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, 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 (mc.manuscriptcentral.com/appi-ps).

Consumer-Directed Behavioral Health Care

To the Editor: The March 2007 Best Practices column, "Implementation of a Consumer-Directed Approach in Behavioral Health Care: Problems and Prospects," by LaBrie and colleagues (1) identified several important barriers in realizing the potential of consumer-directed behavioral health care.

It is important, however, to differentiate consumer-directed care as successfully initiated with people who have physical or developmental disabilities and with older adults through such approaches as cash and counseling (C&C) from approaches that utilize a health savings account (HSA) model. Although both focus on promoting greater consumer choice and control over services, C&C and similar consumer-directed approaches typically utilize individualized budgeting for Medicaid consumers to self-manage services. As described by LaBrie and colleagues HSAs typically use the high-deductible approaches in private insurance markets (2).

We agree that consumers require comprehensive information on quality as well as costs in order to fully utilize consumer-directed care approaches. Although we have a long way to go in the mental health system to achieve this goal, we do see hopeful signs with efforts such as the initiative by the U.S. Department of Health and Human Services to promote transparency and value-driven health care (www.hhs.gov/transparency).

We do question LaBrie and his coauthors' characterization that mental health consumers lack adequate decision-making and self-care abilities to fully utilize consumer-directed care approaches. The Institute of Medicine (3) stated unequivocally that a "clear majority of individuals with mental illnesses (including those with severe illnesses such as schizophrenia) and substance use illnesses are able to make treatment and other life decisions." Regarding self-care, there is a wealth of evidence of the utility and effectiveness of mental health self-help as cited in both the U.S. Surgeon General's 1999 report on mental health and the 2003 report of the President's New Freedom Commission on Mental Health. Additionally, C&C approaches based on consumer direction have been successful with people who have significant cognitive impairments—including developmental disabilities—when decision-making supports are in place (4). Perhaps, the true barrier remains the stigma—evident in both society and mental health systems—that perpetuates negative stereotyping rather than focusing on the abilities and strengths of those served.

Evidence is now being gathered on the effectiveness of consumer-directed mental health care. An analysis supported by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration examined results of the C&C program for persons who received mental health services. Preliminary findings showed that this approach "works as well as for clients with mental health diagnoses with no discernible adverse effects on safety or health" (5).

Consumer direction holds great promise in transforming how mental health services are delivered. Such approaches, in which consumers' self-identified needs, preferences, and choices are the principal drivers, will help us reach our shared destination—recovery.

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In Reply: We appreciate the willingness of *Psychiatric Services* to provide a venue for discussing the application of consumer-directed approaches to people in need of behavioral health care. Power and del Vecchio's comments about our discussion draw from their experience with the cash and counseling (C&C) program to question our "characterization that mental health consumers lack adequate decision-making and self-care abilities." They suggest that "the true barrier remains the stigma"

that is associated with behavioral health problems.

As noted in our column, we agree with Power and del Vecchio that stigma is a fundamental problem. However, it is unlikely that we will soon eradicate the stigma associated with behavioral health treatment. For example, the Institute of Medicine (1) report cited by Power and del Vecchio noted that "the proportion of Americans who associated mental illness with 'violent or dangerous behavior' in 1996 was nearly double that found in the 1950 General Social Survey" (2). Although the relationship between violence and mental illness is weak, the public perception of this association is strong, leading to unnecessary stigma.

Although it is important to deal with stigma, there are other barriers or problems that need to be addressed or, at the very least, taken into account when moving in the direction of self-directed care, including neuropsychological complications; poor self-efficacy; cognitive deficits associated with illnesses such as schizophrenia, major depression, and substance abuse; low motivation; hopelessness; and compromised compliance with medication regimens. It would be incorrect to infer, however, that behavioral health consumers necessarily lack adequate decision-making skills. Whether they do or not depends upon both the particular person and his or her particular problems or limitations. It might also depend upon the particular context. As we noted in our column, even behavioral health consumers with intact decision-making capacities—one who can access and understand information about treatment alternatives—might still be unable, for example, to make difficult decisions (we used low motivation to illustrate one such barrier). Capacity is static, whereas decision-making is dynamic and may vary with the circumstances.

In sum, we agree with Power and del Vecchio that consumer-directed health care has promise in the area of behavioral health. In their letter they mention how, within the C&C program, Medicaid recipients benefit from the use of in-house supportive services. (One feature of the C&C program allows consumers to enlist a representative to assist in decision making.) The use of such an enhanced service component actually underscores the very point that we were attempting to make in our article: some patients—in particular, those with behavioral health problems—might be unable on their own to manage the challenges of consumer-directed care. That is precisely why we suggested that the care coordinator role be adopted in behavioral health care.

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