Emerging Trends In Mental Health Policy And Practice

Managed care provides the potential for a more balanced system in the postinstitutional era of mental health care.

by David Mechanic

PROLOGUE: As managed care matures in the general health care market, and the problems of accountability and patients’ rights continue to elude policymakers, it is not surprising that the mental health community casts a reluctant eye on managed care while at the same time submitting to it.

This paper by David Mechanic examines the issues—such as deinstitutionalization, parity in benefits, and integration with general health care—that make the mental health arena a particularly challenging but very attractive environment for care management. Mechanic reminds us that managed care is first and foremost a business strategy and that its implementation in the mental health arena requires a social contract between purchasers, mental health professionals, advocates, and the government to ensure that patients receive appropriate care. Ultimately, says Mechanic, the effectiveness of managed behavioral health care will be determined not just by the accountability of managed care organizations but also by the willingness of all players in the system to commit to change and be responsible for it.

David Mechanic is the Rene Dubos University Professor of Behavioral Sciences and founding director of the Institute for Health, Health Care Policy, and Aging Research at Rutgers University, in New Brunswick, New Jersey. He also directs the National Institute of Mental Health (NIMH) Center at Rutgers for Research on the Organization and Financing of Care for the Severely Mentally Ill. Mechanic is a member of the National Academy of Sciences, the American Academy of Arts and Sciences, and the Institute of Medicine. He is the author of Mental Health and Social Policy: The Emergence of Managed Care, 4th ed. (Allyn and Bacon, 1999).
ABSTRACT: The continuing deinstitutionalization of patients in public mental hospitals and the growth of managed care are fundamentally altering mental health practice. Managed care provides opportunities for achieving parity of insurance coverage between mental and physical illness, but serious problems persist in integrating mental health, substance abuse, and general medical care and assuring an appropriate range of services and programs for persons with serious mental illness residing in community settings. Hospital and community care are poorly coordinated, and hospital care needs to be integrated into a more balanced system of services. Important new roles are emerging for purchasers, patient advocates, and mental health authorities.

MANAGED BEHAVIORAL HEALTH CARE has already had an impact on almost every aspect of mental health practice and has the potential to profoundly shape the organization and provision of mental health and substance abuse services. It has aroused opposition from mental health providers, who see their income and autonomy threatened, and patients' advocates, who fear that patients' options will be restricted. Managed care, however, describes a variety of structures, approaches, and strategies that can be used to improve care as well as to ratchet down costs or increase profits. Change has occurred rapidly and unevenly, and much fine-tuning is needed. How behavioral health care evolves will depend not only on decisions and practices of the managed care industry but even more on the proactive and informed responses of purchasers, advocacy organizations, and regulatory authorities.

The Context Of Managed Mental Health Care

Managed care approaches—including capitation and sharing of risk, case management, and utilization review—can be combined in innumerable ways with varying objectives. A great deal depends on the philosophies and motives of management, the quality of the professionals involved, and the coherence of incentive structures. Because the idea of managed care offers a centralized and clearly visible target, any anecdote of denial of treatment or mistreatment can be attributed to managed care as a generic form. But anecdotes are not evidence. Some of the criticisms typically made pertain to poor professional service, others to for-profit operators trying to make a fast buck, and still others to denial of some service or restrictions on provider choice. These problems are not new or unique to managed care. Payment for anything professionals want to do, the long-standing traditional pattern, is no longer realistic and never was ideal.

Mental health services delivery and policy have a long history of periodic cycles of “reform.” These changes often have been more a response to changes in financial structures, social ideologies, and...
new technologies than they have been to internal practices in the mental health sector itself. In the past thirty years Medicare, Medicaid, Social Security Disability Insurance (SSDI)/Supplemental Security Income (SSI), and other welfare programs have influenced mental health policy directions more than any mental health practice has. More recently the privatization of health provision, a market orientation, and managed care are transforming how we treat mental illness. This is occurring amid significant advances in pharmacotherapy and psycho-rehabilitation. In this evolving context the future of behavioral health care will depend on the sophistication of private and public purchasers in recognizing the relative value of mental health investments, the alignment of managed care strategies with evidence-based knowledge and appropriate quality assurance systems, and the regulatory framework that keeps managed care strategies within appropriate bounds.

The management of care is linked with a number of other themes that have been important in mental health policy debates for decades. First, it can be seen as an extension of the long-term trend in deinstitutionalization. Second, it enables greater parity of mental health insurance benefits with general medical care, because by constraining benefits utilization, it makes the parity concept more economically and politically acceptable. Mental health advocates have sought to eliminate discrimination in insurance coverage for mental health services for decades, but even sympathetic policymakers have resisted because of fears that psychiatric criteria were too vague and utilization controls too weak to prevent abuse and cost escalation. Managed care can change this.

Third, some forms of managed care have strong potential for integrating mental health care into the primary care sector, as some mental health professionals have advocated. The predominant trend, however, has been toward carve-outs. A carve-out separates part of an insurance program covering a categorical area such as mental health or substance abuse and manages it separately, typically through a different organization and network of providers. It has been argued that carve-outs can be used to reduce risk selection and that they offer a specialized network of providers to manage particular problems. Integration, by contrast, is intuitively attractive as a way of reducing problems of coordination and communication and achieving meaningful comanagement of related health problems. But it is difficult to implement effectively.

In the sections that follow I review developments in managed behavioral health care in light of long-term deinstitutionalization trends, the debate over parity, and concerns about integration of care and access to mental health specialty services. Inpatient care for
mental illness and substance use, while the most expensive component, has been less carefully examined than many other aspects have been, and patterns of practice are highly variable.\textsuperscript{10} The thrust of managed care has been to reduce inpatient utilization by reducing admissions and lengths-of-stay. This is not always accomplished sensibly, and hospital care is often poorly linked with community mental health services. The challenge is not simply to reduce inpatient care but rather to make it a meaningful component of a balanced pattern of services. The continuing reduction of inpatient care has serious implications for both the parity issue and future efforts to achieve integration. Finally, I consider the role of standards, quality assurance, and government regulation in progressing toward a more balanced system.

**Managed Care And Deinstitutionalization**

The number of residents in long-stay mental hospitals has continued to decline. Responsibility for many persons with severe and persistent illness has shifted to psychiatric units in general hospitals, private psychiatric institutions, community care programs, and other residential facilities. Hospital admission is the single most expensive component of psychiatric care, and managed care has focused attention on finding alternatives to admission and encouraging early discharge planning and release. Thus, managed care reinforces many other influences that have supported continuing the transfer of care from hospitals to other residential settings and community care.

It is important to trace carefully the types of transitions taking place in inpatient care. There is a common view that inpatient psychiatric care is disappearing as an important treatment intervention, but this is largely incorrect. The number of public mental hospital beds in the United States has declined over time, from 560,000 in 1955 to approximately 77,000 today.\textsuperscript{11} But the number of private mental hospitals more than tripled between 1970 and 1992, and inpatient admissions to these institutions quadrupled.\textsuperscript{12} Moreover, between 1970 and 1992 the number of specialized psychiatric units in general hospitals grew from 664 to 1,516. Discharges of patients with a primary psychiatric diagnosis from general hospitals increased from 1.2 million in 1988 to 1.9 million in 1994, and days of care increased by 1.2 million over that period. This increase, however, is
relatively small compared with the loss of approximately 12.5 million inpatient days in mental hospital care over this same period.\textsuperscript{13}

\section*{Community general hospitals.}
Psychiatric patients in community general hospitals are increasingly more seriously ill, more commonly have substance abuse comorbidities, and are more commonly covered by government programs. Public programs have been rapidly replacing private insurance as the major source of payment for psychiatric inpatient care in general hospitals.\textsuperscript{14} Three-fifths of all psychiatric admissions in 1994 were paid for by Medicare or Medicaid. Managed care and changing attitudes apparently are keeping private patients with less severe illnesses out of hospitals, but these patients are being replaced by more severely ill persons, who in the past were clients of the public mental hospital system. Such patients, however, only come to the hospital for relatively short stays during psychiatric crises. Lengths-of-stay in nonprofit and public general hospitals, the primary sites for general inpatient care, have been falling rapidly in recent years, and this reduction is continuing.

The pattern of succession in which more severely ill public patients replace privately insured patients raises many important questions. Are the reductions of inpatient care for privately insured patients appropriate, or are some being denied the care they require? How appropriate is the content of general hospital inpatient care for clients with more serious and complex illnesses? How do we develop a balanced system of care with appropriate linkage and cooperation between inpatient and outpatient services?

\section*{Residential facilities.}
Bed days in public mental hospitals fell by more than eleven million days, net, during 1988–1994. However, reducing the costs of care for the public mental health system or the managed care contractor does not necessarily reflect real reductions in the overall cost of care. Many long-term patients who once occupied mental hospital beds now live in small community institutions such as nursing homes, intermediate care facilities, community mental health institutes, board-and-care homes, and supervised residences, but we know relatively little about their care or the quality of their lives.\textsuperscript{15} These patients commonly use general hospitals during times of crisis. Increasingly, they are enrollees in managed care plans under contracts between government and private contractors; the quality of these arrangements and performance under these contracts need to be monitored carefully.

Deinstitutionalization and managed care have both contributed to a broad dispersion of persons with mental illness among residential facilities, making it difficult to monitor or even describe clearly the de facto mental health system. Beyond the hospital patterns
already described, patients are dispersed in Veterans Affairs (VA) hospitals, nursing homes, facilities for children, and a variety of other mental health and residential facilities. Although many patients with a mental illness or dementia reside in nursing homes, few of them are under age sixty-five and have no comorbid condition. In recent years states have operated or funded residential care for as many as half a million clients with mental illness in a range of facilities such as group homes, board-and-care facilities, supervised apartments, and a variety of other arrangements. Persons with mental illness also are often found in homeless shelters, on the streets, and in jails and prisons. We have no reliable numbers for any of these settings and their clients, but they are clearly significant, involving several million vulnerable persons. The dispersion of mental health care among so many different sectors and varying budget streams allows many opportunities to shift costs and responsibilities to others, which gives the appearance of cost saving.

- Nonmedical services. A recent study of spending for public clients with serious mental illness in Wisconsin found that a significant proportion of expenditures were for types of services not typically provided by managed care organizations. For example, 12 percent of spending went for residential services, 8 percent for community support services, and 6 percent for vocational services. The researchers estimated that more than two-fifths of all spending was for broad rehabilitative services, not typically paid for by health insurance. If state and local governments transfer responsibility for the care of public clients with serious mental illness to private providers, they must either hold these providers accountable for community support functions or maintain public programs to do so. Maintenance of public programs is not a given, because a major motivation for state conversion to private behavioral health care is to reduce state costs.

The Parity Issue

Mental health advocates have fought for parity in insurance coverage with general medical care and won a symbolic victory with passage of national legislation that went into effect this year. This legislation requires employers to maintain the same annual and lifetime benefit limits for mental illness as they do for physical illness. Parity, however, is a somewhat hollow accomplishment because it does not prohibit employers from eliminating mental health coverage, differentially increasing coinsurance and deductibles, or setting limits on number of inpatient days and outpatient visits. In fact, this legislation could make things worse if employers respond negatively. In all probability it will have minor effects, but it may redis-
tribute some expenditures among persons with mental illness by lifting the cap on total spending for those who are the most seriously and persistently ill.

Eliminating discrimination in insurance coverage is an important goal. But even if coverage were fully comparable, serious problems would remain. Health insurance benefit design is based on an acute care model, not a long-term treatment orientation, and is largely confined to traditional medical services. The largest unmet needs of persons with serious mental illness, however, involve community, rehabilitative, and long-term care services that are typically not covered even under the most comprehensive private health insurance policies.¹⁹

Managed care offers one approach to the parity issue. The Clinton health care reform task force took the position that once a national management structure was in place, there would be no need to restrict the availability of services through benefit design. Managed care would provide all “necessary medical services.” The evidence shows that managed care strategies greatly reduce overall mental health costs, although the case seems less clear for persons with the most serious and persistent mental illnesses.²⁰ More importantly, the consequences for quality of care remain uncertain. There are many possible scenarios within the ambiguous concept of “medical necessity,” and it remains unclear how this concept is likely to be defined under varying circumstances.

Let me briefly illustrate with a study my colleagues and I recently completed of highly disadvantaged patients with schizophrenia.²¹ These patients typically have difficulties and commonly need to be rehospitalized. We found that somewhat fewer than half of these patients had no continuing source of care when they came to the hospital and typically were off their medications. If these patients are linked with an outpatient therapist, with whom they meet while in the hospital, they are more likely to be successfully linked with services after their discharge.²² Payers, however, are unwilling to reimburse such outpatient therapy while the patient is receiving inpatient treatment, because they regard such contacts as duplicative and “not medically necessary.”

Integration Of Services

- **General versus specialty care.** There is much discussion about the advantages of integrating medical services with mental health and substance abuse services, but carve-outs seem to increasingly dominate the health care scene. While some group- and staff-model health maintenance organizations (HMOs) continue to focus on developing integrated services, they are an increasingly small com-
ponent of the HMO sector, and even they commonly find carve-outs administratively advantageous. In the private insurance sector, behavioral health care companies have demonstrated, at least to the satisfaction of their corporate purchasers, that they could greatly reduce costs without major complaints from employees, and most private mental health care is now managed via carve-outs through risk or administrative contracts. Mental health and substance abuse carve-outs are increasingly common as well in Medicaid for the nondisabled population and are now slowly being introduced for the disabled population as well. The difficulties of such carve-outs for persons with serious and persistent mental illness raise particularly challenging issues.

Despite the fact that most psychiatric disturbances first become evident in the context of general medical care and that primary care practitioners provide much mental health treatment, there is a clear separation between general medical services and specialty mental health care. This separation often makes it difficult for primary care physicians to receive helpful guidance in managing less severe problems or patients who resist referral; it limits helpful collaborative treatment arrangements; and it may make it more difficult to achieve cost offsets in medical care by appropriately treating depression and related impairments that contribute to much general disability. Such separation can lead to neglect of serious medical needs and to medication errors and other confusions.

Despite the arguments for improved integration, there remains much skepticism that busy general physicians will have the time, interest, or skills to provide sensitive and meaningful care to persons with more than minor psychiatric problems. Despite efforts over the past forty years to upgrade the skills of primary care doctors to appropriately detect and treat depression and other psychiatric problems, research studies show continuing poor care. Mental health specialty professionals do much better. They are more likely to appropriately diagnose and treat psychiatric disorders and to have the interest in and empathy for persons with mental illness, who are commonly time-consuming and difficult patients. The evidence of generalist physicians’ failure to recognize and appropriately treat persons with depression has been quite consistent over time, and physicians’ behavior has been difficult to change. Moreover, doctors in managed care organizations do this even less adequately than those in fee-for-service practice. Thus, the theoretical benefits of integration are difficult to realize in practice. Current efforts to develop management strategies in organized primary care settings, building on team efforts of primary care physicians and mental health professionals and well-established practice guide-
lines, have greater promise.\textsuperscript{25}

■ Carve-outs. Substance abuse services often are carved out of managed care plans separately from mental health services, and children’s services, from adult services; this can create significant discontinuities of care for persons with multiple conditions and families with multiple problems. Pharmaceutical services also may be carved out, which can exacerbate coordination problems and confusion. “Mainstreaming” mental health into general medical care, in contrast, usually involves the generalist physician as a gatekeeper to specialized mental health services and encourages closer communication between primary and specialty care. But this is often more rhetoric than it is reality. In the busy context of primary medical care, everyone is too rushed to give much effort to collaborative activities, and while medical and mental health services may be provided in the same setting, communication is not necessarily better.

We still lack good evidence allowing us to evaluate varying models for integrating versus carving out services.\textsuperscript{26} Much depends on the quality of the personnel involved, the incentives that affect their behavior, the burdens of their workloads, and generalists’ interest in dealing with psychiatric disorders. There also is a risk that integration will result in “medicalizing” the treatment of mental disorders more than is appropriate and that needed psychosocial treatments will be neglected. If integration is to be effective, the relationships between generalists and mental health specialists must be more than perfunctory.\textsuperscript{27}

If carve-outs are inevitable, as they appear to be, much attention is needed at the boundaries (areas of overlapping responsibilities) and in developing mechanisms to improve communication and define responsibilities carefully. Patients with serious mental illness increasingly have their medical, psychiatric, substance abuse, and pharmaceutical needs managed separately by varying contracts and networks. Clinicians and patients frequently complain about cost shifting and denial of responsibility at the boundaries, but we have no good data that allow us to assess the pervasiveness of these problems. It seems clear, however, that purchasers need to pay close attention in contracts to clarifying how such boundary issues are to be resolved.

Access To Specialty Mental Health Services

A major concern of consumers of mental health services is that managed care will significantly limit their access to specialty mental health services.\textsuperscript{28} Whether this is true depends on the definition of access. Issues include whether persons can receive a mental health service and treatment, whether such services must be obtained
through a gatekeeper, and the intensity of services received. The evidence indicates that a larger proportion of patients in HMOs than in fee-for-service medicine receive a mental health service. Most such organizations make it relatively easy to obtain an evaluative visit but limit the intensity of services that follow.\(^29\) As a result, treatment in HMOs is usually of shorter duration; more likely to be provided by social workers, nurses, and psychologists; and more likely to be offered in group than in individual settings. Such economical patterns of practice need not be inferior. Less expensive professionals can offer comparable and sometimes superior evaluative and consultative services, and research has shown that care in group settings, such as family therapy, may be more effective under some circumstances than when provided as an individual service.\(^30\) Apparently, family members learn from and give social and emotional support to one another. There is no evidence for the general population that the different pattern and lower intensity of services characteristic of HMOs result in poorer outcomes.\(^31\)

The evidence is less comforting in the case of persons with more serious and persistent psychiatric disorders. Although the studies are limited, they indicate that persons with schizophrenia and major depression may do less well in capitated practice than in fee-for-service medicine.\(^32\) These effects generally do not appear immediately but increase over time, requiring long-term outcomes studies. Meaningful differences also exist between different types of HMOs, with prepaid groups performing somewhat better than physicians associated with independent practice associations (IPAs) and networks. In the case of depression, the RAND Medical Outcomes Study found that poorer outcomes were linked with less continuity of medication among patients treated by psychiatrists in HMOs.\(^33\)

**Psychiatric treatment in general hospitals.** General hospitals have become a major locus of psychiatric inpatient care. In recent years there have been approximately 1.5–2.0 million discharges of persons from general hospitals each year who have a primary psychiatric diagnosis, and such care accounts for a large share of mental health spending.\(^34\) Thus, it is no surprise that inpatient care is the main target of managed care. This is reflected in significant efforts to divert admissions, reduce lengths-of-stay, and reduce hospital reimbursement. Hospitals in turn respond by reducing nursing and social work staff, substituting less expensive personnel for physicians, and increasing professional workloads. We know almost nothing about the effect of these changes on quality of care. A recent study found that for each day of requested inpatient care reduced by utilization management, there was a 3 percent increase in the likelihood of readmission within sixty days.\(^35\)
Given the size and importance of the inpatient psychiatric sector, it is remarkable how little we know about it. This perhaps reflects the fact that mental health researchers have had an anti-institutional orientation and have devoted almost all of their attention elsewhere. In the past several years my colleagues and I have been studying the practices of specialized psychiatric units in general hospitals and their effects on patient outcomes following hospital discharge. We were drawn to this area of study when, evaluating a psychiatric reimbursement methodology for the state of New York, we were impressed by the lack of continuity of care for public patients with severe and persistent mental illness between hospital and community care. Although the state was paying large amounts for inpatient episodes, inadequate attention was given to successfully linking patients with community services after discharge. The typical pattern was one of repeated rehospitalizations, with great cost to the state and questionable value for patients.

We subsequently initiated a study of 103 general hospitals in New York State with specialized psychiatric units. Conceptually, we differentiated between hospitals that followed an acute care orientation and those that were more likely to follow what we called a long-term treatment orientation. We identified and measured seven dimensions that we believed were important for such an orientation: medication management, medication education, illness education, family involvement, substance abuse management and education, psychosocial rehabilitation and coordination, and linkage to outpatient services. In the case of linkage, for example, we developed a sixteen-item scale that measured linkage arrangements; contact with future outpatient clinicians; linkage to needed services such as housing, social supports, and prevocational training; and follow-up efforts to ensure that linkage had been successfully achieved. Hospitals varied a great deal in the extent to which they carried out these activities.

Managed care and long-term treatment. Managed care offers both opportunities for and barriers to achieving more of a long-term treatment orientation. On the one hand, managed care has strong incentives to avoid expensive rehospitalizations and to ensure appropriate aftercare that maintains the client in community settings. Thus, managed care is likely to seek balanced systems of care, where inpatient care is closely integrated with patterns of care in the community and where close cooperation is directed at reducing rehospitalizations. Capitation and other risk incentives will be applied increasingly to hold hospitals accountable for poor linkage and unnecessary rehospitalizations. On the other hand, all of the aspects of a long-term treatment orientation are more likely when
average length-of-stay is greater. But managed care is applying relentless pressure to reduce lengths-of-stay, putting an increased burden on inpatient staff and making it less likely that they will direct attention to long-term treatment activities.

Inpatient practices need careful study to examine how essential activities can occur within shorter lengths-of-stay. General medicine and surgery have done much to organize services more efficiently, doing more in shorter periods of time. Mental health must confront a similar challenge. This is possible; some hospital units that involved families in treatment planning were more likely to carry out linkage activities, even when length-of-stay was relatively short. Involved family members may help to monitor care, remind staff of patients’ needs, and generally help to maintain staff responsiveness. Involving family members can make them an unpaid part of the treatment team, helping to motivate and support the patient, reminding the patient of treatment schedules and appointments, and making sure that the patient gets to services. Family attention also may contribute to patients’ motivation and vigilance in maintaining their care. But in depending more on families and communities, institutions must avoid shifting undue responsibility and burden to them. Some exploratory work we have done recently suggests, for example, that managed care may increase families’ caretaking burdens.

**Processes Of Accountability: Advocates, Managed Care Organizations, And Government**

It is too easy to focus attention on managed care organizations as if they have full responsibility for the future of mental health services. The implementation of managed care is a social as well as a business contract, with responsibility shared by purchasers, professionals, patient advocates, and government. Managed care has been greatly motivated by cost reduction, but simply reducing expenditures is the easy part of the task. Purchasers have a responsibility to know what they are buying, to understand how to assess and monitor quality, and to pay a reasonable price for the services they demand. Mental health professionals have to stop lamenting the changes and devote their energies to better defining good practices and putting into place disease management approaches that are informed by evidence. Advocates have an important role in making neglected
needs salient and working constructively with other partners in improving practices. And government must establish a reasonable framework for shaping the development of managed care without micromanaging it.

The National Alliance for the Mentally Ill (NAMI), an advocacy group representing some 160,000 families of persons with mental illness, recently issued its first report card on behavioral health care companies, those firms that typically manage mental health and substance abuse services. NAMI set a high standard, and all of the firms it evaluated failed their evaluation. The traditional system of care probably would rank no better, so such evaluations realistically represent goals we should strive for, not lost realities. The criteria, however, are not unrealistic and are consistent with what all of us would probably judge as high-quality services. NAMI addressed nine areas of concern: whether the companies involved use scientifically up-to-date guidelines; whether they provide adequate inpatient care to all who need it; whether they provide the best alternative care, such as the Program of Assertive Community Treatment (PACT); whether patients have access to the most effective medications (which sometimes are also the most expensive ones); whether suicide attempts are handled as medical emergencies; whether consumers and their families are effectively engaged in treatment and care; whether policy is guided by outcomes research; whether clients have access to rehabilitation services; and whether clients are assured a stable living situation.

These criteria involve important questions about when hospitalization is needed, the quality of practice guidelines, how to measure outcomes, and many other issues about which the field is not agreed. They thus constitute guideposts for future work as much as a serious grading of managed care. Moreover, managed care companies cannot be held fully accountable for all of the components addressed by NAMI, unless their contracts require these services. Purchasers are now bargaining vigorously with behavioral health care providers over capitation levels and putting contracts out for competitive bid. There is no magic in this. If capitation rates are set unrealistically low, managed care cannot meet high expectations. For example, the NAMI criterion on medications implies the availability of selective serotonin reuptake inhibitors (SSRIs) for the treatment of depression and clozapine, risperidone, and other new atypical antipsychotic medications for schizophrenia. These drugs may cost several times more than conventional ones, and capitation levels must reflect this if access to these drugs is to be a realistic goal.

We cannot realistically address dilemmas in mental health policy without seriously considering the economic context. Managed care
is a process of rationing in which the demands of patients and their advocates are balanced against the price purchasers are willing to pay. Managers presumably try to allocate care as cost-effectively as they can within the financial constraints established by payers and the political process. Thus, there is an inherent tension between persons who want the best that money can buy and allocators who seek to provide the best services they can within a budget.

■ **Community services.** A major disappointment of deinstitutionalization has been the failure to develop good community care systems and support networks alongside rapid reduction of mental hospital beds. As a consequence, inpatient care has often been poorly coordinated with aftercare, clients often fail to get needed services, and patients have unnecessary repeated rehospitalizations. Efforts have been made to enhance coordination and improve continuity of care, but only with limited success. For the most part, incentives to provide a balanced system of mental health services have been absent.

Capitation of the care of persons with serious mental illness can induce more careful treatment planning and better coordination between inpatient and community services. If managed care companies are at financial risk for repeated hospitalizations, they have an incentive to plan transitions and aftercare carefully and take measures that reduce the need for rehospitalization. Thus, high-cost patients will have to be managed with the goal of maintaining their tenure in less expensive alternative treatment settings. This will require continuity of care and aggressive case management to ensure treatment compliance. Managed care providers will have to give the same attention to community supports that have been the focus of the federally sponsored community support program and related programs such as PACT over the past two decades.

■ **Managed care contracts.** As public programs move their disabled mentally ill populations into managed care, the contracting process assumes great importance. If the contract is intended to replace publicly funded community support program elements, these must be carefully delineated with the specific expectations to the contractor made clear. In some areas of outcome where influences outside the control of the behavioral health care company may play a significant part, such as arrest or victimization rates, it is possible to set targets based on experience. It is unrealistic to hold a behavioral health care company responsible for avoiding all arrests, but when its patients have higher rates of arrest, victimization, and homelessness than other similar patient populations have, this suggests that the quality of care has to be carefully scrutinized.

■ **State mental health authorities.** The growth of behavioral
health care will fundamentally change the responsibilities of state mental health authorities, and some will become simply shadows of their former selves. But the new environment establishes opportunities for state mental health authorities to become the watchguards of the privatized public safety net, helping to establish appropriate standards and norms, ensuring that the needed data elements and measures are in place, and carefully monitoring performance as it relates to each of the vulnerable subpopulations. Particularly important are the boundaries with primary medical care, social services, vocational rehabilitation, housing, and the criminal justice system. It seems clear that active state involvement will be needed to bring together the constellation of services that many of the most vulnerable patients require.

**Managed care regulation.** Managed care also will have to be regulated to ensure that public responsibilities are appropriately fulfilled and quality of care is maintained. Much controversy now surrounds regulation of managed care. The poor public-relations efforts of managed care companies put them at risk for ill-advised public policies and micromanagement that respond to public anger and anecdotes. There are, however, serious questions in the mental health/substance abuse area that transcend those in much of medical care because of the stigma and sensitivity so characteristic of these services. Among areas requiring a regulatory framework are access to specialists, impartial review of care denials, and the management of confidential information. The social contract with managed care requires the trust of the public, now being severely tested.\(^4\) There is serious need for the managed care industry, consumer groups, professionals, government, and advocates to work together to establish reasonable norms and understandings and to provide a framework for enforcing them.

The organization, financing, and patterns of mental health care will be different in the future. Such changes threaten providers’ income, autonomy, and prior patterns of service, and they are naturally resisted. Dedicated professionals and mental health researchers have a responsibility to use their efforts and ingenuity to help make the system work better. Managed care is simply a framework. How it functions in mental health will depend greatly on professional communities and the commitment of mental health professionals, managers, and policymakers to ensure that persons with mental illness be granted access to and quality of care that are appropriate for the proper management of their disorders and disabilities.
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NOTES
10. D. Mechanic, ed., Improving Inpatient Psychiatric Treatment in an Era of Managed Care, New Directions for Mental Health Services, no. 73 (San Francisco: Jossey-Bass, 1997).
13. Ibid.
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29. Mechanic et al., “Management of Mental Health and Substance Abuse.”
33. Wells et al., *Caring for Depression*.
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