A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

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LESSONS FOR JAPAN FROM U.S. REBALANCING OF MENTAL HEALTH CARE

Richard G. Frank[1]

Introduction

As of April 2013, the Japanese government will make mental health a fifth national priority for national medical services, along with cancer, stroke, acute myocardial infarction, and diabetes. This change is a result of multiple factors: an aging population; increases in the demand for mental health care services; and a concern about a system that overly emphasizes institutional mental health care. The plan for shaping the future of mental health delivery in Japan is focused on changing the balance of care from institutional services to community-based services. In pursuing this goal the Japanese government has identified four aims for change: create a system of care that differentiates functions according to the intensity of need of patients; assure high-quality care throughout a restructured delivery system; make investments to support community-based services; and expand community education and expand opportunities for patient preferences to drive the delivery system.

The United States initiated a formal policy of reorienting mental health delivery away from large public mental institutions during the late 1950s and early 1960s. President John F. Kennedy set out a vision for a new mental health system, and the Community Mental Health Act was signed into law in October 1963. The U.S. policy goals of that era are quite similar to those recently identified by the Japanese government. The United States has been developing approaches to this problem for 50 years. During that time the United States has managed to dramatically reorient mental health care, expand the portion of people with mental disorders that receive treatment, and create new opportunities for support of community living by people with severe and persistent mental illness (SPMI). At the same time, mental health policy has had to contend with vexing failures reflected by increased rates of homelessness among people with an SPMI, high rates of victimization and incarceration experienced by this population, and neglect of the physical health of people with an SPMI.[2] For this reason, there may be some valuable lessons for Japanese policymakers from studying the experience of the United States.

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[1] Richard G. Frank is the Margaret T. Morris Professor of Health Care Policy at the Harvard Medical School.
[2] Richard G. Frank and Sherry A. Glied, *Better But Not Well: Mental Health Policy in the United States since 1950* (Baltimore, Md.: Johns Hopkins University Press, 2006).

In this paper we focus on three sets of lessons from U.S. mental health policy. The first set of lessons results from reducing reliance on hospital-based mental health care. The second set organizes observations about the essential ingredients to support community-based care. The third set of lessons involves how best to coordinate care for people with complex needs.

The paper is organized into four additional sections. The first focuses on the shifting locus of care in the United States. The second focuses on the use of financial incentives to drive change in the mental health delivery system. The third focuses on organization and financing of mental health care. The final section of the paper offers some concluding observations.

U.S. Deinstitutionalization

Figure 1 reports on the number of beds per 1,000 population across member countries of the Organization for Economic Cooperation and Development (OECD). What is striking about the figure is the contrast between the United States and Australia on the one hand and Japan on the other. The role of hospital-based psychiatric care in Japan today resembles that of the United States in the late 1960s. Yet the number of psychiatric beds alone does not reflect the management and emphasis of a nation's mental health system.

Figure 2 reports on the number of days of institutional mental health care by major types of provider. The figure shows that the number of days of care provided fell sharply in the 1960s and 1970s but began to increase around 1980. Figure 3 further illuminates the history by showing that the number of institutional episodes of care increased between 1965 and 1990. The implication is that as the total days of care fell the number of episodes grew, the intensity of inpatient care increased, the average cost of a day of care increased, and the length of stay fell.[3] One consequence of this is that the share of spending on institutional mental health care remained quite stable throughout this period.

The factors driving these trends are several. First, is that consumer protection litigation, unfavorable exposure in the press, and administrative actions aimed at improving the quality of institutional care began to have an impact in the 1970s. A key consequence of that impact was to increase the cost of care in public psychiatric institutions, which created new budget pressures for states. Second, new public investments in community-based treatment increased capacity in the form of Community Mental Health Centers. The enactment of Medicaid and Medicare created new sources of funding for mental health treatment for older and low-income Americans. These new sources of care, combined

[3] Gerald N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 1994).

Figure 1. Number of Psychiatric Beds

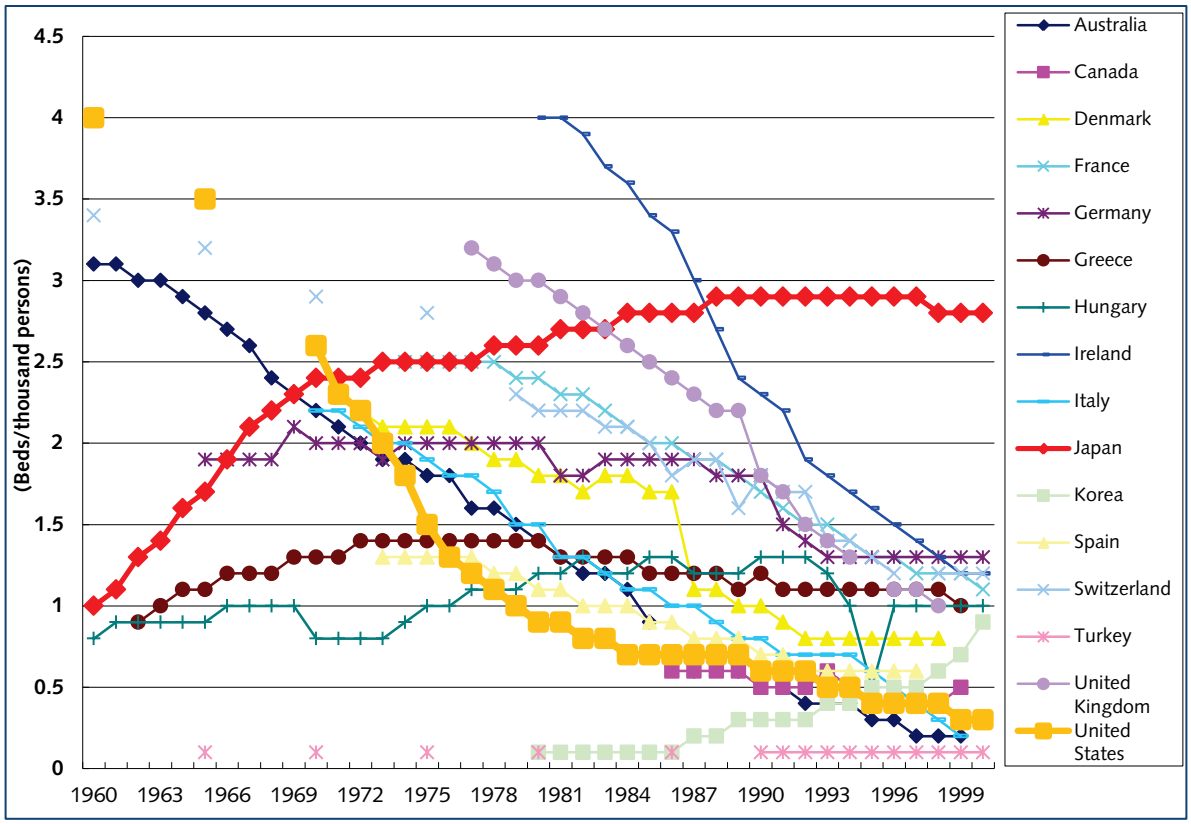
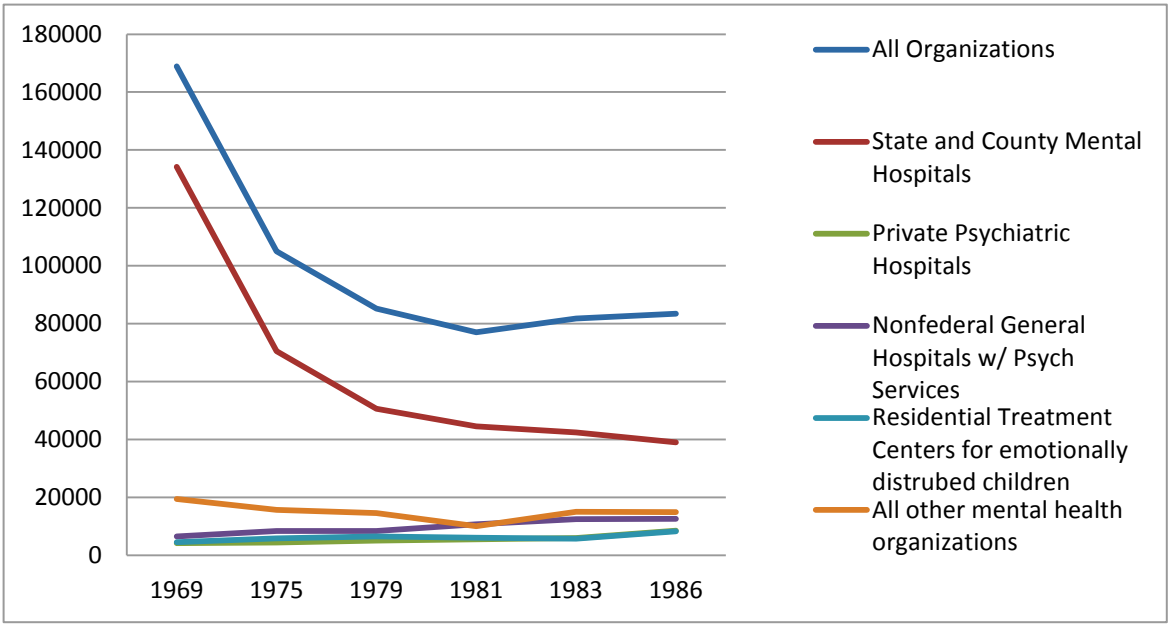
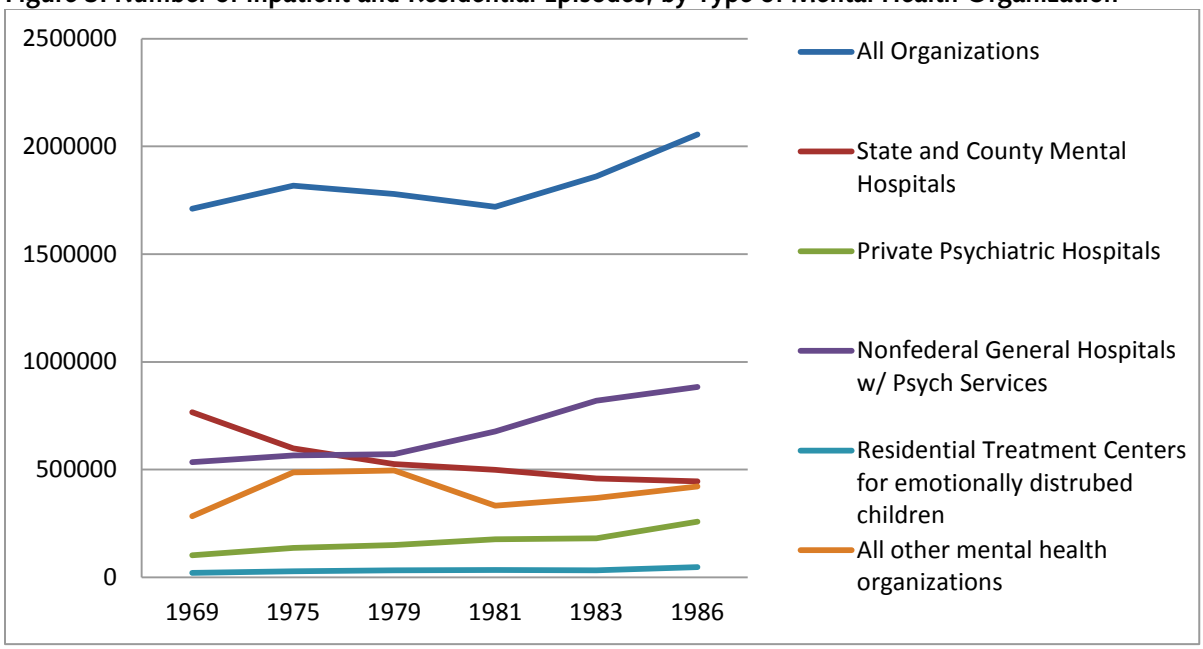


Figure 2. Number of Inpatient and Residential Treatment Days, in Thousands, by Type of Mental Health Organization



Source: Published and unpublished inventory data from the Survey and Reports Branch, Division of Biometry and Applied Sciences, National Institute of Mental Health.

Figure 3. Number of Inpatient and Residential Episodes, by Type of Mental Health Organization



Source: Published and unpublished inventory data from the Survey and Reports Branch, Division of Biometry and Applied Sciences, National Institute of Mental Health.

with new treatment technologies in the form of psychotropic medicines, at once expanded the range of institutional forms of treatment and the potential for community-based care. Medicaid and Medicare both created new revenue streams for general hospital psychiatric services. Thus utilization and spending on both community-based treatment and hospital-based care expanded during the late 1960s and 1970s.[4] Community mental health centers were too frequently focused on care for the larger numbers of people with less severe mental health problems and neglected those with an SPMI.[5] The result was a kind of revolving door for people with an SPMI between community and hospital. This proved costly and often resulted in inadequate care. Income support for low-income disabled Americans, via the Supplemental Security Income (SSI) program, became available in the 1970s and grew continuously through the 1990s as a source of support for people with an SPMI.[6] The expansion of treatment capacity along with resources that could be used to support basic needs in the community was critical in enabling more people with an SPMI to live successfully in community settings.

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[4] David Mechanic, *Mental Health and Social Policy*, 4th ed. (Boston: Allyn & Bacon, 1999).

[5] Comptroller General of the United States, *Returning the Mentally Disabled to the Community: Government Needs to Do More*, Report to the Congress (Washington, D.C.: GPO, 1977), http://www.gao.gov/assets/120/117385.pdf.

[6] Frank and Glied, *Better But Not Well*.

Table 1. Percentage Distribution of U.S. Mental Health Treatment Expenditures, by Site of Service, Selected Years, 1970–2005

Site of Service	1970 (percent)	1986 (percent)	1993 (percent)	2000 (percent)	2003 (percent)	2005 (percent)
All Service Providers	100.0	100.0	100.0	100.0	100.0	100.0
Inpatient	41.3	47.8	40.8	32.9	31.2	29.1
Outpatient	30.6	27.1	36.6	45.7	47.5	50.0
Residential	28.1	25.1	22.5	21.5	21.3	20.9

Sources: Substance Abuse and Mental Health Services Administration (SAMHSA), *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2005* (Rockville, Md.: Center for Mental Health Services and Center for Substance Abuse Treatment, 2010); National Institute of Mental Health (NIMH), *The Cost of Mental Illness, 1971* (Bethesda, Md.; NIMH, 1975).

Table 1 reports on the composition of mental health spending between 1970 and 2005. The table underscores the fact that the share of spending directed toward institutional care (inpatient plus residential) remained high (from 63 to 69 percent) through the mid-1990s. This figure shows a persistent stickiness in spending on institutional care even as the location of patients shifted. This in part occurred because Medicaid permitted a shifting of people from one set of institutions to another (public mental hospitals to nursing homes and general hospital psychiatric services). In addition to this stickiness, the nation saw people with mental disorders increasingly falling in among the homeless population and rapidly increasing rates of victimization and incarceration among people with an SPMI.[7] The lesson that emerges here is that new community-based treatment capacity and funding of community-based care are necessary but not sufficient to shift care and resources so that money follows the patient to support successful community living.

Community-based Services

Table 1 also shows that between 1986 and 1993, spending on inpatient mental health care began to decline notably, initiating a trend that continues through the present. This shift represents the second stage in a transformed U.S. mental health care delivery system. The late 1980s and early 1990s comprised a period during which several additional forces emerged to influence mental health care delivery. These included the appearance of managed behavioral health care; new emphasis on affordable housing targeted to people with an SPMI; and expansion of community supports in the form of mobile treatment teams, case management, and supported employment programs.[8]

Managed behavioral health care arose because the 1980s saw a rapid expansion of for-profit chains of psychiatric hospitals. Spending on inpatient care began to grow rapidly as a consequence. The increase in spending is evident in Table 1 through an examination of the spending share for inpatient

[7] Christopher Jencks, *The Homeless* (Cambridge, Mass.: Harvard University Press, 1994).

[8] Sandra Newman and Howard H. Goldman, "Housing Policy for Persons with Severe Mental Illness," *Policy Studies Journal* 37, issue 2 (May 2009): 299–324.

care between 1970 and 1986. A major innovation was the creation of specialized care management organizations that apply targeted expertise in mental health care, in combination with information technology and high-powered financial incentives, to control mental health care spending in both private health insurance and Medicaid.[9] These organizations shifted the format and financing of mental health care from an uncoordinated fee-for-service environment to one where inpatient and outpatient mental health care was managed together under a budget. This new model focused management on trying to match patient needs with the most appropriate and cost-effective resources. In that way it encouraged community-oriented care that relied on outpatient treatment and psychotropic drugs (drugs were not part of the managed care contracts in most cases, thereby effectively making them "free" to the managed care organization). It also directed management attention toward all high-cost care, not only that used by people with an SPMI. The resulting shifts in the patterns of care were dramatic. Rates of treatment increased, inpatient care declined as a share of spending, and there was a sharp increase in spending on psychotropic medications.[10]

During this same period, expansion in income support for people disabled by mental disorders continued to grow. The McKinney Act was signed into law in 1987 and provided a designated source of housing support to people with an SPMI that were homeless or unstably housed. Housing supports for people disabled by a mental illness expanded through the 1990s. Together these developments made new resources available to support community living among people with an SPMI. Statistical modeling indicates that the financing and availability of income support, human services, and broad-based medical care were the factors that enabled the most significant reductions in reliance on inpatient care. Mental health specific capacity and treatment programs were considerably less influential in realizing the desired outcome.[11]

During the late 1980s and 1990s, there was a great deal of innovation in treatment. These innovations spanned the introduction of new drugs, the development of "manualized" effective psychosocial interventions, intensive community-based programs that targeted the most severely ill patients, and the introduction of programs that linked services and supports to housing, work, and school.[12] The combination of new funds and new approaches to organizing care enriched the potential to care for people with mental disorders in communities. The lesson that emerges from this body of experience is that promoting community living for people with mental disorders, in a fashion that effectively shifts resources away from institutions, combines strong economic incentives to reallocate resources, targeted specialized management of care, income support, and complementary human services.

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[9] Richard G. Frank et al., "Risk Contracts in Managed Mental Health Care," *Health Affairs* 14, no. 3 (Fall 1995): 50–64.

[10] Richard G. Frank et al., "Trends in Mental Health Cost Growth: An Expanded Role for Management," *Health Affairs* 28, no. 3 (May/June 2009): 649–659.

[11] Frank and Glied, *Better But Not Well*.

[12] U.S. Department of Health and Human Services (HHS), *Mental Health: A Report of the Surgeon General* (Washington, D.C.: HHS, 1999), http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf.

In spite of this experience, a persistent challenge for U.S. mental health care delivery has been to foster organizational and financing schemes that create incentives and regulations to make provider organizations accountable for effectively and efficiently addressing the full array of needed services. There have been multiple attempts at building organized systems of care that coordinate the array of effective services that can benefit people with mental disorders and SPMI specifically. This is particularly the case with programs that service low-income and disabled people with mental disorders. Unfortunately, many of these efforts have fallen far short of their goals, including the organization of comprehensive community mental health centers, central mental health authorities, and organized systems of care.[13] All of these efforts were focused primarily on delivering specialized mental health services.

Coordination of Care

The successes that occurred under managed behavioral health care arrangements, alongside features of public mental health systems that worked to improve the well-being of people with an SPMI, point to some directions for future program designs. The first key element is the enduring function of inpatient psychiatric care. There are still regular circumstances, even with the most comprehensive community-based services, where some patients need to be managed for a short period in relatively restrictive settings. These circumstances include cases when patients are dangerous to themselves or others. The failure to provide adequately for such services, in part, explains why incarceration of people with an SPMI has increased in the United States over time.[14] Thus, the availability of high-quality inpatient services is a key part of a community-based mental health system.[15] The implication is that the mental health delivery system must be closely linked to the criminal justice system to provide opportunities to divert people exhibiting disturbed and disturbing behavior away from conditions where they may end up victimized or incarcerated.

The organization of services that span medical care, housing, employment supports, education, long-term care, criminal justice, and substance-use-disorder care faces the challenge of fragmentation in financing and delivery. Funding of each of these service lines involve different mechanisms, different incentive designs, different program integrity rules, and different units of payment. Medical care is frequently paid for by the service, housing through monthly vouchers, and substance-use-disorder care by grants to local treatment programs. The boundaries between programs create difficulties in defining the populations to be served, the ability to coordinate through shared information, accountability issues, and incentives to cost shift, among other problems. Recent extensions of

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[13] Howard H. Goldman, "The Program on Chronic Mental Illness," in *To Improve Health and Health Care, 2000*, ed. S.L. Isaacs and J.R. Knickman (San Francisco, Calif.: Jossey-Bass, 1999).

[14] Virginia A. Hiday, "Mental Illness and the Criminal Justice System," in *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems*, ed. Allan V. Horowitz and Teresa L. Scheid (New York: Cambridge University Press, 1999).

[15] David Mechanic et al., "Changing Patterns of Psychiatric Inpatient Care in the United States, 1988–1994," *Archives of General Psychiatry* 55, no. 9 (September 1998): 785–791.

managed behavioral health care initiatives include the range of services that people with mental disorders "touch" under one broad contract that defines a population with respect to its income and mental health needs. Then a single organization is given responsibility for managing services to care and support that population under an actuarially sound budget. Such programs are underway in New Mexico, part of Pennsylvania, and Louisiana. In each case, a budget is set along with a vector of performance indicators that touch on the range of domains of need for the client population.

When these programs work best, coordination mechanisms are used to arrange for packages of services that meet the needs of individuals. These range from the use of intensive mobile treatment teams, known as assertive community treatment programs, to lower-intensity case management systems.[16] The lesson learned about these efforts is that coordination of care for people with an SPMI are most effective when they have regular face-to-face contact with patients and when the teams are responsible for the full range of services that meet the needs of their client.

Recent developments in information technology suggest that these efforts can be enhanced with the application of interoperable health information technology (HIT). Some new programs are using a tablet-based support system for care managers working in the field. This enables them to quickly establish links to other service resources, obtain answers to clinical questions, and longitudinally track the progress of their clients. Delegating the management of the full range of services required to meet the needs of people with an SPMI under a single budget and set of accountability yardsticks is critical to organizing community programs. This superstructure is made effective when quality services are coordinated by teams of mental health professionals that have regular human contact with their clients and can obtain information on the types of services and supports used by each individual client in a systematic and longitudinal fashion.

Concluding Remarks

The United States has struggled for 50 years with the task of shifting the orientation of its mental health system. American deinstitutionalization in actuality happened in two parts. First was the reduction in use of public mental hospitals alongside increased utilization of other forms of institutional care, but in different ways. Acute inpatient care consisted of shorter, more-intensive stays in hospitals. Long-stay custodial treatment cases were shifted to nursing homes and other residential settings. These changes were driven by regulations and litigation that raised the cost and quality of public mental hospital care and the availability of new sources of funding for the support and care of people with an SPMI in the community (Medicaid and SSI). This set of policies would fit into current Japanese institutional and financing structures without requiring dramatic structural change.

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[16] Leonard I. Stein and Mary Ann Test, "Alternative to Mental Hospital Treatment," *Archives of General Psychiatry* 37, no. 4 (April 1980): 392–397.

The second stage of deinstitutionalization reduced the use of, and resources devoted to, most forms of institutional care. This change was driven by aggregating the components of care and delegating the management to specialized organizations that did so under a budget and were held to performance indicators. Enacting such policy change in the Japanese context would mean modifying key features of the existing approach to payment and organization of services. There is some recognition of the need for such change in the most recent plans for regionalization of the mental health planning process. There are several prominent conclusions that stem from these experiences. First, inpatient care has a role in a well-functioning mental health system, and driving capacity for hospital-based care to very low levels will result in unwanted outcomes such as increased rates of incarceration and victimization of people with an SPMI. Second, one must rely on multiple policy instruments applied in a coordinated fashion to achieve the best results. This means aligning health care payment policy with housing, human services, and income support/disability policy. Failure to align these policies results in fragmentation in services and people "falling through" holes in the social safety net. This has been evidenced in the rise in homelessness among people with an SPMI. Coordination and integration of care under budgeted systems, where caregiving organizations are accountable for the support of a vulnerable population, has emerged as the best bet for continued progress in community support of people with an SPMI. Finally, it is important to note that despite some of the imperfections that still exist, the vast majority of people with significant mental illnesses are better off today than they were in 1970 or 1985.

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