Mental Health and Mental Health Policy

# Economics and the Transformation of the Mental Health System

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**Abstract** Mental illnesses provide a difficult set of challenges to American health and social institutions. Those challenges have been a continuous concern of David Mechanic's over the course of his career. In this article we trace the development of modern economic and organizational structures that drive the delivery of mental health care in the early part of the twenty-first century. We show how the nature of mental disorders themselves and the treatment for addressing those illnesses pose fundamental difficulties to health care organizational and financing structures. We analyze the factors that have caused the dramatic changes in how American society has addressed mental illnesses over the past fifty years. Specifically, we note the central influence that mainstream health, income support, and disability programs have had in shaping mental health care. We argue that the interaction of the unique features of mental illnesses and changes in mainstream health and social policy led mental health care to evolve so differently from general medical care.

**Keywords** mental health economics, managed behavioral health care, Medicaid

In 1963, President John F. Kennedy laid out what remain today the principal goals of US mental health policy. He called on the nation to change the functions of psychiatric institutions toward a focus on active high-quality treatment, to shift the orientation of care from institutions to the community, and to integrate people with mental disorders into the mainstream of American life (Kennedy 1963). In 1990, David Mechanic, in an article with David A. Rochefort, described the dramatic changes that transformed the United States' mental health care system in the wake of this call (Mechanic and Rochefort 1990). Over the past sixty years we have dramatically

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shifted the locus of care. In 1955 77 percent of treatment episodes took place in inpatient settings (President's Commission on Mental Health 1978). In 2012, fewer than 6 percent of people receiving mental health treatment used inpatient care (Substance Abuse and Mental Health Services Administration 2013). In 1955, the outpatient mental health system provided just 379,000 episodes of treatment. Only thirteen years later, that figure had increased to almost 2 million (Grob 2001). In 2011, over 31 million reported receiving mental health treatment (Substance Abuse and Mental Health Services Administration 2013). Coverage for mental illnesses in private insurance is mostly on par with medical care. The share of people with a mental illness getting treated has increased from just over 15 percent in 1977 to over one-third by 2000 (Frank and Glied 2006). However, the well-being of people with mental illness remains far from ideal, and mental health problems continue to impose enormous human and financial costs on our nation. We spent roughly $352 billion of public monies on care and support of people with mental illnesses in 2010, an enormous amount of money—but a level of funding that many believe is inadequate (authors' tabulations; Insel 2008).

Many of the efforts to pursue Kennedy's goals have relied on administrative and regulatory directives to alter the settings where people with mental illnesses are treated, to expand insurance coverage for mental health care, and to realize fuller community integration of people with mental illnesses. These efforts to direct actions through rules, however, generated only modest progress. Mechanic and Rochefort (1990), in their analysis of the factors generating the transformation of the mental health system between 1963 and 1990, attribute most of it not to mental health–specific government policies, legal decisions, treatment changes, or changes in social norms but to economic forces unleashed by expansions in the mainstream social welfare system.

Two changes to the US mainstream social welfare system were of most importance in the well-being of people with mental illness (Mechanic 2014). The first was the introduction of Medicaid (and, to a lesser extent, Medicare) in 1965 and the new stream of federal funding it created for the care of disabled and poor Americans. Medicaid was designed with the intention of preserving existing state-based mental health financing and therefore largely excluded coverage of services provided in specialized inpatient mental hospitals. It did, however, offer federal matching dollars for some of the services provided to people with these disorders if they were provided in other settings. This opportunity to defray state costs with federal dollars led states to encourage the shift of many people with mental

illness to other nonexempt institutions, such as nursing homes. It also encouraged them to treat people with these illnesses in the community.

Shifting services from institutions to the community had the potential to provide care to people in less restrictive settings. Many of those who had been (or would have been but for these changes) institutionalized, however, had impairments in functioning too severe to allow them to support themselves financially outside institutions. The second key element, the subsequent introduction of Supplemental Security Income (SSI) in 1972, a mainstream income support program for people with serious disabilities, including but not limited to those caused by a mental illness, reinforced the incentives generated by Medicaid by enabling people who could not support themselves to survive in the community (Frank and Glied 2006).

Changes in economic organizations and policies continue to transform mental health care. More recently, as Mechanic has written, the mental health system has evolved through the growth of a new institutional arrangement, the managed behavioral health care carve-out in health insurance plans (Mechanic and Bilder 2004).

Economic forces have, of course, had enormous effects on the general health care system as well. The changes in mental health, however, differ in scale and nature from those in the general health system. In the general health sector, economic forces have led to rapid growth in spending, both through the direct effects of improved insurance coverage on utilization and by spurring the development of new, more effective—but more costly—technologies. In 1960, the overall health care accounted for 5 percent of the gross domestic product (GDP)—by 2012 it accounted for over 17 percent of the GDP. By contrast, there has been much more modest growth in mental health spending. Despite expansions in the prevalence of care seeking and improvements in the quality of care received, the share of GDP accounted for by mental health care has remained relatively steady at about 1 percent since 1971 (Frank and Glied 2006; Glied and Frank 2009).

In contrast to the general health sector, economic forces in mental health have primarily been felt through changes in the structure of the delivery system. Economic forces have caused spending to shift substantially among sites and types of service. In the mid-1950s, roughly 84 percent of spending on mental health care was accounted for by state and county mental hospitals and specialty mental health clinics (Fein 1958). Spending on hospital and other residential care has declined to just below 50 percent of mental health spending (Frank and Glied 2006). Only about 10 percent of mental health spending goes to psychiatric hospitals of any kind. By contrast, despite rapid growth in overall spending, the shape of the general

health care sector itself has remained relatively impervious to structural changes. In contrast to the pattern in mental health, in 1960 hospitals accounted for 33 percent of US national health expenditures, while in 2012 hospitals accounted for 32 percent of (much larger) US national health expenditures (Centers for Medicare and Medicaid Services 2012).

As Mechanic and Rochefort noted, in 1970 there were relatively few opportunities for low-income disabled people with mental disorders to assemble the resources necessary to live independently in their home communities. The advent of income support programs for people with disabilities has dramatically changed the circumstances faced by large numbers of people with severe and persistent mental illnesses. In 1974, about 32 percent of people with a severe and persistent mental illness received support from either Social Security Disability Insurance (SSDI) or the SSI program. By 2000, the number was greater than 70 percent (Frank and Glied 2006). Similarly, there has been a significant expansion of people with a severe mental illness who are receiving housing subsidies in the United States. The mental health sector looks very different today than it did in 1960.

This article analyzes the characteristics of mental illness and of the mental health service delivery system to explain why economic forces had such transformative effects on the shape of the mental health sector. In the next section, we describe the characteristics of these illnesses and of the service system that make them particularly responsive to economic incentives. Next we explain how the most fundamental economic problems of the health care sector are exacerbated by these characteristics of mental illness itself. We then illustrate how the mental health carve-out arose in response to these market failures. We conclude by discussing three areas where further innovation is needed to better harness economic incentives in the service of improved lives for people with mental illness.

## What Makes Mental Illness Special

The care of people with mental illness responds differently to economic forces than general health care does, for reasons that have to do both with the nature of these illnesses and with the nature of the service delivery system that responds to these inherent characteristics. Mental illnesses are prevalent and often disabling conditions. People with these illnesses, and their families, incur enormous personal and financial costs. These illnesses and their treatment also pose significant challenges for the design of public policy.

## Mental Illness

Mental illness is a health care category that comprises a vast array of conditions (schizophrenia, bipolar disorder, depression, and anxiety disorders, among others) that have a wide range of effects on people experiencing those conditions, such as social withdrawal, limits on functioning including work and parenting, cognitive impairments, troubling behavior, and, in some cases, violent behavior (Mechanic, McAlpine, and Rochefort 2014). There are no definitive biological tests to determine the presence of these illnesses (or to provide evidence of the amelioration of their effects). Within the category are conditions that are profoundly disabling and conditions that may not cause substantial impairments in daily life functioning. At any point in time, about 30 percent of Americans meet diagnostic criteria for a mental illness (46 percent of all Americans meet criteria for a diagnosis of mental illness over the course of their lives) (Kessler et al. 1994). About 10 percent of all Americans report that they are significantly impaired in their ability to live their lives because of a mental illness at a point in time. About one-fourth of those who meet diagnostic criteria for a mental illness also experience significant impairment (Narrow et al. 2002).

Mental illnesses are often (but not always) chronic. Among people who have had an episode of depression, for example, the risk of recurrence is about 50 percent (Eaton et al. 2008). About half of people with schizophrenia who are receiving appropriate treatment will have a relapse episode within a year (Ayuso-Gutiérrez and Río Vega 1997). Observable patterns of prior service use provide a strong prediction of future mental health service use (Ettner et al. 1998; McGuire et al. 2014).

Another important feature of mental illnesses is that, while attitudes toward these illnesses have changed, these conditions remain highly stigmatized (Frank and Glied 2006). Many people—both those who have and those who do not have a mental illness—continue to doubt the efficacy of treatment, and these negative perceptions interfere with service use (Corrigan 2004).

Mental illnesses are also more likely than many physical illnesses both to generate significant costs in terms of disability among those who suffer from them and, often, to impose substantial costs on others. Because these illnesses can create profound impairment, they generate increased costs for income protection and social insurance programs. For example, about 28 percent of SSI/SSDI recipients suffer from mental illnesses (Social Security Administration 2014), and over 60 percent of people with a serious and persistent mental illness receive SSI/SSDI benefits (Frank and Glied 2006).

The external effects of mental illness on others also have implications for other social welfare programs, including the education system and the justice system. A growing literature documents the intergenerational transmission of problems generated by mental illness. Children whose mothers are depressed are six times as likely to suffer from depression in adulthood. Children of depressed mothers also experience delays in development and weaker cognitive skills (Lovejoy et al. 2000; Glied and Oellerich 2014).

One type of external effect of mental illness has received considerable attention—the relationship between mental illness and violent or criminal behavior. This relationship is often overstated. Mental illness is not a very specific predictor of violent behavior. Nonetheless, the rate of violent behavior among people who meet criteria for mental illness is about twice as high as the rate among those who do not (Glied and Frank 2013). Rates of mental illness are very high among people who engage in disruptive (but often not violent) behavior that leads to incarceration in local jails. A recent study finds that about 17 percent of male jail inmates and about 34 percent of female jail inmates meet criteria for a serious mental illness; the rate in the general population is about 4–5 percent (Frank and Glied 2006; Steadman et al. 2009). Rates are somewhat lower in prisons, where about 7 percent of inmates meet criteria for a serious mental illness (Frank and Glied 2006; Glied and Frank 2013). While most people with mental illness are able to live safely in the community and do not commit offenses, especially with appropriate social and financial supports, the disproportionately high prevalence of mental illness among those incarcerated suggests that existing community support systems are not sufficient for all people.

## Treatment

In parallel to the great heterogeneity of conditions, there is a similar heterogeneity of treatment in the mental health system. Addressing the complex needs of people with mental illnesses requires the involvement of an array of health care, specialty behavioral health care, and human services providers and a wide array of treatments.

A wide range of providers can and do provide care for people with mental illness. A substantial share of the burden of care for people with these conditions, especially for children, is borne by family members (Garrett 1996). Many people seek care for psychological distress from providers outside the health care system, including clergy. A wide range of clinicians—including primary care physicians, psychiatrists, nurses, social

workers, and psychologists—with various levels of training provide therapy. Some among these providers also prescribe medication. Because of the social costs and disability costs associated with these illnesses, many systems outside of health care also deal with people with mental illnesses, including schools and, importantly, the criminal justice system.

The nature of treatment provided also varies and is often difficult to monitor. People may receive one of the many forms of talk therapy; these are particularly challenging to monitor. They may receive medication treatment. They may choose alternative treatments, such as the use of herbs. Among those with a serious illness, there are many levels of more intensive and even coercive care—assertive community treatment, day treatment, residential treatment, general hospital inpatient treatment, psychiatric hospital treatment, and outpatient and inpatient commitment. In some cases, effective care can be brief and involves only a few visits to a primary care physician and prescriptions for medications. In other cases, treatment and support may continue over an individual's lifetime and involve a mental health team (made up of psychiatrists, psychologists, nurses, social workers, and community mental health staff); general medical professionals (primary care physicians and nurses); prescription drugs; supportive housing programs; and employment supports.

## The Nature of Mental Illnesses Exacerbates Inherent Economic Problems

The field of health economics is based on the idea, first formalized in 1963 by Kenneth J. Arrow (1963), that health care markets exhibit many forms of market failure. The three most important are moral hazard, or the change in the use of services that arises because of risk pooling; selection, which occurs as people (or providers or insurers) sort themselves among health insurance plans or services based on information that is not available to the market; and agency, through which expert providers act on behalf of their patients. The fundamental characteristics of mental illness, and of the mental health service system, exacerbate all three of these economic problems. One consequence is that mental health care is more sensitive to changes in economic incentives than other types of care are. Another consequence, addressed below, is that new organizations have evolved in the mental health area to address these problems. These new organizations have been less important in the general health arena in part because the underlying economic problems are less severe.

## Moral Hazard

The introduction of Medicare and Medicaid in the mid-1960s, and the expansion of private insurance for mental health services since then, has greatly increased the extent of insurance coverage—and hence risk pooling—for mental health care. Providing people with lower-cost access to mental health services, in turn, led to large increases in the use of these services, a behavioral response known as moral hazard. For example, at various times, the extension of coverage for adolescent residential treatment has led to rapid increases in the use of these services (Bruzzese 1989; Hutchins, Frank, and Glied 2011). Evidence from the landmark RAND Health Insurance Experiment similarly showed that outpatient mental health services were more sensitive to variations in cost sharing than general medical care was as a whole (Keeler, Manning, and Wells 1988).

This higher sensitivity to costs reflects several characteristics of mental health services. Many—though by no means all—services provided to people with mental illness, and particularly the outpatient psychotherapy that was the staple of care in the RAND experiment, consist primarily of talking to patients. Visits to psychotherapists require patients to incur time costs, in addition to the financial costs of visits, but, unlike many general health treatments, involve relatively little pain or discomfort.

The high external costs of mental illness for families and society also explain part of this greater responsiveness. In the case of children and adolescents, the presence of insurance allows substitution of paid professional care for informal and family care. This ability to substitute among types of therapies means that expansions of health insurance enable responses both in terms of increased use of any service and in terms of switching from noninsured to insured services.

These possibilities for substitution explain a different form of moral hazard, which is much stronger in mental health care than in general health care. Risk pooling not only changes the quantity of care provided but, because of the diversity of providers and treatments available, can also alter the site or provider of that care. One example of such substitution was the pattern of transinstitutionalization—shifting patients from one type of institution to another—observed in response to payment changes. In the wake of the introduction of Medicaid, for example, states moved substantial numbers of people out of mental health institutions and into nursing homes. For many patients, the care provided in nursing homes differed only slightly from the care provided in psychiatric hospitals, making this substitution relatively easy. This kind of substitution greatly inflated the costs

to the Medicaid program but had little effect on aggregate mental health spending (Goldman, Adams, and Taube 1983).

A final example of how the multiplicity of treatment modalities exacerbates problems of risk pooling comes from the evidence on capitated mental health services. Patients covered by contracts that pay on a capitated basis for mental health services are more likely to use medications than they are psychosocial therapies, presumably because the contracts cover payment for therapists providing a psychosocial therapy but are not at risk for the costs of medications (Mechanic, Schlesinger, and McAlpine 1995). Because two different therapies exist, substitution in response to risk pooling is much easier.

## Adverse Selection

Selection happens in markets whenever prices do not fully capture information available to market participants. In insurance markets, adverse selection leads people who anticipate that they will use services to seek better coverage than that sought by people who think they will not use services. Among providers, selection, often called cream skimming, leads physicians or clinics that are paid capitated fees to seek out the healthiest patients. In competitive insurance markets insurers seek to avoid selection by restricting coverage of services where private information about the risk of use is most prevalent.

Selection in insurance markets is a problem with respect to many chronic conditions, but several features of mental illness and of mental-illness treatment make this area particularly susceptible to selection problems. Mental illnesses are chronic and recurring, so people who have had an illness in the past are more likely to seek coverage that will protect them in case the illness returns. The presence of mental illness may also lead to higher costs for the treatment of other co-occurring illnesses, such as diabetes and hypertension. Finally, the high level of stigma and the conflicting opinions about the efficacy of mental health services also allow patients to sort themselves between those who think they would be likely to use mental health services for various problems and those who would not (Mechanic 1998). These various kinds of selection raise the cost to insurers of covering mental health services. In response, in the absence of regulations, and prior to the passage of the Affordable Care Act, many plans excluded mental health conditions from coverage altogether.

Selection is also a problem in mental health treatment. Because mental health problems do not show up as lab values, it can be difficult to adjust

payment to reflect the severity of the patient's underlying condition and the cost of appropriately treating it. If payments to providers do not vary enough with severity, providers will fill their rosters with relatively healthier patients. In the wake of deinstitutionalization, this pattern led community mental health centers, which were paid using fixed budgets, to treat more of the "worried" well and avoid the care of recently deinstitutionalized people with serious and persistent mental illness (Grob 2001).

Concerns about this kind of selection have slowed efforts to control moral hazard in mental health through mechanisms widely used in general health, such as prospective payment (Lave 2003).

## Agency

The consequences of the disparity in information between providers and their patients have befuddled health policy makers since Hippocrates. Again, however, the problem is more serious in mental health than in general health. Mental illnesses may impair the ability of patients to assess and respond to the quality of their providers' services. In some cases, patients may be coerced into treatment through the legal system, leaving them with little control over the care they receive. Even in cases without coercion or impairment, the nature of treatment makes it difficult for patients to compare providers or for outsiders to monitor the quality of services provided. A given kind of treatment—psychotherapy, for example—may be provided by many different types of practitioners and may take many different forms. This diversity makes it challenging to assess the appropriateness of care provided or the quality of the provider.

The challenges of measuring performance in mental health services—monitoring the behavior of the agent—have made it difficult to develop quality metrics for such services and for payers to determine how much care is appropriate in a given situation. Most of those measures that have been developed pertain to adherence to medication algorithms or the timing of visits. While many evidence-based psychotherapies exist, and assessments of fidelity in adhering to these evidence-based strategies are used in research trials, there are no widely used metrics for assessing adherence to these therapies in routine practice. The limited evidence available suggests that the labels psychotherapists assign to their modes of treatment are only moderately correlated with the practices they actually use (Hepner et al. 2010).

The difficulties of assessing provider performance have further amplified the heightened effects of financial incentives generated by moral

hazard and adverse selection. Since it is very difficult to determine from readily available data whether one mental health provider is better than another, the variety of providers has broadened considerably. The proliferation of lower-cost providers (e.g., social workers) has been one of the factors that have kept the cost of mental health as a share of the GDP so stable.

## Organizational Innovation in Response

The factors that have made mental health services so responsive (perhaps excessively responsive) to economic incentives have also made it difficult to apply rule-based policies to this area. Just as the heterogeneity of need, condition, and treatment has made it easy for the system to shift care from site to site, from treatment to treatment, from patient to patient, or from provider type to provider type in response to changes in incentives, it has made it easy for actors within the system to evade what appear to be clear rules. In sum, progress on many fronts in mental health delivery could not be achieved in the insurer and provider environment that existed through the 1970s, even when regulators tried to address underlying problems by imposing rules around coverage on the system. This environment did not permit provision of "parity" in insurance coverage for mental health care in the private sector, coordinated care outside of institutions in the public sector, or efficient allocation of services across the population.

Progress in mental health required the development of new organizational arrangements that could overcome at least some of the moral hazard, adverse selection, and agency problems inherent in the existing system. The development of the mental health carve-out plan provided this new organizational framework (Frank and McGuire 1997).

Under mental health carve-out contracts, mental health risks were separated from competitive public and private insurance contracts and managed separately. Specialized contract managers had the expertise and incentive to monitor and manage utilization. Carve-out companies could also draw from the broad array of providers and match treatments to patients.

The separation of mental health services into a distinct contract, while often criticized for formalizing the existing split between physical and general health services, provides significant protection against adverse selection. Instead of insurers competing for individual enrollees—a system that exacerbated selection pressures—insurers compete for the contracts themselves (Frank and McGuire 2000). Competition at the level of the contract not only limits selection but also allows the public or private

entity that is managing the contract to evaluate the performance of the contractor at the level of the entire population, for example, by assessing the rate of emergency hospitalizations. This ability to measure outcomes at the population level offsets some of the challenges of performance measurement in mental health more generally.

Carve-out contractors could develop expertise in the management of utilization in mental health. Utilization review, which had fairly limited effects on general health services, significantly reduced hospital stays for mental health care (Frank and Lave 2003). The ability to monitor service use in this way allowed contracts to eliminate the high cost-sharing requirements and restrictions on service use that had been typical of coverage for mental health in the past. This ability to manage moral hazard without high cost sharing paved the way for parity in mental health care. A substantial body of evidence, capped by analysis of the quasi-experimental introduction of parity in the Federal Employee Health Benefit Plan, has shown that differential cost sharing can be eliminated at virtually no system cost in a managed mental health care environment (Bao and Sturm 2004; Barry, Frank, and McGuire 2006; Goldman et al. 2006).

Finally, carve-out contractors could develop expertise in matching treatments to people. In principle, that should allow contractors to take advantage of the vast array of mental health resources available by assigning simpler cases to less specialized forms of treatment and triaging more complex cases to more intensive treatment. Moreover, carve-out plans that contract with specialized providers should be able to accumulate population-level information about at least some outcomes of care received by their patients, such as the fraction who have an inpatient readmission. In this area, however, carve-outs have not yet performed as well as theory would suggest. The evidence that carve-outs effectively use information to direct patients to treatment in this way is mixed (Alegría et al. 2001; Alegría, Frank, and McGuire 2005).

Managed carve-outs have been more successful in addressing many of the underlying economic problems of the mental health system than either the public budget-based or traditional fee-for-service systems that preceded them have been. Nonetheless, they have certainly not been a panacea. They have created some new problems and exacerbated others.

A principal complaint about mental health carve-outs is that by separating the financing and management of mental health services from general health services, they institutionalize and formalize the distinction between mental health care and general health care (Frank, Huskamp, and

Pincus 2003). There is little evidence to suggest that integration between mental health and general health was better before carve-outs were introduced. The growing role of primary care practitioners in diagnosing, treating, and managing mental health problems, however, has made such integration more important. Growing recognition of the high prevalence of untreated physical illness in people with mental health problems similarly highlights the need to better integrate these sectors (Mechanic 2012).

A second important complaint about carve-outs is that they have incentives to shift costs to other health and social service sectors. Carve-outs may lead to increased reliance on medication treatment in primary care (since this care is generally not part of a managed care contract) (Frank, Huskamp, and Pincus 2003). There is also some evidence suggesting that carve-outs may shift costs to other public programs, such as jails, by providing insufficient care for serious cases. The empirical evidence for such cost shifting is mixed and highly contested, but the incentive undoubtedly exists (Mechanic, Schlesinger, and McAlpine 1995; Domino et al. 2004).

## Moving Forward

The past fifty years of experience in the transformation of the mental health sector suggests important directions for moving forward. Like the efforts that preceded them, these new directions are likely to require new organizational and regulatory arrangements that appropriately channel well-designed economic incentives.

One potential direction for such institutional innovation would build on the idea of a health home, a new benefit introduced into Medicaid under the Affordable Care Act. Under the health home provisions, a provider or team of providers can be compensated for providing care management and coordination, including referrals to community and social support services. This model suggests the possibility of expanding the scope of responsibilities for carve-out providers to include a broader array of social services and general health services, at least for people with serious mental illnesses (Mechanic 2012).

To make such a broadening of benefits successful, these broader carve-out plans would need to face an appropriate payment mechanism. This payment mechanism needs to give organizations an incentive to seek out and provide care for the most serious cases. It needs to offer compensation for services directly provided to this population and funding for coordination of care with other social service sectors. It needs to encourage

provision of useful services and to discourage excessive and wasteful treatment. In prior work, we have proposed one such payment scheme in the context of treating young people with first episode psychosis, incorporating a prospective component, a fee-for-service component, and a performance-based payment component (Frank, Glied, and McGuire 2015).

Finally, successful implementation of carve-out plans with broader scope will also require the development of broader outcome measures. Current measures of quality in mental health are woefully inadequate, focusing attention almost entirely on the process of care. If new organizations are to be compensated for providing a broader array of services, measures will be needed that capture how well treatment is helping people with mental illness to function in the community (Glied et al. 2015).

Providing coordinated and integrated care for the complex needs of people with mental illnesses continues to challenge public policy and our social institutions in 2016 in many of the ways it did in 1963 when Kennedy set out the vision for mental health policy that continues to guide us. Over the past fifty years, we have improved our understanding of mental illnesses, their treatment, and the interplay of economic and organizational arrangements that affect the amount, quality, and costs of mental health care. Today we insure and pay for mental health care on par with other health conditions. We are increasingly integrating medical and mental health care by offering effective services to people with mental disorders wherever they encounter the health care system. Our understanding of the organization and financing of care for people with severe and persistent mental disorders continues to require specialized resources and expertise. Yet our learning has permitted a continuous evolution in how we organize and pay for the care of people with the most severe illnesses so that more of their needs can be met in a fashion that allows them the maximum degree of autonomy and opportunity to engage in the American mainstream.

Nevertheless, there remains much to be done. The diffusion of lessons learned is incomplete, and we too often fail to apply what we know about effective care, effective organization of services, and efficient payment arrangements. Advances in neuroscience and clinical science are pointing to new opportunities to intervene in the course of severe mental illnesses that can attenuate the most disabling effects of mental disorders. Yet we are in the infancy of developing treatments and programs that support such treatments. Thus today's state of affairs offers both continued challenges and sources of optimism for those concerned with addressing the problem of mental illness in America.

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