The Evolution of Fairness in Mental Health Policy

Anyone who is involved in health policy, whether as a patient, a health professional, a payer, or an administrator, has at some time experienced feelings about the fairness of a policy. Policies stir intense controversy about who is getting what benefits from a policy, and why. The purpose of this article is to examine fairness in mental health policy as it has evolved over several decades. Because the mental health system has been heavily dependent on public funds and public policy, especially for those persons with the most chronic and severe mental illness, this discussion will be limited to public policy in mental health.

States differ in the quality of mental health care and the amount of money earmarked for mental health, but the intent of mental health policy from one state to another is strikingly similar. Thus, the fairness of mental health policy can be discussed as a national issue. Those policies that have been applied in every state throughout the United States are broadly described as institutionalization, deinstitutionalization and community-based care, and the community support program.

Many groups of people have a role in the development of policy as well as a personal stake in its outcome. Professionals in the mental health field have traditionally been advocates for patients' interests but also have spoken for the economic and political interests of their various professions. The government must advocate for the interests of society as a whole, consider the effect of policies on persons with mental illness as a particular group within society, and be responsive to particular lobbies. In recent years, persons with mental illness and their families have formed organizations and begun to advocate for their interests in mental health policy.

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Rarely do all interested parties benefit equally from a policy; often, benefits are realized by one group over another, and some groups may suffer a loss.

The fairness of the allocation of benefits can be viewed from the perspective of theories of social justice, which present reasons for or explanations of how the benefits and losses that occur in a society should be allocated and, most importantly, why they should be allocated in a particular way. As might be expected, the why reflects a value system of what is important in society (Veatch, 1981). These value systems are very different from one another, and I think they are the crux of controversy about health policy.

An analysis of major mental health policy initiatives (i.e., institutionalization, deinstitutionalization and community-based care, and the community support program) shows that mental health policy does not share one common underlying theory of justice. Rather, policy development has been an evolutionary process in which the particular interests of persons with mental illness have been addressed differently at various stages.

Institutionalization

Prior to the 20th century, there was widespread belief that mental illness was due to possession by the devil or to immorality. In either case, it was viewed as an uncontrollable phenomenon to which the individual's own weakness contributed. People were fearful that the person with mental illness would cause physical harm to others or in some way negatively influence their morality. This fear was perhaps the most basic reason why persons with mental illness were extruded from society and locked in poorhouses and jails against their will. In essence, institutionalization was viewed as a method of protecting society from the physical harm and moral wrongdoing of persons with mental illness (Mechanic, 1959).

Around the mid-1800s, social reformers began advocating that persons with mental illness be treated more humanely, pointing out that the state could provide care more efficiently in large institutions than communities were providing it in poorhouses and jails. Thus, by 1900, state governments had assumed responsibility for persons with mental illness (Gruenberg & Archer, 1979).

Institutionalization of persons with mental illness provided several benefits: (a) society was protected from the physical harm it was feared persons with mental illness would inflict; (b) treatment offered the potential of a cure along with the potential future economic benefits of a healthy and productive member of society; and (c) economies of scale could be realized through the provision of care in large institutions where it could be handled en masse with personnel working to their fullest capacity.

The fairness of institutionalizing persons with mental illness can be best explained by a utilitarian concept of justice. Utilitarian theory evaluates social actions strictly in terms of their impact...
on general human welfare (Veatch, 1981). If society is happier or has increased "utility," the policy is fair. Certainly, the general society seemed to benefit from institutionalization—From their perspective, they were being protected from the dangerousness of persons with mental illness.

However, utilitarianism also generally places a great value on individual liberty, thus, institutionalization seems to conflict with utilitarianism. While society was protecting its safety, it was depriving persons with mental illness of liberty. But the utilitarian doctrine accounts for this. John Stuart Mill, a utilitarian philosopher, wrote:

The sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection.

That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. (Mill, 1956, pp. 72-73)

Thus, if members of society believed they were in danger from persons with mental illness, they were just in depriving those persons of their liberty.

The harm principle is a widely accepted principle to limit liberty, but its extensive applicability to persons with mental illness is doubtful. In some cases, it is true that persons diagnosed as mentally ill are dangerous and present a serious threat of physical harm to others. It does not follow, though, that every mentally ill person poses a threat to others. Studies have shown either that mentally ill people, as a group, are no more dangerous than others or that, if they are, the differences are so small that they allow little success in predicting dangerousness.

This harm principle, then, has limited applicability to persons with mental illness, at least in the present day. It might be asked if it was fair to apply the harm principle in previous times, when society believed that persons with mental illness were dangerous. Because society had to decide based on the information available at that time, it was fair to apply the harm principle. It did not conflict with the principle of liberty as explained under utilitarianism.

In later years, the perceived dangerousness of persons with mental illness diminished somewhat, but institutionalization remained with the argument that persons with mental illness could not care for themselves and often were not rational enough to determine their own best interests. This protection of persons with mental illness fits within fairness under the utilitarian concept because mentally ill persons are not able to look after themselves. In assigning a high value to individual liberty, the utilitarians also define instances in which paternalistic intervention is appropriate, in order to bring the greatest good to the greatest number.

Another factor that figured into the welfare of society is the economic cost of providing care for persons with mental illness. These costs were paid by society through taxes. However, society attached great value to having the objectionable behavior of persons with mental illness removed from society's view. In this respect, while institutionalization generated cost, it also generated benefits equal to the value of the nonpecuniary cost no longer imposed on society by the behavior of persons with mental illness. Thus, institutionalization was just, according to utilitarian doctrine, because it protected society, provided certain economic gains over the nonsystem of care in communities, and benefited society overall.

Deinstitutionalization and Community-Based Care

During the 1950s, several factors coincided, beginning a policy of deinstitutionalizing seriously mentally ill (then called chronically mentally ill) patients, discharging them to live in the community and receive care on an outpatient basis. An important factor that spurred this policy change was the burgeoning population of mentally ill people and the increasing economic strain on the states to maintain psychiatric patients in state hospitals (Rose, 1979). Also, the development ofpsychotropic medications was advancing, making it possible to better control the overt symptomatology of mental illness. This made it more possible for patients to live in the community. Another important factor was that the federal government became aware of a national problem presented by psychiatric illness when 1.75 million Americans were rejected for service during World War II (Greene, 1986). This prompted Congress to pass the National Mental Health Act of 1946 (Public Law 79–487). This act established the National Institute of Mental Health (NIMH), which served as a major advocate of mental health care on a national level (U.S. Department of Health and Human Services, 1980).

For several years, there was controversy over government's role in mental health care and whether federal funds should be directed toward preventive, acute, or chronic care. In 1961, President Kennedy appointed a committee to study the federal role in mental health care. The committee came up with the community mental health plan, which led to the Community Mental Health Centers Act of 1966 (Public Law 88–164). Through this act, the federal government provided funding to establish community mental health centers (Bachrach, 1983).

Public Law 88–164 was enacted with a wide base of support and seemed to have the potential to give something to everyone. It was expected to increase the accessibility and availability of mental health services to the public; expand the professional area of psychiatrists and other mental health professionals into primary prevention; and decrease the costs associated with state hospital care (Rose, 1979). It also was expected to benefit persons with serious mental illness by reintegrating them into the community where they could, with the aid of medication, live more independently and participate meaningfully in community life. The community mental health centers and the state hospitals were expected to function together to provide a broad array of services (Bachrach, 1983).

In a short time, many problems began to surface. Because of the funding structure of Public Law 88–164, community mental health centers could be federally funded and operate independently of state hospitals and state mental health authorities. Because no economic link existed between them, no communication link developed (Clarke, 1979). Patients were discharged from state hospitals, but their linkage to a community mental health center was tenuous. Even when seriously mentally ill patients were linked to a community mental health center, few services were designed to meet their needs.
In addition to the lack of community-based services for seriously mentally ill patients, legal issues further tested the treatment of these persons. Legal cases were increasingly concluding that serious deprivation of liberty (i.e., hospitalization) could only be justified if adequate treatment was given. This principle was known as the "right to treatment." The economic implication was that more effective demand (by the courts) for better quality care, with no shifts in available supply, raised the costs of care to the states. Along with the right to treatment, another ruling essentially said that a person should be deprived of liberty only to the extent absolutely necessary. Thus, patients hospitalized either voluntarily or involuntarily could demand to be treated in the least restrictive environment. All of these legal rulings created an effective demand for community-based care.

As a result of these political and legal developments, it became increasingly apparent that the state hospitals had not developed after-care services and that community mental health centers were focused on prevention and acute care. This meant that chronic patients being discharged into the community were not receiving necessary services.

In reviewing the long, complicated history of the deinstitutionalization and community-based care policy initiative, one is faced with the question of who benefited from the policies and whether their benefit was fair. The state governments seemed to have benefited economically overall. Several studies suggest that, after considering all costs (i.e., cost shifting between levels of government, the cost of supporting community inpatient services and state hospital back-up care), the cost of deinstitutionalization was less than that of inpatient care provided through the hospital alone (Buck, 1984; Nash & Argyle, 1984; Rose, 1979). Additionally, the census in state hospitals decreased.

The general public also seemed to benefit in that more psychiatric services were available for persons who needed psychiatric care but were not necessarily severely or chronically mentally ill. Also, mental health professionals grew in number and kind and had opportunities to expand their roles and professional skills.

People with serious mental illness, however, were in a questionable position. Although they gained their liberty, it became clear that many of them were mentally disabled to the extent that they could not provide for their own basic human needs. After-care services were sparse and often did not address their special needs. As a result, some patients had frequent rehospitalizations, some lived in unhealthy or unsafe conditions, and others were in the dubious circumstance of depending entirely on their family members. Persons with serious mental illness essentially traded security for liberty.

The fairness of the deinstitutionalization and community-based care policy initiative can best be explained from the perspective of the Pareto doctrine (Pareto, 1935), which considers an action, or policy, to be fair if no one is worse off. Another important element of the Pareto doctrine is that each person is the sole determiner of his or her own welfare. However, this concept is based on the premise that all rational people seek to maximize their welfare.

Persons with mental illness clearly did not express any particular interests to spur the policy initiative, and it is debatable whether they would be considered rational enough to do so. However, advocates for these persons served as spokespersons, advocating liberty as the goal. Liberty was achieved. On balance, persons with serious mental illness received the benefit of liberty, but gave up some security. The fact that they benefited the least of all interested parties is significant under the Pareto doctrine.

Community Support Program

The NIMH developed the community support program in 1977 as a policy initiative aimed specifically at improving the quality of life for the chronically and severely mentally ill people who were deinstitutionalized and living in the community. The community support program provided funding for states to set up a community support system, which was intended to address the comprehensive needs of persons with serious mental illness and drew on elements from the medical rehabilitation and social support models of care (Stroul, 1984). The 10 essential components of a community support system were as follows:

1. Identification of the target population
2. Assistance in applying for entitlements
3. Crisis stabilization in the least restrictive environment
4. Psychosocial rehabilitation services
5. Supportive services of indefinite duration
6. Medical and mental health care
7. Backup support to families, friends, and community members
8. Involvement of concerned community members
9. Protection of clients' rights

The community support system model was flexible in that implementation was not prescribed; every state was expected to implement it according to their own particular needs, circumstances, and resources (Stroul, 1984).

Legal rulings, coupled with public moral outrage, seemed to have prompted the community support program initiative. As mentally ill people lived in the community, the public could see the deplorable living conditions of many of them. The public media also began to expose the plight of persons with mental illness. The low level of benefits received by persons with serious mental illness, in comparison to the much greater benefits received by others, was obviously unjust, and public opinion was that the deinstitutionalization and community-based care policy was unsatisfactory.

Another factor might be at least equally important in explaining how interest in the community support program initiative was generated. The legal rulings regarding civil commitment, the right to treatment in the least restrictive setting, and the right to refuse treatment all stood as rights to be asserted by persons with serious mental illness. These rulings provided a legal mandate to the public sector to develop services that respect patients' rights.

The Omnibus Reconciliation Act of 1981 (Public Law 97-35) combined formerly categorical grant programs and established block grants to states (Nash & Argyle, 1984). This resulted in a reduction of the federal contribution to mental health care by approximately...
sons with serious mental illness, as con­
available and accessible to all categories
of mentally ill people. That is, any ment­
tally ill person who went to a communi­
ty mental health center and requested
service could theoretically receive ser­
vice (assuming they lived in the catch­
ment area and were able to use the ser­
vices that were offered). In this sense,
there was equal access and availability.
What really seemed to hinder the pro­
sion of services to persons with serious
mental illness was a lack of consider­
ation for their special needs. For exam­
pie, these persons often were not capa­
bile of following the intake procedures
of the community mental health center,
such as making and keeping an appoint­
ment. They also spent a great deal of ef­
f Fort attending to their basic needs,
which could preclude their ability to
participate in traditional therapeutic
regimens. In this sense, access and
availability were equal but not equitable,
because persons with serious mental ill­
ness did not have the same capacity as
the general population to seek services
in a community mental health center.

The Rawlsian concept of justice
(also referred to as the egalitarian con­
cpt of social justice) accounts for in­
equities of opportunity (Rawls, 1971).
The Rawlsian concept of justice is that
those persons with the greatest need
should benefit the most, and the alloca­
tion of benefits should be available in
consideration of equal opportunity, or
ability, to seek potential benefits. Those
persons not able to seek benefits
should be given additional help. Thus, a
policy such as the community support
program, which gives special consider­
tion to persons with serious mental ill­
ness, would be fair under the Rawlsian
concept of social justice.

In contrast to the Rawlsian theory
of justice, the Pareto theory, which
could explain deinstitutionalization and
community-based care, does not consid­
er the individual's initial level of welfare
or his or her ability to use established
procedures.

Conclusion
The mental health policy initiatives have
been formed by interdependent eco­

c, social, and political factors. So­
cial factors that have affected mental
health policy have sometimes been spe­
cific to mental health, such as percep­
tions and public attitudes toward mental
illness and definitions of mental illness.
However, these social factors usually
operate in tandem with broader social
factors. The decade of Public Law 88–
161 (late 1960s and early 1970s) illus­
trates this point because it was marked
by public disappointment in and dis­
trust of government and a movement
toward social change across many as­
pects of society. During that time, sys­
tems changed to promote public wel­
fare. The Social Security Amendments of
1965 (Public Law 89–97) were enacted,
and court decisions affirmed the rights
of persons with mental illness. The
mental health system, by advancing the
rights of persons with mental illness,
participated in the activism to promote
social change.

Once social change is in the air,
the political process responds. Special
interest groups want to be sure that
their best interests are considered dur­
ing a time of change; often, public inter­
est takes a secondary position to the
narrower interests of politicians and
others in the policy-making arena as
they pursue economic benefits and per­
sonal power. Thus, the political process
shapes an idea for change to suit the di­
verse needs of the most powerful seg­
ments of society. In this way, social fac­
tors can lose some of their strength in
creating change.

Economic factors also enter into
the mental health care policy-making
process as either constraints or oppor­
tunities. The crisis in state hospital care
that led to deinstitutionalization pre­
sented as an economic problem created
by a rising census and overcrowding.
The economy of scale of large institu­
tions was outstripped. The solution to
this economic problem was either to al­
locate more funds to state mental hospi­
tals, and thus increase the supply of ser­

tices, or to decrease the use of services
(i.e., decrease demand), and so de­
crease the cost of mental health care to
the states. The choice was made to de­
crease the use of state mental hospital
services.

Social justice reflects the values of
society at a given point in time. These
values are most directly expressed as
public opinion and social movements
for change. The political process re­
sponds to these values but tempers
them and determines the specifications
of policy.

The fairness of mental health policy
has evolved with these social, political,
and economic factors. It evolved from
the institutionalization policy of the
mid-1800s, when society's idea of fair­
ess was providing the greatest good
to the greatest number of people,
through the deinstitutionalization and
community-based care era of the 1960s
and 1970s, when society thought every­
one could benefit to some degree and
fairness meant that no one should lose,
to the 1980s, when society began deal­
ing with perceived limitations in re­

tources and designated special popula­
tions to receive greater benefits. This
latter policy perspective aims to address
issues of equity in addition to issues of
equality.

Whether or not a policy is fair is
still a matter of values at a particular
point in time, in the context of social,
political, and economic factors. One
particular social justice theory cannot al­
ways be fair under all circumstances.
However, social justice theories are use­
ful in explaining the most common per­
spectives on fairness. Society has ap­
peared to formulate mental health
policy within social justice theories of
one kind or another as society's values
and circumstances have evolved.

References
Bachrach, L. (1983). An overview of
deinstitutionalization. New Directions for
Mental Health Services, 17, 5–14.
Buck, J. (1984). Block grants and federal
promotion of community mental health ser­

cives, 1946–65. Community Mental Health
Clarke, G. (1979). In defense of deinsti­
tutionalization. Milbank Memorial Fund
Quarterly/Health and Society, 57(4), 461–

479.
Community Mental Health Centers Act
of 1963 (Public Law 88–164).


National Mental Health Act of 1946 (Public Law 79–487).


Social Security Amendments of 1965 (Public Law 89–97).


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