LINKING HEALTH and MENTAL HEALTH

edited by
Anthony Broskowski
Edward Marks
Simon H. Budman

Volume 2
SAGE Annual Reviews of Community Mental Health

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the mind-body connection

Series Editors' Foreword

This second volume of *Sage Annual Reviews of Community Mental Health,* edited by Broskowski, Marks, and Budman, addresses a critical issue that will affect the future of the mental health system in the United States for some years to come. For several decades our health and mental health systems have operated on somewhat separate trajectories. This has been true despite the fact that a substantial proportion of mental health care has been delivered by primary medical care practitioners. In addition, many of the groups served by the mental health care system are not easily separated into those needing mental health and those needing generic health care services. All too often the results of the separation of mental health and health care have been inadequate care and fragmented services.

We are living in an age of soaring costs for health care and a corresponding concern for cost containment. At the same time, the pressure for more specialization among health and mental health care disciplines increases. Increased specialization can have an impact on attempts to understand the possible areas of common interest between the health and mental health fields. Whether the impact is positive or negative may depend less on specialized knowledge than on the recognition that our clients are people with a broad array of human and social needs.

In the past, the term "medical model" has been used as a kind of shorthand critique by many mental health professionals who believed that complex human problems were too often dismissed as "illnesses." Now, however, the mental health field appears to be going beyond this critique and asking serious and detailed questions about ways in which behavioral science can contribute to medical care as well as how medical care systems can improve the quality of lives of individuals in the community.

Broskowski and his colleagues have produced a book on the cutting edge of the field of health and mental health. The book amply documents the value of coordinating the health and mental health care systems, and suggests that coordination can have an impact on the quality of care and on the cost of that care. Professionals concerned with both health and mental health will find much of value in this volume. Because these issues cut across many disciplines, this volume should be valuable to social workers, nurses, psychiatrists, psychologists, health planners, and medical care administrators. It is a book which points the way to a better-integrated system of care and which recognizes the unique contributions of both mental health and health oriented professionals in enhancing the quality of life and health for each of us.

—Richard H. Price
John Monahan

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PART I

INTRODUCTION AND OVERVIEW

1

The Health-Mental Health Connection

An Introduction

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This book is about the problems and prospects of coordinating health and mental health care. The coordination of these services will require coordination in related areas: planning, administration, training, and research. Most readers who have picked up this book are probably already open to considering this topic as a problem needing solutions. Others may want some persuasive arguments.

Each chapter, to some extent, sketches the dimensions of one or more problems associated with no coordination or poor coordination. At the level of the individual seeking help for poorly understood or self-diagnosed problems, a highly specialized or fragmented service system tends to reduce accessibility, accurate assessment, early intervention, treatment effectiveness, and on-going continuity of care. The most global index of societal benefit, the quality of our lives, must surely be diminished when health and mental health services are so organized as to reduce their effectiveness. Costs, of course, go up when inefficiencies occur and when ineffective outcomes must be repeatedly reassessed and redone. While knowledge in some delimited areas is advanced by specialization, a case will be made for the gains in knowledge realized by investigations that bridge separated specialties. Training and skill acquisition also tends to be organized in academic systems to achieve some initial, internal efficiencies at the expense of subsequent discontinuities and costs for service recipients—and professional rivalry and obsolesence.

If poor coordination produces problems, we would also argue that overintegration, or total consolidation, would create an equally negative state of affairs. This book is *not* about ignoring useful distinctions and eliminating all organizational separations of health and mental health resources. We may be visionary, but we are not revolutionists!

Forces Promoting Specialization

The mind-body distinction is an ancient and widely accepted dichotomy. It was strongly reinforced at the level of the federal government after World War II, when separate "institutes" for the various health specialties were created, including the National Institute for Mental Health. These actions were only a minor expression of a growing trend in this country to establish separate, categorical solutions for every significant problem coming to the attention of government administrators and legislators. Beginning in 1798, when the federal government established and operated the first merchant seaman hospital in Boston, the human service programs of the federal government slowly grew, undergoing numerous expansions, consolidations, and reorganizations (Attkisson & Broskowski, 1978). After World War II there was an accelerated rate of growth. By 1960 there were over 100 categorical programs in the Department of Health, Education and Welfare. By 1973 there were over 300 programs. Between 1965 and 1975 DHEW's share of the federal government's costs rose from less than 20 to 33 percent (Attkisson & Broskowski, 1978). In 1980 the Department of Education was elevated to Cabinet status and the Department of Health and Human Services (DHHS) was the new name for what was left. Will the future be any different?

This tendency toward growth and specialization, and its resultant fragmentation, inefficiency, and discontinuity, is also played out at levels of state and local government and in multiple institutions, universities, and service agencies. At last count in 1973, the average state government had between 80 and 100 separate human service administrative agencies, and the average community had from 400 to 500 direct service unts or agencies that were sponsored or funded by the government (Richardson, 1973).

These observations are not intended as an indictment of governmental concern for citizens but as a backdrop against which we can understand the general forces that promote and maintain the separation of the health and mental health sectors. We believe that the roots of the problem, if one will accept for the moment that it is a problem, can be traced to some generic, as well as specific, forces acting in systems and particularly in contemporary American society.

"Differentiation and specialization are common human responses for coping with complex and not very well understood phenomena" (Yessian & Broskowski, 1977: 271). The human body, and human feelings and behaviors, are extremely complex and poorly understood, not to mention highly valued. The search for reliable knowledge has promoted specialization, partly to ease and quicken the discovery process, partly to handle the storage and retrieval of facts as they accumulated. No one person is capable of maintaining depth and breadth in a world of exploding knowledge. Unfortunately, specialization in research tends to have two perhaps unintentional side effects. First, it promotes and reinforces specialization in the knowledge *application* process. For example, specialized research in health and illness tends to promote specialized delivery of health care services. Second, there is little conscious effort to ask research questions that cut across separate specialties. For example, how does the chemistry of the brain and cells affect behavior? When such cross-cutting questions begin to be asked, we invariably create a new specialized research and service application area to answer them. Specialization as a knowledge discovery strategy is not intrinsically wrong or damaging, provided we can balance that tendency with emphases, incentives, and strategies for integration, coordination, and generalization of findings into application.

"Generalists find it difficult to demonstrate the utility of their contributions" (Yessian & Broskowski, 1977: 272). The benefits of integration are seldom apparent in an immediate fashion. Rather, they are likely to be less dramatic, more subtle, take time, be difficult to evaluate, and be untraceable to any single individual. Patience is not valued in an environment of rapid change, and modesty seldom couples with ambition. New medical discoveries or new mental health interventions are likely to be well publicized, while directing a well-managed multiservice agency (perhaps an oxymoronic endeavor) is likely to go unnoticed. This second problem root is related to a third.

"Career rewards go to those who specialize" (Yessian & Broskowski, 1977: 273). Although profit-making industries pay their highest salaries to their "general managers," the human services sectors, governmental and private nonprofit, continue to give recognition and reward to their specialists. In some respects, specialization is easier. For career advancement it requires less effort to stay current, once an initial educational plateau is reached. Refining established research or treatment methods is less risky and hence more probable to lead to professional recognition and reward. One exception to this general rule is the rare person who achieves recognition by combining, integrating, or synthesizing two or more previously separated fields of endeavor, such as Jacob Bronowski, author of *The Ascent*

of Man (1973). Major scientific and service advances have also come about in that fashion and are duly rewarded. However, a fundamental integration is a long shot on which few will risk their time and reputation.

"Legislators at the federal, state, and local levels are easily induced by the lure of categorical legislation" (Yessian & Broskowski, 1977: 273). Although this observation may be losing validity since it was written in 1977, it remains an accurate representation in most circumstances. Since 1960 the U.S. Congress enacted more than 400 categorical programs designed to meet specialized and narrowly defined needs of potential service recipients, professional providers, or researchers. The executive branch of government also tends to create specialized units, rules, and procedures in their search for a "quick fix." The scarcity of resources and the chaos of complexity are finally beginning to backwash the flow of narrow, categorical thinking in government. But special interest groups, some of which were spawned by earlier legislation, will continue to lobby mightily to maintain their unique and specialized existences and their care and feeding by government. Schon (1971) vividly describes just such assertive action to remain the same as "dynamic conservatism." Unfortunately, "dynamic conservatism" also leads to active aggression as resources dwindle. One profession must begin to fight another to increase or maintain its share.

Emanating from growing concerns with service fragmentation, inaccessibility, discontinuity, duplication, and inefficiency, major efforts were made in the 1960s and 1970s at all levels of federal, state, and local government to better coordinate and integrate the entire range of human services being provided at the state and local levels. Some of the major efforts in this area, called Services Integration Projects, were funded by the Department of Health, Education and Welfare (Spencer, 1974). These efforts were characterized by large-scale plans to create integrated structures for policy-making, planning, funding, and service delivery. Most of these large-scale projects were subject to review and evaluation (John, 1977; Henton, 1979).

These general concerns for improved services coordination achieved greater focus with respect to special high-risk target groups and those persons who were likely to have greater than usual problems gaining access and continuity of care across specialized settings. Some of these specific concerns were then brought together by the President's Commission on Mental Health (1978). The commission's final report and associated appendices documented the continuing needs of high-risk groups which remained unserved or underserved. The reasons for these problems included the barriers to care presented by existing organizational service methods, the poor match between the distribution of needs and resources (facilities, programs, and

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