Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

WILLIAM JAMES COLLEGE

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Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated. For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE SIXTEENTH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

The Privatization of Community Mental Health: For People or for Profit?

Case Conference Participants

Eileen Elias: Comissionner, Massachusetts Department of Mental Health

Deborah Weinstein, MSW: Executive Director, Massachusetts Human Services Coalition; Co-author, The Poor People's Budget

Michael J. Bennett, MD: Eastern Regional Medical Director, American Biodyne Inc.; Assistant Clinical Professor of Psychiatry, Harvard Medical School

Judi Chamberlin: Board of Directors, National Association of Psychiatric Survivors; Program Director, Ruby Rogers Advocacy and Drop-In Center, Cambridge

Moderator

David G. Satin, MD, FAPA: Assistant Clinical Professor of Psychiatry, Harvard Medical School; Assistant in Psychiatry, McLean Hospital

Friday, April 30, 1993, 2:30 – 5:00 pm

Massachusetts School of Professional Psychology
221 Rivermoor Street, Boston, MA 02132

Introduction by Eugene Thompson

Mostly I'm here to welcome you all. It's really tempting, as a sponsor, to use this time and a captive audience to express some personal views about privatization, but I'll refrain myself and become a participant from the audience. But I do want to welcome you. The North Suffolk Mental Health Association has been a sponsor of these lectures from their inception back, I believe, in the early 70s, which, our first treasurer of the North Suffolk Mental Health Association knew the Lindemann family and has been very much a part of the community mental health movement right from the very beginning as a citizen participant. The issue of privatization is one that is very near and dear to the hearts of those who founded the North Suffolk Mental Health Association, as well as those like myself who are staff, and we're very pleased to be able to help sponsor this today. North Suffolk has been in existence as a private, non-profit corporation for 35 years, so we've always been part of the private sector. However the nature of the very close relationship or partnership that we shared in those early years with the Department of Mental Health has given North Suffolk a sort of quasi-public nature, as all its private as well as public access to the system, so we're in some ways right in the middle of the debate. Once again, welcome from the North Suffolk Mental Health Association.

Eileen Elias

Comissioner, Massachusetts Department of Mental Heatlh

It's an honor to have the opportunity to be part of the Lindemann Memorial Lecture series. The privatization of mental health services is not a new activity. This is part of the current construction of mental health services, national health care and managed care as part of health care reform is a topic of primary importance.

I am confused by the title of today's presentation: 'The privatization of community mental health: For people or for profit?' implies that the privatization of services results in an either/or situation. Either the privatization is good for people with mental illness or it is the implementation of policies that shift healthcare profit to the private sector, thereby reducing the state's… to provide mental health services. I have never used…the community, but rather the opportunity to redirect dollars to improve the quality of care throughout the system that allows for the obtaining of clinically appropriate inpatient, residential, and support services in the community for mental health consumers.

For over 20 years the state… residential community support services across the state by highly reputable mental health providers. Over 250 members currently provide an array of clinically appropriate and high quality mental health services. Well, the Department of Mental Health has provided and is providing an array of the necessary services, private and public services. The signals associated with these in the State… profitable… by consumers… reform…discriminate and devaluate. Integrating mental health care, the business community and the general hospital system is a major step forward from the locus of care which oftentimes isolates the unaccredited state hospitals and it addresses discrimination. The position of fee-based mental health services in private and general hospitals allows the department to immediately place general licensed and accredited hospital units, without the additional long-term debts and capital improvements. Placing the…in contact with various hospitals and general hospital… public and private…well-kept community mental health cente. Our standards historically…of general hospitals…for the town, even if it starts in a general hospital without a contract. The department has worked cooperatively with state employee union, state offices committee… The state workers now keep contract to provide mental health services.

What we need is to provide a formal organizational structure whereby managed competition transfers to training. Upon my appointment as commissioner, I made a commitment to design and implement a fully-integrated, quality-based, cost-efficient system of public managed care support system. Consumers truly need a service system which…revenue that cannot…non profit across the state. From the most sensitive and

concerned conservative you'd least expect the support. Public community care is designed to meet needs, public and private services, the public can find. The department's objective is to have criteria, protocols by all third-party payers with other state agencies to ensure people access to quality mental health care, regardless of source or location of services. Contracts for mental health care is not about who wins and who loses. Service delivery becoming more a reality and cost-effectiveness is an important factor, but the person who is serviced by the state…public accountability, including delivery, including clinically appropriate, quality care.

My goal today is to explain the integration of services in private and general hospitals and in community mental heatlh centers. This contract and future contracting support services with venders do not resolve the…consumers to the quality of care, or to venders. It is not a win-lose situation, it's rather a win-win situation. The mental health consumers, vendors, state government, and the citizens.

Prior to 1991, there had been an overall budget reduction of approximately more than $38 million. More than 500 people who are clinically ready for discharge. Some are state hospitals having most restrictive of patient units…while houses are almost…because the state cannot afford to staff them. The community support services have been cut dramatically, putting the consumer in the community at great risk of rehospitalization and for homelessness. The department does not insure an unlimited accountability because it's licensing and quality assurance staff have been dramatically reduced at the central and area office levels. General hospitals are being used without any standard requirements for discharge, or quality of care monitoring. As we saw, patients were being inappropriately discharged and put at greater risk for rehospitalization. Given the state budget crisis in 1991, the department continued to make dramatic cuts in the mental health budget. Such decisions would have resulted in a continued overcrowding, antiquated and uncertified state facilities, and a further crippling of the community-based system of care. Faced with this reality, the decision was made to restructure the system under the public managed care commission.

The question then arises, what does the department mean by public managed care? Basically what it means is private managed care to ensure active, quality, cost-effective services and the appropriate management of services. Not necessarily the appropriate management of the consumer, appropriate management of the system of care. The department's primary goal is developing a system of public managed care which provides care that is clinically appropriate and of uniform quality to all individuals in need of mental health services, regardless of where the services are provided. The foundation of public managed care is a statewide network of geographically defined local service areas that mean a broader way of integrated mental health services. The predominance of this system of public managed care has not been driven by use of a capitation model. We

deliberately did not want to have it fiscally-driven. Instead the system has to be first driven for developing a service system that learned to work and talk with each other.

The first step toward development of the system of public managed care was three major steps to move the structure forward: the closure of state hospitals, the integration of acute care in the public and private generals and psychiatric hospitals, and the redirecting of inpatient operated dollars to expand community-based services. Each one of these steps resulted in the delivery of clinically appropriate, quality services throughout the state. Without the process a renewed emphasis has been placed on the department's monitoring, evaluating and training responsibilities, especially the clinical and professional services. The department completed an organizational-wide quality assessment and improvement plan.We have established quality counsel in our central office and are now in the process of doing so in our area offices as of January, and we've begun to oversee all the department's quality assessment and improvement after this. I'll be going over the specifics later upon the questioning.

The monitoring evaluation requires appropriate training staff. This all began with leadership training, department's objectives, senior and quality management staff who have received training in quality assessment, improvement and leadership skills. To date, over 310 participants, representing all of the department's area offices have attended 10 quality management training programs. All that is being done without money from the legislature. What we've done is take our budget and restructured it. The Office of Consumer and Ex-patient Relations, or OCER a 19member council has been created and are operational to serve as advisors to this department. OCER members have provided valuable insights to the planning process. The consumer involvement and advocacy has increased dramatically in all areas of the state, an area-wide consumer council has been established to ensure that family members provide the state staff and other constituent groups are all participating in the planning and development of managed care.

A multicultural advisory group has been established and is fully operational to evaluate the services delivered by the department's staff, vendors and providers, and to identify the strengths and gaps in the services. The status has already begun to impact the planning process to ensure that the delivery of appropriate services remains culturally competent. Representatives from the entire mental health community have participated in the development guidelines. In addition, all DMH committees, selection committees, oversight committees, the central offices across the state, the major involved consumer, family members, advocates, mental health professionals and DMH staff. Fiscally implementing the system of managed care, public managed care, has resulted in the following: consolidation of facilities, increasing the state's ability earn, patient care of public and private, substantial progress of eliminating…system of in-patient care with

the establishment of these revenue-generating…redirection of inpatient operating dollars to improve facilities to expand the community-based system of care. For the end of fiscal year '94, these initiatives will have generated the state $69 million, and redirected in the community $55.8 million, and resulted in the…of community-based services across the state, which, in fact, is more than $38 million, more than $38 million deduction from the state's pay. Savings for expenditures of $43.7 million in capital resources qualifies state certification and accreditation. Redirection of the $54.8 million expand and enhance, as I've said, the community-based managed care.

Over the course of fiscal year '91 through the current fiscal year the department has developed over 804 new community-based, residential units, and we've expanded crisis intervention programs, case management and increased funding for clubhouses and social clubs. Quality management is one of the integral pieces of glue to make our to make our public managed care. A renewed emphasis has been placed on the department's monitoring, evaluating and training responsibilities. We have hired, as I have said, specialists in this area central office, to develop state-of-the-art quality management, utlization management, education and training, all the emphasis on having clinical, not fiscal… The department quality assessment and improvement plan to establish quality council to oversee all of the department's quality assessment and improvement activity…area and central office level. We have developed clinical and utilization management standards for inpatient care in community-based programs to be used by both public and private payers.

Based on the department's increased monitoring and evaluating requirements, the area offices are in the process of reorganizing and reassigning the staff responsibilities to integrate human rights, utilization review, citizen monitoring, and other evaluation activities in each of the area offices manage a different structure with the current administrative funds. I know there is a concern now. Yes, we can move this forward. Can we move fast enough? No, we can't. Are we moving? Yes, we are. The department has a system for monitoring the service providers. The monitoring system includes mechanisms which incorporate the consumer, advocacy staff, it provides for the oversight of the financial and programmatic management services by the department.

We are also looking forward to have the same expectation for vendor-run programs as well as state-owned programs. With the recent development in the new program of standards contracting, the department is working to develop an expanded monitoring system which would elevate the requirements to ensure consistency across the state. Many of the department's new initiatives require cooperation and coordination among the state's agencies who especially address the neediest individuals who receive multiple services. Included in this group are individuals with special needs such as children, adolescents, elderly, consumers with dual diagnosis, and patients with HIV/AIDS. The

department has negotiated for example, the Department of Retardation and the Department of Public Health, and as well with elderly services and with MHFA as well as DOCC, to ensure that our consumers are able to reside…paying their housing and subsidized living situation, and ensure nothing will affect the concern of homelessness.

The accurate and complete pooled consumer information is vital to the provision of appropriate services within an integrated and coordinated system of public managed care. The department has a plan for improving the consumer and management information systems. For years, legislators, advocates, special family members, department staff, have asked the question: how many consumers do we each serve, and where are they? The department expects to have a state-wide consumer registration tracking system on-line in May of 1994. After all the consumer-related information is gathered, privacy and confidentiality are our primary concerns. Community-based systems have recognized the need for finding additional support.

The department developed a standard contract to ensure that consumers in our acute care units receive high quality care. Specifically, the requirements are licensure, national accreditation and federal certification, consumers treatment discharge plan, quality assessment and improvement and citizen monitoring and patient satisfaction service. The standard contract protects consumer rights and includes the department-approved process of handling complaints investigation, human rights, citizen monitoring program as well as protection. In particular, the model contracts two critical aspects of acute inpatient hospitalization, which has not been effectively managed in the past. Clinically appropriate access to acute-care bed screening performed by the department-designated emergency screening team, or EST, an appropriate discharge plan including the provision of medical services.

With the restructuring of the mental health services it is entirely appropriate to experiment with new methods of service provision. After lengthy negotiations with the union, ODC was formed in January of 1993 as a public sector office residing in the department. The organization philosophy of ODC acknowledges that it is no longer acceptable to isolate people in institutions and emphasizes the development of a continuum of care, and to provide an array of treatment for responding to consumer needs. The primary strength of ODC is access to a sizeable pool of state employees, and a demonstrated commitment to the department's consumers. ODC is in the process of assembling committee bids for state-operated vendor programs and evaluating an identical manner utilizing the same selection standards for private and non-profit. The department is further reinforcing a shared commitment to the delivery of high-quality services.

In summary, public managed care is a reality in the health care reform. It is incumbent on the…in this state, the Department of Mental Health and the mental health

services delivery, it is still in touch with cost. It is not about who wins and who loses but rather all of us wins. Mental health consumers do receive high-quality care, and will continue, and we'll increase that expectation in both state and vendor programs across the state, and it is entirely appropriate for the state to seek new ways to provide quality services which are ensuring the quality, most important, and are cost-effective. The integration of acute care and private and general hospitals provide the same quality of care received by all other citizens. The...monitor the quality of the utilization of these services and the expenditure of state and federal dollars to provide standards. In summary, public managed care is about public accountability. Public managed care is a system which provides quality care, equitable treatment, and clinically appropriate services while controlling health care costs for children, adolescents and adults. The only way, though, to ensure that what I said continues to be met and, I'm saying that it will be met, is through consensus building. I thank you.

David Satin:

Thank you, Commissioner Elias. You can see how much effort and how much passion has been put into adapting and renovating the department to meet very new needs.

Deborah Weinstein, MSW

Executive Director, Massachusetts Human Services Coalition; Author of The Annual Poor People's Budget

Introduction by David G. Satin, MD

The second speaker is Deborah Weinstein, Executive Director of the Massachusetts Human Services Coalition, and co-author of *The Annual Poor People's Budget*. She represents many private and non-profit mental health and social service agencies struggling to maintain their unique contributions to human service under radically changing rules and supports.

Deborah Weinstein, MSW

Good afternoon, everybody. Well, I don't start out with too many assumptions or premises. For one thing, the membership of the Human Services Coalition doesn't really allow me to. It does include those private and non-profit human service providers certainly, it also includes Local 509 SIEU. It also includes The Alliance of the Mentally Ill, it also includes The National Association of Social Workers, for instance, other consumer organizations, religious organizations, et cetera, so people are part of the coalition from most of the different sectors, if you want to call it that, that this debate has involved, and so it certainly isn't easy for me to just kind of make some assumptions, such as the direct state salary workers necessarily better or not better than the contracted employees that gets his state dollars, or hers, through an intermediary. We don't assume necessarily that the short stay in some sort of mental health facility is better or worse than a long stay. We don't assume necessarily that the hospital setting is the appropriate place versus the community setting. I think all of these are crucial questions that need answering, that it probably does well not to start with any set assumptions.

How do you test those assumptions, and for us, we like to think that participation of all those folks in our membership causes us to look at the person. The person who would be the user, the consumer, of those services. To start with the person as a human being before we label that person consumer, recipient, patient, client, and try to see that person in the complexity of his or her relationships with a lot of different elements of government and the community, perhaps way beyond the Department of Mental Health. What would we want, starting with that debate, and clearly, I don't think anyone here on the panel or anywhere who would say they were starting any other place, of a mental health system? How should that mental health system interact with that individual, and I

guess a lot of what I'm saying is quite obvious, and I apologize for that, but there's something about the setting that made me in a way want to take a longer view. Ideally, that individual should be able to experience some happiness and some growth, some satisfaction, mastery, and minimally that person should be protected from harm, from discomfort, from want. And so, then, of course, that brings to view what is it about the system that we can measure.

A director of a private agency, she said, 'We know what a process costs, but not whether it will make a difference.' And I think that in terms of the monitoring that the commissioner spoke of, that we have a long way to go in that area. We have a long way to go to decide for ourselves what is working, what helps people, and how we go about finding that should be part and parcel of every decision that we make, every step of the way, and so as I say, I'm not sure if we learn as we have that privately-run, acute care units that we are now contracting with are discharging people after an average of ten days, and that is a shorter time period than has been the case before. I don't lean to conclusions. I don't know whether that's better or worse, but unless we try and find out, we know that we are definitely in danger of doing a terrible disservice to our human beings, who turn out to be our clients, patients, recipients, and consumers.

So what information do we have that sort of passes as a monitoring of our system? We know that 55 patients were readmitted within 90 days of being discharged from the closing facilities, and obviously I would consider that cause for alarm. If we don't know a whole lot about measuring what a success is, presumably if someone is back in an acute care facility that we need to know why and what we can do about it. The Department of Mental Health is mandated to focus on priority one clients, and that means they tend to be seeing patients in crisis, and that's the only time they are frequently seeing those patients, is if we sort of launch them into the mental health system, that if all the money of the system, or so much of the money in the system, is devoted to crisis intervention, then we are going to be very, very far from the ideal of that I ineloquently express as resolving the increase of a person's happiness and mastery and satisfaction and independence, and we have to get back to that.

The work that I do is not largely within a mental health care unit. It is largely in the income security area, and I know that the various hands of government don't work very well together in terms of understanding the full needs of folks, and one of the big struggles, for instance, that we've engaged in has been with a program that used to be General Relief that's now called Emergency Aid to the Elderly, Disabled and Children. When I've said the name of the program I've usually used up my time, but this is a longer speech so I can say something beyond the name, but that program has served many mentally ill people over the years. It used to be possible for such a person not to have to get the label 'mentally ill' for that because it used to serve people over the age of 45

without a current work history, and amongst those people there were folks who definitely had mental illness problems who didn't necessary have to label themselves that way, and were at least given minimal medical care and survival needs met. That is no longer the case. The mentally ill people who ought to be part at least of the General Federal Emergency Aid to Elderly, Disabled and Children Program are very often not getting any assistance from that program right now. There are thousands who have been rejected by the Disability Review process, and it's very hard for them to get their foot in the door to all of the various difficult hurdles that have to be filled out. They need to prepare a medical form, they need to see doctors, all of which is very problematic for people.

Why do I say all of this in this context? Because we are not recognizing the basic survival needs of folks. To the credit of the Department, they're starting to put money into housing for the mentally ill, for the homeless mentally ill, and clearly that is one beginning of an understanding of the survival needs of people, and that's obviously doing good, but there's far too little of that happening, and so that when the various parts of the government don't work very well together, when we manage mental health care through Medicaid, it doesn't necessarily coordinate as well as it might through the Department of Mental Health, it doesn't help us. When the cash assistance programs deny assistance to people who are mentally ill, it doesn't help us.

Well, we need to figure out a monitoring system that allows us to judge what is happening to people. At the moment we frequently don't know. We know how many services there are, we know many beds are in the system. We don't necessarily know whether one person used a service hour 20 times or whether 20 people use it once each. We don't know an awful lot of what we ought to know, and I'm sure the Commissioner, and people from the administration would say, 'We're doing our best, we're putting things in place, and we have very limited resources,' and all of that is true, and I suppose it would lead one to what I think was a reasonable stance early on, which is, if that's true, then close one general hospital and monitor resources and see what happens to those folks, and see what works and what doesn't, and then go ahead and apply what you've learned to other situations, as opposed to closing three, if not simultaneously, and worry about what happens later. It isn't, I'm taking the longer view, and I'm not really addressing my remarks specifically to what this administration is doing.

It is absolutely clear that the serious budget cuts in mental health occurred before this administration, and this administration has made some more cuts on its own, but in here when we're together at this memorial lecture it seems worth taking that longer view of how can we get out from under this. How can we figure out what works for people and go ahead and do what works for people. Just a couple of other comments. We are deriving a great deal of our assistive medical in terms of Medicaid reimbursement, and I've been a party to that. I have happily said, 'Let's do something this way because it gets

federal dollars, so it saves us money.' I understand the thrust of doing that, but we'd better watch out what we're doing because we're entering into a very uncertain system. We're not at all sure what the future holds in terms of national health care and what may happen to the state's Medicaid programs. We have put all our eggs in that basket and we better be sure that we can protect those eggs. There's a lot uncertainty there, but we don't want, we can't rely on providers to monitor themselves, and we can't rely on consumers or volunteers to be monitoring. That's obviously a piece of the any overall monitoring effort, but it can't be the whole of it. There needs to be a system in place that says, as the agency director said, not what something costs, but whether it works, whether it's doing something for anybody.

I guess I would stop there, except to note that what little we have in terms of treatment delays, waits up to six weeks to see a psychiatrist or a prescription of medication after a release from a hospital, the somewhat revolving door aspect, where people seem to be leaving facilities after a shorter time, not being very well sustained and coming back causes me to do some questioning whether we're entirely on the right track. Understanding that we should not be diverted too much from the issue of privatization, well, the issue of privatization can divert us to some extent from the issue of whether enough resources are being directed in whatever form to really care for the people who are in need, so that's, I guess, how I would leave it for you, that the source of the paycheck has got to be the state, to that degree we have to understand that privatization is a misnomer. The state has got to pay for these services. Whether it does through contracted private agencies or directly through public facilities, that, to me, in a way is not the central question. The central question is, how do we monitor the facilities, wherever they are, with a need equally for both state and so-called private, and how do we make good with the resources that are there to care for people in whatever format we choose to give? Thank you.

David Satin:

Miss Weinstein speaks clearly as an advocate for the client, for the recipient, and is remarkably polite about the way she goes about it. I can imagine it being done in another tone. I am impressed that you only began to address the financial aspect of this. You talked about what the services were and were not there, and not what funds there were for it. You began to speak about it, but not about how these private agencies and non-profit agencies get funded for doing what is being privatized, shifted, at least in part, from the public area, and maybe that is something we will address more in the discussion.

Michael Bennett, MD

Eastern Regional Medical Director, American Biodyne Inc.; Assistant Clinical Professor of Psychiatry, Harvard Medical School

Introduction by David G. Satin, MD

The third speaker is Michael Bennett, Eastern Regional Medical Director of American Biodyne, a major mental health care managing organization which develops and implements ways of controlling and yet providing the costs and the services for private agencies which fund and which provide mental health services. And I look forward to this being a real change of pace about how this is done, the mechanics in the private sector in this relatively new, at least relatively newly-recognized, way of providing and managing mental health services.

Michael Bennett, MD

When Dr. Satin asked me to be part of this, I was both honored and puzzled. Honored because Erich Lindemann is a giant, historically known for his work, some reinforcement for any point of view that one has, because he was so protean in his approach to mental health care and to psychiatry. As a psychiatrist, I think of him as a psychiatrist, although he was also a psychologist, somewhat more. I also was favored and fortunate to be at the company during his final years, and so had some opportunity to see him, if not having direct contact. I was puzzled because I don't think of myself necessarily connected with the phenomenon of privatization as it is occurring, and yet clearly in my role as the medical director of a managed care company, I certainly have interests that overlap the position. I have spent 22 years as a clinician and as administrator in health maintenance organizations, and have been a medical director of a managed care company.

Managed care and privatization are two distinct phenomena; what can I contribute to this discussion? As I considered the provocative title, however, three ideas emerged, and I'll limit my remarks to these three ideas. The first is that of management, the second is that of ideology, and the third is that of boundaries. Let me say briefly what I mean by each and then go on to elaborate.

Medically, our mental health care system is in disarray. It's a mess. It's certainly no more or less of a mess than our general health care system, but it is a mess. It is characterized by maldistribution of resources, by overlap, duplication, inequity in the face of manifest and sometimes very embarrassing excess. It's the frustrating specter of deprivation in the midst of adequate resources that are inadequately distributed. Change is essential. Resources must be allocated and managed more efficiently. If we are to meet

the twin objectives of affordable and effective care, then approximately 20-25% of any given population will require.

Ideology: no field of health care evokes stronger conflicts of ideology than mental health. Mental health practitioners have been fighting like tigers with each other for hundreds of years. There's something fundamentally wrong with that. When it comes to methodology, for example, though practitioners may be fiercely adherent to one school or method or another, and have been fighting over this, as I have mentioned, the literature on treatment effectiveness fails to distinguish among them. In fact, within broad limits, we have no sound basis to choose one approach of care over another. This applies surprisingly broadly across mental health services. In 1975 Lester Luborsky wrote an article comparing various alternative treatment strategies, in which he found them all about equally effective. The article is subtitled, 'Is it True that Everyone Has Won Almost Have Prizes'. Almost 20 years later, I don't think we know a great deal more about which treatment for which patient. This has enormous implications for resource allocation.

Point number three: boundries. If the nineties are to be the decade of managed competition, the core of which is managed care, then a reshuffling of the cards is called for. Systems long in place will be dismantled, and new alignments will be forged. All boundaries and barriers will be based more on entrenchment than enlightenment will be destructive. The risk of this is instability, and I think we will talk a great deal here about instability and its impact on patients and providers alike. The potential benefit is that what may emerge is a better-integrated, fairer and non-sectarian system of care. Let me go a little more in detail about these three. How does this relate to managed care and the phenomenon of privatization?

First, on management. Privatization refers to a change in ownership. Managed care essentially refers to what happens on an operative basis once the system is owned by whomever. In other words the activities of those who operate the delivery system. At the generic level, managed care refers to the application of sound business methodology to health care. It's the introduction of an executive function to the free-for-all which is sublimely ironic term of health care, since of course it's neither free nor for all. In large part, the managed care phenomenon, and I don't speak of it as a movement, and I'll say why in a bit, the managed care phenomenon is private for the most part, and yet, for the most part, is a reaction to privatization, rather than a manifestation of it.

What I mean by that is that as the managed care phenomenon stems from the cost implications and consequences of an unregulated privatization in 1980. It was a product of the failed experiment that contained cost through unmitigated competition. Arnold Relmer has referred to managed care as the revolt of the payers. Now, I know that the payers are considered to be revolting by many, but Arnold put it in that particular way.

Privatization in the '90s will look very different from privatization in the '80s. We'd actually probably could be more characterized it as privateering. Privatization in the '90s, and I think some of the comments this morning or this afternoon already alluded to this, will be a mix of competition and regulation. It's very clear that this is essential. As articulated by Paul Elwood and Jackson and as now the Clinton administration is developing an evolving concept there will be some mix of the two: market driven competition and public regulation.

One aspect of this that's of particular importance is the establishment and maintenance of floors as well as ceilings of costs. This is a very important concept. We have talked a great deal in the field, certainly as a managed care person, I think a great deal about ceiling costs. Very important that there be some concept of floors as well. This concept will be manifest by emphasis on the need for care and on outcome, and in fact many are now advocating a formalized national approach to measuring, gauging and keeping records of outcomes. We are at a unique point in our history, emphasis is being placed on reconciling social need with cost. Experiments are underway in several states to allocate health care resources systematically. If this is to be done ethically and with proper attention to human need, the interest of payers must be reconciled with those of consumers, patients, clients, and so forth, as well as providers. They're all a customer, and when we think of this in the business sense, this is a relevant term.

At the system level, this calls for accessible, affordable services. At the individual treatment level, which is where I spend most of my time looking and thinking, it requires planning and monitoring episodes of care with an eye toward parsimony as well as effectiveness. Neither will be achieved without planning, coordination, constant assessment and monitoring, in other words, without marshalling and managing resources.

Ideology: managed care is godless. I take a little risk in using that term here, I suppose, but if it's provocative, so be it. By it's nature, it's atheoretical, pragmatic. This is something that disturbs a great many people about it, and I think it accounts for much of the difficulty in introducing within the professional community, to where deification of a methodology is a condition. The concept of pragmatism is uncomfortable because it sounds callous, but expeditious care, with attention to outcome variables, such as patient satisfaction, decrease in the symptoms and level of dysfunction, and the like, is both humane and cost conscious at the same time, and simply sensible. If there is no consistent advantage to one method over another, as I was indicating before, then choice of method should be based on patient need and preference, and on demonstrable effect. The guiding principle might be called the principle of parsimony, and I'll quote, 'The principle of parsimony: the preferred intervention is the least intensive, least extensive, least intrusive, and least expensive one that will accomplish what the patient needs at the

time.' Whoever owns the delivery system, accountability will be an essential feature. The public, whether in the form of consumers or shareholders, or both, will need to remain informed, educated and involved.

Boundaries: finally, the matter of boundaries. The polarization between private and public, for-profit and not-for-profit is largely artificial. Over the almost more than 100 years of its history, the HMO movement, and I do speak intentionally the term 'movement,' altered from one driven by largely social objectives to one dominated by cost and competitive consideration. There is very little practical operating difference between a contemporary for-profit and not-for-profit health maintenance organization. The community mental health center movement, also, in the nature of its social values and aims, is run by pioneers such as Erich Lindemann with its early interest in prevention and health promotion gave way over the years to a multiplicity of special interests and agendas. The fee-for-service world of mental health care, accessible to only a favored few, has likewise failed to meet the needs of the population at large. Each, however, has taught us valuable lessons. The emerging system must grow on both the public and private sector in imaginative ways, and perhaps as we get into the discussion section I can share with you some of the ways in which our system tries to do that.

As an example, however, the concept of affordable contemporary care is that of the network. This has succeeded earlier emphasis on containing costs through controlling access to care. The shift, if you will, is from concern over shaping demands to concern over shaping supply, that the question in trying to contain costs and monitor them in effectiveness and in quality is largely a matter of what you offer when the patient gets there, rather than preventing their access. This is unwisely a closed system. This is accomplished through the use of a continuum of services that may be drawn upon selectively and through an emphasis on educating providers to practice collaboratively and efficiently. Milo Shor has reminded us through an article he wrote a while ago, saying we're reinventing the wheel, that many of the managed care techniques and strategies increasingly in use in the private sector were drawn from the public sector experience. However, network development and management is no more a continuation of the public sector of mental health care than it is a simple continuation of patterns developed in HMOs, or for that matter in military psychiatry and military medicine which are antecedent. It draws on all three, as well as on lessons learned from the fee-for-service practice community. The challenge is to integrate the parts and use them selectively.

In closing, I would like to further confound whatever tendency we have of polarizing by reading to you a quote from a very unlikely source: a psychiatrist whose words are those of egalitarianism and community mental health, and I'll quote you now, and some of the language is a bit stilted, so bear with me.

‘And now, in conclusion,’ the writer says, ‘I will cast a glance at a situation that belongs to the future. One that will seem fantastic to many of you, but which I think, nevertheless, deserves that we should be prepared for it in our minds. You know that our therapeutic activities are not very far-reaching. There are only a handful of us, and even by working very hard, each one devoting himself a year to only a small number of patients, compared to the vast amount that arrive…there is in the world and perhaps need not be, the quantity we can do away with is almost negligible. Besides this, the necessities of our existence limit our work to the well-to-do classes, who are accustomed to choose their own physicians, and whose choice is diverted away from psychoanalysis by all kinds of prejudices. At present we can do nothing for wider social strata who suffer extremely seriously form their neuroses. Now let’s assume that by some kind of organization we succeeded in increasing our numbers to an extent sufficient for treating a considerable mass of the population. On the other hand, it is possible to foresee that at sometime or other the conscience of society will weigh and be reminded that the poor man should have just as much right to assistance for his mind as he now has to the lifesaving help offered by surgery, and that the neuroses threaten public health no less than tuberculosis, and can be left as little as the latter to the care of individual members of the community.

When this happens, institutions or outpatient clinics will be started, to which analytically-trained physicians will be appointed, so that men who would otherwise give way to drink, women who have nearly succumbed under their burden of privations, and children for whom there is no choice but running wild with neurosis may be made capable by analysis of resistance and efficient work. Such assistance will be free. It may be a long time before the state comes to see these duties as urgent. Present conditions may delay its arrival even longer. Probably these institutions will first be started by private charity. Sometime or another, however, it must come to this. We, then, shall be faced by the task of adapting our technique to the new conditions.’

It could have been written by Erich Lindemann, but it was in fact in the year 1918 in a speech delivered at the International Congress of Psychoanalysis in Budapest, Hungary, and the speaker was Sigmund Freud. He went on to talk about modification of technique as deriving and developing what he called ‘psychotherapy for the people.’ Psychotherapy and other forms of mental health care for the people are both feasible and affordable, and well documented and demonstrated. We cannot afford in fact not to have it. What has been lacking until now is the means to see that those who require it, have it. Society has done a poor job of it to date. Old polarizations, like old dreams, will have to be surrendered if we are to do better. Thank you.

David Satin:

An interesting perspective on how to do what you're doing, no matter who is paying you for it, and I guess, somewhat affected by how much is available to be used, how much money there is to be used. I am reminded that the impression that I had of community mental health and of public health in general was always to feel that there was going to be inadequate amount of money and people and that the creativity came in finding how to meet needs with the resources available.

Judi Chamberlin

Board of Directors, National Association of Psychiatric Survivors; Program Director, Ruby Rogers Advocacy and Drop-In Center, Cambridge

Introduction by David G. Satin, MD

Our fourth speaker is Judi Chamberlin, member of the board of directors of the National Association of Psychiatric Survivors, and program director of the Ruby Rogers Advocacy and Drop-In Center, who speaks from the perspective of those experiencing the need for mental health services, and the services that they, in fact, receive in this new world. Miss Chamberlin.

Judi Chamberlin

Thank you. Over the last 20 years or so, people who've been at the receiving end of psychiatric treatment have organized, and the primary motivation behind that organization has been a sense of deprivation: not a deprivation of mental heath services, but a deprivation of liberty and rights. We see our movement as primarily a civil rights movement, which is analogous to the black movement, the women's movement, the gay movement and the movement of physically disabled people to secure full citizenship in society. We find that very often what's been described to us as our mental health needs and our mental health treatments are in fact things that we experience as being punitive and not meeting our needs, and in fact has contributed to additional problems that we have of getting along in society. So that it's been a very difficult struggle to get this point of view to be part of the dialogue over what do we mean by mental health care, what funding should be available, what models should be used, how is it services should be provided, how is it services should be governed. It's been a long, hard road getting to the table, and over the last few years, at least we're beginning to receive that seat at the table.

One of the kinds of things that's happened in Massachusetts in the past few years, was the formation within the department of the Office of Consumer and Ex-Patient Relations, the Consumer Advisory Council, the institutionalizing of methodologies for allowing that voice to be heard. But the history of organizing of patients, clients, recipients, and those who refuse those labels, in this state has been a much longer one and that has gone on largely outside the system. Mental patients were great to try and organize in Massachusetts in 1971, and it is the oldest organization of former patients. In fact our organization is involved with the Community Center, which is a client-run program funded by DMH but operated, controlled by it's membership who are all people who are receiving or have received mental health services, and who operate together a

model of what we think of as an alternative to the traditional services provided seven days a week, drop-in at the services for people.

We've seen many, many changes over the years in the ways that the system is described and the model that is used, and from the perception of the people at the receiving end, very little changes ultimately. The names of things change, where you go changes, but the ultimate power relationships don't change and the relative impotence of the recipient of services really doesn't change. The mental health system is built on a foundation of coercion. It's built on a model that assumes that the diagnosis of mental illness means you don't know what's good for you. If you want, a person's articulate words are probably just maybe delusion speaking, and professionals know best what to do what he or she thinks the client needs, rather than what the client him- or herself says he or she wants. In the language of the contemporary mental health system, we've evolved now into being clients, consumers and customers, that total quality management piece of the customer, and in the TQM approach I've often wondered, who is the customer? Is the customer the patient or client? Is it the family? Is it the state? It's the total. Whose needs are being serviced? Whose needs are being met? Who's being asked? Who has the opportunity to make decisions?

Managed care is being proposed to us. It seems to have a lot of different purposes. One seems to be very simple, of saving money, and let me relate to you a story that I heard recently from someone that I know, about a person who is a client of the public mental health system, and in this case, everyone disagrees/was in agreement: the client herself, the clinician, the hospital where she was going to go to get some inpatient services—all agreed that this was what she needed. She was feeling suicidal, she felt she needed safety, the clinician felt that this was the appropriate place, the hospital agreed to accept her, and the managed care system refused the inpatient hospitalization for this person, as a Medicaid client who is under public managed are, and ended up being admitted to a bed that was supposed to go to people who have no coverage, in other words, the bed that the state owns, because the managed care company said, 'no there was no need', whereas the patient herself and all the people who directly serve the patient had quite other opinions, so sometimes it seems like its just saving money.

It's also projected as a way of getting better services, and improving the quality of life of people who are in the system. The goal of eliminating or minimizing inpatient hospitalization is one that I am in partial agreement with. I think it is possible to upgrade the mental health system in which there is virtually no inpatient hospitalization. I think closing our state hospitals is a wonderful and long-overdue idea. These are places that are not good places to be. Not pleasant places to be, not places where a whole lot of good things go on for people. So I thoroughly support these models that close state hospitals.

But I wonder what it is that we're putting in place, and whether it really will lead to better services and better quality of life for people.

When I went to Italy a couple of years ago, a person who brought me over is a psychiatrist who operates the part of the public mental health system in the area of Florence, Italy, and he operates a system in which there are, I can't remember whether its four or six, inpatient beds that he has available to him for this whole health district. And those were short-term beds. There were no long-term institutional beds. Everyone was living in the community, and everyone was living in integrated settings in the community. I would recommend very highly a book called, 'Community Mental Health: Principle and Practice,' by Loren Mosher and Lorenzo Berti, that supports a model of systems that do not use, or very minimally use any kind of inpatient services. I think that this could be possible, but it's not possible if what we mean that instead people end up homeless, living on the streets, or living in total squalor and desperation. We need good support services in the community, and that means finding out from people what they want, and working to help them get it, and not coming in with a model that says, 'We know what you need.'

We have to look at our values. We have to have values that are humane, that value people's independence, people's choices, and people's rights to make their own decisions, even when those decisions might be other than what somebody else might decide is good for her. We have to find ways of working with people, rather than doing things to people. There are real risks, as I said. A money-driven system can lead, and I see it leading, to people becoming homeless, people being neglected, people becoming extremely desperate. On the other hand, we have a system that's overly-clinical, that evaluates everybody in terms of what are called their clinical needs, and overcontrols people's lives.

Somebody I just talked to had just come back from a trip to Wisconsin, is also being put forth as a model of community mental health, and he said it's just astonishing to what degree people's lives are being managed. These are people supposedly living in the community, yet they are being required to come into the mental health center on a daily basis to take their pills under supervision, for which they were then given a few dollars of their own money. No pill, no money, their own money. What would be a good system? When we talk about a client-centered system, what that means to me is giving people a wide range of real choices, real choices, not just the ones who live in this community residence versus that community residence, but what kind of housing do you want? How can we help you get it? How can we help you pay for it? How can we give you the services so you can keep that housing? What will it take? Will it take someone coming in on a daily or weekly basis? Will it take matching you up with a mentor or a friend? The availability of self-help and mutual support services so the people who are successful in

living in the community can teach these skills to others, can provide buddy systems, can provide a sense of being part of the community. We use this phrase, 'in the community,' and yet the real meaning of community is that kind of interlocking of lives. If we just create segregated settings that are in but not of the community, we really haven't closed the state hospitals, we just chopped them into little pieces and seeded tem all around in the community.

When we ask people what they want in terms of housing, as the Massachusetts Housing Preference survey did, we find out that people want to live in normal, integrated housing. They want to live in their own homes and their own apartments, by themselves or with one or two other people of their choice. They don't want to live, by and large, in community residences, and yet we see more and more money being put into congregate living and not enough money being put into independent supported housing models. When we ask people what they want, we find out that they want real educational and work experience. They don't want busy work. They want education, they want the opportunity to learn new skills or renew old skills to get back into the world of real work at real jobs for real wages at a skill level that's commensurate with their intelligence and their ability, and that means there has to be everything, from entry-level jobs all the way up to professional jobs. There are people who are successful role models working who have histories of long-term mental illness, and these can once again serve as role models for people.

A workshop that I did recently as part of my work for the Center of Psychiatric Rehabilitation, my colleague and I put on a workshop for community clients, called 'How to Get What You Want from the Mental Health System,' and one of the principles of psych rehab is that skills learned in one setting are not necessarily transferable to another settings.

Looking at what has gone on in the prior two years or so in the department as far as closing facilities and movement of patient care and a range of other settings other than institutions for mental diseases, pretty much those efforts have been accomplished already. It's more how to now stabilize the system, how do we ensure that the infrastructure is in place? The infrastructure is not just around standard of care necessity. It's not just ensuring that there's necessary changes for staffing and regulations. It's absolutely necessary. It's also what we said around the importance of the role of the consumer in this whole effort, and it's also changing the headset--a cultural change—of providers.

Out of this whole effort that we've been doing at the OCER, what we've done is educate the consumer to be pivotally involved at the planning table, an equal player. And so the training for the department in this effort has been training the consumer, training over more than 700 consumers across the state, and training on anything from what is

the legislative process to assertiveness, to how to stand up to someone who happens to be a provider, or the Commissioner. I cannot tell you how many times I have been taken on appropriately, and it needs to occur from my level, and I see myself as a model all the way down, to the mental health worker, and being able to be questioned, and being able to have that questioning seen as equal to equal. And that is the hardest change of anything in this system that needs to occur, because it's a totally different piece to have a consumer say, 'I disagree,' and say, 'Well, you're in an inpatient unit now, and you shouldn't be disagreeing with me,'. But rather how do you see that as in fact a sign of health or accepting the fact that it might be an issue, but it's a whole process of how do you accept, and that's a major training piece, and we could move forward on it, but I am not going to sit here and say that's an easy process. So that simplistically, when I'm talking about the infrastructure, the consumer role are the changes most pivotal in ensuring any administration as it continues to evolve.

Discussion

Michael Bennett:

I'd like to take a shot, since I'm one of the business persons on the panel it's just ridiculous for people who know me. I've been arguing with my colleagues for 25 years and 25 years ago they called me a lousy socialist, now they call me a lousy capitalist, having exactly the same arguments about health care.

Nevertheless, I believe that there are, that the resources do exist. There's a great deal of money going into mental health care in this country. If you simply look at the margin that exists, and think about how you shift the dollars so they're now being spent, there's a great deal of money available.

Characteristically when a population, an insured population, moves from an indemnity-type program to even the first level of managed care, which is utilization of the new system, is the most primitive kind, the most basic kind of managed care. Now if you will get dropped in inpatient utilization that may be any place from and here is the conventional measure, days per thousand members per year, it's the conventional way of measuring this, but should, in order of magnitude, it's not uncommon for one to two hundred days per thousand members per year to be a hospital inpatient experience prior to initiating utilization of review of management, and for those figures to drop to something in the range of 50-75 days per thousand members per year in even the first step, I think what is particularly problematic is that it can become a trap, because the expectation is that you continue to do that. If you want to continue to do that, and in fact if you want to make it work, the key is not on the inpatient side, it's on the outpatient side, especially what resources do you put in place with other alternatives.

Years ago there was a study which took place in Colorado in which they experimented with a population and hospitalization. Under no circumstances was anybody hospitalized. This went on for some period of time, and they followed these people for years. Afterward, they found there was absolutely no difference down the line. However, the gauge that I use to determine whether a program is feasible to be sustained is, are the people who wrote the article still working in the same place, because if it costs you such an enormous amount personally to accomplish it, it's not sustainable, and in fact that's frequently the case, that if you look at where you can go with that initial statement in order to make it more lasting and more substantial, it has to go through health and network development, you have to know the direction, and educate providers. It's not the patient behavior that's the key variable, it is provider behavior, and what managed care providers increasingly are doing now is looking at provider behavior from the ground up.

We're beginning to talk about medical education, social work education, psychological education, and so forth, we're talking about a need to change the nature of the way we think about the work that we do, what are our aims, what are our goals, what are we trying to do, actually? I resonate with what Judi has said, because I think that certainly I, in my training, was taught a very straight medical model. I was taught about illness, I was never taught about health, and I think the concept is one that evolved practice, but to think about the next generation of providers and what we're doing there is really the key issue, so that we get into network development, we get into transforming professional behavior, and ultimately what we get into is not only consumer education, patient education, but provider education as well.

Deborah Weinstein:

I guess I could throw something in on the initial question on resources. You know, we spend a lot of money through the national level or the state level on certain areas of things, and people either buy into it or they don't. It happens anyway, whether it's at the national level of the military or whether it's the local level, considerable additional expenditures being pumped into the system. It's not as though there is a definite path, and there is a number beyond which the public will not go. A lot of money is being spent all the time, and so the question is, what needs to be put in place so that some of that money is spent on mental health needs and the other human service needs?

My organization is one that brings together a coalition of all different kinds of organizations, so we struggle with what are those cross-cutting issues a lot, and certainly I agree fully with what Judi said in terms of the kind of coalition-building that understands that there are a lot of vulnerable people who are across categories, whether they are single mothers trying to raise children, or mentally ill people, or people with physical disabilities, or any number of other categories, or people generally. There needs to be some understanding about how they have common problems, but as a coalition that is not only of low-income people, I would say that they need help, that they should not be asked to do that alone because it is not only their problem. It is everybody's problem, and so when I try to point out in the usual stuff that I do that almost a quarter of the kids in Massachusetts today under the age of five are on AFDC, then the point is, that's a lot, that's not a small matter. A marginal issue that only affects a few, and similarly, people who have substance abuse problems, people who have mental illness problems, those are substantial numbers, or who have at some point in their lives, those are substantial numbers of people who, if that commonality could be understood, we might feel that it was more worthwhile making some investments in those areas.

But the other thing I guess we have to recognize is that people are going to need to feel that the investment they make will have a payoff, and that is the difficulty. So it's one

of my problems that I don't think there's enough monitoring going on and we're not exactly sure what works, I think that has to be a part of it, because I don't think we can necessarily demonstrate the payoff that builds the case that says, commit those additional dollars, unless we can say something about that.

Judi Chamberlain:

I don't think that the problem is simply a lack of resources. I think it's a problem of how those resources are allocated. If we could get people in accounting we would eliminate a lot of very, very expensive services that are not what people want and are not meeting their long-term needs. If we could figure out ways, and there are models out there, it's not as if we have to start from scratch, there are models out there of supporting people living in their own homes through difficult times and through good times that are no more expensive than where our money is going now. The problem is allocation, and the problem that there are very entrenched interests that are taking in a lot of the money and the people for whom the services are designed are not getting the benefit of a lot of that. We have those people who are making very good salaries, and we have a lot of very poor people who are then seen as the problem. We should reconceptualize how we look at things. People who have disabilities, psychiatric disabilities, as one model, should be seen as not just the problem, but as part of the solution, and the solution is to help people become full participating citizens in their communities.

David Satin:

Are there some thoughts from the listeners? Somebody want to join the debate?

Participant:

I want to ask the commissioner a question. Is there in use at present a creation of a management information system to standardize the measure of client satisfaction. And if there is not, how can you restructure the department so that there is a cost-benefit ratio of these records? And how do you actually manage from area to area of each region?

Eileen Elias:

The question has a number of varied answers, so it's not an easy question. In your question I hear: one, how are we ensuring a measure of consumer satisfaction? Two, I'm hearing, what are we to do with any type of cost model to actually standardize costing out? And I'm also hearing, what's in this MIS business? I mean, I don't have to tell you this department does not have a centralized MIS system. What I said in my remarks is that we'd move forward, and we are maintaining the objectives so we have every expectation by May of '94 we'll have online consumer registration systems. It's not district management, it's for all consumers we serve, and without that we would have no

way to really have an objective measure of utilization. In our process we are just about to complete a major needs assessment. How do we know what services you need, etcetera. There's been a whole objective survey process done with consumer input across the state. In it an objective needs assessment that will further tell what is it the consumer needs. Beyond the type of information processing we talked about. When I came in as commissioner, I didn't want any notion of anything that had fiscal attached to it. I didn't want to talk about cost, wouldn't talk about capitation, wouldn't talk about any kind of standardized, fiscal processing because the department had historically been fiscally driven. It's not been a process of it being system driven, service driven. So our major effort was to use the process. As that gets into play, we are now driven back into, moving into looking at the costs, and looking at standardized costs for all of our various program elements, but that's got to be integrated back into the needs assessment and what in fact is being said is necessarily, so that we don't develop a cost model for the program types that are currently in place may well change, getting that point of view being made in light of what we've been doing up until now may need to change to meet the needs of the consumer. So yes, that's the direction we're heading to, and yes, we need to standardized that, and that's my best answer.

Participant:

The thing that's interesting to me, obviously the speakers come here to represent certain perspectives on this issue, and I actually was much more struck today with the common ground than I was with differences, and I guess my question has to do with that common ground. The commissioner was talking at one point during her comments about trying to find a win-win situation, and in some ways, rather than focusing on differences, I would be intrigued at where each of you thinks the common ground is, what is it? There obviously are some differences here, but, for example, since we're here in part to remember Erich Lindemann, talking about and that we could see with managed care comes straight out of writings, we could find quotes from 1959-1960, an era that talked about least intensive intervention, about getting people out of hospitals. The mental health systems in general are very strong advocates, Erich Lindemann talked about getting people out of mental health systems, back to their homes, into their jobs, real reasons having everything community-based, which is very much what we're hearing as well. We think about total quality management—what's at the center of that is listening to the customers, so I think Erich Lindemann would agree with that. Each new perspective that we're talking about in fact we can find the principles on which to build a system, a set of standards against which to evaluate what we're doing. What do you think are those principles that you have common ground in each of your perspectives that you can build upon?

Deborah Weinstein:

Well, I think certainly the person-centered, client/customer/recipient aspect, that in a way is almost too easy. It's really easy for us to sit up here and talk about those things. But some of the conflicts that are not so easily worked out. Even having said that, if we moved everything we do based on what is in the best interest of the clients, then I think we're going to be on much stronger ground, and that does involve, therefore, a monitoring evaluation process that allows those folks to speak for themselves as well as bringing mental health systems in to be heard as well, but, to keep that really central, I think at least you'd be fighting on the right battleground.

I guess the one or two things that I would add that we really haven't talked about at all is still keeping, obviously, the needs of the individuals requiring the services central, that there ought to be something said about the person who works in the system, and for one thing, people who are perhaps underpaid, low benefits, etcetera, etcetera, tend to turn over rapidly, and I think that you can find a very direct and immediate consequence to the experience of the person in his care. One of the things that is very unfortunate in this debate is where it appears that on one side, there are workers who are perhaps somewhat better paid and somewhat better benefited, and on the other side there are workers who are not. What I would like to see is the state should see itself as a kind of model employer, and recognize that it is really just as much an employer contracting with an agency and pay the more than three-quarters of that agency's budget, that it would equalize out the situation for workers in all settings that the state chooses to fund, so that there are no dramatic differences in the benefits and salaries, and that I think that would have important implications for care. I'd like to see, maybe that's exactly not the area you're talking about before, but the area of potential. I think there could be common ground if we understood the cost of containment cost control, that it isn't acceptable to say that the way we do this, this is trying stabilize, because now workers don't have any more retirement benefits, or something like that, and that that would be acceptable, I don't think so. I don't think that that's a recipe for a healthy system in the long run, and that one way, if we're avoiding getting to commonalities, is that there shouldn't be such strange divisions in what's available.

Michael Bennett:

I think if you consider what we're talking about a circle, and various points on the circle, maybe cost, the quality and nature or outcome of services, patient, the consumer satisfaction, days per thousand, there are many different points on that circle. It's possible to start the discussion at any point, and you ultimately come before the others. Any point can be a point of departure, however. What we're really talking about is the fundamental transformation in the way we conceive of health care, in particular the

relationship between the payer and the provider of care, consumer or patient who receives health care, that we're talking about movement from a strict definition of illness and cure to what is rehabilitation, recovery, self-help and so forth. And I think we have some common values among those of us who've spoken here today. The fact is it's very compatible with making a lot of money. That shouldn't be a reason to throw it out, and I think that there can be some cynicism about that, but that's kind of missing the point. That we're talking about fundamental revision in the way that we conceive of health care and people's right to and need for it. This is a very major overhaul to talk about it. Years ago, one of my heroes, an analyst who practices and who taught general practitioners how to do psychotherapy, was asked, what does it take to teach someone to be a psychotherapist? And his response was, it takes a small but significant change of personality. We're talking here about urging people to make a small but significant change in the way they operate and think about themselves. In fact, in economic terms, this tended to reinforce greatly the notion of illness and cure and of an absolute counter between the helping system and the patient. We have to do away with that. We don't treat illnesses—we treat people who may have an illness, and I think it's very difficult working with clinicians who are trained in effectively a pathological model, and who consider themselves often detectives who ferret out and stamp out pathology. To help, it would help to begin to think about, what are the resources we're trying to accentuate here? What's the patient's motive for being here? What is it that the patient brings as their agenda? And not move so quickly to the Multiaxial DSM-III Diagnostic system, and look at diagnosis as a human enterprise in which such notions have relevance because it's a language in which we can speak with each other, but not sufficient, and it certainly doesn't address in most instances patient care, so we're talking about a major overhaul, something more than the structure and cost service.

Judi Chamberlin:

But certainly using words like rehabilitation and recovery are words that are pretty new to the mental health arena, where people with serious mental illnesses were and still are people. The whole thrust of the psychiatric movement has been to show that people can and do recover, and rehabilitation is really possible, and that full personhood and equal citizenship are the rights of everyone, so illness and diagnostic disability and bringing back the whole civil rights orientation, I mean, to discuss this is what is very important.

Participant:

I appreciate your comments, especially those of Miss Chamberlin and Miss Weinstein. I have a comment about what you were just talking about. I'm a mental

health consumer, and I have a master's degree, and I've had some very good work experience, and when I was ready to go back to work, and I wasn't in Massachusetts, but the mental health center I've spoken to sent me to a jobs program, and they were offering me washing dishes, you know, at something like $1.25 an hour, and, I mean, I worked for 23 years, and you know, it's like I'm not a person when I'm confronted with that type of thing. The other thing I wanted to ask you is, I have Medicare, and not Medicaid, and Medicare, as you may not know, doesn't cover any medications, and perhaps I should have come to one of you, but I've had a lot of trouble when I first moved back up to Massachusetts and I was living in Cambridge. I really had a lot of trouble getting medication because the medication I take costs $88 a month, and I live on a small disability check, so for the moment, the matter has been handled, but I wonder, there's a possibility that I'm going to be moving again, and there are some localities where there's a mental health clinic with a pharmacy, and there are other sections, like Cambridge, which is where I was living when the problem arose, that have no clinics, there's no way to get medication. And I found out there are other sections too, that don't have a pharmacy, so I wonder, do I have to live…for the rest of my life, whatever you might have to say about that, I'd appreciate it.

Eileen Elias:

You've raised two issues, one issue is the whole issue of Medicare, and also the issue of employment, and the stigma that's attached once one is identified as having a mental illness. In regards to the Medicare issue, I will be very frank with you. With regards to Medicare and your specific issue, my recommendation is that when you know where you're moving to, that you should get in touch with one of two possible areas: either the area director of the area you'll be living in, in the Office of Consumer and Ex-Patient Relations. We have a 1-800 number to provide to you, and through that process make sure that you are appropriately linked with the support so that you are able to maintain the medication and you have the cost issue addressed. The whole issue of Medicare, though, is really a dilemma, because even under health care reform medical care, you can have medical care set out over here, not be part of the reform process. And however we move to ensure that it's a part of the whole issue, at least for mental health in light of what that entitlement does and doesn't pay for in initiatives much broader than just the state of Massachusetts, but I'll say to you that we've realized this problem and we are going to be addressing it, but there's not an easy solution. Employers mediate discrimination, …mental illness…have to lower your expectations as to what you can and can't handle. It's that part of that whole education process. It gets at the fact that when we talk about rehabilitation, rehabilitation is a process, it's a whole process of helping a person to reach the maximum level of functioning, and what we have been doing with

the OCER funding a myriad of different opportunities for consumer-run programs, consumer-run businesses, one. Two, regarding transitional employment as part of a clubhouse, and sometimes there, and it's a good opportunity as a way of helping the person get back to work. If it does not lead to competitive employment, it continues, and yet it can be if it's worked correctly. When I mentioned the OCER piece, it's not just that aspect in the department. We ourselves have been hiring consumers as employees, and in other positions, high-level positions, not just support, entry-level, so that we, the department, serve as a model for the competitive world. They learn from us, if we can do it, so can they. Channel Five did a whole wonderful piece on the clubhouse in Worcester, talking about employment opportunities, and where consumers have in fact obtained higher level positions that never before would ever been thought to be possible.

Judi Chamberlin:

I want to comment, I think you make a very important point, and that the demeaning nature of taking someone who has work experience and higher expectation and slotting them into these awful jobs. This has a crushing effect on the self-esteem, and those are the jobs that people tend to get offered. One tool that has become available to people who are seeking employment is the Disabilities Act, a federal law that protects people with all disabilities, including psychiatric disabilities, from discrimination, in housing, in need of public accommodations, transportation, and so forth, so that people who feel that they have been discriminated against and can perform essential function of the job with or without reasonable accommodation are now in the position to take legal action, because that's discrimination.

Deborah Weinstein:

On the medication specifically, you might want to be in touch with the organization, Health Care For All, which does a lot of work in general on getting access to health care. I have the feeling that this only applies to the elderly, but there's a recent program where there are arrangements with drug companies to provide certain drugs at no cost, and I just read about that, and I really can't give you the details, and, so don't get your hopes up.

Participant:

I read about that. You say that's called Health Care For All?

Deborah Weinstein:

Yeah, Health Care For All is an organization that's a private organization that does a lot of work in terms of increasing the access to health care for folks, and it's conceivable that there's some way having to do with your eligibility for some program or other that

they may know about it. Basically, of course, what you're describing is the idea that we have a system that's set up that doesn't allow you your vital medication but allows you to continue and be in the community et cetera, et cetera, it's dumb, but I think everybody here knows that.

David Satin:

Any other thoughts? Reactions?

Participant:

You can hear me if I talk from here without coming down there. I have some concerns. We talked about people who actually are getting services. What are you going to do about tracking all those people who show up at the service and they're refused, they're either refused in the private sector because they don't meet some qualification, or they're refused by DMH because they don't meet some criteria. I've watched this happen in the last three years. Now you can set up tracking systems either way. What are you going to do to address those people who aren't getting services because you refuse them? Which goes back to talking about philosophy of the community mental health movement, and what Lindemann was interested in was sort of shoring up people, and if we are not dealing with primary prevention anymore because none of those systems are going to pay for it, and we are not dealing with secondary prevention, we're not getting into early diagnosis and helping those people before they have major problems, we're denying them right and left in the commonwealt. How is that going to be addressed?

Michael Bennett:

I can speak about the public sector in New York, about the managed care system in which that works. People self-refer, they have access to seeing health care professionals based on their wish to do so, and at least a brief number of meetings, whether they continue in some form of treatment depends on the assessment and planning, if there in fact is a demonstrated need for continuing treatment, but within a short-term time frame, which is what most people require to get help for the problems that bring them in, there's very little access barrier in place at all, in fact a strict self-referral system, and people do have that available to them. They may be referred or they may refer themselves, either way. I think that you begin to develop systems which place an emphasis on providing outpatient care and service and place an emphasis on access, that this would be more the case. We were able to do this because we have a system in which there is a clinical person who does review the authorization. Essentially we try to manage the process of care somewhat indirectly through the relationship with the clinician, the network provider, rather than managing the benefit. In the past, what's been done I think in the more, in the simpler, initial models of managed care, which were essentially

retrospective review of utilization, and looking for excess visit misbehavior, rotten apple theory, having to deal the containing cost. These sorts of things don't go on, because they're protocol-driven, and often times the review process is retrospective. What we emphasize in our own system, and I know other managed care companies are increasingly doing this now, is having clinical determination made at the point of service, and having people have relatively easy access to at least some initial care.

Eilieen Elias:

In the public sector, let's talk about that openly. Let me start from the easier and then build up. Let me pick up first of all on the issue of just where we are, the gatekeeper notion, and the designated emergency screening past. Historically, a decision if someone needed care, didn't need care, assessment if they were a priority population or not…a person doesn't get [services] until they're in a high level of crisis. If they're not a danger to themselves or others, if they're not requiring hospitalization, go back to where you are and you shouldn't come. That has been history for however many, many years. We confronted that directly. In fact many of my points that I made earlier, the development of standards, a set of utilization management standards that are clinically-driven, that are developed with private payer as well as public payer, such as mental health management. The importance of that is that they are clinically-driven. They are not based on risk as far as what the assumed length of stay, it's not based on rates. The decision someone doesn't require hospitalization means then what clinical standards to assess? Do they then require a crisis stabilization program needed to help them remain in the community, and not just send them away with nothing.

In fact, if they're using our designated emergency services system to help get into the system, then that is also appropriate linkage if the person is in fact hospitalized and assessment the person is still acute but requiring more hospitalization, then the clinical criteria help to decide, do they remain there, and just have a longer length of stay? Are they being transferred to a continuing care facility? Or in fact clinically discharge. We have developed these standards just recently. We're in the process now of doing training on talking about the whole process of development implications. It's a major change. And not just individuals who are on Medicaid or Medicare, without any payer, but also applies to any other payer who will be using private payer That's one.

Two, I talked about plans, and the necessity of how the system works with each other. I will just account that right now all this change that we're part of that in fact there is the dollar factor in there. I've seen the dollar factor make the system work right, and to use the dollar in the best, efficient manner possible, and the fact that in that our effort is much more on expanding support services as part, that's the residential, the outpatient, the day program, the clubhouses, and etcetera. And that's the fact that $64 million went

to develop the support system that works and talks with each other, not to just to have the programs there, but the residential talks to the outpatient service provider, and the case manager and the emergency services, and we're working around the person at early crisis to more effectively prevent unnecessary hospitalization, kids and adults, number two.

Number three is what we're doing for kids and adolescents, and we are putting much more emphasis on intervention and prevention. We're doing this in two different ways: one is in the department, in fact it's really one, it's not the Department of Mental Health especially for kids, in that we've got to be able to work with all the other systems that have an impact on our kids: education, the juvenile justice system, the Department of Social Services, etcetera. To do that, we have obtained money through the Patient Foundation. We're just finishing up our first-year plan, we're submitting our proposal, we expect that the proposal will be accepted for a neighborhood in metro Boston that covers primarily Mission Hill and other nearby areas. A major project of intervention and prevention. It necessitates the city and the state together work, pooling their dollars to an entity at the neighborhood level.

Under health and human services, there is also a whole emphasis now on looking at the western area, around the same aspects of how can we view the western area as another example, a pilot to look at DSS, DMH, DYS, at least, and DMR, and how do we all pool our dollars together with Medicaid and welfare dollars, so that we look at where we're fat duplicate money, where we're inefficient with money, and we're each duplicating each other, and with that, better use our dollars toward prevention and intervention. Within the Department of Mental Health and I know the issue, is that we have kids in our system who diagnosing are not just the classical mental illness. It also includes severely emotional disturbance. When they age out, that means when they either are 18 or turning 21, all of a sudden they don't fit into our adult system, because we don't have a classic mental illness priority population. I said from the very beginning I knew that was an issue, that there's just so much that we can take on and direct and redirect at any one time. We know that we've got to look at our priority population, and we know that we have to do that with a combination of child and adolescent. The wider priority population we define to begin with, and that was to be able to be clear on who the resources needed to be for and prior to, the seriously mentally ill, under the…Female Health Center Act… much history can't be ignored …more dollars that mental health systems were not going towards the necessary services for that group. The priority population changed, the shift did occur, and direction and prioritization of dollars has gone. But in so doing, when the issue of individuals who may not have a serious mental illness, but if there is not the necessary support provided etcetera may in fact become, could become, clinically depressed. And what is there for prevention, intervention factor

in here, as well as just the cost that it has overall to the economy etcetera if we don't do that. This is more than a mental health issue, and it is an area that gets back to what Gene asked about where are there some commonalities around consensus-building. I talk about how we're beginning to address it for children and adolescents, but for adults who we all need to look at. We have stretched, as we well know, our outpatient programs. Medicaid is continuing to support, even though it's managed care in the past to some degree.

I think there still is, and this is the when we talk about that segment of the private sector that's still around that I think is a very positive part of privatization, and that's the many community-based agencie. Our commitment has always been to the children and the adults in our communities, in our primary communities, and it comprehends all their needs. What we're able to do now by focusing on that population and this specific community by working with police and health centers and schools, as well as the Department of Mental Health, which is focusing on the seriously ill, and getting contracts with the Biodynes, the mental health maintenance of the world, and doing fundraising and in public school contracts and working with the Department of Public Health. Over…and Medicaid and Blue Cross, we could really hustle, we could really create… In fact we can fit the department over the commonwealth, and we can contract with an agency like Howards, and we can expand those resources by 20-30-40%, while quoting the most recent yearly DHS document that came out last week. So I think the artificial separation between privatization and the public sector, between managed care, profit and for-profit, I think, in many ways we can bridge those gaps if we're real clear what it is we're about, what is our mission, what we're really setting out to do, and how do we define good care? So I'm very hopeful. Frankly, I was in despair when we were in the fee-for-service era. Remember when all of the federal money ended, and what we were told is, now there's not going to be any more federal money, so you go out and you charge fees, $50 an hour for care, $29 for a day, and then that's how you can support things. We had a hard time meeting our principles, the Erich Lindemann principle. Frankly, I don't find any trouble meeting those now with the kind of thinking that the Department of Mental Health is doing, the kind of thinking that the commonwealth is doing about managed care. I think we're coming back around to where we were in the first place. This is a very appropriate place, I think, to celebrate.

Michael Bennett:

I think it's kind of hopeful to realize how much our brilliant innovations are rediscoveries of the past. I think it's only that if you're around for a while and you accept that as the way it is, and feel good about that. At least you're smart enough to recognize the past has some value. I think with ethicists now becoming consultants regularly that

what we need with these shotgun marriages among the various systems and cultures is the cultural and logical consultant as well, because what oftentimes is involved in creating these bridges and making them work properly is bridging cultures. We talk about the cultures, and we talk about the milieus in therapeutic centers. There are milieus made up in treaters and they have very strong cultural values, and it's very difficult sometimes to get people to accept, acknowledge, that there's a need to soften one, someone to reconcile them with the competing cultural set of values, so much of what our case managers do is essentially anthropological in nature. But that's part of the problem, because we use a number of public facilities who are public, now privatized, or en route to privatization, and sometimes we don't even know for sure where they're going to be in a couple of months, but it works together well if there's some way to link it, and to make the oftentimes language translation that's required.

David Satin:

Traditionally the role, the lot of the prophet is not a happy one. People who remind people about the past or predict what's going to happen in the future are not often gladly accepted, but you remind me that even the idea of an anthropologist as a guide in mental health services is not a new one. I remember being back in the 1960s visiting the Mental Health Study Center in Prince George's County run by the National Institute of Mental Heath, and an anthropologist was one of the senior administrators of that center, feeling that one needed to know the life of the community and people's function in it in order to tailor supportive services.

But I'm very pleased to see that the discussion has flowed into the channel of how to do best, how to give services best, and we have sort of avoided the pitfalls and conflicts of funding and of control, and everybody seems to be talking about the same kind of thing. I think the issue of funding is important, because it allows you or it doesn't allow you to do things. We haven't talked about long-term services: either long-term preventive services or long-term maintenance services, which don't get you in and out quickly, no matter efficient you are, how do you maintain people, how do you make real change in people that takes a long time, or how do you prevent things by giving long-term services to the community in preventing things that cause casualty. That's one of the things that Dr. Lindemann was interested in, and in terms of public health, he was looking at what causes, what are the environmental circumstances that cause illnesses to pop up more and more often. One of the things I remember him saying was, that if you have a little war, that really makes a lot of mental ill health, and people don't usually look at war or at environmental circumstances as a mental heath issue. But I'm very pleased that people are talking about doing good, doing good care and trying to bring all resources to bear on it. I want to thank all of you for coming and sharing your perspectives and your agonies

with this: Commissioner Elias, Miss Chamberlin, Dr. Bennett and Miss Weinstein. Thank you.