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THE STRUCTURE OF PUBLIC PSYCHIATRY

REVIEW SUMMARY # 1

NOVEMBER 14, 2007

I. INTRODUCTION

1a. Course Design

The Structure of Public Psychiatry is a sequence divided into four parts

I. The American Welfare State and Public Psychiatry (summer)

II. The Structure of Public Mental Health Services, 1948 - 2006 (fall)

III. Public Mental Health and Medicaid Managed Care in New York State (spring)

IV. The American Welfare State and Housing for the Mentally Ill (late spring)

The presentation of each part is largely historical. This approach reflects a conviction that the best and easiest way to understand the structure of public psychiatry is to know how it came into being.

The following summary reviews Part I, which we covered during the summer. Numbers in parenthesis refer to readings in the summer binder. The summary should be read in conjunction with *Fig. I, The Fiscal and Jurisdictional Structure of Public Mental Health*, which is attached.

1b. Two Underlying Dimensions

The Structure of Public Psychiatry Sequence is conceptualized in terms of two underlying dimensions. Both dimensions are represented graphically in *Fig. I, The Fiscal and Administrative Structure of Public Psychiatry*.

One dimension concerns the Type of Legislation that constructs public mental health as a sector of the American welfare state. Fig. I represents this dimension spatially. It diagrams public mental health as a small sector of the American welfare state that overlaps three much larger sectors – health care, income support, and housing. It conceptualizes public mental health as made up of four legislative ‘zones’. The three “outer zones”, labeled A, B, & C represent programs derived from legislation on health, income support, and housing in general. The “central zone”, labeled D, consists of programs that derived from legislation on public mental health in particular.

The second underlying dimension of the Structure of Public Psychiatry Sequence concerns the structure of centralization/de-centralization in each legislative zone. This dimension is constructed from combinations and permutations of five elements, represented in Fig. I, by color-coding: national government authority (red); state government authority (green); local government authority (blue); non-profit organization auspice (brown); free market profit-seeking competition (gray).

II. THE AMERICAN WELFARE STATE AND PUBLIC PSYCHIATRY

IIa. Introduction

Part I of the Structure of Public Psychiatry sequence, titled *The American Welfare State and Public Psychiatry*, focused on the “outer zones” of *Fig. I*, labeled A, B, & C. It described the consequences for public mental health of legislation on income support, health care, and housing in general.

The structure of centralization/de-centralization in the ‘outer zones’ of public mental health largely involves the division between national government and state government authority within the constitutional framework of American federalism [2.1,2.2].

IIb. The Social Security Act: Core of the American Welfare State

The core of the American welfare state for both income support and health care is the Social Security Act, originally passed in 1935 and continually modified by amendments ever since. [1.1, 1.2a, 1.2b, 1.3, 1.4, 1.5, 1.6, 1.7]

In both income support and health there has been a strong tendency to centralize titles of the Social Security Act that have political prestige and to de-centralize mean-tested titles that lack this status. The most centralized titles are Old Age Insurance and Medicare, which are funded and administered entirely by the national government. The most de-centralized title is Temporary Assistance to Needy Families (TANF), formerly Aid to Families with Dependent Children (AFDC). TANF is administered wholly by state and local government and terminates a nationally legislated right to income support that formerly existed under AFDC. [1.5]. With respect to centralization/de-

centralization Medicaid and Supplemental Security Income (SSI) are in the middle, as we shall see below.

IIC. SSI and Medicaid

The most important titles of the Social Security Act for public mental health are SSI and Medicaid.

SSI

SSI, provides income support for disabled individuals who have little or no work history. The federal government establishes a minimum benefit level that is uniform throughout the nation and administers the SSI program through its own social security offices. State government, however, plays an important role in the certification of individuals for SSI and can augment the minimum SSI benefit level with state funds. [1.3]

Medicaid

Medicaid provides health benefits to a large proportion of public psychiatry patients. When compared with Medicare, Medicaid, is distinctly de-centralized. [1.2b]. Its direct administration is delegated to state government.

Because health care is complicated, the structure of Medicaid must be described in terms of three separate features: eligibility, benefit design, and fiscal responsibility [1.2b].

Eligibility

It is common to assume that if individuals are poor, they automatically qualify for Medicaid. This assumption is profoundly incorrect, as the size of the uninsured population in the country dramatically shows [5a]. Federal Medicaid law only stipulates that all individuals who receive SSI and TANF are automatically eligible for Medicaid. It also allows that individuals may be eligible for Medicaid by virtue of 'medical indigence', meaning medical expenses so high they leave nothing for the necessities of food, shelter, and clothing. The definition of 'medical indigence' is left entirely to the discretion of state government, however, and state governments have used the provision in very different ways.

Benefit Design

Federal Medicaid law defines a minimum benefit package that all state Medicaid programs are required to provide. This package includes all care by any general hospital and also nursing home care. [1.2b]

In the original Medicaid law a further federal benefit requirement was that Medicaid beneficiaries have “freedom of choice” to obtain services from any qualified provider. With the advent of managed care, the federal government modified this freedom of choice requirement in ways we shall discuss in detail in the spring [1.4]

In addition to the above required benefits, federal Medicaid law includes a long list of benefits defined as optional. Discretion over which of these to include is left entirely up to state government. Many states have used optional benefits extensively in the area of outpatient mental health care to pay for free standing clinics and rehabilitation programs.

Fiscal Responsibility

Federal Medicaid law dictates that federal and state government are to share all Medicaid costs. The law includes a formula that determines the ratio of federal to state dollars for each state. In the wealthiest states, including New York, the ratio is 50:50. In Mississippi it is 90:10. Two states, New York and California, have decided that local government must pay half the state government share.

IId. Outside the Margins of the Social Security Act

The Social Security Act does not provide benefits to all public psychiatry patients. Adults who are not certified as disabled or who do not have children receive no guaranteed benefits under the Act, no matter how poor they are. For both income support and health care this population depends entirely on the discretion of state and local government. Many public psychiatry patients fall into this category. It is important, however, to underline a difference in state government policy with respect to income support and health care. With respect to income support, the program known as General Assistance has been severely reduced by all states in the last decade and in some states has been eliminated entirely. A willingness has emerged to leave individuals without any guaranteed income safety net at all. [4] With respect to health care the situation is not quite so extreme. In one idiosyncratic way or another every state has felt unequivocally obligated to fund health care for the uninsured. On a variety of measures, however, this health care remains sub-standard and distinctly inadequate. [5b]

IIe. Housing

During the summer we presented only a schematic introduction to the relationship between the American welfare state and housing for the mentally ill. We will fill in detail on this topic in Part II, to some extent, and even more so in Part IV in the late spring.

The schematic introduction presented during the summer consists of four basic elements

(i) General Housing Programs Legislated at the National Level

This element does not play a large role in housing for public psychiatry patients, but remains important for context and background.

In the American welfare state the largest national housing program by far is the mortgage interest tax deduction for homeowners, a program from which the poor do not benefit at all. Federal housing programs for the poor have been entirely separate from the homeowner deduction and represent a much smaller level of public expenditure.

The first federal housing program for the poor was passed in 1937 as part of the New Deal and provided funds to local government for the construction of new units of low rent housing. The program lasted until the 1970's and for the most part resulted in gigantic public housing projects that dot the American urban landscape to this day.

By the 1970's widespread disenchantment with public housing construction set in, and the federal government initiated a major change in its housing programs for the poor. It began rapidly to phase out funding for public housing construction and to introduce instead funding for rent supplements to be used by the poor on the open housing market.

At the national level this voucher program, generally referred to as the Section 8 program, is now the primary vehicle through which the American welfare state addresses the housing needs of the poor. Expenditure on the program is currently around \$28 billion, but Dolbeare makes the following argument for its inequity. [7a].

For every dollar of outlays on low-income housing programs, the federal treasury loses four dollar to housing-related tax expenditures. (This phrase refers to the mortgage deduction. – SR). In 1994, more than three-quarters of these expenditures benefited households in the top fifth of the income distribution. The top fifth got an estimated 61% of all housing benefits, compared to only 18% for the bottom fifth. (p.42)

(ii) The New York City Homeless Shelter System

New York has a far more extensive homeless shelter system than any other state in the nation, because of a legal victory by advocates which established a 'right to shelter', based on a sentence in the New York State constitution which declares that "the aid, care, and support of the need are public concerns, and shall be provided by the state and by such of its subdivisions...." [7b]

The New York City Homeless shelter system consists of both general shelters, located in zone C, and program shelters for the mentally ill, located in C'.

We will discuss the history and future prospects of the homeless shelter system in Part IV.

(iii) State and Local Government Programs of Housing for the Mentally Ill

These programs are located in zone D. Julie will discuss them in detail in Part IV.

(iv). Local Housing Markets

In the Structure of Public Psychiatry sequence we do not concern ourselves much with the operation of the free market, profit-seeking sector. Variation in local housing markets has such an important influence on what kind of housing the mentally ill can buy with SSI or a Section 8 voucher, however, that we must include it in our conceptualization [7a] We represent the free market in the the *Fig. 1* color-coding system with the color grey. Including the profit-seeking free market sector will prove valuable in relation to a number of other topics during the course of the year, as well.

**III. THE AMERICAN WELFARE STATE, PUBLIC PSYCHIATRY,
AND SOCIAL STRATIFICATION**

As a complement to all we have discussed above, it is useful briefly to think about the general relationship between welfare state institutions and social stratification. Overall, welfare state institutions reduce the degree of social stratification and increase equality. In addition to this overall effect, however, welfare state institutions simultaneously have other effects on social stratification as well.

A distinctive feature of the American welfare state is that it creates within the population who are poor a bi-modal pattern of social stratification that is steep and discontinuous [10] This social stratification is manifest directly in public psychiatry practice at the clinical level. On the one hand, many of the spmi are favored beneficiaries of the American welfare state and constitute a veritable aristocracy among the poor. They have a guaranteed income through SSI, receive an array of clinical and rehabilitation services, and reside in stable, community-based housing. On the other hand, a substantial number of the spmi continue to reside in grim, dormitory shelters or remain homeless altogether. The number of immiserated patients grows dramatically, furthermore, when one includes adults and children who live in poor single parent families, an emblem of whose condition is the infamous Emergency Assistance Unit here in New York City. [8a] These public psychiatry clients have fallen off a social cliff.

The perpetuation of an immiserated segment among the poor in the American welfare state has been labeled “the poverty paradox”. The “poverty paradox” refers to the reality that since the 1970’s the economic and social condition of certain segments in bottom fifth of the U.S. income hierarchy has become steadily worse on an impressive variety of indicators, despite gains in social welfare spending since 1960’s and dramatic growth in GNP during much of the 1980’s and ‘90’s. Compared with other Western industrial nations the acuteness of the poverty paradox in the U.S. is unique.[9]

Why is the American welfare state different from that of other Western nations in this way? One factor, as Rimlinger says, is America’s tradition of individualistic values [1a]. The full answer, however is far more complex. The summer binder includes as an Optional Reading a superb paper on the topic, “Understanding American Social Politics”, by Weir, et. al. [11].

IV. THE STUCTURE PUBLIC MENTAL HEALTH SERVICES, 1948-2007

Over the next two months we will cover Part II of the Structure of Public Psychiatry Sequence, titled ‘The Structure of Public Mental Health Services, 1948-2007’. Part II is concerned with legislative zones A’, C’, and D. In these zones the structure of centralization/de-centralization largely involves the relationship between state and local government authority and also the relation of each, respectively, to the non-profit sector.