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

Table of Contents

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 EIGHTEENTH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Carving Mental Health Out of Health Care: What Becomes of Community Mental Health?

"Carving out" (segregating) support and control of mental health services, and managed care affects community mental health and comprehsneive health by stigmatizing mental health problems, care, and caregivers. It also undermines the comprehensive, integrated approach to health promotion and illness treatment. How can different authorities and rules address community mental and physical health, and what support will mental health receive under these conditions?

Lecturer

William Dalton: Commissioner of Mental Health and Mental Retardation, State of Vermont

Discussants

Nancy Langman-Dorwart, RN, MS, MPH: Director of Mental Health, Blue Cross and Blue Shield of Massachusetts

Nasir A. Khan, MD: Director, Bournewood Hospital; Clinical Psychiatrist

Joyce Burland, PhD: Alliance for the Mentally Ill of Vermont

Moderator

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

Friday, May 5, 1995, 2:30 – 5:30 pm

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

Introduction by David G. Satin, MD

Let me welcome everybody to the 18th Annual Lindemann Memorial Lecture, this year titled Carving Mental Health out of Health Care: What Becomes of Community Mental Health? A brief introduction to the topic. What does it mean when a group of people or a human activity is segregated from the rest of the community? The metaphor that we have here common today of carving out things to me has a particularly brutal and bloody connotation. Exclusion often means isolation from the fabric of society, and sometimes subjection to separate standards and treatment. The intention may be to give special care and added resources, but historically it is often been associated with devaluation, limited opportunities and ultimate rejection from society. This is why democratic societies resist segregation of population groups in favor of equal opportunity and equal treatment. Of course exceptions are made, even in democratic societies and for people in special need, such as the young and the infirm, or those who present a special danger, such as those with infectious diseases or dangerous criminals. These are segregated out of society.

The mentally ill and mental illness have often been targeted for bad repute and bad treatment. They more often have been seen as witches, maniacs or disturbers of the public tranquility than those who have been specially favored by the gods. Thus reform movements have most often sought to have lunatics or the insane treated like others of God's creatures, or like other sick people. For these reasons carving out mental health and the mentally ill might well raise apprehension.

Why is mental health being carved out of health care now? This is an era of economizing of expense, and, as a consequence, reducing societal caregiving. Surely much effort is going into reducing public expenditures and tax contributions to government programs. Health care, welfare, veterans administration medical services, Medicare, nutritional programs all have been reduced or future reductions are taken for granted. State mental hospitals have been emptied and closed. Deinstitutionalization means reduction of state mental health budgets under the guise of community care. Both the number and level of expertise of mental health clinicians is being reduced to the minimum. Funding for psychiatric treatment has always been below that for physical treatment, whether it's state budget or insurance benefit. Newer forms of health care--health maintenance organizations, preferred provider organizations, captitated health care benefits--minimize mental health care by means of limited numbers of treatments, group instead of individual care, ideology-favored short-term treatment and resistance to hospital services. Is mental health being carved out of health care because economies can be achieved in ways they cannot in physical health care? Does this mean again that mental health care and the mentally ill than other groups in the society, or is mental

health care to receive special attention in order to enhance it's effectiveness or increase it's availability, as was the goal in the era of community mental health?

Both state governments and private HMOs look to manage care and capitation to establish priorities in mental health services and save money. This often means reducing services and excluding the severely and chronically mentally ill. In response, consumers form collaboratives, collecting evidence of problems in obtaining mental health care and lobbying for improved care. What becomes of community mental health when mental health is carved out of health care as a whole? Community mental health used to mean the comprehensive health, not only of individuals but of communities, as in James Kelly's Lindemann Memorial Lecture, cities, as in Leonard Duhl's, and society's, as in William Ryan's. Erich Lindemann saw physical, mental, social and environmental health as an indivisible network of relationships, supports and vulnerabilities. Can people be mentally healthy, or their mental illnesses remedied, without dealing with the totality of their health and lives? Conversely can people be physically healthy or their physical illnesses redressed without dealing with their mental health, their lives and their communities as a whole? What are people and communities, and how are they bettered when their mental health and mental health services are carved out? Our speakers could not be better chosen to address these issues, for each represents one of the social entities dealing with mental health and mental health care, including governmental, health insurance and mental health clinicians as well as mental health patients.

William Dalton

Commissioner of Mental Health and Mental Retardation, State of Vermont

Introduction by David G. Satin, MD

Let me start with our lecturer, William Dalton. He is the outgoing Comissioner of Mental Health and Mental Retardation for the State of Vermont and has long experience in administering many forms of human services under state auspices. He not only supervises the state apparatus but is an advocate, and developer of systems that deliver the care that he believes in. He is a member of the National Association of State Mental Health Program Directors and the New England Mental Health Commissioner's Organization. He has been charged with developing a unified community based service system, and downsizing and closing of the state's only institution for persons with mental retardation and developmental disabilities. He was reappointed by the current governor, Howard Dean, during whose tenure he closed the Brandon Training School, reduced utilization of Vermont State Hospital to 65 beds, and pushed for coordinated and integrated thinking on acute care and long term care behavioral health issues. He is co-chair of Vermont's Behavioral Health Care Data Advisory Group, that brings together public and private sector mental health and substance abuse service providers. As a member of the National Association of State Mental Health Program Directors, he presented testimony on health care reform before the U.S. House of Representatives. Other duties over the past fifteen years include serving as Comissioner of the Vermont Department of Mental Health, and the Vermont State Hospital and the Brandon Training School.

Interestingly, he is the only one of our speakers who is not trained as a mental health clinician, but is an attorney by trade. His education was gained at the Boston University School of Law and the school of hard knocks. It is reported that Commissioner Dalton's championship of caring and his concern for the level of funding for mental health care became unacceptable in this era of reduction services; which is why I introduced him as the out-going Comissioner of Mental Health. I was given some information about his tenure and also the advertisement for his replacement, which includes qualifications. Qualifications include the ability to integrate public sector programs with managed care systems. I would venture to say that Commissioner Dalton continues to learn and has even more to teach about the provision of mental health services in the current era.

William Dalton

Thank you, Dr. Satin. I am pleased to have the opportunity to talk with you, but more importantly to participate in a discussion with you about the subject of mental health care and what might happen to community mental health in this era of reform. The subejct is obviously extremely topical. It has been forced upon us. Some of us have participated in the evolution of health care reform and it is one of the few topics I think that has the interest of almost everyone... whether it is politicians, whether it is the general public, whether it is employer payers or insurance payers, whether it is providers, consumers, family members, or academia. It continues to be quite surprising to me to experience, coming across my desk, literally hundereds of invitations to conferences, invitations to submit articles to periodicals such as, Hospital and Community Psychiatry, or in whatever other ways one involves oneself in the nation's mental health agenda. In short, the subject has consumed a great many of us for a number of reasons.

The specific focus of this discussion is whether or not to carve out mental health services from health care services and what may become of the traditional community mental health service system. I think these subjects would be of great interest, and probably of great concern to the founder of this lecture series, Dr. Lindemann. I think this is true first because he was very concerned about systems of care and what may be necessary to provide for the most normal support for people with serious mental illnesses. And secondly, and probably most importantly, I think because of his personal concern for individuals that these systams have traditionally attempted to care for in the past, and probably will need to care for in the future. How community mental health will respond is the subject for today's discussion.

A lot of what Dr. Satin said I am going to repeat, from the lay person's point of view, because I think we can't go forward in this are without some sense of history, where we came from, who it is we are paying attention to and how it is that we have chosen to attend to mental health consumers. Why look back? Because clearly it looks as though things will change in the future. I hope I will be able to give you a bit of a less clinicial and a more political or policy kind of an overview of these issues.

I believe it has been my job over the past eight years to permit delivery systems the opportunity to work, to change and to evolve. That means that I am not doing the service delivery and I am looking for other people to tell me exactly what it is we should be doing, and to actually implement these ideas.

One of the first things, and it has been a struggle for me through the years, is to try to define what a consumer is. For purposes of this discussion I wanted to try to briefly lay out what I saw as five or six kinds of consumers. And although it labels individuals, it also gives us the ability to focus on what the needs of those individuals might be.

The most traditional in the kind of client or consumer that community mental health has dealt with over the course of time is a person with a severe and persistent mental illness. For lack of a better term, someone primarily with an Axis I diagnosis, and someone who used to depend heavily on state public institutions for his or her support.

Secondly I think there is a cutting edge consumer population that we will need to deal with in health care reform... children and adolescents with a severe emotional disturbance and their families. These are kids who experience behavioral, emotional and/or social impairments severe enough to disrupt academic and developmental processes, and to disturb families or other interpersonal relationships, and such conditions are generally antricipated to be more than a year in duration.

A third category is persons suffering from the abuse of substances for an extended period of time. Fourth, persons with a diagnosis of a developmental disability. And fifth, persons who are in need of short or long term therapy or counseling on an outpatient basis.

Category six, and a very important caregory, is any combination of one through five, because many consumers that you come in contact with in the public sector carry a primary diagnosis such as the ones I have described, and also has B, C, and D working for or against them as they try to deal with their lives.

Besides this superficial effort at categorizing people, I want to highlight several changes that have influenced service systems over the past twenty years. One Dr. Satin mentioned, “deinstitutionalization”. We can discuss it at some length, both the legal and clinical aspects of what deinstitutionalization is all about and how in Vermont we have tried to shift the focus away from “deinstitutionalization” and towards enhancement of community based services.

One of the forces influencing deinstitutionalization is the cost of institutionalization. David mentioned this point. Is that good or is that bad? How have various states dealt with the problem of institutional cost? Did it take them in directions that enhanced the quality of care for people, or did it put people on the streets without support?

Two, service financing. The dollars do count. Or the limitations on the dollars count. And clearly beginning in the early 80’s, we need to remember the shift in the relaitonship between state financing and federal financing of services. We need to understand the impact the original block granting process had. Will a new round of block grants have perhaps an even more profound impact in the future as we deal with the new Congress?

The third change is one that is near and dear to me personally; the role of the “state mental health authorities” and what these organizations have done, and where they have or have no stood in changing public policy about services and supports for these aforementioned special needs populations. The efforts of state mental health authorities to improve the quality and the number of interventions brought to bear to support

persons who are in need of treatment I think really has moved forward quite dramatically in the last decade or two. We have learned so much about what peoples' real support needs are.

Civil rights, the fourth change, again one that is important to me personally, is the good and bad that has been caused by the intervention of our courts over the last twenty years.

Finally, I think our discussion of change will lead us to analyze more carefully the distinction between acute care and long term care and how much service systems may have come to recognize that their commitment is evolving more and more to the long term care side of what is needed; beyond acute care intervention and beyond outpatient psychotherapy. Again, in this acute care-long term care area, in particular if you keep in mind a personal concern I have with children, I believe we will have to come to terms with the extended needs of this, our most critical consumer population.

I would argue that the agenda of healthcare reform is very simple…cost containment. The concerns in behavioral health care, for example, of the increased expenditures during the 1980's of inpatient services (paid for by employers and insurance plans), and the increasing cost of medicare, explains whya t this point in time Congress is struggling with whether or not it is going to put caps or limits on what we do with that program. As well, there has been an explosion of costs, our tax dollars, paying for services available under the state-federal medicaid program. There is not a state in the country that hasn't in the last ten years figured out that with limited state resources there ought to be a "medicaid option" that a state could implement that would guarantee it's access to approximarely 50 federal pennies on each dollar states needed to spend on healthcare for low income citizens.

The most recent effort at shifting financial program support to the federal governement is state access to "disproportionate share" payments under medicaid. State hospitals that were once 90% funded by state general funds are now being funded over 50% by our federal medicaid tax dollars. The pressures of state cost containment, I think, are overwhelming and continue to drive the evolving conservative federal agenda.

Finally in this area… employers. As employers discovered that to keep a work force viable they had to spend a larger and larger share of their money, of their earnings, on employee health care.

Following on the heels of cost containment is a second major issue, one that is given a token nod by some members of the U.S. congress and is very seriously of concern for other members, for the Clinton administration and for many states, is the issue of access. There is an unacceptable percentage of our citizens who do not have access to health care and behavioral health care services. These patients then tend to cost more for example, when they come to emergency rooms for their care.

Access has also caused concern, I think, for those of us in the middle class because we perceive that its cost will have a negative impact on our benefits packages. With universal access to care we feel we may not be getting the same array of benefits because overall costs need to be contained. This is the medicare issue again. And therefore the middle class has gotten very anxious about the direction of health care reform; perhaps not as much about behavioral health care reform, but still the concern is there... so we have issues of cost containment, we have issues of access.

One agenda that I think is hidden, but that a number of people are concerned about, is not treatment for illnesses, but prevention of illness. Moving care "upstream", and if this is a meaningful approach to doing things more efficiently, more normally, is a less talked about agenda for health care.

State mental health authorities, administrators in my current position, began to worry that they would be left out of the reform process, and in being left behind, the special needs populations that we have traditionally served would be somehow victimized again, as Dr. Satin pointed out. Last summer (1994) the national State Mental Health Program Directors Association and an organization that recently came into existence representing managed care companies, the American Managed Behavioral Healthcare Association, took a tentative step towards eom collaborative thinking on where they could go together to convince the powers that be, particularly the U.S. Congress, that behavioral health care could and should be an essential part of a comprehensive health package under any national legislation. So, driven by the mutural need to influence Congress these two organizations produced a report that showed that with managed care principles in place, behavioral health care was being provided in both the public sector and the private sector at a reasonable cost.

The study was done in the spring of 1994, covered the previous two years, and became public in time to have some impact on some of the proposals that were coming out of Congress. A comparision of both analyses: the Clinton plan had a behavioral health care cost of $241.00 per person per year. That was the information the Administration was giving Congress. This cost included limits on benefits and co-payments. The commissioners association and the managed care association, in its report, cosed the same level of care with the same limits at between $202.00 and $228.00 per person per year. So, an argument was being made that care could be provided in the public sector and in the private sector, as long as it was managed, that was relatively reasonable in cost. This data had an impact upon Congress. The message to the policy makers was: don't forget about behavioral health care and don't worry so much about artificual limits in benefits.

Unfortunately, these points were eventually lost in the federal politicians inability to move the national healthcare agenda foreward. In Vermont, interestingly enough as a

result of some of those studies and as a result of substantial consumer advocacy, the State is committed to the principle of parity between behavioral health care and physcial healthcare for medicaid recipeints that are going to get care through a manged care system. That was the first time it feels to me that we had some political ability to say you can't ignore the behavioral health side of things.

The problem with the study is that it surveyed only traditional inpatient and outpatient services. It did not consider the cost of other services many of us see as essential to quality care for adults and children with longer term support needs. So, the study was a nice step, but it did not cover the waterfront when you think about what most of us feel would be important for an integrated, comprehensive system of care. In my opinion the biggest issue is to determine where we go in both the public and the private sectors, in providing care for people with special needs. That is, for lack of a better term, long term care. Long term care is the health care "box" that those special needs consumers, families, and even communities, fall into and is where the bulk of these services needs in fact get deinted.

Again, for the purposes of this discussion, I am talking primarily about adults with a severe and persistent mental illness and children and adolescents with a severe emotional disturbance and the families of both. Somethwere about six months ago it feels to me that managed care organizations became aware of long term care. They will tell you that they have always provided a fair amount of services for long term care consumers, but I would argue that they became aware of it as a result of medicare and medicaid opportunities. They started adding up all of the resources spent on extended care; our tax dollars primarily, because these are low income populations. They began to think about whether or not they could provide some of these services more efficiently, more cheaply, and therefore more profitably than state governemtns or the non-profit providers that work with state governements. The number of dollars available in the little Vermont's budget for long term mental health and mental retardation services is about a hundred and five million dollars. There is probably no more than fifteen million dollars of acute care in this number. So you can see how attractive this might be for a profit managed care organization to think it might be able to provide services for 90 cents on the dollar; to suggest an existing system is inefficient; to argue that managed care has developed the technology to efficiently provide this care.

The one issue that these organizations ahven't yet carefully assessed, in my opinion, is whether or not there is profit in long term care. By that I mean they are used to managing and triaging in the acute care world. They are accustomed to defining and redefining care. Do consumers need mental health services, do they not need mental health services, how much, how few. The need for care can be determined as much by what the bottom line looks like than the actual needs of the patient. But if you accept

somebody into a long term care service delivery system most of these services are going to be life long. I don't know if they know yet what that means in terms of their bottom line.

But these organizations are looking and they are asking. There are a number of administrators who have left the public sector and have taken their knowledge of long term care, knowledge of medicaid, knowledge of state governments, and become in-house consultants to some of the major managed care organizations. Their task is to change the internal culture of these providers to determine whether or not managed care can prosper in the long term care environment.

In many locations the traditional community mental health delivery system in my opinion has done a remarkable job. I believe that programs have succeeded where they have had a commitment to and a focus on the special needs populations we've discussed earlier. However, in the present environment is that food or is that bad? Is that focus segregating in nature or is that focus necessary? Because otherwise consumers simply will not get what they need to remain in or return to their communities and be productive members of those communitites. I am going to suggest an answer to the question a little bit later. But at this point in time I think it is clear that if you do not have some commitment to those individuals, then any particular community mental health service system you are talking about probably isn't as good as ones that do have that commitment, that focus.

In the new managed care environement can these systems survive? Can they survive because of that purpose? I would argue that yes, probably they need that focus or they will not survive. The question becomes whether or not there are better ways to do business if they should survive. Clearly one of the things that I think community mental health centers will have to do is to steal some thinking from managed care concerning efficiencies and how to quickly and effectively provide services in ways that they may not have thought of in the past. I know that there are community mental health systems and organizations that perceive the need for change.

Given the tendency of long term care consumers to quickly find themselves disenfranchised without the focused services, we will need to fight for the continued and enhanced involvement of key stake holders to sustain these systems. And, one of the key stakeholders will continue to be active, aggressive state mental health authorities. And, state mental health authorities cannot effectively do their jobs if the other stake holders are not active participants. Consumers, family members, more recently our communities, and providers, need to contribute. I believe that state governments, for all their warts, are the glue that will drive healthcare reform forward and be at the table representing these special needs populations.

My perception is that where state mental health authorities and state governments have not thoughtfully represented consumer interests, there ahd been serious problems. An example: the first 1115B Medicaid Waiver approved in the country was in Tennessee. It was intended to move low income citizens onto managed health plans. Perhaps because the Vice President is a Tennessian the federal Health Care Financing Administration approved the waiver very quickly. The behavioral health portion of the Tennessee plan has had to be rethought several times, and is still not effectively implemented. I believe this part of the overall health plan needed retooling because the state mental health authority had little involvement in its development. The managed care organizations that got the contract, to provide behavioral health care, thought the quick way to implement plans was to go to all the community mental health centers and ask them to continue to do whatever they have been doing. But they did not know how to cost long term care services and they couldn't tolerate the magnitute of these costs.

Therefore, somehow, the management of these policy issues needs to occur. Developing strategies for the involvement of all those stake holders I feel is important. It is the politics of gaining understanding and support on a number of fronts for those policies and services we know work that must come first. And one of the most important policy decisions is to commit to a process by which change can occur. What we know works today will hopefully get better tomorrow. What we know works may not be what other people think sohuld work. Somehow we need to be able to make sure that there is a way for various views to come together.

The issue of integration: how do you move between acute care behavioral health care delivery system and a long term care mental health, mental retardation, substance abuse delivery system? Supported housing, supported employment, day treatment, intensive case management, wrap around serives for adults and children, home-school coordination, the relationships between child welfare services, school services and community mental health services. How can we be sure that no for profit organization puts a plan in place without that plan being able to articulate what those services and relationships will look like? Does the organization know the community mental health centers in the jurisdiction that they are going to cover/care for? Does it have any sense of what the medical community looks like in that area, if in fact a medical community is responsible for persons with long term care needs? Besides going out and signing up providers for a plan, other relationships have to be dealt with. Does a plan have a sense of what kind of school systems it will be dealing with? And does it know, or can it learn, the effect of special education law for the children that it will be serving? These are service entities I think managed care organizations have perhaps not traditionally dealt with. Hopefull the private sector managed care organizations will come to understand that society will require the creation of working relationships. The current problem is

that I don't think society itself knows what it wants. Again, I would argue that the best approach is that some authority has to be able to require that plans that want to do business in a certain jurisdiction have as part of any proposal a way of addressing these issues and showing that they do know what relationships are important.

Some managed care organizations operate on a "staff model", directly employing acute care providers. Most others "carve out" to another plan. For example, Blue Cross/ Blue Shield will contract with a Medico to manage the behavioral health care portion of a certain plan. Another service and financing process could be an affiliation with a new management organization and an existing service system. Developing relationships; understanding, for example, how a young adult with a serious mental illness, needing more than the plan's benefit package provides, can effectively move into the appropriate support system. And if appropriate, understanidng how such an individual can move out of that support system back into a more traditional acute care plan.

To accomplish this we may be able to take advantage of some things that managed care organizations do well. I think that managed behavioral health care has the capacity to create a comprehensive database that could provide decision makers with the information necessary to create and sustain working relationships. The first test will be whether, without divulging confidential information or identifying individual patients or clients, we can figure out how to make this kind of information non-proprioritary. There is a substantial amount of information I think should be available, not only to plans, not only to state governemtn, but to the public at large. Good, comprehensive information could give us an opportunity to think seriously about meaningful report cards on care. It would give us an opportunity to make future decisions based on clinical outcomes. With a sold, broader database some interesting and potentially important long term care agendas might be shifted. Are public mental institutions viable components of an effective long term care service system? I am not arguing for the closing of state hospitals. I am just saying that intensive care should be appropriate. And, most care should be provided to people in their home communities. Can successful programs, backed by good data, move us in that direction? Again as with the state hospital example, can you generate the behavioral healthcare information that will test the clinical success of keeping kids in school?

A strong, universal database that included both acute care and long term care outcomes could also move systems away from a restrictive case management system to an aggressive utilization review process that will more effectively tell us where we have failure, where we have success, what seems to be working, what are the costs of providing care. Making sure that managed care organizations understand what their expanded responsibilites are means knowing what expanded databases can tell us.

Somehow there has to be a parallel track of comprehensive outcomes based information to go with cost attainment.

My final thought is that these actual and potential changes in care delivery are not frozen in time. There needs to be a means for a jurisdiction, a stte, a country to permit the process to evolve. How do you move and adjust the health care and behavioral health care agendas forward? How does community mental health keep up? How do we begin to talk about benefits packages that deal with prevention issues? How do we hold onto the principal of normalized services? Services that permit consumers to have a sense of community as opposed to a sense of isolation. How do we develop, in a managed care context, a process where we provide for meaningful choise and service flexibility? What I hope all of these new challenges are leading us to is a health care and behavioral health care agenda that stops limiting care and moves us to a comprehensive, integrated, and universally accessible system of health care; accessible to everyonen and tailored to what individuals need and not what plans can afford or what the public believes it cannot afford.

David Satin:

I think what I think what I heard the Commissioner say was that carving out mental health is beneficial, because it sees to it that mental health is attended to, and to do it right you need to do it knowledgeably, you need to comprehensively to see that it's done, and you need to do it with some oversight to follow through on it.

Nancy Langman-Dowart, RN, MS, MPH

Director of Mental Health, Blue Cross and Blue Shield of Massachusetts

Introduction by David G. Satin, MD

Our first discussant is Nancy Langman-Dowart, who is a mental health clinician, a psychiatric nurse who is responsible for developing policies for and implementing the funding of mental health care through private insurance. Ms. Dowart is the director of Mental Health for Blue Cross and Blue Shield of Massachusetts, and has her training in psychiatric nursing from the Boston University Graduate School of Nursing, or formerly, when it was there, has a Master of Public Health degree from Tulane University School of Public Health in community mental health programming, and is enrolled in the Mahler Executive Management Training Program. She has been the manager of mental health for Private Health Care Systems, Limited, manager of mental health and substance abuse for the Harvard Community Health Plan, clinic director of the Human Resource Institute in Lowell, and director of consultation education at the Mystic Valley Mental Health Center, so a former community mental healther, perhaps still. Her publications include Failure of Managed Care or Failure to Manage the Care, in the Harvard Review of Psychiatry, which is coming out soon.

Nancy Langman-Dowart, RN, MS, MPH

Community Mental Health Centers (CMHCs) began to flourish in the early 1960's as a result of direct federal grants available through the Community Mental Health Acts of 1963 and 1965. CMHCs sought to make comprehensive mental health services available to all those in need, exclusive of financial means (Foley and Sharfstein, 1983). The core values that shaped the community mental health movement were access to treatment and continuity of care. Additionally, CMHCs became the primary treatment sites for people who had been previously cared for in long-term state mental institutions. Due to the nature of the population served, CMHCs often worked closely with hospitals and other providers to ensure continuity of care when patients transitioned from hospital to outpatient settings (Dorwart and Hoover, 1994).

The values and work practice of the traditional CMHC are being currently touted by managed care organizations (MCOs), although the future of CMHCs is quite tenuous while MCOs are experiencing unbridled growth (the proportion of private employees enrolled in managed care plans grew from 5 percent in 1980 to 55 percent in 1992, GAO/HRD). Change and reorganization is currently required of CMHCs to meet current Managed Care Organization (MCO) and National Committee for Quality Assurance

(NCQA) standards. By the end of the decade, some will remain strong and integrated into managed care while others will have dissolved or been subsumed. This chapter will outline the changes in the CMHC system particularly since the adcent of managed care, and how CMHCs have a foundation in place to potentially be key players in the rapidly changing marketplace of mental health care.

Community Mental Health Centers: Ideology, Practice, and Politics

CMHCs have been overshadowed by MCOs and are rarely integral in today's managed care networks except when other providers, private or hospital based, are not geographically convenient or numerous. Understanding this requires a brief overview of the historical forces which have impinged upon CMHCs and diminished their capacity to be competitive mental health providers.

Advances in psychotropic medication, coupled with new successes with brief treatment interventions developed during World War II to combar war neurosis paved the way for a view of mental illness as both treatable and in some cases preventable. Beginning with the Kennedy administration, the federal governement assumed leadership for a number of social and health care initiatives, which eventually made institutional care unnecessary for all but a small percentage of patients (Ray and Finley, 1994). The 1960s was a period of significant federal government activity in the realm of mental health. The Joint Commission on Mental Illness and Health, established in 1955, filed a report in 1961 entitled "Action for Mental Health" which promoted the concept of community mental health (Morrisey and Goldman, 1984). This concept became the "bold new approach" adopted by President Kennedy in the Community Mental Health Acts of 1963 and 1965 which provided federal grants to create the elaborate system of CMHCs where access to mental health care was available to all those in need, independent of their ability to pay. The CMHC Act marked the federal government's investment in an alternate system of care for the mentally ill.

CMHCs were designed to provide five basic services: inpatient, outpatient, partial hospitalization, emergency, and consultation and education. Funding also required that CMHCs guarantee continuity of care; provide services to a defined catchment area of 75,000 to 200,000 people; and provide these services regardless of client's age, sex, race, or ability to pay (Weiner et al, 1979). The CMHC movement gave momentum to deinstitutionalization which called for the demise of state mental hospitals and the rise of a new community-based and community-controlled mental health service delivery system.

The federal CMHC grants were originally given as "seed money", decreasing by a specified amount each year, and resulted in non-profit CMHCs looking for funding from

other sources, such as local and state governments, third-party payors, and fee collection. The "seed money" concept was amended by Congress 11 times, and finally was expanded so that CMHCs could receive federal financial support for up to 12 years. The 12-year funding period would consist of a 1-year planning grant, 8 years of operations (staffing) grants, and 3 years of financial distress grants (Weiner et al, 1979). Through the original development plan for CMHCs incorporated a self-sufficiency clause in its framework after federal funding dissipated, there was a concurrent expectation that CMHCs would continue to principally treat people who had been dischared from public mental institutions, even though many of these patients had no ability to pay for their services.

Deinstitutionalization policy took shape in response to civil-libertarian litigation over the state hospital commitment process, the Medicaid-Medicare amendments to the Social Security Act of 1965; and the fiscal crises that enveloped the states in the early 1970s (Morrissey and Goldman, 1984). Between 1955 and 1980, the resident population of state mental hospitals was reduced by more than 75% or by approximately 420,000 occupied beds. While large numbers of chronic patients entered the community, federal seed money decreased annually. CMHCs therefore had to often abandon poorer (often chronic) patients with a pattern of high service utilization in favor of insured patients who might respond to brief interventions. Direct funding of CMHCs eventually did end in 1981, resulting in CMHCs increasingly resembling profit-maximizing firms as they came to depend on clients for a large proportion of their revenues. CMHCs found themselves in an ethical and financial bind because the move towards financial stability and viability made it more difficult to provide the array of comprehensive services to those people most in need of care, those people who once were the primary patient population of the CMHCs.

Retrospective research (Woy et al, 1981) shows that 10 years after the end of federal funding, CMHCs began to submit to financial constraints imposed by defunding, sometimes resulting in jeopardized ideology. Two groups of CMHCs emerged as direct funding evaporated: 1) those achieving full fiscal viability independent from federal funding by moving away from the original CMHC model of care; and 2) those CMHCs remaining true to the CMHC ideology and experiencing great financial risk.

The pattern that emerged in the CMHCs achieving financial independence and solvency was one of maximizing the more readily reimbursable services while downsizing less lucrative programs. Inpatient care and the medically associated services such as outpatient care and emergency services were provided more readily while the less lucrative or less traditionally accepted services such as partial hospitalization, home visits, and consultation and education were dramatically scaled down or abandoned. CMHCs began to feel pressure from the Department of Health and Human Services as

well as advocacy groups like the National Alliance for the Mentally Ill because their once primary patient population was at risk for being underserved given the dramatic service reductions (Torrey, 1988).

CMHCs struggled with the questionable desirability of operating a mental health center like a business and opinions have varied based on seemingly conflicting concerns for administrative efficiency (Brotman, 1992; Roundy, Kasner and Kansner, 1988; Edwards and Mitchell, 1987), and quality of patient care (Kane, 1989; Levine et al., 1989; Woy, Wasserman, and Weiner-Pomerantz, 1981). The survival of current CMHCs can be attributed to their strong ongoing ties with organized medicine, allowing them to remain free from dependence on government funds by receiving large portions of their revenues from third party payors.

The Shift to Privatize

Concurrent with the changes in funding for CMHCs in the 1980s, the birth and growth of MCOs was happening at a rapid pace, as well as the growth of for-profit psychiatric hospitals. In the mid 1980s, the grown of for-profit psychiatric hospitals and the rapid increase of providers and states with expanded vendorship led to privatization and the growth of the managed mental health care industry. Privatization refers to the delivery of health care services by private non profit and for-profit facilities, and the increasing purchase of services from private agencies by public organizations.

The trend toward privatization is an outgrowth of several changes in the way healthcare is both provided and funded in the US. Dowart and Epstein (1993) discuss how the confluence of financial instability of community general hospitals in the early 1980s, deinstitutionalization, perceived quality differences among providers, and decreased social stigma of mental health care, contributed to the growth of privatization. In the early 1980s, the limited growth potential for general community hospitals was offset by the increasing profitability of psychiatric services. Inpatient mental health care promised higher occupancy rates, fewer operations costs, fewer restrictions on payment mechanisms, and the ability to transfer difficult (and expensive) patients to public facilities. At the same time, when public funding of CMHCs was finally eradicated in 1981, private vendors swept in to fill the gaps and began to provide support services such as crisis intervention, aftercare, and residential treatment. These newly created privately-owned facilities were financially supported by state governement contracts which judged these private providers to be of higher quality than their government-operated counterparts. Private facilities also carved out a new niche for mental health services in the treatment of disorders other than severe mental illness, such as eating disorders, panic, stress, and addictions.

Market forces promoted the most expensive treatment and competition resulted in increased costs through inflated capacity and utilization. The number of inpatient beds rose dramatically, partially compensating for the decrease in medical/surgical bed occupancy following the introduction of payment based on diagnosis related groups (Jellinek & Nurcombe, 1993). From 1980 to 1986, there was a more than fourfold increase in adolescent admissions to private psychiatric hospitals; the average length of stay increased from 36 to 41 days for children younger than 18 years. By 1988, 64% of all inpatient facilities were privately owned, with the most rapid growth in corporate chains (Jellinek & Nurcombe, 1993).

Current Models of Private Sector Managed Mental Health Care

Jellinek and Nurcombe (1993) argue that the mental health delivery system has undergone a two-stage evolution in the last 15 years since the advent of privatization. The first stage was free-market competitive expansion where the use of inpatient services increased. The second state was managed care, dramatically decreasing the use of psychiatric hospitalization. They write, "the engine for both the first and second set of changes was not innovative treatment or outcome studies; on the contrary, it was profit that filled psychiatric beds in the 1980s. and it is profit that empties them in the 1990s" (1993, p.1737).

Managed care evolved as a solution to out-of-control health care costs, but also as a means to remedy the gross abuses in the mental health care industry. Some examples of abuse within the field were admissions to weight reduction programs for obesity being billed as depression and charged to a patient's psychiatric benefits. Other abuses included the over-admitting of adolescents for long-term hospitalization and the length of stay for inpatient substance abuse treatment programs mysteriously matching insurance benefits (Dowart and Epstein, 1993). Today, fewer thatn 10 substance abuse private treatment center programs in the nation have average stays of more than 20 days, down from about 400 programs five years ago. Another driver of managed behavioral health care was the trend of large national corporations to offer consistent nationwide benefit administration to reduce their liability for inequities in employee treatment.

"Managed care" is a fluid and evolving concept that refers to a number of different strategies in diverse settings. Definitions of managed care have been described as "imprecise", thought the term frequently refers to strategies designed to control costs by influencing the types of care delievered and the access to these services. "Managed care" is also used to characterize a wide range of health care plans such as Health Maintenance

Organizations (HMOs), Preferred Provider Organizations (PPOs), and Points of Service Plans (POS).

Managed mental health care showed early savings through its impact on the utilization of inpatient services. Insurers have seen their utilization rates fall from between 80 and 120 days of inpatient care per 1,000 enrollees per year to 20 days. Lengths of stay have been reduced from between 30 and 60 days to between 11 and 13 days. These initial clinical savings, however, were offset by high administrative costs resulting in little or no dollar savings (Schreter, 1993). Two new mechanisms emerged to deal with this shift in costs: the "carve out" of mental health services and the emergence of preferred provider networks.

The Emergence of "Carve Out" Mental Health Programs

The trend toward privatization has also resulted in an ever increasing emphasis on economics and the 'bottome line'. The mid 1980s saw many major employers with generous insurance plans implement managed care with increased cost sharing and reduced benefits as they attempted to contain costs (Sharfstein and Stoline, 1992). Competition among insurers to provide quality service with limited cost resulted in mental health benefits being "carved out" of benefit plans because of hard to manage costs. Large national employers with Employee Retirement Insurance Security Act (ERISA) exempt status and self-insured for health care found financial relief through carve-out arrangements. A guaranteed one time savings was often promised and delivered. "Carve out" programs allocate separate mental health funding from other medical services. Speciality behavioral health MCOs sprung up to manage the mental health benefits of health plans. These companies were successful in reducing overall costs of mental health care, primarily by limiting the use of inpatient treatment.

Carve-outs emerged as a way to reduce costs. Presently, carve-outs may provide contract benefits to an independent company or a mental health subsidiary of an insurance company. They may manage mental illness internally through an Employee Assistance Program (EAP), case managers, or other gatekeepers to the mental health system. These are systems of care in which mental health and substance abuse services are provided apart from general medical and surgical care. Reidy (1993) argues that carve-out approaches are vulnerable to creaing discontinuity of care, as well as adding additional layers of administrative expense to the health care system at a time when cost efficiency and containment should be of paramount importance.

Failure to develop case managed approaches to care with long term treatment planning left many people disillusioned with carve-out companies' performance. Since early HMOs attracted younger and healthier members, carve out companies were able to

manage with an “episodic” approach to care without considering long-term patient needs. Early carve-out programs with episodic approaches to care, national rather than local control, and financial incentives often at odds with quality care, ended up functioning as gatekeeper programs rather than fostering easy access to early interventions for all mental disorders.

Today, more than 50% of both HMOs and self-insured companies nationwide carve-out their mental health benefits. Between 1994 and 1995, specially mangagd behavioral health programs (carve-outs) reported an enrollment increase of 7.5 million people, from 102.5 million on January 1, 1994 to 111.00 million on January 1, 1995 (Open Minds, 1995). As more people are forced to choose managed care, more severely mentally ill people must be cared for in a system not compatible with severe and persistent illness. This increase in care for more chronic population results in “adverse risk” to the insurer. This term refers to the situation in which enrollees choose an insurance product because they expect to use more services than the actuarial average. With older and sicker members now joining HMOs, the carve out companies have had to rethink and redesign their models. Care delivered by cave-out companies is still often nationally based and centrally managed rather than locally based. This creates many difficulties for providers and patients such as having care managed through central 800 numbers and referrals managed by clinicians unfamiliar with local geography and local providers.

Today, in an effort to meet standards put forth by NCQA, a nationally recognized accreditation organization, contracts are negotiated which make greater attempts to assure that financial incentives support quality of care initiatices. One attempt is to hold the vendor to performance standards that have measurable results and financial rewards or penalties depending on those results. Standards address issues such as access, outcomes, and member satisfaction. For example, an access standard might require immediate access for emergencies and 5 day access for routine outpatient care. Contracted agencies would track and report actual access usually on a monthly or quarterly basis. This report is then used to identify problems and improve overall quality.

What’s Ahead in Health Care Delivery?

A close look at health care delivery across the nation offers insight into developing trends and practice. These trends and practice should be important considerations for CMHCs which aim to survive and be competitive in today’s current market. The trends towards mergers, integrated delivery systems, shared financial risk, and standardization of care, must be practiced by CMHCs if they are to remain viable providers of health care.

Mergers will continue to take on many shapes in order for organizations to provide an ever increasing array of services. MCOs will continue to undergo horizontal and vertical mergers and acquisitions. The merger of mental health benefits with Employee Assistance Program (EAP) benefits is a national trend which will likely continue. 19.4 million people are currently covered by EAPs. These broad based programs often have drug screening components, supervisor referral programs for troubled employees, smoking cessation, weight control, and prevention programs such as parenting skills, stress management, and financial planning. Their philosophy is based on early intervention and prevention services to avoid disabilities and the need for expensive services.

Integrated delivery systems, which combine mental health with primary care, are facing opportunities to develop diverse product lines, while traditional inpatient revenue bases erode as consolidation occurs nationwide. Health care at its best is delivered as an integrated process. The marriage of primary care and mental health provides a model of assessment and delivery where patients are treated holistically. Studies show that patients with chronic pain who receive mental health interventions report fewer pain symptoms, are less anxious, less depressed, more active, require fewer medications, and reduce their medical visits by up to 34 percent (Inside Preventive Care, 1996). The data also show that many patients who visit hospital emergency rooms have a substance abuse problem, and many other emergency room visits are due to underlying panic disoder that present as cardiac problems (Milliman & Robertson, 1996). The integration of diverse delivery systems holds the future for quality, cost-efficient health care.

The new and rapidly forming PHOs offer increased collaboration with medical staffs, shared risk arrangements with MCOs, and direct contracting with employer groups. Improved collaboration and blurring of roles (often financially driven) have the capacity to result in improved quality. The focus of health care delivery will increasingly be on primary and secondary prevention. Clinical guidelines should begin to reflect prevention priorities. “Quality Improvement” will focus on population based improvement requiring new skills and signficant resources.

Insurers will increasingly seek collegial, partner-like relationships with health care providers as responsibility for care management shifts to providers, and insurers take on the role of ‘overseer’. Capitation will be the payment method of the future. There will be incentives for cost consciousness. Shared risk may build in financial rewards for controlling costs while meeting quality standards. If global budgers ever become a reality, at the state level, insurers and providers will have to work collaboratively to manage limited dollars.

The Future of CMHCs: Integration and Collaboration

With the current emphasis on integration of primary care with mental health and diverse delivery systems, the original continuum of care model underlying CMHCs appears quite contemprary and applicable in today's managed care environment. The elements and components of the early CMHC movement seem to have found a new incarnation in the evolving health care reform (Ray and Finley, 1994). The key areas of overlap include an interest in alternative to hospitalization, delievery of service to a defined population, accessibility to services, continuity of care, and prevention (Bloom, 1996).

Survival of CMHCs in a mangaged care world is not guaranteed by merely an overlap in service delivery philosophy. CMHCs must become full service providers which offer an array of mental health services that are well integrated into the medical delivery system. Affiliations with hospitals and PHOs is crucial in order to open up a broader base of services. Close linkages with Primary Care Physicians (PCPs), and other medical and surgical specialists is essential.

CMHCs must prepare themselves clinically, administratively, and financially to weather the trends in payor/provider partnerships. Clinically, CMHCs must continue what has been a strength of theirs all along, the recruitment of providers that represent diversity of race, ethinicity, language, and cultures. It is of paramount importance that CMHCs continue to offer services to the hearing impaired, the disabled, and the elderly. Administratively and financially, the needs for strong financial expertise, reporting capabilities, liability and reinsurance have never been so crucial. The blurring of traditional roles which we are seeing between providers and MCOs needs to be translated into CMHCs where a responsibility of costs is shifted to providers or at a minimum shared between providers and insurers.

CMHCs must understand the NCQA environment as their services must support insurers' ability to become NCQA accredited. This has become increasingly more important as large national accounts like GTE and Digital Equipment Corporation plan to do business only with NCQA accredited HMOs. CMHCs would be well advised to develop internal credentialing processes that line up with local payor and NCQA requirements. Education of all staff on NCQA criteria will be critical to become providers of choice. Having a broad understanding of capitation and systems that manage capitated contracts will be essential to survival. Training in quality improvement and an administrative structure that supports quality efforts will be a minimum requirement.

Finally, building linkages to broader systems of care will be required if CMHCs are to be players in this new era. They must either merge together, formaing partnerships with smaller specialty providers as the public payor system of care or they must evolve and integrate with a broader spectrum of medical care to service the for-profit sector. No

CMHC can today stand alone and expect to be standing in the aftermath of the rapid health care consolidation of services.

Conclusion

The strength and future of CMHCs reside in their history and tradition. CMHCs can provide valuable guidance in mapping the course of the future because of their expertise in community networking and provision of services to a diverse population. In the past, their success has been due to broad access to culturally diverse services in non-threatening, geographically convenient locations. This framework, often characterized as "continuity of care", has offered creative, responsible, consumer-oriented services. Services have traditionally been provided as needed with virtually no criteria for exclustion. Though this framework is the backbone of CMHCs, the viability and competitive presence of CMHCs in today's health care environment fall within the framework of integration and standardization.

To be successful in the future, CMHCs must maintain their tradition while evolving to meet new requirements and standards. Integration of the continuity of care paradigm with accreditation and quality assurance standards will be the framework of success. Integration of mental health services with primary care and medicine will also be critical to the model of the future. Current quality assurance guidelines and policites must co-exist with the traditional framework of community commitment and orientation. No longer can CMHCs afford to view managed care principles as contrary to community service, but instead must strive towards complimentary integration in order to survive. Success will combine clinical experise, business savvy, and some risk taking in order to participate in an integrated delivery care system.

References

Bloom, J.D. (1996) "Psychiatry: Three Models in Search of a Future". *Psychiatric Services*. 47(8), p. 874-875.

Brotman, A. (1992) "Report From the Field—Privatization of Mental Health Services: The Massachusetts Experiment". *Journal of Health Politics, Policy and Law*. 17, 541-551

Clark, R.E., Dowart, R.A., & Epstein, S.S. (1994) "Managing Competition in Public and Private Mental Health Agencies: Implication for Services and Policy". *The Millbank Quarterly*. 72(4), p. 653-677

Dowart, R.A., & Epstein, S.S. (1993) Privatization and Mental Health Care, A Fragile Balance. Auburn House, CT. 1993.

Dowart, R.A., Hoover, C. (1994) "A National Study of Transitional Hospital Services in Mental Health". *American Journal of Public Health*. 84, p. 1229-1234

Edwards, L.G., & Mitchell, C.C., (1987) "Strategies for Cutback Management in Community Mental Health Centers". *Community Mental Health Journal*. 23, p. 140-151

Foley, H.A. & Sharfstein, S.S. (1993)Madness and Government: Who Cares for the Mentally Ill? Washington, D.C. American Psychiatric Press.

Inside Preventive Care (1996). August, 2 (5), p.3, Montpelier, VT.

Jellinek, M. & Nurcombe, B. (1993) "Two Wrongs Don't Make a Right". *JAMA*. 270 (14), p. 1737-1739.

Kane, T.J. (1989) "Systematic Discrimination: A Strategy for Surivial". *Administration and Policy in Mental Health*. 16, 179-182

Levine, S.R., Rosen, T., et al (1989) "Corporation and Community Health Services". *Administration and Policy in Mental Health*. 17, 67-78.

Milliman & Robertson, Inc. (1996). "Behavioral Healthcare Risk-Sharing and Medical Cost Offsets". Seattle, WA.

Morrissey, J.P. & Goldman, H.H. (1984) "Cycles of Reform in the Care of the Chronically Mentally Ill". *Hospital and Community Psychiatry*. 35(8), p. 785-793.

Open Minds (1995). November 9 (8), p. 12, Gettysburg, PA.

Ray, C.G. & Finley, J.K. (1994) "Did CMHCs Fail or Succeed? Analysis of the Expectations and Outcomes of the Community Mental Health Movement". *Administration and Policy in Mental Health*. 21 (4), p. 283-293

Reidy, W.J. (1993) "Staff Model HMOs and Managed Mental Health Care: One Plan's Experience". *Psychiatric Quarterly*. 64 (1), p.33-43

Roundy, J.T., Kasner, S. & Kasner, K.H. (1988) "Introducing Business Practices in Community Mental Health". *Administration and Policy in Mental Health*. 16, p. 44-47.

Schreter, R. (1993) "Ten Trends in Managed Care and Their Impact on the Biopsychosocial Model". *Hospital and Community Psychiatry*. 44(4), p. 325-327.

Sharfstein, S.S. & Stoline, A.M. (1992) "Psychiatric Care and Health Insurance Reform". *American Journal of Psychiatry*. 150 (1), p. 7-17

Stroup, T.S. & Dorwart, R.A. (in press) Chaper for Managed Mental Health Care in the Public Sector: A Survival Manual. Edited by Minkoff, K., & Pollack, D.

Torrey, E.F. (1988) Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill. Harper & Row, New York.

United States General Accounting Office, GAO/HRD (1992/1993)

Weiner, R.S., Woy, R.J. et al (1979) "Community Mental Health Centers and the "Seed Money" Concept: Effects of Terminating Federal Funds". *Community Mental Health Journal*. 15 (2), p. 129-138.

Woy, R.J., Wasserman, D.B., & Weiner-Pomerantz, R. (1981) "Community Mental Health Centers: Movement Away From the Model?" *Community Mental Health Journal*. 17(4), p. 265-276.

David Satin:

I guess I get a mixed message from Ms. Langman-Dowart. One is that carving mental health is a fact of life and is only a question of how you do it and how you do it well, and the other is an unexpectedly alternate view that maybe it'll get carved back in again, and there'll be some way I guess of protecting the service while integrating it into overall health care, which is optimistic from a community mental health point.

Nancy Langman-Dorwart:

I'd like to talk later about that opportunity to carve back in--it's an important issue.

Nasira A. Khan, MD

Director, Bournewood Hospital; Clinical Psychiatrist

Introduction by David G. Satin, MD

Nasir Khan is also a mental health clinician, a psychiatrist, who has much experience in public service and business management as well as in psychiatry. He was educated at King's College and Westminster Medical School at the University of London, and is a real renaissance man in medicine. He has been a house officer in surgery, in medicine, in obstetrics, and in psychiatry, so you're capable of handling it all. He was also a fellow at the Laboratory of Community Psychiatry at Harvard Medical School, Gerald Kaplan's program to prepare mental health professionals of a variety of sorts for knowledgeable leadership in community mental health. He has his board certification in psychiatry with additional qualifications in geriatric psychiatry. He's currently assistant clinical professor in psychiatry at Tufts University, formerly Chief of Geriatric Services at the Massachusetts Department of Mental Health, and Superintendent of the Danvers State Hospital, and is currently Chief Executive Officer at the Bournewood Hospital, Bournewood Health Systems, on the active staff of psychiatry at Newton-Wellesley Hospital, and in private practice in psychiatry in Newton. He comes wearing his hat as a clinician and as the director of a clinical institution, though he's had a lot of background in public service. He is formerly a member of the Committee on Legislation and the Committee on Insurance at the Massachusetts Psychiatric Society, and formerly President of the Massachusetts Association of Private Psychiatric Hospitals, and currently a councilor at the Massachusetts Medical Society. Dr. Khan will talk about how a clinician gets clinical services done under a carved-out system.

Nasir A. Khan, MD

I am very happy and honored to be a discussant on a subject that is very topical at this time—the carve out of mental health out of physical health—and its impact on both the private and public sector.

Commissioner Dalton gave an excellend overview of the subject, but I would like to specifically make some comments from the perspective of a practicing clinical psychiatrist, and administrator of a psychiatric hospital, and an active member of the Medical Staff of a community general hospital.

We have also heard the perspective from Nancy Langman-Dorart, the director of mental health of a major insurance company in Massachusetts.

What is Meant By Carve Out

The carve out implies the separation of mental health and substance abuse care, not often refrred to as behavioral healthcare, away from general health care. The care to this population is “managed” separately from their general health by professional and institutional providers.

In 1995, an increasing number of privately insured Americans have mental health and substance abuse coverage that is involved in some form of “managed care”. There are certain advantages and certain disadvantaged with this phenomenon that I would like to mention later, and also make some predictions about the future.

Why Did This Occur?

Providing care for patients with mental health and substance abuse disorders, or behavioral health difficulties, often requires specialized knowledge and skills different from those needed to manage general medical care. For this reason, and especially in response to escalation in costs of the traditional indemnity benefits in the 1980s, separate entrepreneurial companies began developing and focusing exclusively on mangaing behavioral health care. Subsequently, these managed care companies truly flourished. In addition, many HMOs, as well as insurers, began offering separate “carve out” behavioral health care insurance products to large employers, in addition to their regular insurance offerings, esepcially those companies exempt from the ERISA provisions. The carve out product has had a major impact on mental health care that has especially controlled escalation of costs.

The principles that led to the formation of managed care companies were probably embodied in the employee assistance programs (EAPs) in the 1950s initially with refard to alcoholism services and occupational health services. They were often available at large employers and they focused on early intervention for alcohol and drug abuse and gradually expanded to other crisis situations. One of the main advantages of their programs was ensuring employees easy access, and after evaluation, referrals to qualified providers for appropriate care.

Next, the utilization review industry developed and brought tremendous cost savings to health care plans by reducing inpatient utilization. However, initially UR had no interest in the outpatient component so that significant cost-shifting to that area occurred that limited effective cost and quality control. In that era, there was a very adequate coverage for inpatient care, but minimal coverage for partial hospitalization and outpatient services.

Initially, UR companies focused exclusively on disability and medical/surgical cases and subsequently expanded to include psychiatric and substance abuse disorders. The

reviewers were typically registered nurses, supervised by physicians, and they began to develop written criteria based on statistical norms for hospital lengths of stay. As these companies became more expert, large employers and even insurance companies, began to contract with these managed care companies for utilization review and behavioral health care services. Thus was formed the roots of "carve out" of mental health services from physical health.

Mental health care had long been considered "unmanageable" and open-ended in cost, and attempts to deal with this were through restriction of benefits. Even Medicare in the 1980s when it implemented the first major restructuting called diagnostic related groups (DRGs) specifically exempted mental health services since the Federal government at the time could not agree on an appropriate methodology to manage them.

In the 1970s and 1980s, "managing benefits" were common with attempts to limit access to care with deductibles, copayments, lifetime maximums, gatekeeping and obtaining prior authorization. This was followed by "managing care" with costs being contained by limiting authorization of benefits to reimburse only necessary care delivered in the least restrictuve, most appropriate setting by qualified providers.

Advantages of Mental Health Carve Out

Separating behavioral or mental health problems away from general health required obtaining agreements with mental health professionals and hospitals with comprehensive mental health services, and integrating the clinical services into a continuum that included inpatient care, partial hospitalization care, respite beds, triage and outpatient services.

A major advantage of the carve out is that higher priority is placed on behaviorally difficult patients by nature of their visability rather than being "lost" in the general health care system. Managed care companies with their access to capital and ability for innovation, began to show the cost advantages of integration of services that also resulted in data showing increased levels of quality and customer satisfaction. Easy access to mental health and substance abuse services was vital as it was known that when access is difficult, overall medical utilization increases with subsequent higher costs within the health care system. Access was initially through "gatekeepers" who were often primary care physicians; but subsequently, some managed care companies have been offering 24 hour, 1-800 intake lines whereby referrals of properly credentialed clinicians can be given to a prospective patient. Managed care companies have further improved access by minimizing copayments especially for the evaluation period. However, carve out companies have no incentives to decrease general medical utilization.

When managed care companies have “at risk” contracts with an insurance company or employer, being paid on a member-per-month basis, within acturarial guidelines, i.e. capitation, maximum innovations are possible in the provision of mental health services. In addition to the integrated continuum mentioned, therapeutic residential services became another component of the continuum thus insuring that the patient moves from the most intensive and most costly setting to the least intensive and the least costly setting as quickly as possible. However, the cost containment cannot be overshadowed by the need for quality control. Since a provider has already been paid in advance, there is every incentive to minimize treatment, and the potential for underutilization has to be monitored.

A fundamental principle of managed care is that more is not necessarily always better. Outcome measures including clinical outcomes, patient satisfaction and use of practice guidelines all become important in order to monitor clinical care. Initially, these indices were important for the employer so that quality of the purchase could be measured, and these have now expanded to included perceptions of the provider, both physician and hospital, as well as the beneficiaries or patients. Recently, advocacy groups, especially for the severely mentally ill, have been speaking out on quality of clinical services as have certain national organizations including the National Committee of Quality Assurance, the Utilization Reveiew Accreditation Commission and the Joint Commission on Accreditation of Healthcare Organization. The importance of customer satisfaction that has more recently been recognized in American industry, has now been applied to the health care industry. The teachings of Edward Demming, the innovator of the concept of competitive advantage in responding to products and services which a customer needs, is increasingly being accepted.

As managed care services become more integrated, information management technology becomes critical. It is expected that we will see more computerization of the medical record that will be available at multiple locations.

Disadantages of Carve Out of Mental Health from General Health Care:

From the professional provider’s point of view, there has been a tremendous realignment of roles of various mental health providers. Psychiatrists are increasingly being seen for traige work, evaluation of problem patients, utilization review, and psychopharmacological assessments. In contrast, psychotherapy has now been relegated to less expensive mental health providers including licensed social workers, psychiatric nurses and Ph.D. psychologists. This has caused tremendous anxiety especially among the psychiatric profession as psychiatrists often initially went into this profession with the intent of working with individual patients in long-term psychotherapy. In addition,

the psychological profession has noticed a tremendous decrease in the use of psychometric testing. Psychiatric nurse clinical specialists, however, have seen their roles expand as their unique nursing background superimposed on their psychological training has resulted in the authorization, in certain states, to prescribe psychotropic medications with appropriate safeguards. Similarly, social workers now licensed as independent clinical social workers are frequently the main clinicians doing ongoign crisis intervention and supportive therapy. The key issue remains an assessment of quality. These mental health professionals must have access to high quality psychiatric consultation, and the question is to what extent the less-trained and lower-cost providers have developed the clinical skills to know when this is warranted.

Another major concern of this implication of carve out of mental health from health care has been the disruption of the role of the primary care physician who is often best able to recommend an appropriate mental health professional to a patient. The patient's primary care physician will recommend an appropriate referral to a cardiologist, oncologist, orthopedic surgeon or other specialist, but cannot do so now in certain mental health carve out programs because access is obtianed through a 1-800 number and not by the primary care physician. There is a tremendous discontinuity potential which is not in the best interest of the patient. Emotional distress causes physical manifestations that can result in expensive diagnositc ancillary workups, especially when there is no readily available collegial relationship between the psychiatrist and the internist.

With the proposed Medicare managed care product for the elderly which several HMOs and insurance companies are now proposing, a critial question will be whether mental health will be carved out from general health for this high-risk population. The interface between mental health and physical health in the young adult is vastly different than that between the older patient. Frequently, it is difficult to separate emotional difficulties causing physical distress and physical difficulties causing emotional distress. Carve out of behavioral health from physical health for this population in my opinion is extremely unwise.

I think it is important to mention the role of the psychiatric unit in general hospitals vs. the private psychiatric hospital. I am familiar with both. Whereas both can deliver high quality care, the higher fized costs of a general hospital, because of the need for ICUs and operating rooms, not present in a psychiatric hospital, in general results in comparable services being more expensive in general hospital psychiatric settings than in private psychiatric hospital settings. In addition, because of the specialized product in the psychiatric hospital, more comprehensive services are more readily available often in a setting that is less institutional; but quality can only be maintained if various medical consultants are available on a daily basis in this specialized setting. Certainly, other

specialized facilities such as children's hospitals, rehabilitation hospitals and cancer hospitals have shown the advantages of being able to concentrate on one facet of medical care.

Managed Care in the Public Sector

The principles of community mental health which was proposed in the federal legislation of 1963 are now seen as not that dissimilar from the concept of managed care, particularly with capitation payment, whereby the insurer or managed care company assumes responsibility for a defined population. In the public sector model, this defined population is called "catchment area". Within that, there has always been an attempt to integrate the services often to a much greater degree than currently exists in the private sector but with perhaps less efficiency and cost effectiveness than in the private sector. In the public sector, the inpatient setting was dominant; but not with the shift toward community programs to include different levels of day care, residential care, crisis evaluation, triage services, as well as many support groups, conceptionally the difference between the public sector and the private sector is now converging. Logically, therefore, the next step would be to attempt to integrate the two and this is not beginning to happen.

The trend by different states, including Massachusetts, to contract out mental health and substance abuse needs of the Medicaid population to a private, for profit managed care company will lead to this. The federal Medicaid waiver activity (Section 1115) is a trend that I feel is in the right direction. We can learn a lot from what the public secot has been doing, but it is essential that we aim as a nation towards one class of care. This dialogue between the public and private sectors is very welcomed. Traditionally, managed care companies have tended to extrude to the public sector those patients with long-term mental illnesses; but, with managed care being applied to both, and managed care companies having responsibility for total care, this shifting will become more difficult. However, a safety net is important and it is essential that the public sector, for example the DMH, retain care for the most difficult patients. It is easier to care for acutely ill public patiens than severely chronically ill patients by managed care principles. Current dialogue between the Massachusetts Department of Mental Health and Mental Health Management of America, the current vendor for the mental health carve out of the the State's Medicaid program, is of interest. MHMA, the comprehensive, privatized public sector managed care program, has recently been independently reviewed and found to have been successful in that quality of care, patient satisfaction, and cost savings occurred at the same time.

The Future

There is clear evidence tha there will be further consolidation among managed care companies. The smaller companies have been acquired by larger companies, and now the larger managed care companies have been acquired by the insurance companies or pharmaceutical companies. One example is that American Biodyne grew substantially and acquired Assured Health Systems, Achievement and Guidance Centers, Inc., and Personal Performance Consultants. This multiple entity was acquired by Medco Containment Services, a mail-order prescription pharmacy, in 1992, and became Medco Behavioral Care that was subsequently acquired by Merck Pharmaceuticals in 1993.

Another concern is that as industry consolidation occurs, there will be increased pressure to cut costs further, particularly with capitation, to a rate that will almost preclude delivery of quality care no matter how well streamlined and efficiently it is delivered. We are already seeing that the dollar figure carved out from health care for behavioral healh care has been decreasing over the years. It is as if success in delivering care cost-effectively is penalized by subsequent contracts being leaner.

Another trend that I foresee is the possible “carve in” of behavioral health to general health as insurers who deliver general health care now also own the managed care company delivering behavioral health care.

Lastly, I do feel that there will be increasing public-private collaboration and integration particularly as the country moves towards universal health coverage. This wll be a tremendous advantage in that the administrative costs of health care that are now about 25% of all health care dollars will diminish. The Canadian health care system has approximately 10% of its health care dollars go towards administration. Medicare is about 7%. There is no reason why Medicare/Medicaid, Veterans, CHAMPUS, state programs, Blue Cross, HMOs and commercial programs need to be independent entities. The recent response to the Massachusetts Department of Medical Security rebidding of the MHMA contract with many national managed care companies showing interest, clearly shows that managed care companies are moving into the new public care niche quite rapidly. I am therefore optimistic that “what becomes of community mental health” in the title of this lecture will be that mental health will include both the public and the private sector, and perhaps even be carved back into general health care.

In conclusion, health care is in turmoil which we are all very much aware, but how to deal with it remains controversial. Even when President Clinton made universal health coverage his No.1 goal that was a major factor in his election, the fact that he was not able to succeed in this his first year indicated how complex is the situation. I personally feel that we should move towards a single payer system as soon as possible. In that way, care will again be delivered by the physician or other health care professional directly to

the patient with minimal third or fourth parties intervening and attempting to micro-manage care. Thank you.

David Satin:

I hear Dr. Khan too accepting the reality of managing care and of dealing with financial structures and financial constraints. The things that struck me about were the mentions about what it does to the care of patients, and what it does to the practice of clinicians. How it divides mental health practitioners even more than traditionally from physical health practitioners, how it limits access of patients to clinical care, how it makes everybody--clinicians and patients--deal with middlemen who may or may not be knowledgeable about the issues that they're dealing with--mental health, and are sympathetic with providing care.

Joyce Burland, PhD

Alliance for the Mentally Ill of Vermont

Introduction by David G. Satin, MD

Joyce Burland has the last word on purpose, in responding to government, insurance and clinicians, because she represents patients and patients' families, what should be the reason for everybody else's existence in this business. Although as a clinical psychologist, she understands the caregiver's role, she is also a member of the Alliance for the Mentally Ill, and an articulate spokesman for them in the struggle over resources, priorities and public policies. Dr. Burland is a clinical psychologist who specializes in working with people with serious mental illness and their families. She was president for the Alliance for the Mentally Ill of Vermont, and has been still for the past three years, and is the originator of the AMI Vermont Family Education Course, a family-to-family teaching project, is director of Curriculum and Training for the Journey of Hope Family Education Program, and is the author of The Journey of Hope Family Education Curriculum, and the monograph, What Hurts, What Helps: A Guide to What Families of the Mentally Ill Need from Mental Health Professionals. Dr. Burland.

Joyce Burland, PhD

I am particularly happy to be here as a Vermont participant, to laud Commissioner Dalton's dedication to developing a public mental health system in our state that has been rated best in the nation. I'm delighted to have this opportunity to respond to his thoughtful commentary on what might happen to community mental health under managed care, and to bring a family perspective which will (as he knows from out encounters over the years) differ in some regards from his own.

I want to add that I am honored to be a part of this annual tradition remembering Erich Lindemann. Dr. Lindemann is a great hero of mine. As a graduate student, struggling to dinf a clinical home for my visions of working with individuals and families who have been traumatized by the devastating impact of mental illness, his compassionate, humane approach to people valiantly coping with life crisis gave me a philosophy of lasting relevance. His work also helped me grasp the radical implications inherent in his definition of a community of care, where all the people invloved in the treatment and restoration of a beloved family member had a vital role to play, where the subjects and the witnesses of life trauma were to be provided a network of support, and intrinsically valued, simply by virtue of their own lived experience.

I decied, then and there, that anyone involved in community mental health and dedicated to its egalitatian public mission, was surely on the side of the angels. Now I'm not so certain. We have strayed a long way from our goal to invent a caring community which grants true standing to all participants; we have seen a provider-driven bureaucracy grow pnderous and resist opportunities for flexible services which would greatly enhance consumer recovery; we have not yet instituted in any state a fail-safe system to serve those who suffer most persistently from severe disorders of the brain.

From the vantage point of consumers and families, progress has been slow and hard, and the winds of change bring little that is really new. Community mental health centers have always been "capitated" mangaged care providers of last-or-only resort, and the majority of these systems are understaffed, undertrained and underfunded. Public care for the seriously mentally ill has always been "carved out" from the full funded, full spectrum of clinical responses accorded to other chronic medical conditions. In fact, when you look at the record of mental health reform, each new epoch has left in its wake a graver problem for the mentally ill and their families to confront than those we were coping with before.

As I consider the history of reform that Commissioner Dalton annotated, I am struck by how differently we perceive it. Back at the turn of the century, the institutionalization of the mentally ill represented a movement with the highest moral purpose, but it devolved into a morass of human abuses that cried for redress. As a consequence of the patient's rights movement's response to institutional degeneration of care, we are left with such stringent requirements for obtaining treatment that a mentally ill person must deteriorate to the point of excruciating danger before criteria for hospitalization and refuge can be met. Some progress!

Deinstitutionalization, too, originally served the high ideal of "least restrictive" settings for patients responding to improved medications, but the array of services in the community, vital to the support of these disabled people, never fully materialized. We now have a permanent homeless mentally ill underclass in our cicites, and a huge population of mentally ill people in our jails. We also have a two-tiered system of service delivery that developed because very few private providers wanted to treat the "released" mental patient—a separate and grossly unequal system of public care which consigns thousands of young Americans to poverty and hardship because they cannot qualify for private insurance. Some progress!

The history of "sweeping change" in mental health systems has repeatedly propelled the mentally ill into the margins, back into invisibility, obscurity and perpetual insignificance. The wages of change have brought us more stigma, more stereotyping, and more isolation. Nor has the empowerment of the stricken individual ever, in over 100 years of reform, come to pass.

Now we are heating about another systems "improvement" called managed care, promising the ideal of comprehensive integrated services, promising parity with health care, promising the painstreaming of the mentally ill into services and benefits enjoyed by normal folks. Although this new goal is an ideal we may devoutly with, I ask you to consider this current revolution from our, by now, skeptical perspective: here we are, after a century of abject failure of high ideals, being approached by big time managed care players saying, now, "we haven't had a shred of experience with people who are seriously mentally disabled, and most of our data comes solely from outcomes in acute care cases of full-time employees of major corporations, and we don't know a thing about comprehensive, long-term services needed by people who are persistently mentally ill (except we have figured out how to unload the high risk consumer onto the public system)... but we want you to trust us to take good care of your relative with medication refractory schizophrenia!" Richard Surles, a former Mental Health Commisioner of Vermont, recently observed, "virtually no managed care organizations of HMOs have a product to serve the seriously mentally ill disabled". Yet without our ever being asked, we are being propelled headlong down the managed care road. The truth is, we really have no idea where we are going; except to feat once again that the more things change, the more they will remain the same...or get worse.

I also suspect that our definitions of parity and integration are utterly foreign to the managed care companies. To our mind, integration means a whole lot more than equitable insurance coverage. In out world, integration mandates that housing options and social support services must be joined with medical management; it would link mental health and substance abuse services, preserve non-Medicaid rehabilitation services, expand services to children and elderly people. Integration means getting equitable funding for these special populations so that capitation strategies can permit individualized services, encourage innovation, and expand choices. Is this interpretation of integrated service delivery even remotely relate to the entrepreneurial imperatives of mangaged care companies? Do they feel any real obligation to provide this array of services and options for individuals they have historically excluded from care?

Commissioner Dalton suggests that because community mental health providers have always been relied upon to deliver long-term care to the mentally ill, that these providers seize the moment, shape the future, and make managed care work for the special needs populations under their traditional jurisdiction. That is, thake what is best in managed care strategies and combine it with what we know must be done to improve the outcomes of those in the pubic system.

However, what is best about managed care principles is precisely what will cause us to founder when we seek to incorporate it into the existing public system—and that is its singular orientation on customer satisfaction, and its definitions of quality based upon

the value of the service recipeint. Are we saying that after generations of exclusion and marginalization, the public system will now enforce the ideal of consumer and family satisfaction as the litmus of service delivery? That we will be invited to sit at the table, to pariticpate in policy, planning and decision making? That our hard-won experise will be solicited and valued?

I have my doubts. As good as the Vermont Community Mental Health system is, it still has a long way to go—particularly in the realm of establishing any meaningful collaboration among the stakeholders. In Vermont last year, all 10 CMHCs organized to form a Behavioral Health Care Corporation without asking anyone to the table. No family advocate was there, no consumer advocate was there, to participate in a decision that would directly affect eheir lives for years to come. It has been almost impossible to achieve any sort of de-centralized access for consumer and families to address local service needs, or be involved in any way in the planning and delivery of services. "Customer satisfaction" is a standard we embrace wholeheartedly, but I'm not sure we think it will ever come to pass.

Nothing of the sort will happen unless we get in the middle of it and make it happen, demand that the providers of services live up to their word that outcomes will reflect sensitivity to primary and secondary consumer needs. The single most signficant change in the community mental health landscape in the last 15 years is the maturing of the advocacy movement on behalf of those with serious mental illness. Although families and consumers are the partners in the original blueprint of community care we have had to fight tooth and nail to gain the standing we were to be granted in the first place! Professor Lindemann could never have imagined how long it would take for us to become a meaningful part of this community of care, how much opposition we have faced from the system that was to welcome our participation. But we are here, and we are here to stay.

I think that in the torrent of change engulfing us, community mental health must return full force to its radical roots. It must re-invent intself and transform itself from a bureaucracy that has grwon too comfortable, and a bit too self-satisfied, into the creative system of its yester-years. You will need to rededicate yourselves to special populations requiring innovative approaches; you will need to reduce service fragmentation and cost shifting, and boldly integrate multiple levels of care for those who suffer chronic, relapsing illnesses. If you think the community mental health system does the best job of long term care, steal anything you need from managed care concerning efficiencies and cost savings, and use these surpluses to expand services for the people who need them so badly. As the Commissioner says, the quality and effectiveness of care for the seriously mentally ill can be improved. As Nike says, "just do it!"

But remember, this reform will fail like all others, and you will jeopardize the very people you are charged to protect, if you persist in going it alone. Don't "carve out" the participants who belong in this enterprise, who are the recipients of services, who will beat the consequences of the oversights of unilateral decisions made in their behalf. In this cost-consious New Order, we are at cirical risk of losing whatever ground we have gained. The need for joined advocacy, for strong joint leadership, for the monitoring of public monies in managed care systems, for public education about serious mental illness to assure that our "special populations" are well served, is more vital than ever before. We must include consumer and family advocates in the design, development and evaluation of any reformed system of care, and we must see that they are substantively involved in all facets of quality assurance.

I certainly agree with Commissioner Dalton's visionary key to the future, which would designate meaningful roles to all the key participants. This suggestion itself is radical: it requires a decisive step toward second order change—that is, altering the rules of relationship so that system improvement is the shared responsibilit of equal partners. We know that bringing in all the stakeholders, giving charted duties and granting "insider" status to family member and consumer advocated means a fundamental power shift that many community mental health agencies have stoutly resisted. I happen to believe that any vestige of institutional paternalism is a grotesque anachronism in this day and age, but some agencies hang onto this sovereignty for dear life.

I think we need to return to the essence of "community" as Professor Lindemann defined it. Community signifies a moral obligation to share power and resources, to establish peer relationships among those with differently-earned expertise, to create and involve para-professionals who are respected because of their hard-won experience, to form effective networkds of support and trusted alliances without regad to position or status. We must, as a necessary first step, secure this essential democracy in our work together.

No, it won't be managed care, or any other epochal change that will dramatically distribute power to the stakeholders in the mental health system. It will be you yourselves, you as the stewards of community mental health, who must do this, so that we can finish what Dr. Lindemann started.

David Satin:

I hear Dr. Burland saying that the people affected by the system need to participate in the system, and it needs to be for their good. I would like to hear how that connects with the technical issue of carving out or reintegrating or managing or capitating. The hour is late, so why don't we open the discussion to everybody.

Discussion

David Satin:

Carving out can mean different things in different settings. It can mean carving out on the basis of service, carving services out, then that can be good, that can be focusing special resources and special attention on giving. If things are carved out on a financial basis because of costs, to me that is danger, that means the special attention is going to be special attention in terms of cost savings. I don't hear anybody saying special attention to give more money to, or more other kinds of resources to, and the whole tenor, the whole language of mental health endeavor has changed. People don't talk about asylum, they don't talk about caring, they don't talk about therapeutic relationships. They talk about behavioral health. What is behavioral health as compared to psychiatric care, for instance? Some of the other organizations have such creative names, Nasir rattled off several of them, and all of them get around the issue of, is it caring for sick people, is it giving comfort to those in need? Where comes consumer, vendor, market, product? What does quality assurance mean? Brought back to 1984 newspeak--what does quality assurance really mean? What does utilization review really mean? What do case managers manage? What do patients advocates advocate for? What is the system we are involved in, and who is it for? And does carving this out, and paying special attention to it, who is it doing good for? I must say that we're all talking money these days, and my suspicion is that it all has to do with what it costs, and what it does, who it does it for comes after that. My last question is, we cannot afford it. We cannot afford this care system. The nation cannot afford it. What can the nation afford? What is the money going for? Why is it we can't afford this kind of thing when we can afford that kind of thing?

Participant:

I have a couple of questions and a couple of comments, but just reflecting on what you last said, I guess my question for you is ,under the old system of community mental health, what is it that we were buying, with notions like asylum and care and the therapeutic relationship? Did you, as a provider or a purchaser, have any idea what it was that you were buying? Because while you emphasize the dollar notion, I could turn around and say what were we buying under the mental health system? Because if you can measure what you're buying then you can talk about quality, and I agree with you that quality assurance is out, I think we're talking about quality of management. And by the way, one of the main indicators leading to depression, which affects the chronically mentally and I think that's great, and I think that gets people in the ballpark.

My second question is that I wonder what people from Vermont think of the Massachusetts care? I work for NHMA, I'm the regional manager, I think we have done a good job, we're not… but I think we told our customer, Medicaid, we told them what to fund, we told them…stay, we told them…outpatient, we told them… diagnostic categories. In some ways we've been able to work with the Department of Mental Health as a major stakeholder from the bottom level all the way up to the top in ways that I think have worked well. I think we've helped them drive their own… in a lot of good ways, but I'm interested in your perspective, what you think. But I think the quality in whatever you've bought…

William Dalton:

I'll try. I don't think that we knew too clearly what we bought ten years ago. I don't think we know too clearly what we're buying now. I think Joyce was right on the mark, it's because we haven't paid attention to people and what they're telling us what it is, what it should be, what we should be buying. And this is so variable again, for the lawyer in me, from jurisdiction to jurisdiction, I mean there are some economies of scale in Vermont that make it so completely different from Massachusetts. When your organization first came into Massachusetts, it could succeed easily. All it had to do was put a gatekeeper at the front door of every institution in terms of support for chronic individuals, and to redirect and you were very cost-effective in that fashion. I think probably what I don't know is what you've evolved into and how much more sophisticated you are. I also don't know how much you're doing with the non chronic population at this point in time, whether you're managing, like for example the waiver. I've heard less exciting things about some of the things that occurred there in terms of pushing, avoidance of services, and I don't know if that is even an organization that's doing that, but I'm not up to speed at this point. I'm not saying these things to avoid an enraged phone call either. I do think that if you're a service provider, that you could become a stakeholder, that you should be at the table as well. I don't think that you should take over, and I fear greatly the responsibilities of any managed care organization taking over responsibilities of the state mental health authority. That's my bottom line. I only have one answer, and that was the answer of making sure we keep working at this and fine tuning it and making sure it becomes a more and more inclusive process, and we don't know, and then all of a sudden we're going to have a change in the state of the art that we're going to have to respond, some of these new medication have done some wonderful things and have caused some unexpected problems that have forced changes in the delivery system. If we could have jurisdictions that would be committed to that change process and committed to involvement, I think we would go a long a way.

The other point around the money is quite simply we're going to pay now, we'll pay later even as we're paying now. If we do not begin to seriously address the costs of long-term care now, they will double in the year 2004 or whatever the case may be, and it will eat us alive, but it is in fact the long-term needs of our citizens, in my opinion, which are the bottom line. Acute care is almost an afterthought, if you really think about what it is. If you want to live in your community and want to lead a normal life, then these are the support systems that are necessary to do that, and then if you get sick or have an episode, then you ought to have access to that as well, but we are simply not addressing this. The Clinton administration didn't address it. In Vermont we are hell-bent for…leather on putting in universal access in acute care, and by God we know it's too scary to think about long-term care and what's really there on behalf of elderly needs, of elderly individuals, anybody with a developmental disability or a person with chronic mental illness.

And again where I see this being doubly frightening is is that I think that we have done an even worse job, if it's possible, in terms of support for children than we have for adults, and I think that's the tip of the iceberg. I think that societal pressures and everything else on our kids, the undiscovered biological problems that they have or the mix of those things is absolutely frightening and inpatient and outpatient services, case management won't do it. What are we going to do about that? That's a long-term care need that has to come, that has to be put up front, and it's not. Nobody's dealing with it, and if we don't deal with those things then we will truly reopen the institutions, because we won't know what else to do, and half the institutions will be correctional.

Joyce Burland:

I think it's already happening now, that there are more people today in jails than in mental hospitals. I mean, we have institutions, they just aren't the ones that are needed, and again the population gets shifted and marginalized and becomes invisible again. If you don't have long-term care, you can make them real invisible, and that's, so we see this happening again.

Nancy Langman-Dowart:

I think also broadening the scope of looking at this, I think it will be very important over the next couple of years to look at what's going on in primary care practices, and how much of that really is behavioral, and I hate the term behavioral, I want to make a comment on that too. You didn't hear me use that term in my presentation. I say mental health because I think all the companies have moved to the term behavior to say this is behavior, this is not a biological disorder, this is not a serious illness. It diminishes it, it

undermines it, it says it shouldn't be covered by a payer, so I always avoid the term behavioral. I dislike it intensely. Anyway, I don't hear any disagreement on that.

The issue of looking at primary care practice, the enormous amount of dollars being spent probably inappropriately for care for people who are coming in with anxiety disorders, with untreated alcoholism, with untreated depression, that if we were better at keeping those patients out of primary care offices and shifting those dollars over to the mental health side, people would feel more comfortable with parity, and I think until we can identify that we're never going to get to parity, and we're never going to get those dollars to be spent for the seriously mentally ill.

William Dalton:

And I say that we've got to find a way to quantify that, I think that's just a down and dirty underpinning to all of this, which is if we don't get our act together to figure out what that really means, to find a new buzzword or whatever it takes in terms of what we're talking about then we will continue to be a stepchild in this whole process, because there simply isn't enough money to go around, and money is going to go to the services where people value, and at this point in time I think we have a ways to go.

Nasir Khan:

David, I just want to add one point on the money aspect which is the trend which is really disturbing is it's happened in capitation, it's happened with other managed care. A job is done, certain capitation wages is agreed upon, and care is provided, and when that contract comes due, three years later or five years later, they see that in fact a suitable savings has been proved by efficiencies and therefore the recontracted wage is less than the original. In other words there's a sort of penalty for being efficient, and there might come to a point where the money is not there, no matter how efficient you are. In other words there's a ratcheting down. To some extent it's appropriate because when you have a totally unmanaged system there is a lot of waste, and so the people who got in first have the potential for making profits from the managed care company. There is this pressure…

Nancy Langman-Dowart:

It was easy in '85.

Nasir Khan:

I think we have been vigilant because there is a certain minimum beyond which we can't go. By the way, also on the money, the cost of mental health, in fact all health care, is one of the highest in the country. Is that bad? It's very well managed care…utilization and everything else, so maybe another way of looking at this is that in fact in

Massachusetts you will get your needs taken care of, because there is less and less inefficiency and waste. If Massachusetts is the number one in the country in terms of managed care penetration, and the cost is the highest, I feel bad for the other people.

Participant:

I won't know that and I won't trust it until I hear from your customer that they are satisfied with the quality of the services and these are the services they want. And that's what always seems to get left out when you say, what is quality assurance? It is going to the customer. Not just saying 'Did you like it, did you not like it?' but actually involving the customer in the design of services and letting them be a part of the creative mix. People who are certainly mentally know a lot about what they need, they know a lot about what they need, and what they don't need is to go back to the hospital, and then we do everything in the world to keep people out of the hospital, because there are so many interventions that we can use without that.

Participant:

Well, I actually, it's more of an observation than a question. My observation, and I live in Rhode Island, very near Massachusetts. The consumers in southeastern Massachusetts are not getting…I was really getting a little agitated…presentation…quality assurance and in fact Dr. Burland finally mentioned outcomes. That to me is consumers most…You can say everything you want about managed care. What I want to hear is what are you going to do to get me better and get me to function. Bottom line. I don't care about the rest. I don't care about what doctors get paid, anything else. And I think that I can advocate for myself…really having to consider what we need to do. You know, I looked at that quality assurance thing and I saw customer satisfaction. That should be the very first thing--not down the list, I mean I talked to people who, frankly, I wouldn't trust giving directions to. Credentials don't mean that much. I've gotten better treatment from LCSWs than I have…and so, you know, those are main factors for everybody to consider.

Nancy Langman-Dowart:

You know one of the things that clearly the insurance environment the payer side has to learn from community mental health, demonstrated in a program we put together, Catastrophic Case Management Program, where we actually bring the patient, the family members and all of the treatment providers and we say, 'What would be helpful?' And we…benefits and talk about finding appropriate treatment plans and having them be community-based and having them be not episodic oriented, and in that program we work with, MHMA, we work with DMH we never dump the patient. We literally sit down and figure out where's the best care for this person. Unfortunately, the resources aren't

there to do that at the level we'd like to do it. We have 250 cases in that program, we have too many uncovered lives, so it's not enough. It's clearly not enough.

William Dalton:

One of the things that's interesting to me is whether or not we could ever get to the point where, and probably this is not inconsistent with the single-payer system, where we would view whatever premium we use to purchase services as being owned by the consumer, she would control the dollars, and therefore have a weapon or a tool to not only pick and choose but ??? that's sort of my socialistic feeling about. You don't tax anything but people anyway, they're the base entity. But anyway, the question of control that Joyce is talking about is a very, very serious one, and there is not one other stakeholder in the process, including family members, who don't have a need for control probably that's greater than anyone else's need for control. So it's a real challenge to try to make that compromise.

Participant:

I'm a psychologist at…Health Center, and part of the… that we're having is trying to… the long-term cases are the children, not so much…the children who are really disturbed and…that are both services that the city dried up because it's not a viable financial business, but our adult services should be handling adult cases are on my case…I have three children…mothers, I have a multitude of mentally ill, schizophrenic, very characteristic character disorders of parents where the work is hard and I'm trained as a generalist, but I'm not trained specifically in dealing with the kinds of mentally ill that both the services are…child clinician, and many of the child clinicians are not trained at all to handle those services. They're not trained to be dealing with where the work needs to be done--with the parents, because these children are … And these are the cases that we are carrying for many years because it's the only…in the child's life… a connection…but we just don't have the resources in this managed care system that even a less viable…the family, and…disturbing… For us we're not viable, our purpose right now is on hook them…them, getting them out…all those marketable things that people have been questioning here…experience with working with primary health care and the market match…

William Dalton:

Yup. The only good thing that I think structurally on that issue that's happened in Vermont, there's some programmatic issues such as intensive family day services, where welfare and people are trying to deal with the totality of the situation, but is is that we have three populations that are actually incorporated into our law that says that the state mental health authority is supposed be open. One is MR/DD, the other one are adults

with serious mental illnesses, and we allude to children and adolescents with a severe emotional disturbance, and that population is defined as children and adolescents with severe emotional disturbance and their families. Now that's intended to provide support for families with tough kids. It also means, from a clinical point of view, that the wrap-around services that might be needed can be brought in to just an individual kid. But that's in statute. I'm not saying that we get comprehensive services anywhere near at the level that…But at least family members got mentioned once.

Joyce Burland:

What I'd just like to say is that family members that maybe is part of the creative mix here is as these cases come to through the, if you want to find an area that's really invisible it's the understanding of mentally ill people in parents, the people in families themselves, and they feel hopelessly lost, they are not supported, and I would hope as we move forward that this may be discovered, and there may be discovered clinical ways of looking at families with mental illness which is less pejorative and more helpful, because this simply hasn't been done. You're going to hit these invisible conflicts all the way along. Mentally ill people and AIDS--my gracious--we don't talk about that either, you see. That's simply, we're going to find it clinically, they're going to be there, and I would hope under the systems that are coming that that in turn engenders some understanding, and that's a target area, and this is what we have to learn.

Participant:

One question, though I hesitate to open up a difficult problem, but I'm perturbed by this notion of pharmaceutical companies taking over managed care, and of insurance companies, and this whole issue of what our government would like to refer to as privatization overlooks the nonprofitable area or sector, sometimes called the third sector or the voluntary sector. And I know Blue Cross/Blue Shield is a nonprofit insurance organization, one of the, whereas most of the ones engaged in managed care are doing it for profit, and I don't know how many of you saw the eloquent op ed piece by Suzanne Gordon, and I think in Monday's Globe, and when she talks about the mistakes being made in health care, medical care, it just didn't have to do with mental health services, but I think she alluded to the least trained people are being employed because, of course, they cost less, and there is this enormous profit that I thinks need to be averaged to 25% or perhaps…the large salaries at the top, to bring the administrative costs up 25%, which is I think appalling, and I wonder if we don't need to give attention to developing and emphasizing the voluntary or non-profit oversight and organization and the more humane and compassionate possibilities that exist within a non-profit

organization that are automatically and almost by definition ruled out when they are undertaking the for profit.

Nancy Langman-Dowart:

Let me comment on the pharmaceutical issue. When Merck purchased Medco Containment, they were not pleased to also get American Biodyne along with that. They were not interested in that end of the business, and they have been trying to unload that end of business since day one, they would like to divest that piece of the business, so they don't want it, and they don't see it as a profitable business for them to be in, they don't see it as consistent with their long-term goals.

David Satin:

We've run late, because it's a good topic and people have more to say, and I hope, as with other Lindemann lectures, this is a stimulation to more discussion and more thought and more action. Let me invite you in advance to the Nineteenth Annual Erich Lindemann Memorial Lecture next April or May. Thank you for coming.