American Handbook of Psychiatry

The Federal Government and Mental Health

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THE FEDERAL GOVERNMENT AND MENTAL HEALTH[1]

Introduction

This chapter describes the Federal Government's structure and organization as related to the mental-health sector, its impact on that sector, and its recent advances and retreats in the mental-health arena. Although complete description of the operations of Government is beyond the scope of this *Handbook,* we hope to shed some light on the intricate processes whereby public will is translated into public policy, and policy is implemented in laws, programs, and procedures.

The forces involved in Federal decision-making include a vast, interacting array of Congressional committees, executive-branch agencies, laws, regulations, judicial decisions, fiscal formulae, inpidual personalities, and social and historical trends. For example, Congress debated the "health-care crisis" in the United States for decades. The non-system of care was called inefficient, expensive, unequal, and inhumane. President Truman initiated legislative remedies, but Congress and the American people were reluctant to tamper with the free enterprise of medicine. Most of those early initiatives failed. During Truman's presidency the Public Health Service had a relatively narrow mission—chiefly providing care to merchant seamen and certain other Federal beneficiaries. No coordinated administration of health

activity existed. There was no Department of Health, Education, and Welfare (DHEW). During the next twenty-five years citizen concern regarding health care grew and began to be heard. Congress and the executive branch devoted more time and attention to health issues. Finally, specific programs were agreed upon and launched, e.g., the creation of DHEW, the Food and Drug Administration (FDA), and the National Institute of Mental Health (NIMH); Medicare and Medicaid, and programs of manpower development and innovation in health care delivery.

In the past two decades the influence of the Federal Government on psychiatry and the whole field of mental health has been remarkable. In 1959, Daniel Blain wrote an excellent chapter in Volume 2, first ed., of this *Handbook,* "The Organization of Psychiatry in the United States." He noted that the Government would "on occasion assist a [University] psychiatry department in building up its faculty." In Fiscal Year (FY) 1971 on the other hand, the Federal Government provided funds to over half the nation's psychiatry departments and was the largest single source of funds for psychiatric residency training. Moreover, the Federal Government is now the nation's largest supporter of mental-health research and is supplying one-third of the public tax dollars spent for mental-health services (see Community Mental Health Center Program below).

Because the Federal Government has become a major force in the

mental-health arena, its decisions have profound influence. It seems prudent now more than ever for mental-health professionals to grasp the basic principles of Federal policy formulation and to sharpen their capacity to contribute to this public process.

The Structure of the Federal System

The constitutionally mandated branches of the Federal Government are the executive, the legislative, and the judicial. Career civil servants at the level of bureau chief and below (e.g., the Commissioner of the Food and Drug Administration) can be thought of as an informal fourth branch of Government, the bureaucracy, since they do not always carry out the directives of their politically appointed superiors or of the President himself. Frequently they have their own ties and lines of communication to relevant Congressional committee chairmen.

The Judicial Branch

Judicial branch decisions which influence psychiatry and mental health are not made in the same ways as executive and legislative decisions. Since mental-health professionals influence judicial decisions primarily as technical experts rather than as decision makers or political advocates, we will not discuss the judicial branch in detail. Judicial decisions, however, have shaped

the definition of criminal insanity, the right of patients to treatment, the confidentiality of patient records, and the rights of physicians under Federal laws such as the Harrison Narcotic Act, to name but a few important areas of judicial activity. Judicial decisions and broader aspects of forensic psychiatry of importance to mental health professionals are discussed by Overholser, Freedman, Guttmacher, Polier, Robitscher, and King.

Congress

There are four Congressional Committees playing powerful roles in mental health. The House Appropriations Subcommittee on Labor and HEW (Health, Education, and Welfare) and the analogous Senate Subcommittee *appropriate* (or set aside) public funds for mental-health programs. Legislation establishing or affecting mental-health programs may be considered by a number of legislative committees or subcommittees. The two most frequently and directly involved, however, are the House Subcommittee on Public Health and the Environment, (within the Committee on Interstate and Foreign Commerce), and the Senate Subcommittee on Health (within the Committee on Labor and Public Welfare). Legislation establishing mental-health or other programs includes a level of *authorized* spending for the program. In each fiscal year, an appropriations subcommittee may appropriate all or a portion of this authorization limit. Several other House and Senate subcommittees consider legislation relevant to mental health. In

the House, the Subcommittee on Governmental Activities (within the Government Operations Committee) has held many hearings regarding legislation in the drug-abuse area. The House Ways and Means Committee considers the crucial area of National Health Insurance. In the Senate, subcommittees related to mental-health concerns include the Subcommittee on Alcoholism and Narcotics (within Labor and Public Welfare) and the Subcommittee on Drug Abuse in the Armed Forces (within the Armed Services); the Subcommittee on Intergovernmental Relations (within Government Operations); the Subcommittee on Children and Youth; and the Subcommittee on Aging (both within Labor and Public Welfare); and the Subcommittee on Juvenile Delinquency (within Judiciary). In the Senate, the Finance Committee considers health insurance. The Representatives and Senators on these subcommittees wield more influence in mental health areas than most other Congressmen.

The Executive Branch

The executive branch includes not only departments headed by cabinet officers, but also independent regulatory agencies such as the Federal Communications Commission, and organizations and inpiduals within the Executive Office of the President (EOP). These organizations include the very powerful Office of Management and Budget (OMR), the National Security Council, and the President's personal staff, which consists of counsellors,

counsel to the President, communications director, press secretary, appointments secretary, research and writing staff, and numerous administrative assistants and their staff.

The Federal department with the greatest concern for mental health is DHEW. It has over 100,000 employees and a $72 billion budget. The 1974 organizational structure of DHEW is shown in Figure 43-1. The structure has undergone many changes in the past and undoubtedly will change in the future. Within DHEW six health agencies, collectively called the Public Health Service, are supervised by the Assistant Secretary for Health (Fig. 43-2). These agencies are the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), which includes the NIMH, the Center for Disease Control, the Food and Drug Administration, the Health Resources Administration, the Health Services Administration, and the National Institutes of Health (NIH). The other major components of DHEW are the Education Division, including the Office of Education, and the National Institute of Education, an Office of Human Development, and two welfare agencies, the Social and Rehabilitation Service (SRS), and the Social Security Administration (SSA). It is highly significant that a major portion of Federal health expenditures pays for services administered by SRS and SSA in the form of Medicaid ($3.4 billion in FY 1972) and Medicare ($9.0 billion in FY 1972). The FY 1973 budget for health research, training, and education was $3 billion.

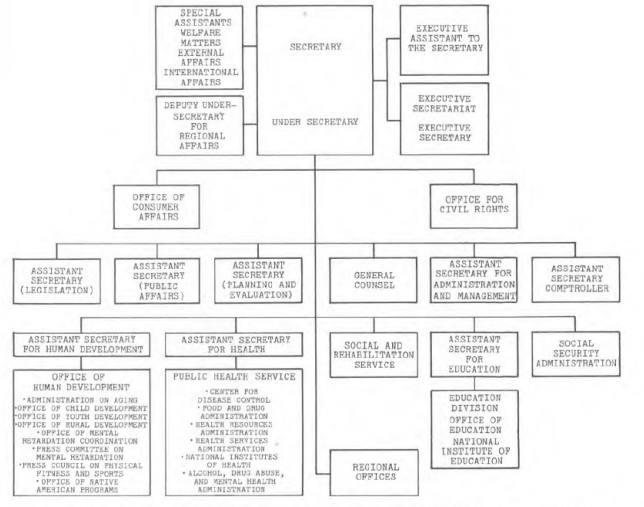

Figure 43-1.
The organizational structure of the Department of Health, Education, and Welfare.

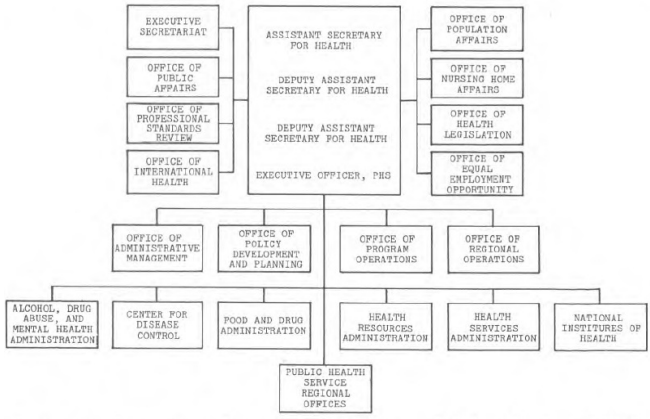

Figure 43-2.
The organizational structure of the Department of Health, Education, and Welfare, Public Health Service.

The focal point for Federal mental-health activity in the executive branch is NIMH, which had an FY 1972 budget of $612 million. From its founding in 1946 under the Mental Health Act (P.L. 79-487) until 1967, NIMH was part of the NIH. On January 1, 1967 NIMH was given the status of an independent Bureau in recognition of its support of service and training programs in addition to the traditional NIH focus on research, and as a result of pressure by constituents and members of the bureaucracy. Less than two years later (October 31, 1968) a reorganization amalgamated NIMH with a number of service-oriented programs into the Health Services and Mental Health Administration (HSMHA), of which NIMH remained the largest part. In 1974 HSMHA was disbanded. Two independent institutes were created from NIMH components—The National Institute on Drug Abuse and the National Institute on Alcoholism and Alcohol abuse—and were joined with NIMH in a new agency, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). The FY 1973 NIMH actual expenditures organized by activity are shown in Table 43-1. The decline from FY 1972 budget levels reflects both the creation of the two independent institutes within ADAMHA and changes in the Administration's health-expenditure priorities. In 1974, the units concerned with NIMH program categories ranged from sections to branches, centers, pisions, and offices (Fig. 43-3). The hierarchical placement and budget of these programs and activities, like the placement and budget of NIMH within DHEW, depend on need, national clamor, legislative and

executive branch concern, and principles of administrative management.

Table 43-1. Mental Health: 1973 Actual Obligations

EXPENDITURE		OBLIGATION (IN THOUSANDS, $)
Research		85,169
Training		77,349
State and community programs		
Construction	13,611	
Staffing	165,100	
Children's services	20,000	
Management and information services		18,056
Total, NIMH		379,285

A considerable number of Federal activities directly or closely related to mental health are located outside NIMH. These are usually directed at limited populations or specific problem areas, e.g., alcoholism or drug abuse. They contribute significantly, however, to Federal impact on psychiatry and offer additional opportunities for psychiatrists interested in influencing Federal mental-health activities.

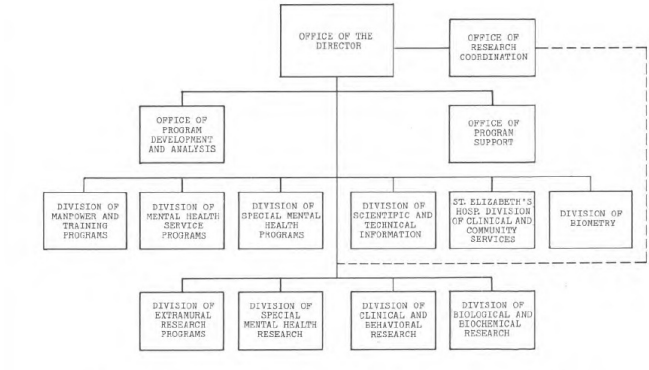

Figure 43-3.
The orgaizational structure of the National Institute of Mental Health.

Within the Health Services Administration, the Indian Health Service places psychiatrists on Indian reservations and funds mental-health programs for Indians. The Federal Health Programs Service operates Public Health Service hospitals and clinics which provide mental-health services for certain Federal beneficiaries. The Community Health Service funds projects aimed at improving the delivery of health services, including mental-health services, and supports state and area-wide health planning. The Maternal and Child Health Service supports projects which include aid for emotionally disturbed children.

A number of other DHEW agencies also support or influence mental-health programs. The Food and Drug Administration regulates the development and use of all drugs, including drugs used in psychiatry. For

example, before lithium was released for clinical use, the FDA evaluated the research on lithium and determined the clinical indications for which there was sufficient evidence of safety and efficacy. Some NIH research institutes, notably the National Institute of Neurological Diseases and Stroke, and the National Institute of Child Health and Human Development, support mental-health related research. In the service area, the SSA and the SRS mentioned above, reimburse citizens who qualify under Medicare and Medicaid for some mental-health expenses. Moreover, SRS, through its Rehabilitation Services Administration and its Youth Development and Delinquency Prevention Administration, funds projects which aid emotionally disturbed and mentally retarded inpiduals. The Office of Education, primarily through its Bureau for Education of the Handicapped, but also through their other subpisions, funds projects related to mental health. The Office of Child Development, in the Office of the Secretary, funds service demonstration projects which may include mental health services.

Outside DHEW, mental-health activities exist throughout the executive branch. The Department of Defense supports psychiatric care for active-duty personnel. Psychiatric research is carried out at the Army Medical Center, Walter Reed Hospital, Washington, D.C., and at the Naval Medical Center, Bethesda, Maryland. The Veteran's Administration (VA) had an FY 1972 budget of $2 billion for its network of hospitals and clinics for ex-servicemen; $441 million of this total was devoted to VA psychiatric hospitals. In addition,

the VA supports psychiatric training and research in its facilities. The Justice Department investigates and controls the production, distribution, and use of dangerous drugs, including several drugs used in clinical psychiatry through its Drug Enforcement Agency, which includes the former Bureau of Narcotics and Dangerous Drugs (BNDD). Criminal Justice grants from the Justice Department's Law Enforcement Assistance Administration (LEAA) often have mental-health significance. For example, millions of LEAA dollars have gone into drug abuse treatment programs. The Federal Bureau of Prisons employs psychiatrists and supports some mental-health training and research.

Support for mental-health-related services and research also originates in the Model Cities Program of the Department of Housing and Urban Development, the alcohol-prevention program of the Department of Transportation, and other executive branch agencies.

Characteristics of the Federal Decision-making Process

The process of arriving at budgets, laws, and policies in the executive and legislative branches has certain general characteristics which the politically active mental-health advocate must recognize. These general characteristics, together with the personalities, resources, values, and goals of the inpiduals involved determine the substance of Federal decisions. Behind almost any particular decision lies a conflict among a number of competing

interest groups (some public, some private), each with its own power base and goals. The sources of power include governmental position or access to a powerful official, skill in inter-personal relations, control over patronage positions or projects, past favors, access to the mass media, ability to deliver votes, promises of future cooperation, technical knowledge, prestige, and money.

Each interest group attempts to influence the others by force of reasoned argument or through bargaining, compromising, and coalition building. Each source of power just mentioned can be used as a bargaining chip. Unwillingness to bargain and compromise frequently means defeat.

Federal decision-makers must often act in the face of enormous uncertainties inherent in attempts to deal with social problems. It is often hard to predict the consequences of particular decisions. The consequences of past decisions may provide little guidance not only because they are difficult to assess, but also because social conditions have changed. Alternately, high Government officials may deny or resist information which demonstrates that previous decisions were wrong. Moreover, few problems exist in splendid isolation and their relations to other problems cannot easily be untangled. Unfortunately, intense pressures for rapid decisions and multiple demands on limited numbers of key policy analysts and decision-makers further decreases the amount of analytical intelligence which Federal decision-makers can

invest in any particular decision. This limitation, however, creates opportunities for interested inpiduals outside the Federal government to supply the information and analysis for which Government officials have insufficient time or resources themselves. Because of the complexities and ambiguities facing the decision-maker, and also because of the need to accommodate multiple, competing interests, he often looks for "good enough" or "sufficing" decisions rather than "optimum ones."

Decisions reached by this process are usually temporary ones. Budgets change yearly; laws are amended, repealed or allowed to fade away; policies evolve in response to public and private pressures. The decisions often are not thoroughly consistent, both because of the necessity for compromise and because no single person or agency has the time, information, or power to enforce consistency.

Budget and policy decisions are usually marked by incrementalism, i.e., changes from past practices are made gradually, in small steps. Legislative decisions, on the other hand, can be more radical in that wholly new programs (e.g., the Community Mental Health Centers program) or wholly new governmental structures (e.g., the White House Special Action Office for Drug Abuse Prevention) can be created.

With the general characteristics of the Federal decision-making process

in mind, let us now examine three specific kinds of Federal decisions: budgets, legislation, and policies.

The Budget Process

Each year the President submits to Congress a budget for the ensuing fiscal year (July 1-June 30) for all Federal organizations and activities. A preliminary draft is drawn up by the Office of Management and Budget (OMB). The OMB is a critical point in governmental decision-making processes. It both prepares the President's budget request, with input from the Departments, and oversees the administration of Federal programs. It may *apportion* (allocate or release) funds *appropriated* by Congress, or may *impound* (withhold wholly or in part) these funds. In FY 1971, for example, the President's budget contained a decrease of $6.7 million in funds for psychiatry training. Congress restored these funds to the budget in the DHEW appropriations bill, but OMB then impounded the restored funds. Only intense lobbying efforts by professional and lay mental-health groups and by DHEW officials convinced OMB to release these funds. Attitudes of OMB staff and OMB evaluations of support for psychiatric residency training and community mental-health centers will continue to influence the future of these two programs.

The OMB planning ceilings for the budget are drawn up in August and

submitted to the executive branch departments and agencies for comment and suggested changes. In responding to this draft, a department is more likely to succeed in increasing funds allocated to a particular program than in increasing the total funds allocated to the department. As a result, programs in DHEW, for example, compete more directly for dollars with one another than with programs of another department. The starting point for each year's budget is the previous year's budget. Changes are usually made in small steps so that the effects of previous changes can be observed before larger steps are taken.' Exceptions to this incrementalism occur when new organizations are created in response to highly visible and politically salient issues. For example, in response to national concern over rising crime rates, Congress gave the Law Enforcement Assistance Administration (LE AA), created in FY 1969, a first-year budget of $60 million. The next three fiscal year budgets for LEAA were $267, $532, and $698 million, respectively. The Office of Economic Opportunity began in FY 1965 with a budget of $237 million. By FY 1970 the OEO budget had grown to $1.8 billion. In FY 1974, however, the Nixon Administration phased OEO out of existence.

In DHEW, the Office of the Secretary analyzes the OMB planning ceilings budget for the department and asks departmental agencies for comments on their budgets. If an agency is not satisfied with its budget allocations, it must argue its case up the departmental hierarchy. The NIMH, for example, must first convince the Administrator of ADAMHA. He in turn must convince the

Office of the Secretary. The Secretary must then convince the OMB that the proposed change is desirable in the contexts of the Administration's priorities and the fiscal constraints imposed by estimated revenues and mandatory (uncontrollable) expenditures such as Medicare. The President's budget, in fact, is a statement of the Administration's priorities for expending public funds. All disputes between cabinet officers and the OMB must be settled by December when the President's budget goes to press. In some instances a cabinet officer will take budget issues to the President if he has been unable to convince OMB and believes they are important enough.

The President's budget, together with a budget message explaining the budget rationale and exhorting Congress to agree, is submitted to Congress in January (see, for example, the Budget of the United States Government, Fiscal Year 1973, OMB). In both House and Senate the budget is then examined in a piecemeal fashion by subcommittees of the House and Senate Appropriation Committees. Each subcommittee has jurisdiction over a specific segment of the budget, e.g., defense, DHEW, foreign aid. Unfortunately, Congress does not weigh one budget category against another and thus rarely tries to decide how many guns versus how much butter. Beginning in FY 1977, however, this may change. The House and the Senate have each established a committee to review the budget as a whole in that fiscal year.

The Congressional Appropriations subcommittees provide the best

opportunity for the mental-health constituency outside the Federal Government to influence the budgets for mental-health activities. Here, through their professional organizations and as interested citizens, they may legitimately lobby Congressmen regarding funds for mental-health programs. Abuses of "lobbying" have left the word tainted. However, lobbying can be pursued in a completely ethical manner. It derives from the constitutional right of the people to petition the Government for redress of grievances and from the need for citizens to inform their elected representatives of their wishes. Congress as an institution invites lobbying.

> The structure, procedure and culture of the Congress tend to obscure the general interest, encourage particularism, and create an environment in which organized interest groups and special pleaders can be assured a sympathetic response, [p. 38]

Lobbying involves using the sources of power mentioned above. It takes many forms. An articulate letter or well-reasoned testimony pointing out how and why an expenditure is in the public interest is important. Informal discussions with subcommittee staff or with the staff of the Congressmen on the subcommittee are also useful. Relating the expenditure to problems and programs affecting the Congressman's constituency can be persuasive. Arranging for local or mass media coverage of the issue creates important pressures. Public statements by respected national organizations carry weight. Recognition of the Congressman's past support and demonstrations of constituency interest are also influential.

House hearings on the budget usually occur in February, although they may be held as late as April. Senate hearings usually occur about a month after House hearings. The subcommittee's budget figures may be changed by the full committee or by the full House or Senate, and these avenues have sometimes been pursued by lobby groups. The House and Senate vote on the budget in segments, since 'hearings on budget segments are finished at different times by different subcommittees.

The House and Senate subcommittees on Labor and HEW have voted more funds for certain mental-health programs than were recommended in the President's budget. This contrasts sharply with the action of most other appropriation subcommittees. The Senate appropriation usually exceeds that of the House and the difference is settled by a bargaining process in a House-Senate conference committee. Once Congress has accepted the conference committee report, this segment of budget is returned to the President for signature or veto. President Nixon, for example, vetoed a DHEW budget which he felt was too big for some programs.

In deciding on dollar amounts for the President's budget, and in legislative and policy decisions, conflicts frequently arise between the President's staff, including OMB, and a cabinet officer-bureaucracy partnership. One source of this conflict resides in the different power bases to which these two groups are attuned. While the White House staff seeks to

maintain the President's popularity with a national constituency, the cabinet officer, or more often the bureau chief, seeks to advocate the interests of particular groups (such as the mentally ill), and to maintain good relations with limited constituencies (such as mental-health professionals) and select Congressional committee chairmen or committee members.

A second reason for the conflict is the different time perspectives of the President's staff and the bureaucracy. While the President's staff has its eye on the two- and four-year cycle of elections, the bureaucracy is focused on maintaining and expanding programs which may take decades to fulfill their social objectives. As Seidman writes:

> The bureaucracy is damned as "uncreative" because it is unable to satisfy the White House appetite for immediate solutions to complex social and economic problems and dramatic imaginative proposals for the legislative program. "Slow moving," "unresponsive," "disloyal" are among the milder epithets used to describe the bureaucracy. [p. 75]

Bureau chiefs who testify before appropriations subcommittees have a limited choice: support the President's budget or resign.

The Legislative Process

There are many steps in the legislative process, but early intervention improves the chances of success. The first step is the introduction of a bill, either by the Administration or any member of Congress. Administration bills

and those introduced by the Congressional leadership are much more likely to get attention from the subcommittees. The number of bills introduced is enormous. In the Ninety-second Congress (1971-1972), 17,230 bills were introduced in the House and 4133 in the Senate. The next step is referral of the bill to a committee. Most bills never emerge from the committee; for example, only 11 percent of the bills in the Eighty-eighth Congress (1963-1964) were reported out of committee. Each committee is different. Seidman writes:

> Each committee has its own culture, mode of operations, and set of relationships to executive agencies subject to its oversight, depending on its constituency, its own peculiar tradition, the nature of its legislative jurisdiction, its administrative and legislative processes, and the role and attitude of its chairman, [pp. 38-39]

Congressional power resides to a large extent in committee and subcommittee chairmen. A chairman can call meetings, schedule witnesses, recognize members, establish subcommittees, and appoint subcommittee members. He plays a key role in determining which bills get reported out. In the course of considering a bill, hearings may be held and inpiduals asked to testify. This is a propitious time for input from the mental-health community. Legislators are often weary of hearing from administrators and enjoy clinical reports from practicing professionals.

After a bill has been reported out by the subcommittee and committee,

it is placed on the respective calendar in the House and Senate. In the subsequent floor debate, clarifications of the intent of the bill help shape the program which the bill creates or funds. Just as with budgetary bills, other bills passing the House and Senate are nearly always different and go to a House-Senate conference committee so the differences can be ironed out. Sometimes the differences are irreconcilable. An example of a bill that died this way is the extension of the Community Mental-Health Centers Act which passed both the Senate and the House in the closing hours of the Ninety-second Congress. The House bill called for a simple extension, whereas the Senate bill included substantive changes. After the House and Senate have approved a conference report, it goes to the President. If the President vetoes the bill, a two-thirds majority is needed in each chamber to overturn the veto.

The legislative process is one of constant and intense bargaining. Bargaining occurs -not only within the Congress, but also between Congress and the President. Sources of information regarding Congressmen and Congressional processes include Bibby and Davidson, Froman, Goodwin, Lees; the Congressional Quarterly's Guide to the Congress, and the Congressional Directory.

The Policy-making Process

Administrative decisions have a large impact on policy. Executive

agency decisions take many forms. One form is a written statement (letter or testimony) from a Federal official taking a stand on a substantive issue raised by a private citizen, a Congressman, or a member of the executive branch. For example, Congress asked the Secretary of DHEW to take a stand on whether stimulants should be transferred to a level of stricter controls under P.L. 91-513; he agreed they should.

A second form of policy decision is allocating staff time to particular problems. For example, in FY 1972 the Director of NIMH directed a small group to work on coordinating NIMH service-oriented grants administered by the Drug Division (now the National Institute on Drug Abuse), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Community Mental Health Services Division. Another group was directed to develop a long-term strategy for increasing the nation's mental-health service resources.

Deciding which programs, budgets, or legislative authorities to pursue each fiscal year with the departmental hierarchy and Congress is a third form of policy decision. In FY 1972, for example, NIMH concentrated its attention on psychiatry training, extramural research, and the Community Mental Health Centers Program.

A fourth form of policy decision is changing an agency's organizational

structure. For example, growing public and Congressional interest, as well as an increase in budget and responsibilities, led NIMH to elevate its Center for Drug Abuse Studies to the pision level. The pision was internally pided into branches corresponding to its functional responsibilities, e.g., administering contracts and grants for research, training, education, and services. The Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) converted the pision to an institute in 1974. The institute was then placed on an organizational level equal to NIMH itself.

Finally, policy decisions may take the form of written regulations published in the *Federal Register* describing in detail how a law will be implemented. Although regulations cannot flatly contradict the publicly recorded Congressional intent which adheres to a legislatively created program, they can substantially influence the program's direction. For example, the NIMH drafted regulations spelling out how Public Laws 88-164 ^ 895>which created the Community Mental Health Centers Program, would be carried out. It was these regulations, rather than the law itself, which specified the size of center catchment areas (see p. 971) and required center directors to be members of one of the four core mental-health disciplines. Of course, NIMH did not make these policy decisions by itself. The regulations were written in consultation with the national mental-health organizations which had lobbied for the legislation. Moreover, the regulations had to pass through a series of DHEW clearances beginning at the agency level and

ending in the Office of the Secretary. Regulations can be changed at any time. For example, the requirement that center directors be members of the four core disciplines has been expanded to include other disciplines.

In any given day, dozens of policy decisions are made at different agency or department levels. The more far-reaching or controversial the policy, the higher the level at which it is made.

There are many checks and balances on these powers of administrators. In the mental-health field, one such check is the National Advisory Mental Health Council. It is charged with advising the Secretary of DHEW on programs of the Public Health Service involving mental-health matters. The Council must approve all NIMH grants before they can be awarded. The Council was established by the National Mental Health Act in 1946. It has twelve members who are private citizens and includes distinguished professionals and nonprofessionals. A second check resides in the fact that administrative decisions must be cleared with higher bureaucratic levels. Constituency groups can influence these levels as well as the initial decisions. Congress exerts additional checks by virtue of its control over the budget.

Thus, through conflict and bargaining among many government and constituency organizations, Federal budgetary, legislative, and policy decisions are made. The decisions, however, are frequently temporary and

certain issues return to the center of controversy like the metal ducks which rotate repeatedly through the pond in a shooting gallery. Four mental-health issues which seem certain to rotate for some time are support for psychiatric training, support for community mental-health centers, the place of mental-health coverage in national health insurance, and support for research. These issues are discussed below.

Current Mental-Health Issues

Support for Psychiatric Training by NIMH

The support of psychiatric training by NIMH began in 1947. Initially, grants were limited to resident stipends and teaching costs, including faculty salaries, in general psychiatry residencies. Over the next decade support became available for specialized psychiatric training in areas such as child psychiatry, geriatrics, and mental retardation. Support for teaching psychiatry to medical students began in 1950. In 1956 grants became available for training psychiatrists for careers in psychiatric education. In 1959 NIMH began supporting psychiatric residency training for general practitioners. In i960 funds were made available for psychiatrists to undertake post-residency training in research. Support for training in community psychiatry began in 1962.

The objective of all these programs has been to increase the number of psychiatrists and psychiatrically trained physicians working to meet the nation's mental-health needs. By the end of FY 1971 NIMH had supported almost 30,000 man-years of psychiatric residency training. From 1957 to 1971 more than medical students pursued extracurricular psychiatric training with NIMH support. From 1947, when NIMH training support began, to 1971, the number of psychiatrists in the nation increased from 3000 to about 25,000.

The intention of the Nixon and Ford administrations to phase out Federal support for psychiatry training has raised serious problems for American psychiatry. The American Psychiatric Association estimates that more than one-third of all psychiatry residency positions will be lost and almost half of the positions in medical schools. No study has been made of how the loss of Federal funds will affect the teaching of psychiatry to medical students, but the effect will be significant. Unlike most other medical specialties, psychiatry cannot rely on patient fees to support residency stipends and teaching costs. Other specialties generate training funds from charges for inpatient and outpatient care which are usually covered by insurance. Insurance coverage for psychiatric services is much more limited than for other medical services, particularly for outpatient care and partial hospitalization, which are increasingly viewed as treatments of choice for most psychiatric conditions. Barton describes the events which followed the

Administration's attempt to begin the phase-out in FY 1971. He also presents the arguments against this policy decision. Torrey, in a companion article, presents the other side of the debate. During the struggle to restore the Administration's cuts in the FY 1971 training budget, it became clear that many psychiatrists did not understand the political and governmental processes outlined above, and in particular the relations between the bureaucracy, the appropriations subcommittee chairmen and the OMB. As a result, their analysis of the situation was marred.

The funding of psychiatry training for the late 1970s is uncertain. Federal expenditures have been an important stimulus to the rapid growth in the number and specializations of psychiatrists. The major question for the immediate future is, who will now pay the bill? Since "he who pays the piper calls the tune," shifts in sources of support for psychiatry training are sure to influence the educational experience of the next generation of American psychiatrists. The examination of training methods, priorities, costs, and results which financial uncertainties necessitated was a healthy one. Hopefully, funds needed to apply the lessons learned will be forthcoming.

Community Mental Health Center Program

A 1971 NIMH staff study of the financing of mental-health services put the NIMH financial contribution to mental-health services in perspective. Of

an estimated $3.76 billion spent to purchase direct mental-health services in FY 1968 (not including services for the mentally retarded), public funds from tax revenues accounted for almost two-thirds (2.45 billion) and private sources (consumers, private insurance, industry, philanthropy) for one-third (1.31 billion). Of the public funds, state and local governments accounted for two-thirds (1.62 billion) and the Federal Government accounted for one-third (0.83 billion). Thus in FY 1968 the Federal Government accounted for two-ninths or 22 percent of the expenditures on mental-health services. With the growth of Medicare, Medicaid, and the population of veterans eligible for federally supported services, this proportion is probably higher today.

Within the Federal Government, the Veterans Administration accounted for 47 percent of Federal mental-health service expenditures, the Social and Rehabilitation Service (Medicaid and other programs) for 33 percent, the Department of Defense 7 percent, NIMH 6 percent, Medicare 4 percent and other programs 3 percent. The FY 1968 NIMH services budget of $49.3 million was only 2 percent of the public expenditure for mental-health services and little more than 1 percent of all expenditures (public and private) for these services. The NIMH FY 1972 services budget of $150 million represented only slightly higher percentages of these totals.

In view of its small financial leverage, NIMH has had a large impact on patterns of psychiatric care. The bulk of the NIMH services budget has been

devoted to construction and staffing grants for community mental health centers (CMHC's). Each center is responsible for providing services to all residents of a geographic area (catchment area) including a population of from 70,000 to 200,000 people. From the inception of the CMHC Program in 1963 through FY 1970, a total of $365 million was awarded to establish 420 centers, which cover catchment areas with approximately one quarter of the United States population. These catchment areas range from inner city ghettos to farmlands, from affluent suburbs to the poorest counties of Appalachia. There are 66 centers with catchment areas in cities of 500,000 or more, 206 smaller cities, and 148 centers serve large rural areas where mental-health services have previously been virtually unavailable. An index of the acceptance of the CMHC Program is the fact that two-thirds of the cost of centers now in operation is born by state and local governments and private sources. One of the goals of the CMHC Program is to improve the organization and delivery of mental-health services so that effective preventive treatment, and rehabilitative services are available to all the people of the nation. Each center must provide five services: (x) inpatient care; (2) outpatient care; (3) twenty-four-hour emergency service; (4) partial hospitalization; and (5) consultation and education services for community agencies and professional personnel. In addition to these five essential services, centers are encouraged to develop diagnostic services, rehabilitation services, pre-care and aftercare services (e.g., home visits and halfway houses), training activities, research

and evaluation programs, and an administrative organization which will achieve the intent of the program. In 1969, only four years after the CMHC Program began, more than 2000 psychiatrists were working part-time or full-time in centers, and centers accounted for more than 10 percent of all inpatient and outpatient psychiatric patient-care episodes. More than 34 percent of new center patients had no previous mental-health service contact, indicating centers are reaching people who might not otherwise have received needed treatment.

Centers have aided the development of new therapeutic concepts such as crisis intervention, partial hospitalization, and outreach to previously underserved groups. The program has also stressed citizen participation in planning center services and formulating center policies. Center staffs are providing consultation to a wide variety of community agencies and caregivers. Nearly one-fourth of consultation efforts are directed toward school personnel, reflecting an emphasis on children and preventive efforts.

Whether the CMHC program will proceed to the goal that some of its originators set—providing centers for the entire United States population—is uncertain. The Nixon and Ford Administrations believe that existing centers provide sufficient models for states and local communities to expand the program if they wish. These Administrations announced their intention to phase out Federal support because they do not favor direct Federal support

for health services. So far, the Congress has disagreed and has permitted the CMHC Program to continue growing. The activities of lay and professional groups interested in mental health will have an important influence on the outcome of this Federal policy struggle.

Health Insurance

With mounting public pressure for health care as a right rather than a privilege, changes in the patterns of delivering and financing health services are inevitable. Insurance benefits will play a large role in determining the changes that occur. Coverage for mental illness in present Federal insurance programs varies. Some health programs do not include mental-health services. For example, the Health Maintenance Organization program, being developed as a form of prepaid health care by DHEW, does not require service providers to include mental-health services in their benefit package. The Federal Medicare program includes mental-health services, but limits coverage of inpatient care in psychiatric hospitals to 190 days during a person's lifetime. This limitation does not apply to psychiatric units in general hospitals. Reimbursement for outpatient treatment of mental illness is limited to 50 percent of the cost or $250 per calendar year, whichever is less. This limitation encourages inpatient treatment of older persons who might do equally well or better with outpatient care. In 1971 approximately 20 million Americans were covered by Medicare and 12 million by Medicaid. Psychiatric

services, however, accounted for less than 5 percent of Medicare expenditures and less than 10 percent of Medicaid expenditures. The Federal Civilian Health and Medical Program of the Uniformed Services insurance program (CHAMPUS) has been a leader in the coverage of mental-health services and has stimulated demand for similar coverage from private industry. CHAMPUS provides both hospitalization and outpatient care in civilian facilities for approximately 6 million inpiduals (retired members of the uniformed services and dependents of active-duty, retired, or deceased members). CHAMPUS provides unlimited coverage for outpatient mental-health services and ninety days annually of inpatient care with a renewal option and no lifetime limit. Partial hospitalization is covered under the inpatient part of the program, with two days of partial hospitalization absorbing one day's full hospitalization benefit.

The ongoing debates in Congress and the executive branch regarding health-maintenance organizations, Medicare, Medicaid, and National health insurance are critical points which mental-health professionals and constituent groups can continue to influence. The future pattern of delivery of mental-health services will be shaped in large measure by the funding mechanisms adopted for purchasing these services.

Federal Support for Mental-Health Research

The Federal Government is the largest source of support for mental-health research. Other government levels and the private sector, however, also contribute to this effort. State governments make a major contribution through their support of State universities, and in some states, research institutes and research units associated with state mental hospitals and other clinical facilities. City and county governments provide indirect support via funds for hospitals and clinics where research is carried on. The contribution of private foundations and other organizations is also significant; in FY 1968 it was estimated by NIMH to be more than $12 million.

As mentioned above, a number of Federal agencies support mental-health-related research. Federal support is concentrated, however, in the NIMH, which had an FY 1972 research budget of $99 million. In FY 1972 NIMH supported almost 1450 different research studies ranging from the molecular to the cultural level. While it is impossible to catalogue the results which researchers have achieved over the past twenty-five years with NIMH support, the information produced underlies much of today's clinical practice. It includes knowledge regarding neurotransmission mechanisms; increased understanding of drugs to treat anxiety, depression, schizophrenia, mania, hyperkinesis, Parkinsonism, and narcotic addiction; and new perspectives on the relation of culture and social class to the prevalence and forms of mental illness. Researchers supported by NIMH have been active in developing the new treatments which have evolved in the past twenty-five years—group

psychotherapy, milieu therapy, behavior therapy, and the use of peer and therapist modeling. They have helped to clarify the genetics of schizophrenia; the effects of early environment on children's social development and intelligence; and the nature of human perception, memory, and judgement. Research is continuing in all these areas and many more, e.g., the nature and functions of sleep, relations between brain and behavior, biological rhythms, biofeedback, psychotherapy, alcoholism, drug abuse, and psychodynamic aspects of attitudes. But Federal support for mental-health research is leveling off rather than growing at a rapid rate. The need to invest research dollars wisely, therefore, is more important than ever.

An NIMH staff task force has examined the entire NIMH research program. The task force asked questions about research substance as well as administrative practices. The issues raised are familiar. How much support for basic research versus applied research? For investigator-initiated research versus contract research? Which areas are ripe for breakthroughs in understanding? Which areas have been improperly neglected? Can the field fruitfully absorb more resources? If so, how can they be generated?

Just as in training and service areas, psychiatrists and other mental-health professionals are needed who are willing to engage in the political and governmental processes which determine the nature of Federal support for mental-health research. The concern for humanity and the intellectual vigor

which researchers bring to their research are equally valuable in the continuous struggle over public policy.

Finally, we would like to raise a few points of appraisal. The trend in the Federal management of domestic programs is clearly toward decentralization. This does not mean that the Federal experience was in vain, but rather that the same policy-influencing techniques which have been used at the Federal level are needed at the state level. For example, two-thirds of the public-health dollars devoted to mental-health services are currently provided by states and local governments.

Sound evaluation is growing more and more important, not only to justify programs to budget committees, but to help program managers make realistic decisions. If programs are to survive, their advocates must master the language and tools of cost-effectiveness.

The American mental-health movement has come a long way in the past few decades. We have moved from a system of asylums and patchy private care toward a national network of coordinated community services. A highly skilled professional and paraprofessional cadre of mental-health manpower has been developed, although it still falls short of national demands. We are now basing clinical practice on a much firmer foundation of scientific evidence gained from a Federal research effort, intramural and extramural, of

unparalleled quality. Our goal must be to ensure that these programs continue. To achieve this we must expand our knowledge base to include a sophisticated understanding of the dynamics of the political process, and the roles of Federal, state and local governments in the mental health arena.

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Notes

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