Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's telephone number and e-mail address. Letters related to material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to Howard H. Goldman, M.D., Ph.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, MS#4 1906, Arlington, Virginia 22209-3901; fax, 703-907-1095; e-mail, psjournal@psych. org. Letters reporting the results of research should be submitted online for peer review (http://appi.manuscriptcentral.com).

Cognitive Dissonance in the Pages of *Psychiatric Services*

To the Editor: Aha! The editorial practice at *Psychiatric Services* is generating good old-fashioned cognitive dissonance. Congratulations. This will definitely keep the readership on their toes.

On page 761 of the July issue, in the Economic Grand Rounds column (1), Robert Schreter, M.D., of the University of Maryland, tells us that we must "make do with less." A scant six pages further, Yih-Ing Hser, Ph.D., and his colleagues at the University of California, Los Angeles (2), present data showing that greater quality and quantity of services would increase retention in treatment.

This is certainly the material out of which cognitive dissonance and a variety of other frustrations can grow.

Perhaps until mental health funding is rationalized, we should just stop publishing papers about how to spend more money.

William S. Masland, M.D.

Dr. Masland is in private practice in Yuma, Arizona.

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1. Schreter R: Making do with less: the latest challenge for psychiatry. Psychiatric Services 55:761–763, 2004
2. Hser YI, Evans E, Huang D, et al: Relationship between drug treatment services, retention, and outcome. Psychiatric Services 55:767–774, 2004

In Reply: Congratulations to Dr. Masland. He is certainly paying attention. In his letter, Dr. Masland highlights the disconnect between the harsh reality of decreased funding for behavioral health services and our ability to provide treatment that is demonstrably more effective. His conclusion, which I suspect was delivered more tongue in cheek than a true critique of the journal's editorial practice, is to stop publishing papers about studies that might require us to spend more money on health care.

A good friend of mine, when presented with a question that appears to demand a choice between two alternatives, often answers "yes and yes." We are now at a "yes and yes" point in time. Yes, we have experienced a significant decrease in funding for behavioral health services. And yes, we should continue to evaluate the impact of our interventions to identify best practices, even if these practices cost more.

The Hay Group reported that between 1988 and 1998 funding for behavioral health services decreased by 54 percent, compared with a 7 percent decrease for all other areas of health care (1). And yes, we should expect more of the same. This restriction challenges psychiatrists to allocate their limited resources wisely.

Dr. Hser and colleagues (2) provide data to support the hypothesis that increasing service intensity enhances patient satisfaction, which increases retention and leads to improved clinical outcome. But interestingly, length of stay and outcome were nearly identical for patients in residential programs and for those in outpatient drug-free programs. In fact, although length of stay tended to be longer in the more expensive residential programs than in outpatient care, outpatients in the study reported greater treatment success than those in residential treatment. It is possible that those treated as inpatients were more severely impaired. Nevertheless, the data support preferential use of less costly outpatient substance abuse treatment in the absence of contraindications. Their study provides clinical outcomes data to inform clinical decision making and case manager intervention and stimulates clinical services redesign. This finding makes it possible for us to "make do with less."

But yes, we should also continue to support the kind of research into the kinds of questions Dr. Hser and his group raised. We are at a point in time when the payers are calling the shots. These payer decisions are highly driven by data. Fortune 100 companies are routinely self-insured. Because they pay the bills, they can track health care costs at a level of sophistication that would amaze most psychiatrists. And they are remarkably attentive to return on investment. As employers discover that they are receiving a positive return on their investment in behavioral health services (through increased attendance, enhanced performance, decreased medical and disability costs, and diminished retraining costs), they increased their investment in behavioral health care.

Work like the investigation conducted by Dr. Hser is a valuable contribution to the emerging database in behavioral health. Many believe that evaluations that compare the efficacy of treatment alternatives and identify best practices will be crucial to our convincing payers that their money is being well spent.

Robert K. Schreter, M.D.

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1. Health Care Plan Design and Cost Trends: 1988 through 1998. Report prepared for the National Association of Health Systems and the Association of Behavioral Group Practices. Arlington, Va, Hay Group, 1999
2. Hser YI, Evans E, Huang D, et al: Relationship between drug treatment services, retention, and outcomes. Psychiatric Services 55:767–774, 2004

In Reply: The pressure of cost containment is ever increasing, and there is no doubt that providers of substance abuse treatment, like other health care professionals, are being asked to make do with less. The apparent "dissonance," as pointed out by Dr. Masland, between our findings showing that greater quality and quantity of services increase treatment retention and favorable outcomes and Dr. Schreter's column about making do with less highlights the tension between research findings and their implications and implementations in reality, largely driven by budgetary concerns. The challenge is, then, how to deliver effective treatment without increasing the cost of delivering services.

The substance abuse field has continued to struggle with strategies to respond to this challenge, many of which are proposed and described by Dr. Schreter. They include promoting evidence-based treatment approaches, expanding the continuum of care, and integrating services. Nevertheless, findings reported in our article suggest that if we want to achieve certain levels of outcomes in substance abuse treatment, we must provide the amount of high-quality services that will effectively address the diverse problems among substance abusers. Several recent developments in the field are intended to increase the efficiency and effectiveness of treatment with existing resources.

One such development is in the area of patient assessment and patient feedback. Services make the greatest impact if they are received by those who need them most. Therefore, it is critical to assess patients at intake and periodically throughout treatment in order to develop and adjust treatment plans and services. In addition, patients' satisfaction with programs, counselors, and services—a measure of quality discussed in our paper—should be taken into consideration in clinical decisions and practice. Routine collection and consideration of patient feedback can improve treatment retention and outcomes for individuals (1) and potentially for the treatment facility as a whole (personal communication, Forman R, 2004).

Developments in the area of organizational process are also promising. Performance enhancement can be achieved through organizational improvement; for example, according to one estimate, 85 percent of errors in the organization were attributable to how processes are designed (2). Therefore, a better organizational process can improve program performance without having to utilize additional resources.

Extending treatment is another area in which recent developments are making a difference. Based on increasing understanding of the chronic nature of drug dependence, recent reconceptualizing and restructuring of the treatment delivery system have emphasized concepts such as continuity of care and the disease-management model for treating addiction. These treatment models involve sustained support to promote recovery. Positive findings have been shown in studies of posttreatment support in the form of participation in self-help programs and other pro-recovery activities or even as a result of continued monitoring. The health services policy and practice focus has begun to shift from intensive to "extensive" disease management precepts, and we expect that these long-term recovery support or management concepts will continue to emerge.

Although there are ways to improve substance abuse treatment to achieve greater efficiency and effectiveness without increasing funding, policy makers and the public need to recognize the chronic nature of alcohol and drug dependence and strike a balance between short-term savings versus long-term cost.

Yih-Ing Hser, Ph.D.
M. Douglas Anglin, Ph.D.

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1. Miller S: Beyond integration: the triumph of outcome over process in clinical practice. Psychotherapy in Australia 10:2–19, 2004
2. Holloway D: Primer on Improvement: How Organizations Improve. Presentation to the Network for the Improvement of Addiction Treatment. Madison, University of Wisconsin. Available at www.pathstorecovery.org

Computer-Administered Versus Paper-and-Pencil Mental Health Surveys

To the Editor: Computers are increasingly used to assess mental health and substance abuse treatment outcomes (1). Computerized assessment has the potential to reduce burden on clinical staff, increase the efficiency of data collection and management, reduce the rate of missing data, increase interrater reliability of clinician-administered assessments, eliminate inapplicable items by using branching logic, provide immediate feedback of results, and help identify individuals at risk of poor outcomes in a timely manner that could allow for clinical intervention (2,3). However, it is important to determine whether responses to computerized assessments are comparable to those obtained by paper-and-pencil methods (4).

We conducted a small study to compare feasibility, respondent acceptance, reliability, and mean scores for computerized assessment versus a paper-and-pencil survey. We used a repeated-measures design in which psychiatric outpatients completed two self-report mental health questionnaires by using paper and pencil and by computer. The two survey instruments used were the Polaris Strength Scales, a new 29-item scale focused on goal setting, resiliency, development of emotional and relational skills, and social supports, and the revised Behavior and Symptom Identification Scale (BASIS-24), a 24-item scale that assesses depression and functioning, interpersonal relationships, psychotic symptoms, substance abuse, self-harm, and emotional lability (5). Both instruments are designed for use among persons with serious and persistent mental illness.

The study was conducted over a two-month period in 2002. The sample consisted of 52 English-speaking adults, evenly divided by gender. The age of the participants ranged from 19 to 64 years. A total of 41 participants (84 percent) were Caucasian, 33 (67 percent) were unemployed, and 28 (57 percent) had been in treatment for more than ten years. Two re-