vision of outpatient psychotherapy with little evidence of clinical progress, and the lack of patient education all contribute to the public's negative views. In the face of such perceptions, it is perhaps not surprising to see funding cuts as cited by Dr. Appelbaum.

In response, the mental health field might consider several objectives.

Increase the level and the effectiveness of public education about brain disorders when they are not diagnosed or when they are suboptimally treated. One cannot succeed in the court of public opinion by simply attacking old perceptions. Those myths must be replaced with new realities. The tremendous technological revolution in basic and clinical neurosciences provides us with compelling evidence of the biological substrate of major mental disorders and gives us a foundation for viewing them as treatable conditions on par with other health problems, such as heart disease, HIV infection, and cancer.

Our field must find ways to educate the public about these advances and about the consequences of leaving mental disorders untreated. The high level of morbidity and mortality associated with psychiatric disorders is not widely appreciated by the medical community—much less by the lay public. The field must find ways to increase consumer awareness and remove the stigma from treatment seeking. When we accomplish this mission, we will be able to demonstrate not only that our interventions improve the functional well-being of the individuals we treat but also that they produce cost savings over the long run.

Create more innovative models for an integrated delivery system. As Dr. Appelbaum points out, reimbursement for psychiatric services has declined to the point that the retention and recruitment of mental health care providers is threatened. I am not sure that managed behavioral health care is the culprit. Managed care has been a response to an existing system perceived by many to be expensive and ineffective. In its own zeal to achieve a profitable margin, managed care has in some cases compromised the ability of clinicians to deliver an optimal level of care and to be appropriately rewarded for doing so.

Why has this happened? Historically we have had a discontinuous system of care in which certain types of services—and providers—have been walled off from one another. This situation does little to benefit patients and has introduced inefficiencies into health care transactions. Moreover, it has made efforts to demonstrate that mental health services are a cost-effective means of reducing indirect costs a substantial challenge. Moving forward into the 21st century, we must strive to find models that better integrate the continuum of care. If we do not, others will.

For example, we should evaluate and support a systems-based approach that incorporates more centralized record keeping, requires the development and regular review of a progressive and coordinated treatment plan, assesses the relative value of various direct costs associated with disease management through the use of objective outcome measures, and exhibits enough transparency to allow funding sources to see the value of their investment.

Foster a partnership among parties interested in the public good and in the provision of mental health services. The solution to the many ills highlighted by Dr. Appelbaum will not be to our satisfaction if we sit back passively and wait for "them" to do something. Not that "they" will fail to act. Rather, they will act in a way that is not in the best interest of our patients or the field. As Dr. Applebaum puts it, we must "sound the alarm."

Thus an alliance of interested and informed parties is necessary—one with sufficient voice and vision to offer solutions that make sense, ensure proper quality of care, and are affordable. The crisis in our teaching hospitals, as noted by Dr. Appelbaum, is a real and present challenge for such an alliance to tackle. None of us can afford to see a falloff in the quality of new physicians. A concerted lobbying effort should call attention to the scope of the problem and to the consequences of not addressing it. Perhaps the American Psychiatric Association could launch such an effort.

Establish mental health parity and access for all as a minimally acceptable position. The creation of the organizational alignments that are necessary to support high standards of care and ready access to care will not occur passively. An active educational and lobbying campaign is needed, one that clearly articulates why it is in the best interest of business and government to get it done. Special interest groups can set the agenda, but the general public must recognize the objectives as a priority and make its collective voice heard.

Perhaps our greatest ally—or our worst enemy—in this mission is the media. A constructive partnership with all components of the media is essential. The partnership must be based on candid dialogue and intolerance of sensationalism or exploitation. We must all be concerned with the plight of mental health service delivery and of the innocent victims of an inadequate system of care and with the false perceptions and beliefs that foster stigma. Addressing these concerns must start among those of us in the field. Improving the quality of care, cost-effectiveness, and education of peers and patients—and insisting on professional integrity—are all the price of admission.

Behavioral Health Care Then and Now: Significant Progress, But More Work to Do

Jonathan Book, M.D.

The behavioral health care system has come a long way in the past ten to 20 years. Managed behavioral health care has brought significant change for consumers, for psychiatrists and other practitioners, and for payers. Although no one would argue that the current U.S. behavioral health system is perfect, it is in many ways an improvement over what came before.

If we look back to the pre–managed care era, we see a system that was fail-

ing society. For patients and payers, this era was not the good old days. There were few standards, little accountability, and a shortage of practitioners. Treatment options and benefits were limited. When consumers were not deterred by powerful stigma, they bore a higher portion of the cost of behavioral health care than they did for other medical care.

A growing share of the costs of care was borne by employers, who had little influence on the quality of, demand for, or supply of services. Expensive inpatient services were overutilized, and alternative outpatient interventions were underdeveloped. There was a gross excess of hospital beds, and rates of hospital occupancy were low. Direct-to-consumer advertising of hospital and residential treatment services encouraged people to seek inpatient services whether they were appropriate or not. This system spawned scandals of excess and clinical impropriety that have been well documented by the media.

By and large, outside the public sector, individuals had two choices—inpatient or office-based treatment. Outpatient practice was oriented toward prescheduled appointments, which left hospital emergency rooms as the primary site for crisis evaluation and intervention. If an individual required services outside routine scheduled hours or services organized and coordinated among several clinicians, the only choice was a potentially disruptive and stigmatizing inpatient stay.

Equally disturbing was the lack of accountability. There was little, if any, oversight of the services being delivered and few standards for quality of care. Stories about individuals remaining hospitalized for months or years with only slight improvement were not uncommon. Treatment was likely to be tailored to a patient's insurance benefit rather than to the individual clinical situation, and insurance companies simply paid up to the benefit limit without asking questions about medical necessity and appropriateness and quality of care, clinical outcome, or patient satisfaction. When benefits and other personal resources were exhausted, patients with serious mental illness had only the public health system as an alternative and faced waiting lists for state hospitals and community clinics.

Employers, faced with staggering increases in the costs associated with providing behavioral health care, attempted to mitigate the increases by restricting benefits. But even this approach was unsuccessful. Costs continued to escalate to the point that employers considered eliminating such benefits altogether. These circumstances led to the introduction of managed care in the behavioral health arena.

What has happened in our field since managed care came on the scene? Managed behavioral health care coincided to a large extent with significant scientific advances in the understanding and treatment of mental illness and substance-related disorders, which led to an increase in the number and diversity of clinical tools available to practitioners. With advances in knowledge, clinical practice has become more evidence based, which has contributed to greater respect for the clinical fields related to behavioral health and a broader recognition that behavioral health disorders are real illnesses—as real as heart disease and diabetes. The advances in knowledge have also contributed to a gradual lessening of the stigma associated with mental illness and substance-related disorders. During the managed care era the consumer advocacy movement blossomed, raising national awareness of the plight of people with behavioral health disorders and attacking the injustice of a prejudicial health care system and the inadequacies of behavioral health service delivery.

Managed behavioral health care brought a focus on medical necessity and cost that resulted in an expansion of available treatment settings. We have progressed from a system that essentially offered two options to one that offers a continuum of services. Thus we have greater flexibility in meeting the needs of patients and greater success in managing costs.

The introduction of managed behavioral health care has improved access to behavioral health services for millions of consumers. Experience in the public and the private sector has shown that the number of people seeking and receiving services has increased since the introduction of managed care. Managed care not only yields an expansion of services but also results in their redistribution. Hospitalization rates and average lengths of stay typically declined with managed care, whereas the use of other treatment settings increased.

Managed behavioral health care introduced accountability to a system that lacked it. Although many people continue to adjust to this change, it was a needed measure that has benefited patients, payers, society, and—I believe—practitioners. We have an obligation to our patients to alleviate suffering in the most expeditious and effective way possible, and we have an obligation to the behavioral health care system and to society to accomplish these goals in a manner that makes the most responsible use of limited resources. The influence of managed care has helped shift practice patterns in the behavioral health care arena in a way that has led to more effective and more efficient treatment.

The managed behavioral health industry has not only imposed accountability on others, it has embraced it for itself. The American Managed Behavioral Healthcare Association has worked closely with other mental health and substance abuse treatment organizations to find common ground on appropriate performance measures and to develop national standards and accreditation programs.

Another benefit that we can attribute collectively to managed behavioral health care, to the consumer advocacy movement, and to advances in the science of behavioral health is a better understanding among payers of the services that practitioners and managed care organizations deliver and the results that can be expected from them. The accountability for quality and cost introduced by managed care has made possible the expansion of insurance benefits through parity legislation. Lawmakers in 34 states have been able to pass some form of parity bill largely because

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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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