they could demonstrate that parity would not break the bank for employers—and they could show it only because of the introduction of managed behavioral health care. Parity legislation that prohibits higher copayments and deductibles for behavioral health care—such as the legislation that is before the U.S. Congress—also eliminates financial disincentives that represent yet another barrier to seeking help for behavioral health problems.

Despite the benefits to the system that managed care has made possible, no one would argue that it is a perfect solution. In many ways, we have made great strides because of it, but we have additional work ahead of us if we want to continue to improve the system. Managed care must become less burdensome for consumers and practitioners. In addition, managed behavioral health care companies must do a better job of streamlining processes, reducing paperwork and micromanagement, and meeting obligations to practitioners to operate efficiently.

There continue to be significant geographic variations in behavioral health practice that are not explained by the needs of the population. Practitioners too often make key treatment decisions on the basis of custom or personal preference rather than patients' needs and scientific evidence. Certainly, we have more work to do to develop a comprehensive service system and to address the geographic maldistribution of resources.

Furthermore, discrimination against individuals with behavioral health disorders must be eliminated. Full parity in insurance coverage for behavioral health disorders should be passed, and the remaining barriers to access to the full continuum of behavioral health services should be removed.

Despite the challenges, there is reason for real optimism. The science continues to advance. More effective diagnostic and treatment alternatives emerge. Traditional but unsubstantiated therapies and practice patterns are giving way to evidence-based practice. To further build on these opportunities, clinicians and managed care companies must work together to bring the best that our field has to offer to people in need in the most effective and efficient manner.

Spending Too Much on Mental Illness in All the Wrong Places

Michael F. Hogan, Ph.D.

At the start of the 21st century, America is indeed confronting a crisis in mental health care, as Dr. Appelbaum points out. But the problem is even deeper and less tractable than his analysis suggests. For one thing, the crisis is clearly chronic, not just a current issue. Did America not confront a similar mental health crisis 150 years ago? For another, it is not just a problem within the mental health and health care systems, unless these systems are defined broadly. For example, we have come to understand that homelessness cannot be solved with treatment alone: affordable housing must be available. Finally, it is becoming apparent that some of the toughest problems are the results of well-intentioned—even well-executed—reforms. There is a crisis, but the way out is not simple, quick, or obvious.

Clearly, a part of the problem is that there is just not enough funding in the right places. In his 1978 transmittal letter to President Carter for the final report of the President's Commission on Mental Health (1), chair Tom Bryant bemoaned the fact that "we now devote only 12 percent of general health expenditures to mental health." The most recent national data indicate that in 1997, only 7.8 percent of personal health and governmental health spending was for mental health and addiction treatment (2). This is not progress.

My analysis suggests that a major reason for this slumping investment in public-sector mental health care—compared with the need for such care and the overall growth in health spending—is in part a "side effect" of successful reform. In the states, the generation-long effort to move from custodial care to community support finally took hold in the past decade. In 1993, for the first time, state mental health expenditures for community care exceeded those for state hospital care (3). This did not happen just because patients were dumped and hospitals closed. Initially, states were generally successful in transferring funds to community care; from 1990 to 1997 states' spending for residential and ambulatory care increased by 78 percent (4).

But this hard-fought and initially successful reform contained a dangerous "policy side effect." In moving resources from state agency payrolls to grants and subsidies to local providers and governments, the states moved from a budget category that increased predictably—driven by collective bargaining and direct state responsibility—to budget line items not indexed to inflation. Starting at about the same time that state spending on community care exceeded state hospital spending, the collective share of state budgets allocated to mental health agencies started to slip. The share had remained steady from 1981 to 1990—in the range of 2.1 percent of all state spending. However, mental health spending as a percentage of state spending slumped to 1.9 percent in 1993 and to 1.8 percent in 1997 (4). This trend was not due to budget cuts; state mental health budgets grew. Rather, during the 1990s budgets grew at a rate that slipped against inflation by about 1 percent per year (3).

This problem is both pernicious and complex. It is easy to exhort governors and legislatures to do more. But in my experience, the dynamics of mental health resource erosion are not political. In the current wave of state budget cuts, mental health is usually not singled out for severe cuts. In fact, mental health programs are often cut less than others. The long-term insidious process of resource erosion is not the result of politics or conscious policy but is a structural problem. Worse, it is the result of successful reform. Additionally, states have financed community care with Medicaid and have relied on this program to underwrite acute care in general hospitals to replace state hos-

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pital care. Reliance on Medicaid has increased mental health spending but introduced many complexities: a poor fit between eligibility and clinical need, dominant roles for managed care and Medicaid offices instead of mental health agencies, and administratively cumbersome billing systems. This financing change has also had powerful side effects.

The field has no successful strategy to counter this subtle but dangerous erosion of the state mental health safety net and the increased fragmentation caused by reliance on multiple funding streams. It is apparent that calls to spend more money on care have not been successful, perhaps because elected officials are concerned about competing successfully in a global marketplace, where jobs move swiftly to where there is value. The mental health community has been dismally unsuccessful at making a "business case" for the link between mental health and productivity. Given the overwhelming data on the consequences of untreated or poorly treated mental illness, we should be making a stronger case. Perhaps the elected officials and business leaders are not entirely to blame.

A second paradox related to dwindling investments in mental health care is that total spending on mental illness has in fact skyrocketed. This spending is not taking place in the treatment system but in the criminal justice system, in the general health care system because of the impact of depression and other mental disorders on the course and outcomes of physical illness, and in the welfare system. Perhaps most striking has been the increase in the costs of disability. Below I amplify this example to show how much is being spent on mental illness.

By 2000, about 2.8 million Americans were receiving Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) because of mental illness (5). In 2000 federal expenditures on benefits for people disabled by mental disorders other than mental retardation exceeded $20 billion. This figure exceeded all of the largest categories of spending on mental health care: budgets of the state mental health agencies, Medicaid mental health costs, and Medicare expenditures for mental illness.

The scope of costs for disability payments, arguably the result of a lack of treatment or inadequate or poor treatment, is less striking than the trends in these costs. In the SSI program alone, people disabled by mental illness are the largest category, representing 34.4 percent of all disabled individuals in the program for whom a diagnosis is known. They are also the fastest growing category. From 1992 to 2000, the SSI mental illness caseload increased by 47 percent. Astonishingly, 64 percent of the total increase in the SSI caseload during this period was attributable to mental illness-related disability (5).

It goes without saying that the excess costs of untreated or poorly treated mental illness in the disability system, in prisons, and on the streets are part of the mental health care crisis. We are spending too much on mental illness in all the wrong places. And the consequences for consumers are worse than the costs for taxpayers.

In an era of public budgeting as a zero-sum game with winners and losers, the mental health community must do more than simply demand increased spending in the treatment sector, when mental health-driven spending in the disability system (and in the criminal justice, juvenile justice, welfare, housing, and health care systems) is increasing. It is evident that our past advocacy tactics have generally not worked to generate equitable investments. Also, given our collective failure to help many people with a mental illness achieve the goals they value, these tactics ring hollow.

There is plenty of blame to go around for the starvation in the midst of plenty. Yes, increased investments in treatment programs are needed. Yes, elected officials must step up to the plate. But practitioners and providers must demonstrate an ability to help consumers achieve the goals that they value. Interestingly, these are the same goals that elected officials articulate. As President Bush put it in his Executive Order establishing the President's New Freedom Commission on Mental Health (6), "the desired outcomes of mental health care . . . are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation." When we are not achieving the outcomes that either our customers or our elected leaders desire, it's time for change.

Managers and policy makers in mental health must commit to making an impact on these outcomes and on the growing "negative investments" in mental illness in disability payments, correctional systems, and shelters. Researchers and funders of research must speedily move beyond studies that cannot be generalized and results that are not aggressively made available to practitioners. The evidence that increasingly counts is the evidence that treatment works for consumers in real-world settings, not for researchers in university clinics.

Yes, there is a crisis in mental health care. It looks remarkably similar to what Dorothea Dix encountered more than a century and a half ago. But the clinical, financing, and even management tools at our disposal today are much more robust. And even more than in the past, this is a time of plenty. The crisis today is unacceptable. While we look to our leaders, the mental health community must demonstrate that we are willing and able to play our part in solving it.

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