient settings. In 1955, mental health hospitals in the United States housed 570,000 patients, or about 0.34% of the national population. By the early 2000s, mental health

hospitals in the United States housed only around 50,000 patients , approximately 0.017% of the national population, a relative change of nearly 2000% from 1955.

In terms of policy, one of the most important contemporary developments vis-à-vis mental health was the passage of the Community Mental Health Centers Act in 1963[1]. The passage of this act can be traced back to developments in the 1940s. As scholars have pointed out, the formation of the National Institute of Mental Health (NIMH), created in 1949 and coming after the 1946 National Mental Health Act[2], was the first indication that the federal government was serious about trying to shut down mental hospitals and move the mentally ill back into communities. The federal government took the Community Mental Health Centers Act of 1963 as the pivot for a new era in American mental health policy. In his statement accompanying the Mental Health Amendments of 1967[3], President Johnson stated that "In 1963, we invested in a totally new idea: the conviction that community centers could bring treatment of the mentally ill out of the darkness; out of isolation---into places where the people live."

In 1967, President Johnson cited a reduction in the number of mental health inpatients from 570,000 in 1955 to 425,000 in 1966 as a metric indicating the success of the nation's new community mental health center-based policy. What is not as clear, however, is how and why such policy (a) initially took form and (b) evolved, particularly in the 1980s. Existing analyses cite the same forces President Johnson cited in his statement accompanying the Mental Health Amendments of 1967, which is American impatience with mental health hospitals that were perceived to not be functioning as efficiently and humanely as they ought to have been. However, a review of the literature indicates that this explanation is only partially convincing. At about the same time that a social consensus was forming against the idea of the mental hospital, pharmacologists and other scientists were pioneering new forms of treatment for mentally ill people that no longer required hospital stays as a precondition of treatment.

The evolution of American mental health policy can thus be understood in light of three major forces: (a) top-down pressures generated by pharmacological reforms of the 1950s and 1960s, (b) top-down as well as bottom-up pressures generated by social and political disdain for the mentally ill; and (c) bottom-up pressures generated by grassroots resistance to abusive mental hospitals during the same time period. Accordingly, one of the purposes of this research paper is to consider the role played by changing pharmacological science in the shift in direction of American mental health policy reflected in the Community Mental Health Centers Act of 1963 and similar legislation of the era. In doing so, a more nuanced account of the genesis of mental health policy can be presented, an account in which pharmacological industry lobbying and related market developments can also be considered as contributing forces to policy decisions.

One interesting theme in President Johnson's statement accompanying the Mental Health Amendments of 1967 was the presentation of a contractarian account of mental health policy, one in which the state was portrayed as owing the mentally ill access to certain public resources. By the time of the Reagan administration, a different political philosophy had been introduced, one in which the state recognized no binding obligations to the mentally ill . This attitude manifested itself not so much in the passage of new legislation as in the blocking of proposed legislation.

While American mental health policy has facilitated a move away from inhumane and outmoded mental hospitals, it has culminated not in Johnson's vision of community-based healthcare for the mentally ill, but in the formation of an inattentive and ineffective system no longer driven by the needs of the mentally ill themselves. This evolution in American mental health policy reflects the country's larger transformation from a vision of social justice

incarnated in Great Society-era policies to the reality of a *laissez faire* market in which the provision of once-public goods and services has been increasingly privatized, with less than salutary consequences for the mentally ill and, arguably, for other kinds of underprivileged and stigmatized populations as well.

Understand as part of a Braudelian *longue durée*, the American disenchantment with institutionalization can be considered a civil rights response to the essentially tyrannical idea of involuntary hospitalization, which, as Foucault has argued, was part of modern states' attempts to extend the regime of regulation as far as possible. However, this kind of argument lacks explanatory power. There had been active and influential anti-asylum movements in the United States from the 19th century onwards. A better argument is needed to explain why federal policy (particularly in the form of the Mental Health Amendments of 1967) began to favor deinstitutionalization in the mid-1960s and not earlier. One such argument is that pharmacological developments made it not only clinically feasible but also economically attractive for federal policy to skew towards deinstitutionalization, especially given changes to Social Security policy in 1965. As discussed in the next section of the paper, the pharmaceutical industry made it clinically possible for mental healthcare delivery to be shifted from the resource-intensive paradigm of a hospital to the more casual environment of outpatient settings in which the main task of health care would be to dispense medications to the mental health patient.

MEDICAL AND PHARMACOLOGICAL DEVELOPMENTS

Perhaps the most important American policy development of 1965 was the passage of the Social Security Amendments that created Medicare and Medicaid and, in so doing, transferred vast amounts of financial responsibility for healthcare from the states to the federal government. By that time, there had been a revolution in pharmacology, particularly as applied to psychiatry. In 1951, Dr. Laborit discovered chlorophenothiazine, a drug that calmed psychotic patients. Over the next decade, pharmaceutical research isolated other antipsychotic drugs and doctors all over the developed world began to administer them in large doses to patients. Such results, it has been argued, created a false sense of triumph in doctors. While antipsychotic drugs indeed treated systems such as delusions and hallucinations, "these drugs provide undesirable neurological side effects, including dystonia, akathisia, parkinsonism, and tardive dyskinesia...". Thus, many psychiatrists in America, the U.K., Germany, and other developed countries were treating the mentally ill with drugs that only masked their problems.

At the same time, doctors and administrators were also keenly aware of the cost savings involved in deinstitutionalizing patients. La Fond and Durham (1992) related that "In 1968 dollars, the state of New York saved an estimated $585 million per year by discharging patients from hospitals and switching them to other sources of income supports.". Thus, by the 1960s, the existence of various pharmacological treatments or pseudo-treatments for some forms of mental illness had provided both clinical and economic relief for individual American states, the federal government, and healthcare leaders. This confluence of factors must surely be considered as a complementary account of the evolution of American mental health policy.

The medical and pharmacological developments of the 1950s and 1960s represented a paradigm shift in the treatment of mental illness. Until the middle of the 20th century, the science of mental illness was limited by researchers' insights into the nature of the brain. Scientific understanding of the brain developed in fits and starts; it was not until the late 19th century, for example, that there was a working theory of the relationship between injuries to the

brain and certain kinds of mental illness. Even as a physicalist account of mental illness took hold, psychiatry and allied fields remained under the profound influence of Sigmund Freud and other scholars who had created an account of mental illness that was based more in the experience of the mentally ill person than in facts about brain function.

The debut of drugs such as chlorophenothiazine strengthened the scientific case for mental illness as a phenomenon resulting from problems of the brain that could, at least in certain cases, be cured by pharmacology. Pharmacology of this kind does not appear to have been invoked in policy; for example, Johnson's statement appended to the Mental Health Amendments of 1967 does not make any reference to the changing science of mental illness. Nonetheless, it is entirely possible—indeed, probable—that the pharmacological revolution in medicine provided an important justification and rationale for the changing face of mental health policy in the United States. However, there was no single point of decision, no one individual who observed the support that drugs such as chlorophenothiazine provided for deinstitutionalization. Rather, doctors, public administrators, policy-makers, and many other stakeholders independently and simultaneously observed that many patients who were deinstitutionalized in the 1960s responded quickly to antipsychotic medicines.

However, as Shadish et al. have argued, the ability of antipsychotic drugs to curtail symptoms did not work in all mental health patients, and, in many cases, required years of follow-up (and combination with other forms of therapy) to be objective. Shadish et al. argued that the invention and widespread dissemination of antipsychotic drugs created an unmerited sense of security among policy-makers, who did not wait to conduct the kind of longitudinal studies necessary to determine the long-term effectiveness of pharmacology. With drugs widely available, with the federal government eager to cut healthcare costs after the Social Security Amendments of 1965, and with the Mental Health Amendments of 1967 on the books, there were numerous pressures towards deinstitutionalization. Still, however strong the policy pressures, they were unlikely to be enacted had the new generation of drug treatments of mental illness not been available. Accordingly, the paradigm shift in the formulation and availability of pharmacological drugs needs to be taken into account when discussing the shift towards deinstitutionalization in American mental health policy. Without the pharmacological revolution of the 1950s and 1960s, deinstitutionalization would not have had as much defense from clinicians.

The idea behind new antipsychotic drugs was that they would be administered in the community mental health centers for which funding had been increased by the Mental Health Amendments of 1967. However, new developments in American mental health policy soon put an end to the idea of the community mental health center as a replacement for the state-run mental hospital.

It is important to place medical developments in their context as part of the larger argument offered in this thesis. Simply put, medical developments related to the development of anti-psychotic drugs—and, in time, other pharmacological solutions to different aspects of mental illness—can be considered as part of a supply mechanism, whereas popular and elite abandonment of the institution of the psychiatric hospital (and, over time, other inpatient-oriented trends in the treatment of mental illness) can be considered part of a demand mechanism. These mechanisms of supply and demand are closely intertwined. Although there was some demand for the replacement or termination of psychiatric hospitals before the discovery of pharmacological treatments of mental health issues, it is unlikely that such demands could have been plausibly met in policy and practice without the existence of a supply of new

treatments—specifically, pharmacological treatments, which could be offered simply and at low cost—to replace the paradigm of the psychiatric hospital, and, more generally, the idea of dedicated inpatient care for the mentally ill.

One of the challenges in discussing the trajectory and characteristics of American mental health care policy lies in the inextricability of the supply of alternative solutions, the demand for new approaches, and, as noted briefly in the review of literature, the difficulty, if not impossibility, of separating scientifically valid research from political pressures and the theory-informed nature of data themselves, as noted by Krippendorff (2009). For this reason, it is important not only to discuss the isolated strands in American mental health care policy but also to describe how the strands are related to each other. The discussion of post-Reagan developments in American health care policy contains an appreciation of the interweaving roles of supply, demand, theory, science, and politics in this regard.

THE REAGAN ERA AND MENTAL HEALTH POLICY

American mental health policy in the 1970s and 1980s can be understood as part of a larger Atlantic shift in the idea of a democratic government's responsibilities. The 1970s saw the political ascendance of two remarkably similar ideological figures, Ronald Reagan in the United States and Margaret Thatcher in the United Kingdom, who both championed a *laissez faire* state in which the rights of the underprivileged—including mentally ill and homeless people—were largely neglected.

In policy terms, perhaps the most important development related to mental illness during the Reagan administration was not a positive act of legislation, but rather the defeat of existing legislation—the Mental Health Systems Act. The Mental Health Systems Act had been signed by President Carter just before the Presidential election of 1980, with the intent being to continue the funding of federal community mental health centers that had first been institutionalized under President Johnson in the 1960s. Carter had appointed a Presidential Commission on Mental Health, which created a National Plan for the Chronically Mentally Ill. However, as incoming President, Reagan allowed the legislation to die.

Anthony Marcus (2006) argued that 1979 is the proper starting date for any analysis of both modern homelessness and mental illness policy because of how "the arrival of Margaret Thatcher...and then the inauguration of her political disciple and confidant Ronald Reagan in 1981" altered policies as well as social attitudes related to mental health. Thatcher and Reagan, Marcus argued, construed both homelessness and mental illness as a social blight. However, in other contexts, the political mood under Reagan was inimical to the recognition of certain social problems, whose very existence could prove to be an embarrassment for Reagan's campaign theme of 'Morning in America.' Min (1999) recalled a statement by senior Reagan administration official Ed Meese to the effect that "hunger not only didn't exist in a serious sense in the U.S., but that those taking advantage of soup kitchens do so because the food is free rather than because they're destitute."

The Reagan administration's attitude proved to be instrumental in the evolution of mental illness, as it indicated the beginning of a period of government detachment from social services and the introduction of so-called market solutions to social issues. By 1983, a combination of *laissez-faire* ideology and Reaganite approach to the mentally ill made the existing problem of American deinstitutionalization worse by shutting down what few resources were left and creating an attitude of enduring contempt for the mentally ill homeless population. Writing in

the *New York Times* in 1983, Sullivan offered a vivid picture of the new reality that is worth reproducing in full, because it captures so many of the prevalent attitudes of the time:

> No one knows for sure how many there are, and there is sharp disagreement on how they got there. Nevertheless, there are thousands of homeless people living in the streets of New York City, and state and city officials agree that their presence has become a major political and social concern. The officials also agree that about a third of the homeless are former mental patients who were discharged from state psychiatric centers during the last three decades under a policy known as deinstitutionalization...Mayor Koch contends that the state's policy of deinstitutionalization has turned city neighborhoods into outdoor 'psychiatric wards...' .

By 1988, Reagan felt empowered enough to openly mock mental illness; for example, in a joke Reagan suggested that Democratic Presidential Candidate Michael Dukakis was mentally ill. Pressed to comment further by the *New York Times*, Reagan famously wisecracked, "Look, I'm not going to pick on an invalid."

The systematic rollback of resources for the mentally ill was complemented by new policies about the use of space, echoing the way in which England under the Tudors combined regulation of the mentally ill with regulation of once-public land. Washington, D.C. passed a right-to-shelter city ballot initiative in 1984, meaning that any homeless person in the city had a right to a bed in the city's emergency shelter program. In passing this initiative, Washington, D.C. bypassed the federal government entirely, and served as a model of local action to serve the homeless (and, intersectionally, the mentally ill) population. However, in 1990, Washington, D.C. voters repealed the ballot initiative, denying homeless people guaranteed access to city resources. There are many other examples of local laws that appear to target the intersection of mental illness and homelessness.

The National Coalition for the Homeless (NCH) conducted two studies, in 2002 and 2008, to track how 224 cities were dealing with the homeless population. Between these two studies, the NCH (2008) detected that: "There was a 12% increase in laws prohibiting begging in certain public places and an 18% increase in laws that prohibit aggressive panhandling…a 14% increase in laws prohibiting sitting or lying in certain public spaces…and a 3% increase in laws prohibiting loitering, loafing, or vagrancy."

These kinds of laws target the homeless and the mentally ill, two populations with substantial overlap, and illustrate how, particularly after the Reagan era, American policies have taken more and more space from the mentally ill. In the 1950s and 1960s, the mentally ill could at least count on a psychiatric bed; in the 1970s, the mentally ill had community centers and medication; by the 1980s, both psychiatric hospitals and community centers were largely absent from the environment, and many of the mentally ill were thus homeless. As homeless people, the mentally ill were also subject to regimes of exclusion and control encoded in local policies about the use of public space. Moreover, after Reagan, many homeless people simply ended up in prison.

The connection between prison and mental illness is not new. In *One Flew Over the Cuckoo's Nest*, the character Randle McMurphy feigns illness to evade a prison sentence in favor of a mental hospital. However, this kind of choice is no longer a reality for the vast majority of mentally ill Americans who might have committed crimes. Instead of receiving treatment, they are sent to prison, with some scholars estimating that nearly a third of the American prison population suffers from mental illness of some kind.

The effect of these changes on public attitudes toward policy changes over time has been challenging to track; studies more frequently provide snapshots of (1) attitudes about the stigmas associated with mental illness, (2) access to treatment, and (3) knowledge of others with mental illness. A 1989 study asserted that community mental health centers might have suffered from a NIMBY[4] problem after the Reagan years, with a greater percentage of respondents stating that they would oppose an outpatient facility in their neighborhood (34%) than support one (31%) (Borinstein, 1992). Additionally, 48% of respondents stated that they would not welcome "any kind" of mental health facility (Borinstein, 1992). A rare longitudinal study of American attitudes on mental health found that "the proportion of Americans who describe mental illness in terms consistent with violent or dangerous behavior nearly doubled" between 1950 and 1996, despite the fact that the mentally ill are far more likely to be a danger to themselves than others (Pescosolido, 2000).

The Reagan era ought to be considered not only as a watershed in terms of the societal approach to the dispossessed, including the mentally ill, but also a time during which trends of *laissez faire* capitalism empowered the pharmaceutical industry to promote its long-held vision of drug-first or drug-only treatments of mental illness. While Reagan-era lobbying expenditures data are difficult to obtain and validate, there are annual lobbying spending data for the pharmaceutical industry from 1998 onwards. A review of these figures, in conjunction with the analysis of other scholars, suggests that the pharmaceutical lobby has become the second-biggest lobby in the United States, behind only the insurance industry.

The public record shows that the vast size and strength of the lobby for 'Big Pharma' has exerted numerous influences on mental health policy, most of them somehow favorable to treatment paradigms in which patients are issued drugs. In such a climate, it is hardly likely that policy could move back towards mental health hospitals, which have no lobbying footprint. As state-run institutions, mental health hospitals were, at any rate, cost centers for government. A pharma-driven paradigm of mental health care, paid for largely by public and private sources of insurance, lowers the government's exposure to costs and farms out once-public decisions to private entities, in particular the pharmaceutical companies that increasingly define both the scope of mental health and how it ought to be treated.

AFTER REAGAN

American mental health policy continued to change after Reagan's second term. As noted in the earlier portion of the literature review, one of the characteristics of policy in the Reagan era was an institutional hostility toward the mentally ill who, along with the homeless (a population that often overlapped with the mentally ill population), threatened the Reaganite vision of an able America. After Reagan, this view of mental health began to change due to a combination of top-down and bottom-up forces. One of the reasons for the shift in the tenor of public policy related to mental health was the recovery movement, as described by Selby Jacobs (2010):

> The recovery movement in psychiatry aimed to empower those who suffered from mental illness, many of whom felt disenfranchised or—more ominously in terms of their attitude toward psychiatric professionals—considered themselves as survivors of psychiatric treatment. Equally important, the recovery movement instilled hope of a fuller life and membership in the community. The movement grew over two decades and eventually was highlighted in the NFC [New Freedom Commission] report of 2003.

Before Reagan, and after Kennedy, the trend in American public health policy with respect to mental illness had been a de-emphasization of the notion of inpatient care (which had become inextricably associated, in both the public imagination and in the estimation of key scientific and policy-making elites, with cruel and ineffective psychiatric hospitals) and an emphasis on treatment and recovery based on community assistance. Jacobs argued that the Reagan era in mental health policy was distinctive mainly for its rhetoric against the mentally ill and the homeless; even during the Reagan era, support for community-based, outpatient treatment had not truly dissipated, but was being re-channeled into the so-called recovery movement. As described by Jacobs, the recovery movement was a big tent based on a small number of shared ideas, mainly (a) destigmatization of the mentally ill and (b) a renewal of the idea and practice of rehabilitation and healing as opposed to confinement and stigmatization. In this context, Jacobs considers the policy goal of the Reagan administration to have been the creation (or, perhaps, the re-expression) of new stigmas against the mentally ill, which, over time, could have led to the decreased funding of all types of assistance for the mentally ill, including both inpatient and outpatient approaches.

The Reagan-era attitude to mental health can be understood in light of Joel Best's (2018) discussion of future warnings: "Warnings about what is going to happen are common; they compete for our attention and concern. In general, the most compelling claims are those supported by what their audiences judge to be *compelling evidence*, and which warn of *big problems* that are *quite likely to occur* in the *relatively near future*. But of course not all future claims succeed; some are dismissed or ignored…"

Jacobs indicated that, over the Presidential administrations of George H.W. Bush, Bill Clinton, and George W. Bush, the Reagan era's harsh rhetoric against mental illness was abandoned. However, otherwise, the post-Kennedy shift away from inpatient to outpatient formals for mental health treatment remained. According to Jacobs, the main reason for the continued dominance of the outpatient paradigm in American health policy under Reagan, George H. W. Bush, Bill Clinton, and George W. Bush alike was the role of Medicaid.

For Jacobs, understanding Medicaid is the key to understanding the direction of mental health policy during and after the Reagan administration. Essentially, after its introduction, Medicaid shaped American mental health policy and practice in one major way, and for two reasons. Medicaid continued to push policy and practice in the direction of outpatient care because (a) outpatient care was cheaper than inpatient care and (b) outpatient care was no less effective than inpatient care. Jacobs (2010) noted that, in the early 2000s, various meta-analyses and evaluations reached the conclusion that mental health prevalence had remained unchanged over the past 50 years, despite the implementation of various policies and paradigms of care. In this context, outpatient services made more sense because of their cost-effectiveness versus inpatient services: "States and local communities did not have the resources to continue construction of community mental health centers. Private nonprofit agencies were strapped by the loss of categorical funding during an economic recession….states pursued Medicaid reimbursement to offset general fund expenses, closed state owned facilities, and contracted with private nonprofit agencies for services to their target population. *Medicaid benefit structure and reimbursement policies shaped the public system* [emphasis added]."

Jacobs' explanation of the uniform progression of American mental health policy toward an outpatient paradigm even in ideologically distinct administrations is based in the concept of cost-effectiveness. Medicaid, as an insurance provider, was not necessarily responding to the policy influence of pharmaceutical companies or mental health providers or groups who favored

outpatient orientations; rather, Medicaid was responding to the fact that treating mental health patients with pills, and keeping them away from dedicated inpatient facilities, was simply cheaper. As explained by Lamberty (2003), this concept of cost-effectiveness was defined and embedded in various aspects of insurance practice—for example, in the so-called diagnostic-related group:

> Similar to the private sector, the federal government was feeling the impact of increased health costs and began making efforts to control these costs….[There] were initial efforts to reimburse only those services that were deemed reasonable and necessary. In 1983, the federal government significantly modified the reimbursement system for Medicare / Medicaid through the Prospective Payment System (PPS), a concept previously used in New Jersey. The goal was to control hospital costs along with creating incentives for hospitals to function more efficiently. The mechanism for accomplishing this was the Diagnostic-Related Group (DRG), which set reimbursement rates for hospitalization expenses based on the patient's diagnosis….This scaling method for rates attempts to take into account the time, mental effort, technical skill, specialty training, and differential costs of malpractice insurance in setting the reimbursement rate for a particular service.

Lamberty et al.'s discussions of DRGs can be considered in light of Jacobs' comments about the equivalent effectiveness of different approaches to mental health treatment. Assuming equivalent effectiveness, Medicaid and other insurance providers would have a strong interest in identifying the less expensive service. In the context of inpatient treatment, as Lamberty et al. noted, the combination of hospital space, the cost of hospital personnel, and the cost of various medical devices is more expensive than the cost of dispensing drugs and providing outpatient services.

As such, the trajectory of the American mental health system in the outpatient, pharmacological era can be understood in terms of both supply and demand. The demand for such an approach is provided by both grassroots and elite resistance to the concept of inpatient care, both in its historical dimensions (as in the context of the rejection of the idea of the psychiatric hospital) and in its contemporary form (in the context of the recovery movement). The supply for such an approach is provided by the increasing ability of pharmacological agents to address various aspects of mental health care. The combination of strong supply and strong demand is explanatorily powerful in tracking the development of American mental health care in the post-Kennedy era.

Jacobs (2010) notes that even Reagan, who otherwise took actions to undercut community health centers, did not attempt to reinstate, or support legislative attempts to reinstate, support for inpatient approaches to the care of the mentally ill. By the time Reagan's former Vice President, George H.W. Bush, became President in 1988, the strain of Republicanism that had directed particularly harsh rhetoric toward the homeless and mentally ill had also been curtailed—according to Jacobs, because of the rising influence of the recovery movement within psychiatry, which was allied to movements for civil rights for the mentally ill. By 1988, it had become more politically costly to stigmatize the mentally ill, and, in any case, the mechanisms (such as Medicaid) to route public funds to healthcare for the mentally ill could not be easily, if at all, rescinded or challenged.

Jacobs argued that post-Reagan trends in American mental health policy can be understood as further refinements of, rather than as alternatives to, the idea of outpatient care. These refinements had the effect, and perhaps the conscious intention, of impelling the American

mental health care system further in direction of privatized, outpatient care—which, as noted earlier in the literature review, is an orientation that inherently supports a pharmacological approach to care. Jacobs (2010) suggested that the NFC report of 2003 was particularly influential in this regard. This report identified six goals for the American mental health system as a whole; while none of these goals identified specific paradigms of care (such as inpatient vs. outpatient paradigms or pharmacological paradigms), the fifth goal implicitly promoted a system whereby mental health professionals could, in concert with pharmaceutical interests and other stakeholders, continue to promote outpatient, pharmacologically oriented systems of mental health care: "Goal 5: The delivery of excellent health care through disseminating evidence-based practices and accelerating research…"

By the early 2000s, the bulk of mental health research published in the United States focused, in one manner or another, on outpatient services, typically enfolded within the paradigm of pharmacological care. In 1965, Wechsler et al. published a systematic review whose purpose was to identify all American, British, and Canadian studies of the effectiveness of pharmacological (specifically, anti-depressant) approaches to mental health care, and, despite an exhaustive search of the literature, identified less than 20 relevant studies. Wechsler et al.'s research had been conducted utilizing scholarly journals indexed by the American Psychological Association (APA); a review of the APA's digital database indicates that, in 2002—the year before the publication of the NFC—there were over 6,000 scholarly articles on antidepressant pharmaceuticals. Clearly, between the appearance of the first anti-psychotic and other mental health pharmaceuticals in the 1950s and the NFC, there was an explosion in the amount of research on pharmaceutical approaches to care, and, as Jacobs suggests, the trend of the research was toward the promotion of pharmaceutical solutions allied to outpatient modes of care.

This trend in research can be explained in light of both market forces and scientific paradigms. As noted earlier, the discovery of anti-psychotic drugs created a supply (quite figuratively) for an outpatient approach to mental health care, and the demand for such an approach originated in the widespread social and elite rejection of the institution of the psychiatric hospital. The existence of these supply and demand forces is not contentious, but the issue of scientific paradigms is. As noted earlier, Jacobs argued that, as of the early 2000s, it was amply clear that the prevalence of mental illness in the United States remained remarkably uniform regardless of treatment approach or paradigm. However, there is also a substantial body of literature—not directly relevant to this thesis—about the effectiveness of pharmacological and outpatient approaches to mental health treatment in comparison to inpatient approaches. It is not necessarily clear that all mental health care paradigms have the same level of success. One possible interpretation of the rise of research interest in pharmacological and outpatient approaches to mental health care is that these approaches work and have therefore received more interest in empirical analyses. However, if a more social constructivist approach to scientific paradigms is taken, it could also be the case that the existence of both strong supply and demand for pharmacological and outpatient approaches to mental health care have driven research interest. As Krippendorff (2009) has argued, "theory informs data," and it could therefore be the case that the empirical data that appear to suggest the superiority of pharmacological and outpatient approaches to mental health care are themselves somehow driven by the underlying belief, or need to believe, that such approaches are effective.

In terms of policy itself, the clear thread from Kennedy to George H.W. Bush and thereafter is that of a bias toward pharmacological and outpatient approaches to mental health care, a bias whose existence is reflected in trickle-down effects of policy such as (a) the kinds of

mental health research that is funded by federal authorities, (b) the kinds of procedures that Medicaid and other funding sources will compensate or not compensate, and (c) the kinds of rhetoric that are applied to mental health care objectives. As such, the big themes in post-Reagan mental health care policy in the United States should not be sought in, or understood through, the passage or repeal of monumental acts of legislation; rather, mental health care policy is more a function of how Medicaid, other insurance decision-makers, and research scientists theorize, and practically address, the problem of mental health in the United States.

THE PREFERMENT OF SPECIFIC INSTITUTIONAL SOLUTIONS

One of the conceptual problems involved in discussing paradigms of mental health care at the high level is that the practical components of these paradigms at the low level (that is, at the level of the street, clinic, home, and community) might be neglected. In the context of the discussion offered earlier, one key question is why certain methods of care came, or have come, to dominate within each paradigm.

One way to address the question of how and why certain specific options come to be preferred is through Jacobs' integrated discussion of Medicaid, research directions in mental health, and political expediency. In Jacobs' model, economics comes first and informs the subsequent (a) definition, (b) development, and (c) ongoing implementation of specific solutions.

According to Jacobs, the decision matrix of American mental health care policy in the post-Medicaid era represents an ongoing transition from the federal to the local, for reasons of cost efficiency. The driving issue is one of specialization. When service delivery is centralized—at, for example, the federal level—then, as Jacobs noted, the infrastructure of health care delivery must be substantial, as the federal authority has to be prepared to meet any and all demands for care. When service delivery is more decentralized—for example, with key responsibilities passing from the federal authority to individual states—then states also face some of the burdens of the federal government, but in a somewhat reduced fashion. Jacobs stated that, when both federal and state authorities bear their own portions of responsibility for building mental health care service mechanisms and trying to manage (for example, through DRGs and capitation) the resulting costs, cooperation between federal and state resources can result in greater efficiencies than if either the federal authority or states alone were solely responsible for service provisioning and cost management.

The addition of local resources to state and federal resources results in what Jacobs described as a far more cost-efficient approach to the provisioning of services and the management of funds, because there are three interweaving levels of service that allow a great deal of specialization. For example, a local clinic that manages a highly specific but rare mental health problem can continue to focus on treatment for that problem, saving state and federal authorities from the responsibility of creating infrastructure to be able to address this problem. At the same time, as Jacobs notes, the local clinics and facilities can rely on aspects of existing state and federal infrastructure for procedures such as laboratory testing that are prohibitively expensive (and economically needless) for the local organizations to replicate.

On the basis of this argument, Jacobs suggests that the logic of patient treatment is driven by increasing specialization and cost-efficiency, which, in turn, both reflects and promotes localization. One of the most important characteristics of this argument is that it relocates the question of how and why certain modes of treatment are preferred from (a) the solely political to (b) the political and bureaucratic realms. Jacobs suggested that, at the level of politics alone, the main trend in American mental health care policy after Kennedy has been increasing support for

outpatient, pharmacologically oriented methods of care. This trend is political insofar as it has been addressed through federal legislation, executive orders, and Supreme Court rulings in response to a genuine, intense social debate that unfolded across at least two decades. However, what happens in specific jurisdictions is either a matter of local politics or, more commonly—according to Jacobs—the result of bureaucratic rather than political decision-making.

The distinction between political and bureaucratic decision-making was discussed at greater length by Fuller. Fuller (2013) noted that, in localities as distinct from each other as New York City and Raleigh, funding for new mental health care initiatives has devolved to localities from state and federal grants, and that the decisions taken by localities have typically been discretionary decisions rather than decisions subject to voting or other overtly political institutions. It is at the level of the federal government, and of the state government, that political pressures and political decisions create funding, decisional pressures, and organizational functions; by the time mental health care policy reaches localities, according to both Fuller and Jacobs, it is expressed in the form of discretionary spending that is not typically subject to immediate and direct public oversight, although, of course, decisions made by local authorities (such as the funding of wards for the mentally ill within prisons) can become political issues in subsequent local elections.

Admittedly, distinctions between the political and the bureaucratic might be fine distinctions that lack conceptual validity. However, in discussions such as those provided by Jacobs and Fuller, there seems to be a distinction between the type of traditional politics that shape federal responses (and, to a lesser degree, state responses) versus the types of local decisions that reflect how federal and state policies are implemented and how federal and state funds are spent. There is, according to Jacobs, a consensus in the United States that the treatment of the mentally ill should take the route of cost-effectiveness, which means that mentally ill people should receive the minimum plausible commitment of resources to assist in their recovery; thus, for example, someone whose depression can be treated or managed with a pill should not be granted a bed in a psychiatric hospital. This consensus is broad enough to admit of several possible implementations at the local level, implementations whose form, according to scholars such as Jacobs and Fuller, is shaped by local dynamics that are more closely related to bureaucracy than to the politics that shape the larger consensus itself.

EMPIRICAL ANALYSIS OF POLICY, LOBBYING, AND SPENDING OUTCOMES

It is possible to explore the connections between policy (manifested as the rise in drugs as treatment alternatives for which the government reimburses pharmaceutical companies and related market entities), lobbying conducted by the pharmaceutical and hospital industries, and other variables, including the overall amount of money spent by the U.S. government and the budget of the Department of Health and Human Services. These data help to illustrate that, on a dollar-per-dollar basis, the pharmaceutical industry has been able to outperform the hospital industry, on the assumption that there is a causal linkage between lobbying spending and mental health outlays. Please see Table 1 at the end of this section for the year-by-year data.

An OLS regression of pharmaceutical lobbying on the amount of money dedicated to retail pharmacy drugs in U.S. healthcare settings (including, it will be borne in mind, settings in which drugs are paid for, directly or indirectly, by government), yielded the following results:

Table 1

Dependent Variable: DRUG$

Method: Least Squares
Sample: 1980 2014
Included observations: 7

Variable	Coefficient	Std. Error	t-Statistic	Prob.
LOBBYING				
$_PHARM	214.4982	12.70006	16.88954	0.0000
C	-8907.501	1717.294	-5.186939	0.0035

R-squared	0.982774	Mean dependent var	16648.43
Adjusted R-squared	0.979329	S.D. dependent var	14944.90
S.E. of regression	2148.708	Akaike info criterion[5]	18.41808
Sum squared resid	23084734	Schwarz criterion	18.40262
Log likelihood	-62.46327	Hannan-Quinn criter.	18.22707
F-statistic	285.2567	Prob(F-statistic)	0.000013

The OLS equation was as follows:

Drug Spending = (Lobbying Spending)(214.4982) – 8,907.501

The regression was significant, $F(1, 5) = 285.2567$, $p < 0.001$. For every $1 million spent by the pharmaceutical industry in lobbying, spending on mental health drugs throughout the United States rose by roughly $214.5 million. This analysis provided some context against which the OLS regression of the hospital industry's lobbying, and its possible effect on mental health spending as directed to hospitals, could be considered. Those OLS results appear below:

Table 2

Dependent Variable: HOSP$
Method: Least Squares
Sample: 1980 2014
Included observations: 7

Variable	Coefficient	Std. Error	t-Statistic	Prob.
LOBBYING				
$_HOSP	246.9862	44.55496	5.543404	0.0026
C	11238.66	2474.019	4.542676	0.0062

R-squared	0.860059	Mean dependent var	23129.29
Adjusted R-squared	0.832071	S.D. dependent var	7959.193
S.E. of regression	3261.611	Akaike info criterion	19.25279
Sum squared resid	53190539	Schwarz criterion	19.23733
Log likelihood	-65.38475	Hannan-Quinn criter.	19.06178
F-statistic	30.72933	Prob(F-statistic)	0.002623

The OLS equation was as follows:

Hospital Spending = (Lobbying Spending)(246.9862) + 11,238.66

The regression was significant, $F(1, 5) = 30.72933$, $p < 0.01$. For every $1 million spent by the hospital industry in lobbying, mental health-related spending on hospitals throughout the United

States rose by roughly $247 million. This regression indicates that, quite possibly, the lobbying of the hospital industry is even more effective than that of the pharmaceutical industry. Nonetheless, analysis reveals that, in the overall domain of mental health spending, the amount of money going to drugs is outstripping the amount of money going to hospitals. This finding is important because, considered from a *longue duree* viewpoint, the rise of drug-driven mental health care cannot be said to be driven by efficient lobbying alone, which supports the interpretation that some structural force deeper and longer-acting than lobbying—in fact, the kinds of structural forces discussed throughout this paper—are better explanations for the observed changes in mental health spending policy.

Table 3

Data Relevant to Policy, Lobbying, and Spending Outcomes (All $ in Millions)

Year	Lobbying$_ Pharm	Lobbying$_ Hospitals	HHS$	Drug$	Hosp$	FedOutlays
1980	52	19	68255	1021	12319	590941
1981	53	20	80821			678241
1982	55	23	88408			745743
1983	54	22	95008			808364
1984	57	22	102374			851805
1985	54	23	114270			946344
1986	58	23	122940	2191	13720	990382
1987	61	24	131410			1004017
1988	59	24	140035			1064416
1989	60	25	152689			1143743
1990	60	25	175515			1252993
1991	64	26	198095			1324226
1992	63	27	231550			1381529
1993	65	26	253821	4165	21509	1409386
1994	65	28	278887			1461752
1995	71	29	303060			1515742
1996	69	30	319788			1560484
1997	69	30	339514			1601116
1998	85	29	350341			1652458
1999	100	34	359429			1701842
2000	99	34	382311	16417	23074	1788950
2001	120	47	425885			1862846
2002	129	51	465326			2010894
2003	146	61	504922	23259	27600	2159899
2004	166	66	542982			2292841
2005	166	78	581390			2471957
2006	186	86	614274	30715	31471	2655050
2007	226	94	671982			2728686
2008	239	99	700442			2982544

2009	272	107	796267			3517677
2010	246	106	854059			3457079
2011	241	97	891247			3603059
2012	235	90	848056			3536951
2013	226	91	886291			3454647
2014	228	88	936012	38771	32212	3506089

DISCUSSION AND CONCLUSION

In the late 1940s, the federal government of the United States entered the field of mental health care for the first time, with the 1946 National Mental Health Act and the 1949 creation of NIMH. In the 70 years since the National Mental Health Act, four instances of legislation—and one instance of blocked legislation—summarize the story of mental health policy in the United States: the Community Mental Health Centers Act of 1963, the Social Security Amendments of 1965, the Mental Health Amendments of 1967, the Mental Health Systems Act of 1979, and Reagan's refusal to sign the Mental Health Systems Act of 1979.

The story of mental health policy is essentially the story of the federal government's attempt to get out of the business of funding mental health hospitals and passing this responsibility on to individual communities. In the 1940s, the federal government had gotten into the business of mental health care regulation with the National Mental Health Act, but developments in the 1950s and early 1960s created the wrong atmosphere for the federal government to continue with the status quo.

As discussed in this paper, the institution of the mental hospital was beleaguered from the bottom up (that is, by ordinary people who had experienced the system) and from the top down (by scholars who were active in the anti-psychiatry movement, by scientists who had faith in pharmaceuticals rather than lobotomies and other inpatient forms of treatment, and by administrators and policy-makers who saw mental health expenditures as sunk costs on a non-productive portion of the American population). Mental hospitals were extraordinarily unpopular by the 1950s and 1960s, and for good reason. Mental hospitals, by their own adherence to outdated and occasionally barbaric clinical practices attracted much criticism. Kennedy was personally affected by modern mental health policy, given the lobotomy of his own sister, and, during the Johnson era, it was easy enough to roll mental health reforms into the vision and details of the Great Society. During a time in which people who had been socially, economically, and politically repressed were empowered by legislation and judicial decisions, it must have appeared natural for both Johnson and the Congress to continue the momentum of Kennedy's mental health policy and shut down the mental hospitals.

In the 1960s, the idea of the community mental health center seemed to have some credibility behind it. Of course, in retrospect, it is easy to argue that the mental hospitals were closed too early, and that time was needed in order to observe what would happen to people who were deinstitutionalized. The supporters of community mental health centers were too sanguine in assuming that the transition from full-time, inpatient care to communities was feasible. However, based on the analysis carried out in this study, the failure of the community mental health centers was not a *fait accompli*. It was not until the mid- and late-1980s that deinstitutionalization was seen to result in the spread of large numbers of homeless people throughout urban America. Not coincidentally, President Reagan had refused to sign one of Carter's final legacies, the Mental Health Systems Act. Hence, it was not until the community medical centers were defunded on a large scale that deinstitutionalization truly came under

criticism. In the 1960s and 1970s, the nascent institution of the community mental health center had, whatever its clinical shortcomings, succeeded in keeping millions of the mentally ill off the streets and away from prison, the two locations that would claim the mentally ill in increasing numbers as the Reagan era continued.

By 1980, mental hospitals had become archaic, and the days of well-funded, numerous community mental health centers were also numbered. It was now the era of the outpatient. Mental health patients would receive treatment in settings that did not require their commitment to hospital beds. This situation was an enormous boon for big pharmaceutical companies, which stood to make vast sums of money from a treatment paradigm based largely on drugs. As the pharmaceutical industry rose over time to become the second-largest lobby in Washington, D.C., "Big Pharma" surely exercised its power behind the scenes to ensure that policy would continue to favor outpatient treatment paradigms driven by pharmaceutical use. In that sense, the biggest development in post-1980 mental health policy is precisely that there has been no development; the status quo of the Reagan era has been maintained, as both the federal and state governments are largely out of the mental hospital business, and the field has been ceded to the private businesses that develop and market drugs for mental health.

A close look at the mental health literature indicates that there are occasions on which inpatient treatment is vital. However, as the American public appears to question more and more entitlements, there is an open question as to whether resource-intensive inpatient options for mental health could ever return. At the same time, the influence of the pharmaceutical industry is immense and unified, whereas the rise of inpatient settings would put together a fragmented coalition of parties (including mental health counselors, therapists, and others who do not prescribe medications) who lack influence in determining the trajectory of American mental health policy.

It is fascinating to observe how policy evolves. When mental illness was considered demonic possession or heavenly inspiration, policies reflected the power of the Church and of theological thinking. Currently, the definition of, and clinical approach to, mental illness reflects the strength of a pharmaceutical industry that has redefined vast swaths of complex problems into physical symptoms that can be resolved with medication. The interests of the pharmaceutical industry have intertwined closely with the interest of the federal government in reducing the costs of care of the mentally ill.

One of the policy issues raised by Kingdon is the question of how and why issues fade from view. Based on the information presented in this paper, the policy aspect of mental health treatment appears to have faded from view in a relative way, given that government has gotten out of the business of institutionalization and, by discontinuing the Mental Health Systems Act, is no longer interested in managing deinstitutionalization either. Rather, government policy vis-à-vis mental health appears to be bifurcated between (a) paying private-sector actors such as pharmaceutical companies and hospitals to render outpatient treatment and (b) transferring de facto management of the mentally ill to prisons and municipal authorities. The main thesis defended in this paper was that the ultimate reason for this devolution in mental health policy has been the successive failure of both institutionalization and deinstitutionalization, which in turn has reduced the policy scope or space that government can apply to the problem of mental health treatment. This reduction in scope is thus best understood not as a single, simple reflection of either public opinion or political orientation, but as the result of a systematic, decades-long failure of two distinct policy approaches.

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Notes:

[1] The Act was the first federal law to encourage the construction of community-based mental health centers. Each center was required to provide inpatient and outpatient services, emergency response, partial hospitalization, and consultation/education on mental health.
[2] The Act called for the establishment of a National Institute of Mental Health, although it did not fund it at that time.
[3] The Amendments separated NIMH from NIH and raised it to bureau status in PHS.
[4] Not In My Back Yard. A characterization of opposition toward the proposal of a new development because of its proximity.
[5] The Akaike Information Criterion, Schwarz Information Criterion (also known as the Bayesian Information Criterion), and Hannan-Quinn Criterion are measures for comparing maximum likelihood models. Each criterion is a sum of two terms. The first term characterizes the entropy rate or prediction error of the model, while the second term characterizes the number of freely estimated parameters in the model.