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

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Foreward

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

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

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

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

The Erich Lindemann Memorial Lecture Committee presents

THE TWENTIETH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Fostering Communication and Collaboration Among Caregivers: Taking Responsibility for Our Community Mental Health

The mental health of the community once was implicit in culture and family. As we became diverse and less self-sufficient government represented our collective responsibility for the community. Now public services are withdrawn in the name of economy and individual responsibility. How do mental health caregivers and agencies assume responsibility for their communities' mental health? Since none can do this alone, how can we pool our concern and efforts to make them effective, fulfill our professional duties, and relieve our lonely burdens?

Lecturer

Bruce L. Bird, PhD, Chief Executive Officer, North Suffolk Mental Health Association; Chairman of the Board, Massachusetts Behavioral Health Network

Discussants

Paul J. Barreira, MD, Deputy Commissioner for Clinical and Professional Services, Massachusetts Department of Mental Health

Peter Gumpert, PhD, Founder, American Mental Health Alliance

Glenn S. Koocher, MPA, Manager of Programs and Advocacy, American Association of Retired Persons for the Northeast United States; Editor, Trends in Integrated Health Delivery Systems

Moderator

David G. Satin, MD, LFAPA: Assistant Clinical Professor of Psychiatry, Harvard Medical School; Chairman, Erich Lindemann Memorial Lecture Committee

Friday, May 2, 1997, 1:30 – 4:00 pm

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

Introduction by David G. Satin, MD

Man's humanity to man, to paraphrase Robert Burns ("Man Was Made to Mourn" 1786), waxes and wanes. There are eras in which society is concerned for the weak and needy, and eras in which other values take priority. This is reflected in cycles of psychiatric ideology—social psychiatry (in which Erich Lindemann was so involved) reflecting a concern for the welfare of people and their communities, and biological psychiatry reflecting a concern for impersonal principles aside from (though often for the benefit of) functioning people and their social environments. Society can implement its values through the action of individuals or voluntary groups, or through government, which, in a democracy, is the creation and will of the people.

The era of community mental health was the flood tide of concern for human welfare and the solution of social problems. Academic studies and voluntary agencies, which pioneered in this, were later swamped by government programs, institutions, manpower, and funding. The political reaction and ideology of biological psychiatry that displaced community mental health emphasized material productivity, business, and financial retrenchment. Government has progressively withdrawn from welfare—and specifically mental health responsibility—in favor of economic development, reaffirming Calvin Coolidge's principle that, "the chief business of the American people is business" (1925). In Massachusetts, budgets have been progressively reduced, facilities have been emptied and closed, programs have been terminated, and services have been transferred to private agencies—sometimes profit-making businesses.

What are we to do when governments no longer provide the structure and resources for mental health care, and private agencies are not capable of replacing them? How are people in need of mental health care and caregivers to carry on? In addition to the welfare of individuals, who is concerned about and responsible for the mental illness—and health—of the community as a whole?

These are the issues we address today: What can the community—lay, clinicians, and administrators—do to take care of its own mental health? Our lecturer and discussants address this question with a rich variety of experience and representing a broad range of interest groups.

Bruce L. Bird, PhD

Chief Executive Officer, North Suffolk Mental Health Association; Chairman of the Board, Massachusetts Behavioral Health Network

Introduction by David G. Satin, MD

Dr. Bruce L. Bird represents the mental health facility which has tried to find ways of continuing to care for its community. He has a grounding in clinical psychology and behavioral medicine. He built from this to the administration of treatment systems for extensive community populations. Currently he directs a large, community-based consortium of treatment programs to meet the complete spectrum of mental health needs. Dr. Bird is the appropriate person to speak about communication and collaboration to meet community mental health needs.

Bruce L. Bird, PhD

Introduction

Over the past 15 years, sweeping changes in the healthcare delivery system have impacted every aspect of community mental health. Driven by the economies of our nation and our world, and corresponding changes in public sentiment and policy, and by advances in the science and technology of healthcare, their effects are felt by each and every individual receiving services (Etheridge et al, 1996).

Community mental healthcare providers are being asked to provide more affective, accountable, and diverse services to meet increasing needs. Resources in the overall system are remaining level or decreasing, and are being managed in new and often challenging ways. Some feel this is progress, others that the changes threaten fundamental values and benefits to the most vulnerable in our communities.

This presentation reviews changes in behavioral healthcare from 1980 through today, and forecasts changes through 2010, from the perspective of a community mental health provider system. Examples from the North Suffolk Mental Health Association, a large comprehensive system serving over 12,000 individuals annually in Boston, with a long history of affiliation with the Massachusetts General Hospital, are used to ullustrate changes and provider responses. Themes from the work of Dr. Erich Lindemann relevant to today’s issues are included. The discussion then describes the challenges and opportunities for community providers who hope to maintain and improve services to those individuals and populations to whom they have committed their organizations.

A Brief History of Mental Health Services

Milestones in Public Health Services for the Mentally Ill

A very brief history of services to the mentally ill in Massachusetts parallels the changes in services throughout the U.S. Eras of service might be defined as the period of rising institutional care from 1900- through the 1960s, followed by privatization in the 1980s, and the beginning of managed care, now moving with full momentum in the 1990s.

Table 1 illustrates salient events in the history of mental health care in Massachusetts, excerpted from the DMH annual report of 1996 (Sudders, 1996). The trends indicating periods described above are obvious. Missing from this list are additional events, defined in Table 2, which have also significantly impacted mental health care in Massachusetts. One notable development has been the splitting of advocacy, in which the National Alliance for the Mentally Ill, with its state chapters, developed as a "pure advocacy" system apart from the provider's sector. The corresponding development of stronger provider associations, such as the Mental Health Corporations of Massachusetts, grew to have their own significant impact on public policy. Although there are not organized policy studies of the impacts of these changes, during the period from the 1970s to the 1990s, most community mental health centers lost the involvement of many or all of their "association" members, and developed more business-like management, with limited nonprofit governance structures. This splitting of advocacy and volunteerism from service provision represented in part an adaptive response to the changing environment, as community mental health centers became relatively large business operations. However, it has posed new challenges described below as community providers seek to re-engage the general community in their missions.

A second notable development has been the rise in dependence on Federal Medicaid and Medicare funding for services to the mentally ill. The enormous rate of growth in these two entitlement programs have contributed to the counteracting movements toward public sector managed care, which have so greatly impacted services in Massachusetts in the past four years.

The trends in institutional vs. community-based care are obvious in Figure 1, which depicts hospitalization from 1910 to 1996 (Sudders, 1996). Trends in the last 15 years, described in Table 3, are equally telling, as care provided in public institutions has been replaced by privately provided hospital and commnity-based care in residential service settings.

Do the changes in Mental Health and Behavioral Healthcare mean that we have been making headway in meeting the needs of our communities? Unlike many public

health problems, we have great difficulty measuring our incidences and our outcomes, and so have very poor indicators of our needs and our successes. As and example, Table 4 illustrates varying indicators of the incidences of serious mental illness in the U.S. population. Frank and Mcguire (1995), in reviewing the varying estimates of what Clinton Administration's National Health Security Act's proposed coverage of Mental Health and Substance Abuse care for the then uninsured, have reviewed major differences in what expert analysts said the plan would have cost. These estimates ranged at the time of the debate on the Act up to 245 percent higher than the cost of covering a typical insured person. Frank and Mcguire (1995) have pointed out the problems and potential errors in these analyses. The rather frightening costs and the large variation in estimates obviously did not help the Act pass.

Clearly the stakes involved in more objective, more available information are critically high. This point will resurface in discussions of expected outcomes of the various stakeholders in public mental health systems, as the U.S. healthcare system moves toward increasing consumer-driven accountability.

The Cyclical History of Community Mental Health

Ruth Caplan has described the cyclical rise and decline of community mental health in three "revolutions", in the 1830s, the 1880s, and the 1960s (Caplan, 1969). It might well be argued that the current period, in which a combination of factors, including the rise of managed care and an increasing array of service options in the community can be considered a fourth. Among the issues Caplan cites as contributing to the previous declines, several echo in today's environment.

For example, Caplan cites one factor as a shortage of skilled manpower. In today's environement, the ussue might be characterized as an oversupply of professionals but a shortage of diverse professionals trained in community- and empirically-based treatment technologies (Sperry et al. 1997). Shortages of economic resources can be translated today into a questionable adequacy of all available resources, and significant problems in the manner in which available resources are distributed.

Three factors in previous declines are clearly being addressed in today's changing healthcare systems—a focus on one parameter of treatment or services vs. a multifactorial approach, a lack of sensitivity to criticism and dissent, and a lack of attention and resources in program evaluation. Today's promising technologies are combining innovative appraches in multidisciplinary and multi-systems approaches (Goff, 1996; Santos et al., 1995), the provider community is actively seeking consumer criticism and input (Kertez, 1996), and funders, consumers, and providers are increasingly acknowledging the importance of outcomes (Fawcett, 1997).

However, two other problems cited by Caplan bear continued vigilance: the overselling of promises and subsequent disappointments by the public, and a failure to learn from history. The development of an effective array of community services, even with today's promising technologies, is imperiled by the very high expectations for cost-effectiveness by the public, and is vulnerable to the clinical and economic resource limitations which eventually impugned the once heralded deinstitutionalization movement in the 1960s. Our ability to learn from history in these matters is an empirical question.

The Lindemann Legacy—Themes for Today

As the behavioral healthcare provider community faces the changes in our systems today, the legacy of Erich Lindemann offers significant implications and guidance.

In addition to the trends in periods in the history of mental health services described in Table 1 and discussed above, the establishment of the first community mental health center in 1948 in Wellesley by Dr. Lindemann is noteworthy because it so precedes the trends toward community services, and had such an impact on Psychiatric and behavioral healthcare policy and training. Erich Lindemann's vision of this endeavor was that it would contribute important knowledge about the social environment to the professional disciplines and science of psychiatry, and would engage the community in diverse ways in the promotion of mental health and the organization of community resources on behalf of mental illness (Lindemann, 1987). In his work on response to crises and grief, the West End Project, his founding of Social Psychiatry, and his contributions in the Group for the Advancement of Psychiatry, Erich Lindemann envisioned a broader role for the psychiatric clinician and researcher as immersed in the community "where the action is".

Several of these themes will be noted in the subsequent discussions of today's challenges and opportunities.

Changes in Behavioral Healthcare, 1980-1995-2010

Table V depicts an overview of changes in behavioral healthcare from approximately 1980 to 1995, and forecasts changes predicted to occur by 2010. The array of available services is predicted to be more diverse, with more flexible and individualized services in community settings. Technology, although more flexibly delivered, is forecast to be more standardized in the form of practice guidelines based on empirical evidence linking diagnoses, functional levels, comorbidities, treatments, environmental supports/resources, and outcomes. Providers will continue toward more integrated systems of care, with physician-developed treatment plans utilizing an increasingly diverse array of professionals, paraprofessionals, and community supporters. Funding

will continue to move toward global capitated managed care, and is unlikely to increase significantly over time, reflecting a net decrease after inflation. The provider community will continue trends toward privatization and consolidation, to improve integration of behavioral and general health care, reduce overhead, and manage large risk-based contracts. Perhaps most importantly, increasingly public data on outcomes and consumer satisfaction will shape the nature and array of services.

Each of these areas of changes are discussed in detail below.

Service Array and Utilization

As noted in the brief history on mental health services, there has been and is predicted to be a continuing shift from inpatient to community based services. Of the 5.4 million people in the U.S. who sought mental health treatment in 1990, the NIMH now estimates that less than 7% required hospitalization. The new NIMH (1997) Guidelines for Hospitalization for consumers and families clearly presents the view that hospitals should be used for evaluation and stabilization, and offers suggestions and supports for those coping with the prevailing philosophies of community-based treatment.

As also noted above, a proliferation of alternative residential and supported housing services are now available to consumers, offering increasingly diverse living arrangements and correspondingly diverse and customized models of care and support for individuals. Within the North Suffolk system, over 300 individuals now live in residences or apartments, with staff coverage and services ranging from one-to-one round-the-clock ratios to arrangements in which staff drop in to check on consumers at appointed times each week.

Likewise, day treatment services, previouslt more standardized in programs for all clients, now offer a range of services tailored for the type of problems addressed, such as diagnostic-specific groups, groups for individuals dually diagnoses with substance abuse and mental health problems, services for specific cultural groups, and short-term services for individuals in community re-entry after acute hospital stays.

Functional skill training for community living, job-related activities, and self-advocacy have replaced the milieu therapy approaches of years ago in borth residential and day treatment settings.

In response to a period of rapidly rising utilization and costs through the 1980s, outpatient services have increasingly been funded and so limited by managed care entities. Examples include public and private sector managed care, with private insurance vendors such as Blue Cross and Harvard Pilgrim Community Health utilizing similar limitations or protocols for outpatient services as the Medicaid vendors such as the new Massachusetts Behavioral Health Partnership (MBHP).

More diverse outpatient models, such as Intense Outpatient (services of 2-4 hours for 3-5 days per week) and Urgent Outpatient services, in which a consumer can receive a physician and clinician appointment within the same day, have been developed to meet new needs. As discussed below, the contents of services have been changing in response to these market pressures—providers have been seeking to develop or adopt "practice guidelines" which will produce the maximum benefit for minimum expenditure of time and effort, given the consumer's needs (Stout et al, 1996).

The development of "Community Treatment Teams" using the Program for Assertive Community Treatment model or variants thereof have also grown in prevalence and diversity (Santos et al, 1995). As discussed below, these services provide clinician and paraprofessional outreach workers who provide for the care and treatment of individuals in the community with needs ranging from very high risk and intense problems to those needing minimal support. As noted below, the cost-effectiveness of thses approaches vs. traditional hospital-based programs have increased their popularity (Degan and Nelson, 1996).

A significant increase in the availability and sophistication in the technology of crisis or emergency services has grown in response to the need to improve the quality and cost effectiveness of dispositions other than hospitalizations. Emergency services in Boston have benefited from reasonable funding and a system which ties many of the major Boston providers in a national model program suppored by superb clinical and information technologies (BEST, 1996). In these models, emergency-room based or mobile clinicians backed by psychiatrists and connected on-line to a sophisticated clinical and data information system use an "expert-system" series of protocols to assess and divert or admit individuals in crises to a broad array of emergency or routine behavioral services. The resulting quality and post data have been impressive (BEST, 1996).

As a result of separated funding sources and separated providers, the lack of integration of services across behavioral and primary medical/health care has been a significant problem in the field over the past several decades. Coordinating care for all cases, and particularly those of chronic, multiproblem high-utilizing individuals, with increasingly complex technologies, has become a major concern of public policymakers and providers alike. New initiatives at the funder level are attempting to improve coordination by providing consolidated funding, or "global capitation", which places the burden of managing all funding and so the responsibility for managing all care on integrated service organizations (Lopez and Rovner, 1997). At the provider level, initiatives are underway to reuinite separated services, including an example discussed below.

Trends across all services include a goals set to produce movement of consumer services from more intense and restrictive and so less costly to less intense and costly. Lengths of stay in all programs are predicted to continue to be under pressures to be minimal, with two notable exceptions. Those are supported living, at some levels of minimal needed support are sustained, and case management, which will be titrated as needed to monitor and assist individuals to access care and services to the extent they need it (Degan and Nelson, 1996; Mullahy, 1995).

Case management services, in which a team-designed service plan is managed by trained clinical staff, with the possible assistance of paraprofessional outreach workers for intense cases, has been increasingly identified as critical for high quality cost-effective care (Mullahy, 1995). In fact, the role of behavioral case management for complex cases has become paramount in successful management of any defined population to be served (Jenkins, 1997). Defining the criteria by which case management decisions should be made in what are termed "clinical pathways" or "disease management" models will be just as challenging as defining the relationships among diagnoses, treatments, and outcomes needed for individual treatment practice guidelines noted above.

Prevention has only recently begun to receive renewed attention of funders and service providers, as public policy and private funders have renewed interest in these approaches (Etheridge et al, 1996).

Technology

Sperry (1997), in reviewing the promise and limitations of the current technology for measuring outcomes of behavioral health services, has identified three major changes in clinical psychiatry since the 1980s: a shift in viewing diagnostic evaluations, from symptomatic distress and personality factors to focused assessments of life functioning (skills, deficits); a shift in viewing treatment emphasis from generic and psychoanalytic to focused treatments aimed at decreasing symptoms and increasing functional capactiy; a shift in viewing measurement of therapeutic changes, from pre- and post-treatment, to concurrent measures, which are effective in guiding both the researcher and the therapist in identifying the indicators of changes during treatment. All of these trends are shaping technology in today's community mental health centers.

At institutions such as the Massachusetts General Hospital, clinical services have increasingly become dominated by treatment approaches supported by scientific data, particularly psychopharmacology and cognitive behavioral treatments. The literature on clinical efficacy has continued to demonstrate movement in the same directions—toward empirically-based therapeutic technologies (Barlow, 1996; Goff, in press; Mueser, 1995). Mueser's (1995) detailed review of the schizophrenia literature clearly indicates the

contrasts in the ineffectiveness of psychoanalytic treatments vs. the potency of pharmacological and behavioral approaches. Alan Stone's recent (1997) popular but scholarly article on the changing role of psychoanalysis in society, no longer a dominant psychiatric treatment, and an ineffective explanatory construct for most Axis I DSM-IV disorders, but a tool for "exploring the mysterious otherness of one's self" to help us deal with "our ordinary human sufferings" is another powerful indicator of these changes.

Despite the significant advances in basic science and clinical literatures on treatments, there are still major limitations (Mueser, 1995). For example, the Serotonin-Dopamine Antagonists have demonstrated great potential for reducing negative symptoms of schizophrenia and extrapyramidal side effects (Goff, 1995).

However, there is still a need for additional evidence to confirm indications of improved patient compliance with medications and reduced hospitalizations. Likewise, despite all of its promise, Voit (1995), in a recent NIMH survey of the psychosocial rehabilitation literature, has again noted the deficiencies in cost-effectiveness data on psycho-social rehabilitation treatments.

Perhaps more troubling has been the lack of scientific support for increasingly popular short-term treatments, such as "solution-focused" therapy, which has been widely promoted and utilized by clinicians, despite having no basis scientific explanatory principles and virtually no evidence from controlled studies of efficacy (Kingsbury, 1997).

The literature on community-based treatment methods, as discussed elsewhere, raises similar concerns. Despite the widespread acceptance among clinicians of the findings that rehospitalizations of chronic cases are impacted by aftercare, the contributions of identified variables in these outcomes are still poorly understood (Own et al, 1997).

Overall, the progress in utilizing data on client progress and outcomes to develop treatment technologies has been promising. And the promise of powerful new communication technologies is great. For example, Baer et al (1995) have reported on the utility of an automated telephone screening survey for depression. It is clearly predicted that more cost-effective and sophisticated electronic linkages will be utilized to bring appropriate care, treatment, support, and consultation into the community to a wider and sicker array of patients. Training community clinicians, and especially re-training traditionally trained clinicians, has been and continued to be a great challenge, as noted below (Fawcett, 1997).

Funding and Public Policy

There are obvious strong public policy limits being places on the total amounts of funding and the allocations of resources for all aspects of healthcare (Etheridge et al,

1996). Unlike many states, Massachusetts experiences its major financial crisis prior to 1991. Many states, with largely unchecked and rising costs in Medicaid and Medicare have found their state budgets overspent by hundreds of millions, or billions of dollars. New York, for example, is attempting to reduce its annual state health care expenses by about $3 billion. The costs of mental illness and substance abuse to our society, when productivity and crime are included, are staggering, at over $314 billion in 1990 (SAMSHA, 1995).

Providers, consumers, and advocates of services all face the prominent public concern about rising health care costs, which have contributed to a $200 billion annual federal deficit, a forecast bankrupting of the Medicare Trust Fund, and an average 12 percent annual increase in Medicaid spending (Abbey, 1996). Managed care has been seen by many as a means to hold down costs without jeopardizing access and quality. This view, however, is not without controversy.

From 1976 to 1995 the number of individuals in the U.S. enrolled in managed care programs grew from 6 to about 56 million. From 1965 to 1995, Medicare enrollees in managed care gre from 309,000 to 2.5 million, and from 1984 to 1995 Medicaid enrolleese grew from about 1 million to 12 million (Health Care Financing Administration). These trends are likely to continue, as managed care companies have been successful in holding down costs.

As indicated in Figure 2, which shows national data on employee benefit programs, expenditures for alcohol, drug, and mental health services as a percent of total health expenses decreased from 1988 to 1992. These decreases are thought to be materially impacted by managed care (SAMHSA, 1995). Estimated per capita costs vary enormously, depending upon the definitions of populations, but range in the thousands of dollars per capita for SPMI populations (SAMHSA, 1995).

The rebidding of the Massachusetts Medicaid Behavioral Managed Care Carve-Out contract awarded to a new vendor, the Masachusetts Behavioral Health Partnership in 1996, signaled continuing support of managed care. Results of the first three years have been reviewed as mixed, with costs held down, access to outpatient services up, and inpatient services down, and, despite progress in this area, a atated need for more objective information on quality and outcomes (Beinicke and Periman, 1996).

Nationally, about 56% of all behavioral healthcare costs are funded by the public sector, which attracts national propriety level managed care companies to this arena. Table VI illustrates the dominance of these companies in the current market.

The public positions of professional provider associations have been increasingly vocal against managed care. In the latest round, in February 1997, an alliance of the American Psychological Association, the American Psychiatric Association, and seven other provider associations representing nurses, social workers, and counselors, joined

in issuing a “Mental Health Bill of Rights” with the stated purpose of protecting consumers against the evils of managed care. The American Mangaed Behavioral Healthcare Association, representing 19 Managed Care companies, has also issued a “Bill of Rights for Consumers Accessing Behavioral Health Services”. Table VII illustrated differences in these two statements (Kertesz, 1997). The AMBHC has challenged the coalition’s statement on its silence on three key issues: public accountability for positive clinicial outcomes and consumer satisfaction; on performance and outcome measures; and on the importance of providing services in integrated delivery systems. Perhaps more notable has been the increasing trend in government and large employer funders requiring performance measures in their contracts with service managers and providers (Kertesz, 1997).

Many authors have noted the conflicting values of clinicians trained to provide all the services requested or “needed” by individuals in an environment of apparently unrestricted resources with the new mandates of funders to allocate services to the population, which many mean restricting or reallocating services to individuals. As Moses (1995), among others, has noted, the change in values from treating individuals with seemingly unlimited resources to treating populations with limited resources is a major shift in behavioral healthcare policy which impacts the ethical and value-based decisions of all providers.

Other issues specific to mental health concern the limits to these benefits compared to those for other disorders. Commercial insurers have also continued to seek options to avoid covering chronic conditions of mental illness (Bradman, 1996), while increasingly, the public has become aware of developments in science which indicate the medical and biobehavioral bases of chronic mental illness such as schizophrenia and depression (Goff, 1997).

In Massachusetts, legislation has been introduced, as it has in five other states, proposing “Mental Health Parity” in insurance coverage. This has been listed as a major goal of the Department of Mental Health, and is certainly viewed by advocates and providers as critical to long term success. This monumental public policy battle pits increasing public awareness of the biological and disease-based nature of disorders such as schizophrenia and depression, and the striking differences in benefits, generally opposed by the business and industrial sectors of the US society. The gross disparities in cost estimates of these benefits noted above in the Frank and Mcguire review of the Clinton Health Security Act must be resolved for the debate to move forward.

Many within and outside of the industry have been predicting how managed care will evolve over the next 15 years (Cummings, 1996). The current generation of managed care manages by limiting the access to and amounts of services, all based on “data” which indicate better or best practices. Service types are often limited in amount and

modality, based on the diagnosis. In some cases, the rationale for limits have been well developed, as the incentives for unmanaged care have not encouraged providers to seek and develop empirically-based cost-effective practices, and in fact have promoted wasteful or inappropriate treatments.

It has been predicted by many (Cummings, 1996; Kongsvedt, 1996) that the nature of managed care contracts, especially in the public sector, will continue to evolve, moving toward larger consolidated sources of funding let as capitated contracts including health and behavioral health, versus today's mix of some behavioral "carve-out" and program-specific fee-for service or cost-reimbursement contracts.

It has been further predicted that the multiple administrative layers of intermediaries, which include public funders, managed care agencies, case management services, and providers, will eventually fall to the pressures of cost-effectiveness, and that large networks of Provider-Sponsored Organizations, or PSOs, will assume the responsibilities of managing and providing care (Ginzberg and Ostow, 1997). The Federal and State governments are beginning to indicate some willingness to allow providers and managed care organizations to link.

Nationally, HCFA has just let contracts to five "Provider-Sponsored Organizations" to provide both managed care and services to Medicare recipients in selected states. Massachusetts intends to seek a HCFA waiver to combine funding for 109,000 elderly (the number nationally is 6 million) who are dually eligible for both Medicaid and Medicare (Morissey, 1997). This will promote development of "Senior Care Organization" which could better coordinate a range of community resources without current bureaucratic obstacles, and avoid the cost-shifting between these two entitlement programs when appropriate community services are not accessed, resulting in more expensive and more restrictive nursing-home or hospital care.

This form of managed care would allow large state or regionally-based non-profit healthcare systems to organize to compete with the current list of national level managed care companies in the behavioral health "carve-out" and the integrated or global capitation, or "carve in" models of care (Cummins, 1996). In these predicated models, providers act as HMOs, and are responsible for all financial management and care, including prevention. They would directly contract with governments and large employers.

The benefits are that there are fewer layers of administration and overhead costs, and alignment of all incentives. That is, keeping individuals healthy and in the community is rewarded, and all- consumer, family, payer, provider- involve must participate to be effective. Problems include the risks to competition, the present lack of ability of most providers to manage such systems, and that such systems may make it less possible for small community-based providers to succeed.

Public Policy and Government

The changes detailed above in the discussion of funding are paralleled by changes in the role of government and public policy. The role of the governement departments of health, health care financing (Medicaid and Medicare), mental health, and even social welfare appear to be evolving away from the provision of care and services toward roles of funding and regulation. Increasingly, that role of regulation appears to be one of standards setting and monitoring quality of care.

Likewise, changes in the role of the Federal Government appear to be changing to be less prominent in funding, and less stringent in setting standards for services and monitoring, which are being delegated to states. These changes are viewed as positive by those supporing local and state controls, and less bureaucracy, and as negative by those concerned about the potential disparities across States and about the historical vulnerabilities sins of lacal and state politics.

The provider community has generally expressed concerns regarding the ability of states to adequately absorb reductions in federal funding which will accompany reduced regulations.

Providers

A cursory review of the media within the past twelve months reveals a non-stop barrage of almost daily stories on mergers, acquisitions, and affiliations among healthcare providers. Sam Their, M.D., of Partners HealthCare, is quoted in 1994 as having stated "he wasn't even sure what the system would look like when he got back to the office that afternoon" (Kassirer, 1997).

This trend, which began in general healthcare, has pervasively expanded into behavioral healthcare, to the extent that the National Council on Community Behavioral Healthcare last year offered guidelines for agencies considering such relationships (NCCBH, 1995). Virtually every agency in Massachusetts has been involved in explorations of some forms of linkages. This trend is forecast to clearly continue, as providers move to reduce administrative costs and become part of systems which have the financial, management, and clinical capacities to acquire and manage large-scale contracts covering whole populations. As indicated in Table V, there has been a shift in the provider community, away from public, mental health-only providers, towards private providers who are integrating or linking to provide services. North Suffolk's forays into this area are detailed below.

At the same time, programs, as noted above, have internally restructured, to customize the delivery of treatment to consumers and funders who request certain options, and utilize an array of professionals, especially for intense community-based services (Owen, 1996).

One continuing point of conflict is the credentialing requirements of managed care and the National Committee on Quality Assurance (NCQA, 1996), which require more stringent credentials for individual providers and the increasing recognition that community-based services can be delivered with high quality, in cost-effective models with paraprofessionals (Santos et al, 1995).

As noted below, recruiting, training, and retaining competent and productive quality staff in a declining service market will continue to be a major challenge to all behavioral healthcare providers.

Outcomes

Jan Fawcett's editorial in a recent special issue was entitled, "The Outcomes are Coming, The Outcomes are Coming" (Fawcett, 1997). It might have more appropriately read "the outcomes are here".

In the past few years, there has been an explosion of growth and development in outcome measurement in all areas of healthcare.

A few examples include:

1. the renewed focus on ourcomes in clinical practices (Sederer and Dickey, 1996)
2. an explosion of methods and systems, many commercially available, in behavioral healthcare (Coughlin, 1997).
3. The Joint Commission on Accreditation of Healthcare Organizations has published its "Oryx" project's list of JCAHO-approved outcomes measurement systems. These include mental health and behavioral healthcare.
4. The Pennsylvania Health Care Cost Containment Council is now annually publishing Pennsylvania's Guide to Coronary Artery Bypass Graft Surgery (Modern Healthcare, 1997). How long will it be before they are publishing their guide to the treatment of Depression?
5. The Foundation for Accountability (Facct) is a recently formed alliance of public and private healthcare purchasers and consumer organizations, founded by Paul Ellwood, M.D., of the Jackson Hole Group, to compile and endorse outcome measuremeny systems for public use.
6. The Health Employer Data Information Set, version 3.0 (HEDIS 3.0) is the National Committee on Quality Assurance's latest outcimes measurement system.
7. The U.S. Agency for Health Care Policy and Research and HCFA are spending $10 million in a national consumer assessments of health plans study, to test

optimal methods for surveying consumers, including those served by Medicaid and Medicare (Kartesz, 1996).

Outcomes in the clinical arena have clearly shifted to those pragmatic areas of the consumer's functioning in the community, including social, medical/health, educational/vocational, financial, housing/living, adpative living skills, and recreation (Liberman, 1991). It has been predicted that outcomes, once set primarily by treating clinicians, will increasingly be specified by consumers and funders. Customer satisfaction and Quality of Life outcome data will certainly be key indicators which are used in consumer-driven systems (Sederer and Dickey, 1996).

In Massachusetts, there are currently several major public policy forces advocating different outcomes measurements systems. The new Medicaid Managed Care Vendor, the Massachusetts Behavioral Health Partnership, has proposed using the COMPASS system, which is one of the JCAHO approved systems, but which lacks reliability and validity data and is not well regarded in the provider community. The provider trade association, the MCHM, has selected the "TOPS" system from a commercial vendor, ACCESS Measurements, inc., which has limitied reliability and validity data. The ACCESS company will aggregate data (anonymously) across providers, so that individual providers may compare themselves to the averages. This has been noted to be the potential first steps toward a public database for consumer comparisons. Finally, the Massachusetts Department of Mental Health has been reported to be considering yet another system for measuring outcomes.

These are some of the many signs that the field is moving to public data on a variety of program management activities and outcomes. DMH began in Fiscal Year 1996 using Performance Based Contracting, which requires providers to track and manage certain idicators of progress. Table VIII displays indicators for Adult Outpatient Clinics in Metro Boston, including North Suffolk. Hospitalizations and consumer satisfaction are included.

As part of a renovation of agency services in Fiscal Year 1995, North Suffolk had already identified numerous key indicators, including measures of service processes, progress, and outcomes, for utilization in each of the agency's programs and departments as part of its internal Quality Management system. Unless consensus is achieved by policymakers, North Suffolk, as all providers in the Commonwealth, will have difficult choices to make among the available and conflicting systems. However, the agency will not have the option to not collect this information and disseminate it to stakeholders.

Challenges and Opportunities

In the newest version of Quality Assurance/Quality Management, now "Continuous Quality Improvement", all problems in program service and delivery have been redefined positively, and are termed "challenges and opportunities". As the previous discussion indicates, we have plenty of these today.

The remainder of this review focuses on a limited number of key challenges and opportunities which appear from the community provider's view to be critical for success in the 21st century.

Developing and Managing Integrated Service Arrays

There is a very large and growing literature and developing recognition among all healthcare providers that for the highest utilizing and so highest cost chronically ill individuals often have interacting serious physical illnesses (Abbey, 1996). Providing an array of services, which allows individuals to live and be productive in the community, and minimizes their dependence on institutional care, is a critical element in their care.

The potential benefits of assertive community treatments for assisting individuals to remain in the community in even the most problematic chronic cases have been well reviewed by Santos et all (1995). These service models are characterized by: care manager considerations of the entire ecology of the individual, pragmatic individualized, and outcome-oriented treatments, home-based interventions, therapist accountability, a shift toward non-doctoral level clinicians, and a care management system which follows cases to identify and intervene in crises. A key ingredient in these services is collaboration with the community, in many forms. A key problem continues to be the lack of defined treatment "content" utilized by case managers and caregivers.

Degan and Nelson (1995) have demonstrated the cost-effectiveness of an intense case management system in reducing hospitalization and maintaining consumer satisfaction in a large cohort of seriously mentally ill in Massachusetts. North Suffolk is in planning with DMH to reorganize its DMH-funded Community Support Services and Community Treatment team services to over 1400 severely and persistently mentally ill to adopt a flexible case management model, similar to the PACT model. Concerns about the treatment technology delivered in such models are discussed below. Key elements will include objective screenings and use of concurrent data to monitor and manage each case (Kazarian and Joseph, 1994).

Science Based Technologies But Caring Services

This challenge is defined as combining in caregivers proficiencies in manageing and delivering technology with a presentation of high interpersonal skills and genuine care for the individuals treated.

This is even more difficult when, as noted above, technologies recognized as effective for treating mental health problems in the community have been changing. Today, the disciplines of Psychiatry and related therapies are increasingly and appropriately empirical-based on science and ensuing technologies developed from scientific research. However, traditional community mental health agencies have been slow to adopt these models of service (Stosahl, 1995). This is often compounded by the discrepancies in staff's objective abilities vs. their own views of their competencies based on prior experiences and training. For example, Hendryx and Rohland (1997) found that indicators used by staff to make emergency admission decisions had low reliabilities, whereas staff were highly confident about the appropriateness of their decisions.

Sperry et al (1997) have discussed the conflicting values which present in training most traditionally-trained clinical staff to utilize empirically-derived practice guidelines in a managed care environment. They note the following beliefs of clinicians, which conflict with the restraining agenda: that each client's basic needs for grown and self-actualization should be met, that services should be provided as much as needed/requested by individuals, that clinicians are advocates, that clinicians are independent, unique healers, that clinicians should be free of any practice constraints, and that subjective assessments are important.

In one of the previous Lindemann lectures, Dr. Raquel Cohen, who was the original Director of North Suffolk Mental Health, discussed the Training Program in Ethnicity and Mental Health, developed in part out of the Group for Advancement of Psychiarty, of which Dr. Lindemann was a primary member. In her discussion, Dr. Cohen noted the difficulties in helping clinicians to integrate the theoretical bases of cultural value orientation with traditional psychoanalytic training. Her clinicians reportedly asked the troubling question, "what do I do with the ethnically diverse patients in the counseling situation itself".

Retaining qualified staff, helping them feel valued and motivated in a general environment which is devaluing clinicians is a great challenge. These issues are true for all levels of staff, including physicians, therapists, and community workers.

The North Suffolk Community Treatment Team provides community outreach and treatment for 75 very seriously and persistently mentally ill patients in Boston, with significant success. The program relies on fearless and dedicated workers who practice "old-time case management", assisting individuals in following medication regimens, maintaining a safe home, getting to a job or training program, problem solving a host of challenges, and following the directions of an agreed-upon treatment plan. When asked what specifically these case workers do, the reply is often, "whatever it takes". In many ways, this is appropriate. However, it also offers an opportunity for improving services by adding specific treatments.

In a recent case of an adult with a long history of schizophrenia and insitutionalizations, adding specific well-conceived but simplistic, easy to use rehearsal of alternatives to threats and angry responses to this individual's daily routines apparently assisted his successful transfer to a community residence after a very long institutional stay.

As noted elsewhere, the content of treatment and training delivered in community treatment models has not been well defined; improving the content should enhance the effectiveness of this service (Own et al, 1997; Sperry et al, 1997).

Involving staff in Continuous Quality Improvement projects, in which they have opportunities to make contributions, and are involced in interpreting and utilizing data to make program decisions, has also been shown to be important in motivating staff (Degan and Nelson, 1996).

In assisting clinical staff in making the transition to practice-guideline, Curtis and Hodge (1994) have suggested a number of specific strategies, among others the following items for a "Mental Health Providers Bill of Rights": the right not to know it all; the right to say no; the right to not be perfect; the right to accept and approve of yourself (guilt is not part of your job description).

Fostering Collaboration, I-Other Organizations

In the past two years, North Suffolk has reevaluated and redesigned its strategic plan to include formal provider and community linkages to strengthen its capacity to serve.

Just a few of the many examples of North Suffolk's formal collaborations with other organizations include:

1. Participation in the Boston Emergency Services Team, which includes other hospitals and community agencies, in which mobile emergency service clinicians of North Suffolk evaluate and provide diversion or admission decisions to individuals in crisis for half of Boston.
2. A formal collaborative project with the East Boston Health Center, in which a team of clinician-managers will plan and supervise case management services for individuals with serious and chronic behavioral and medical problems at the Health Center site.
3. A collaborative clinical research project with the Boston University School of Social Work aimed at improving substance abuse services to Southeast Asian, and particularly Cambodian populations in Revere Massachusetts.
4. A collaboration with the East Boston Social Centers on a federal grant program for substance abuse prevention in families with children in early childhood education and day care.

5. Collaboration with 22 area schools, in which clinicians evaluate and provide treatment to children and adolescents in the school setting.
6. Collaboration with the Chelsea Community Action Program, in which clinicians provide on-site services to children and families in day care.
7. Collaboration with the University of Massachusetts Boston, in which North Suffolk management staff teach in return for stipends for college courses for employees.
8. Participation as a member of the Chelsea Human Services Collaborative, a community-based nonprofit entity which sponsors jointly developed educational programs, grants information exchanges, opportunities for joint projects in community advocacy and awareness, and projects in cultural diversity, among others.

In two special collaborative arrangements, North Suffolk has formally become part of larger service networkds. In the first, in 1996 the agency entered into formal affiliation with the Massachusetts General Hospital and Partners Healthcare, Inc., to engage in a range of services and contractual relations to improve the integration of care for the populations served by both agencies. As part of Partners Healthcare, which includes several other hospitals, the MGH and North Suffolk will participate as part of a Provider-Sponsored Organization as described above, as service providers and risk-bearing service managers in future contracts for large regional populations. In one view of the future, care for the populations served by the system will be coordinated with uniform clinicial treatment technologies, electronic medical records and other high-tech support, and a coordinated case management system. Improved quality of care and cost-effectiveness are obvious goals.

In the second network, North Suffolk helped sponsor and has continued to be a prominent member of the Massachusetts Behavioral Healthcare Network, a Management Service Organization owned and operated by 22 institutions and community agencies and providing about $5 million in service contracts through various member agencies in the Metro Boston Area. This arrangement will continue to allow the agency to participate in service contracts which it cannot obtain alone. The future of the Network will depend upon its ability to obtain and manage unique contracts across its constituents with shrinking revenues available for administrative support.

These arrangements are expected to evolve over the coming years as the relative roles of competitors and collaborators change in the Massachusetts healthcare environment. It is quite possible that as the demands of the marketplace evolve, many of the current affiliation relations will become more formal as small providers consolidate into new corporate entities. In the permutation of the future, the North Suffolk- MGH

relationship becomes stronger, and previous colleagues and collaborators either become formal partners, or, if aligned with other large systems, competitors.

For an agency such as North Suffolk, in partnership with its vertical (hospital system) partner MGH/Partners to provide cost-effective and high quality services, it must have the ability to manage and coordinate care, including prevention, early detection and whatever intervention is necessary, across a wide array of community services and settings. As managed care forces drive consolidation of funding, providers from previously diverse funding, regulatory, and treatment arenas, including health centers, schools, child welfare providers, social/cultural centers, clergy, institutions of higher education, and other human services, will continue to develop creative formal linkages to capture resources and manage them more effectively to meet community needs. The challenge then becomes integrating care across agencies with different corporate cultures and styles, through a continued focus on the ultimate goals- the highest quality cost-effective care.

Fostering Collaboration, II- Re-engaging the Volunteer Community

Organized information is apparently not available nationally through the National Council of Community Mental Health agencies or in the state through the Mental Health Corporations of Massachusetts regarding two issues noted above- the transition of organizations such as North Suffolk from "Associations" to Board-governed nonprofit mental health agencies, and the use of volunteers in community behavioral healthcare agencies. The fact that no data on these issues have been gathered and utilized is in itself telling about the views of these organizations and their member providers.

Anectodotally, in Massachusetts reliance on volunteerism has slipped to very low levels, in part as the rise of NAMI assumed "pure" advocacy, and agencies became more business-oriented to manage larger staffs and budgets with increasing financial accountability.

As part of the need to provide additional outreach for prevention and for community-support of individuals and families served, agencies such as North Suffolk have begun to reexamine the available volunteer resources to do so. The very recent establishment of a community relations and volunteer position at North Suffolk reflects this change.

The role of families in the support and rehabilitation of individuals with chronic mental illness has received renewed focus, there have been increasing efforts to asssist families in becoming self-empowered to cope with not only the disorders themselves, but the funding and service systems which attempt to help them (Spaniol et al, 1994). They also represent key links to the broader volunteer community, for prevention and advocacy.

It is predicted that the pressures of reduced government funding and increased provision of services out in the community will require more development and utilization of community volunteers in services. Volunteer service activities will obviously re-engage the community in a range of educational and prevention efforts needed to muster the resources to meet the mission.

Beyond Managed Care: Capacities, Resources, and Outcomes

Is there enough money in the "system" to take care of everyone who needs it? Eli Ginzberg, among others, projecting beyond today's generation of managed care systems, has asked that question recently (Ginzber and Ostow, 1997). Unfortunately, those who do ask the question are confronted by a paucity of reliable available data on the status of current services and outcomes.

What are the current capacities of a system or agency? These are difficult to define at this point in history. The capacity of an agency such as North Suffolk to manage a certain volume of cases depends upon the effectiveness of treatments at the multiple points of the service array, and the capacity to coordinate care smoothly, as indicated by the case examples earlier in this presentation.

As noted above, to manage cost-effectively, obtaining data on the relationships among diagnoses, functional levels, comorbidities, treatments, environmental supports/resources, and outcomes. As also discussed, funders, consumers, and providers are all interested in obtaining data on many aspects of services, including access, compliance with service specifications, and customer satisfaction, and even quality of life, an enterprise fraught with peril (Beinicke et al, 1995; Gilland and Feinstein, 1994; Kongstevdt, 1996).

All of these increasingly necessary data will require that several key challenges be met. First, staff at all levels and in all positions must be engaged in the Continuous Quality Improvement process, including setting agency goals and using data to improve services for the populations served. Management must maintain the organizations focus on data, issues, and solutions, in order to help staff maintain a self-critical and positive approach to the challenges and opportunities for improvement.

As noted above, this is often a marked challenge from traditional values and theoretical approaches to treatment and services. Successful agencies must invest in training and in Information Systems necessary to coordinate care and obtain data. This is a particularly difficult problem for community mental health agencies, which are notoriously underfunded for operations and have poor working capital and financial reserves. Finally, the agency's internal communications and education systems must be strong, in order to help employees maintain an awareness of changes in technology, and

in the surrounding healthcare environment which impact on the organization and the individuals served.

A Final Not So Final Word

Two weeks ago I spent almost two hours late one evening meeting with the Executive Director of Reach Out to Chelsea Adolescents (ROCA), and her staff, regarding a problem in the community North Suffolk serves. ROCA has 30 adult staff, 70 "youth staff", and touches hundreds of adolescents in the Boston communities of Chelsea and Revere in a wide range of educational, community activism, anti-gang, health prevention, and uncategorisable programs. The problem at hand involved the needs of youth who had been involved in a very recent shooting death in the community—friends and relations of both the victims and the perpetrators have obviouslt been impacted. In the discussion, we identified the needs, resources, barriers, and possible actions in many areas, including grief and traima individual and group counseling, evaluations and potential ongoing service for individuals who many need longer-term help, education and prevention, substance abuse treatment, and potentially creative ways to empower and engage the young people involved in support and development. We met in the gym of the new ROCA multi-purpose building. Some services will likely be there, others in the community, perhaps some at North Suffolk. The local police, MGH clinic, schools, other are involved. We will have the usual "fun" ensuring financial resources for services, some of which will be through mangaged care.

As I left the building I thought about Erich Lindemann and his vision of taking psychiatry into the community. I believe that we are there. How we continue to stay and adapt to meet our mission will be the challenge.

Community Mental Health providers are entering the 21st century in an environment which is increasingly demanding and unpredictable. As a field of science and a discipline of clinical treatment, psychiatry and behavioral healthcare are works in progress. One of the themes evident in the works of Erich Lindemann was that community psychiatry was then an incomplete vision, with many uncertainties and all the "messiness" of multiple stakeholders in a complex, constantly changing environment. And, that's acceptable, at least for now. Enjoying the challenge is the final word in this not at all final chapter in this saga.

David Satin:

Thank you, Bruce. You certainly have the view of a person in the midst of it all, about what it takes to keep all the balls up in the air, an account of all the demands and all the resources. It certainly is a struggle with complexity, responsibility, resources, and how to make it work under the circumstances, but what struck me was the unspoken,

underlying theme about the circumstances that dictate all of these complexities, all of the struggles. In the olden days--- folks don't remember the olden days, Betty remembers the olden days, Louisa Howe remembers the olden days--in the olden days, the needs, what people needed dictated the resources that you needed to have in order to meet those needs. I'm sure it was never perfect, people always battle over it, but it seems to me now that the resources that are available dictate, define what needs are recognized, and what clinicians, what clinical resources are legitimate, not we have so many sick people, therefore we need this money, it is, we have this money to care for these people who we defined as sick, and these many doctors we have available.

Peter Gumpert, PhD

Founder, American Mental Health Alliance

Introduction by David G. Satin, MD

The next step we want to take in this argument, was to talk about...we talked about community mental health in an agency, we talked about the government. We want to talk about clinicians, people who are doing clinical work, mental health work, and how they go about doing it in this environment of resources, of agencies, of government, and what the worker in the trenches are trying to do in mentnal health. Peter Gumpert, I hope, would represent at least one model, one creative model, of clinicians dealing with the lives that they have to live. He is a psychoanalytic and organizational psychologist and a teacher of psychotherapy. From this base he has developed several interesting systems for the practice of psychotherapy and clinical treatment. He has his doctorate in psychology from Columbia University, and a clinical organizational psychologist who practices adult, individual, couple, and group psychotherapy in Boston. He also functions as an organizational consultant to a variety of manufacturing and service organizations, and is involved in research in psychotherapy outcomes and organizational processes--some hard data for his work. He was an academic psychologist from '67 to '81, and currently serves as a faculty member and senior clinical supervisor at Boston Institute for Psychotherapy. He is also co-founder of the Consortium for Psychotherapy, and founder of the American Mental Health Alliance. I think I'll let him introduce his experiences and his ways of coming to terms with his current environment now.

Peter Gumpert, PhD

The purpose of my discussion today is to call attention to certain problems and alternatives that are not fully dealt with in Dr. Bird's interesting paper. Dr. Bird's discussion of policy trends in mental health certainly raises issues that are broadly applicable to mental health services in general, and not just to the treatment of the severe or chronic mental illness.

While I am primarily a psychotherapist, I have non-clinical experience in two areas that are relevant to my argument. First, as a reasearcher and teacher of research since the early 1960s, I read data comfortably, and understand clearly when data do and do not support conclusions. I would urge you, in this regard, to read two critical review papers by Ivan Miller in the most recent edition of the journal *Professional Psychology*. These papers provide a detailed, scholarly examination of the research on ultra-brief

treatment approaches and other research-bases apologies for so-called managed behavioral health care.

Second, I have long and extensive experience in designing and implementing high-performance work systems and quality assurance strategies in major industry, so I know a lot about what works and what doesn't in respect to organizing people to achieve excellence. If I had a little more time today I think I could convince you easily that third party "utilization review" of clinical work (or, as it would be called in industry, *inspection*) does not assure or even assist quality. Instead, it tends to interefere with quality improvement, and mainly adds high cost and adversarial relationships to the work system. In modern manufacturing, the removal of inspection departments is often an early step in achieving quality improvement.

Three strategies actually enhance quality: empowering people to make decisions about their work; providing them with the information and resources they need to do the job right the first time; and encouraging cooperative effort among workers toward common goals. The atmosphere generated by managed-care systems does the exact opposite of what is needed.

So I agree strongly with Dr. Bird's position that broad cooperation and collaboration among treaters is critical to the effectiveness of treatment-both of the chronically mentally ill and of other people whose difficulties are less debilitating. I take issue, however, with certain other implications in this paper. If I read him right, Dr. Bird takes an even-handed "let a hundred flowers bloom" perspective on current trends in mental health services. This perspective at least implies that managed care has much to offer in the treatment of patients with mental health problems-and that the thousands of therapists are objecting strongly to it are an anachronism, and probably not worth taking seriously. I actually believe that the managed care experiment has already failed, and that the system continues to grow partly out of inertia, and partly because it is, overall, so cash-rich that it doesn't know that the end is in view.

So here are some problems with the case for managed care:

- The argument in favor of managed care consistently confounds the question of how to provide effective treatment with the motivation to reduce costs. The two are, obviously, not the same. This confusion of purposes is played out in many ways, including the way treatment approaches and service delivery systems are designed and implemented, and the way research is done and interpreted.
- The only costs in mental health treatment that increased beyond the rate of inflation in the past 30 years were the costs associated with the inpatient treatment of two populations: adolescents; and patients with chemical dependency problems. The evidence seems clear that for the most part, these

populations are equally well treated with outpatient strategies of various sorts. We can thank managed care for teaching us that these expenditures can be controlled. But the managed care movement, as a way of gaining market share, painted the remainder of mental health services with the same brush, as if the entire system were out of control and in need of external management.

- Outpatient mental health treatment has been very inexpensive and cost-effective. Its cost both highly predictable and self-limiting—more than 25 years of research tells us that only a small proportion of the population uses it, that most people use only a little, and the small number of people who use more treatment use it because they need more. Outpatient treatment does not require either external management or externally imposed limits. Despite occasional counterexamples and many bold assertions to the contrary, the research evidence is that psychotherapists cannot hold patients in treatment beyond what the patient needs or wants. Furthermore, one kind of psychotherapy does not work for everyone. Most of us have seen patients whose treatment by some method or other has failed.
- The managed care argument does not address the *value* of providing effective treatment tailored to the needs of the person treated- it mainly addresses controlling cost. Indeed, the value of good treatment spreads out well beyond the patient him-or herself- to the family, the community, the workplace, and to reductions in general medical costs.
- The outcome research that is being done by managed care organizations to support their preferred methods is, for the most part, poorly conceived, designed and implemented. Studies often use un-validated measures and poorly controlled research designes; Ivan Miller's papers point to gross misreading and misinterpretation of results. In general, outcome research is in its infancy, and the arguments being made for its applicability to treatment are tendentious to say the least. The "scientific" basis for comparing the effectiveness treatment modalities is exceptionally weak and oversimplified; we are a very long way from being able responsibly to use this body of research to guide treatment. The primary reason there isn't much research to support longer-term treatment, by the way, is that such research takes a lot of time. A great many patients who start in the samples drop out of treatment along the way. The whole enterprise requires that researchers wait a long time before they can publish. So virtually all solid psychotherapy research based on more than a few cases has been done on short-term methods that generally investigate 20 to 30-session treatment (not the ultra-brief treatment that managed care prefers).

- Mangaed care systems tend to devalue and de-professionalize the people who give care to patients. This does not help anyone, except perhaps the managed care companies themselves. It certainly doesn't enhance treatment.
- One "big lie" sponsored by the managed care industry is that utilization review contributes to treatment quality. As I said earlier, these devices do not contribute to quality—they merely add a lot of cost, create adversarial relationships, and violate patient confidentiality and privacy. Remember-we as professionals are supposed, first of all, to do not harm. There is a solid argument in favor of the proposition that the underminind of confidentiality makes good treatment virtually impossible.
- Another big lie: for-profit care delivery systems lead to treatment efficiency and effectiveness. Which so-called "providers" are unable or un-motivated to create. The truth is that for-profit managed care systems divert a huge amount of money from service to administration and profit-on the average, only 50% to 60% of the premium dollar goes to service. These companies are in the businessof making money by withholding care from patients; care delivered is considered a loss. In their own literature, MCOs refer to the cost of service delivered as a "loss ratio".
- Still another big lie: mental health treatment can be protocolized- made into a technology that can be delivered by people with limited training. I do think that protocols are narrowly useful in dealing with crises or emergent problems. More generally, however, *we treat patients, not diagnoses*. People who fit into the same diagnostic category differ enormously from one another, and often have very different treatment requirements. One size does not fit all. Psychotherapy of any modality depends for its effectiveness on the intimate relationship created between patient and treater. There is no discussion in Dr. Bird's paper of how this can be preserved and encouraged.
- The so-called "second generation" MC that uses sub-capitation to small groups of professionals puts the onus of withholding care—and taking on liability for care—completely on the professionals. The sub-capitated contracts of this sort I have seen make it impossible to deliver an effective level of care. The therapist becomes the bad guy, and the MCO makes the profit.

Lest you think I am simply complaining, let me spend a couple of minutes describing the American Mental Health Alliance (AMHA) to show you that it is possible to create sensible alternatives that build on the importance of professional communities. I was involved in founding the AMHA, so I am particularly familiar with this example.

AMHA is a full service mental health and substance abuse care system now being marketed to employers. It is in direct economic competition with managed care companies. AMHA is wholly owned by its member-professionals as a not-for-profit cooperative. A member can own only one share, and can earn money only from providing service, not from share ownership. AMHA member professionals are cost conscious, but they cannot profit from withholding care.

- AMHA is a self-managed system that functions by valuing and empowering both patients and professionals. Treatment decisions, including modality, are made by the clinician and the patient. Resources are made available to either or both in the event of problems or difficult decisions that must be made. Consultation by professionals with valued colleagues is encouraged in a variety of wats.
- The AMHA panel is not “closed”. Any licensed clinician who is willing to abide by AMHA’s highly ethical treatment principles may join. So it does not limit patient choice of therapist.
- Normal outpatient treatment limits-which are relaxed as an alternative to more restrictive treatment- amount to 50 sessions a year. Treatment duration and frequenct are matters for the patient and therapist to decide. This relatively generous benefit is cost-competitive with managed care because administrative costs are very small, and shareholders who demand profit are not an issue.
- As with managed care, inpatient care is used primarily for safety and stabilization. In general, hospitals are no longer geared up to provide the extended treatment they provided earlier. So AMHA uses intensive outpatient care as much as is clinically sensible. But inpatient care is certainly available when it is deemed appropriate by the patient and the professional, who is asked by AMHA to consult with an expert who can help with alternatives to hospitalization, and with smoothing the way if the patient is to be hospitalized. The decision, however, must rest with the patient and primary therapist.
- AMHA therapists remain a part of the treatment team during a hospitalization, providing continuity of care before, during, and after a hospitalization episode.
- A cooperative professional community is central to AMHA’s quality assurance and cost effectiveness. AMHA therapists work under a covenent called Cooperative Mental Health Care, in which they agree to learn from each other- in effect, to be “in community”.
- In Massachusetts, AMHA has about 750 members. It is now federated nationally, and exists in 22 states.

I mention all this not so much to advocate for AMHA in particular, but to illustrate that we desperately need an active search for alternatives to current attempts to industrialize mental health care. As a social policy experiment, managed care has already been a profound disaster for prefessionals and patients. The disaster is growing, because the industrialization trend is already hurting the graduate education of psychiatrists, psychologists, social workers, and others. If they are taught only breif "solution-focused" and other cognitive-behavioral approaches to treatment, how will the practitioners of the next generation even understand what they don't know?

AMHA is not, as of this date, ready to take on the state Medicaid contract. We don't have enough experience yet, and we would have to create a number of strategic alliances in order to do the job right. But give us a couple of years, and we'll find ways. In the meantime, we hope others of you will take the work away from the managed care groups that inevitably mismanage it, and are in effect unable to do right by our citizens. If we can help, please let us know.

Thank you very much.

Glenn S. Koocher, MPA

Manager of Programs and Advocacy, American Association of Retired Persons for the Northeast United States; Editor, Trends in Integrated Health Delivery Systems

Introduction by David G. Satin, MD

There's an interesting progression that we have here through the issue, from how to live under these circumstances to how these circumstances got structured from the financial and the organization of the supervisory point of view to an alternative to the situation. Another way of looking at the past, what do people need, what do patients need, what do clinicians need to give them and how to make that work aside from the model. We have a clean-up man to come. Glenn Koocher represents one population. We've heard from the mental health facility, we've heard from the mental health authority, we've heard from clinicians. I thought of Glenn Koocher as representing the patients, the recipients of care. I will not say customers or the consumers. I will not go into that modality.

Glenn Koocher represents one population which seeks to maintain good health and mental health services: the aged. He's trained and experienced as an administrator of health and mental health systems. He has, in fact, if I may say so, a checkered past. He's worked in clinical programs, in government, in private profit systems and in consumer advocacy groups. He has a master of public administration from Suffolk University and a graduate of the Program for Senior Executives of the Commonwealth at the John F. Kennedy School of Government. He at present is the manager of Programs and Advocacy for the Northeastern United States and legislative representative for the American Association of Retired Persons, AARP. He is responsible for overseeing all AARP program activities in public policy, including health advocacy, political operations, legislative activity, economic security programs, consumer affairs, and low-income individual services. He is on several national task forces, including that of state implementation for health care reform. In his past he was director of the National Managed Health Care Congress, the nation's largest managed health care conference and exposition. He was manager of external relations in the New England region for US HealthCare, a managed care organization, and was responsible for the development of provider relation networks, business plans, corporate budget and member liaison, in short, to make it work. He was senior program consultant in health program development for Blue Cross/Blue Shield of Massachusetts. He was executive assistant to the secretary of elder affairs in the Commonwealth of Massachusetts. In his comparative youth he was a mental health center administrator at the Beaver Brook Mental Health Center, and secured the first certificate of need and license for a community partnership

clinic, that is a partnership between a private organization and the Commonwealth of Massachusetts, and is at present he is associate editor at Aspen Publishers of the journal, *Managed Care and Direct Contracting*, and *Trends in Integrated Health Care*. He is also the executive producer and host at Continental Cablevision of the program *Inside Out*, a volunteer executive producer and host of a weekly public affairs program. His publications include, *The Economics of the Health Care System: Financing Health Care for the Aged Person*,í a chapter that he wrote on geriatrics that I helped to edit, and is also, as I said, the associate editor of *Trends in Integrated Health Care Systems*. It seems to me Glenn has seen all parts of the system, and probably is a good person to comment on what everybody is up to and how it comes up this way.

Glenn S. Koocher, MPA

Introduction

More than two decades ago, advocates for patients of the mental health system reached out to groups representing seniors to focus attention on their needs and to mobilize the forces of government, advocacy, and provider groups to improve the quality of care to older Americans and the appreciation among the public for this area of medical care. In Massachusetts, Lew Klebanoff of the Department of Mental Health brought together the heads of Departments of Mental Health, Public Health, and Elder Affairs along with the late Frank Manning, the organizer of the Massachusetts Association of Older Americans. They signed a memorandum of understanding, which outlined their plan. While the problems of the aged population within the mental health sphere remain underdiagnoses and underserved, the level of interest has grown moderately. We have seen some progress, but we have not seen sufficient movement.

Sentiors experience mental health problems in significant number. Of those persons over age 65, it is estimated that 15-25% has an unmet need for mental health care at any given moment in time. During their lifetimes, 40% will experience the need for mental health services.

Why focus on the needs of seniors? Through the Medicare program, seniors represent a significant volume of care for most providers, and they have the potential to grow as a share of patient panels among mental health providers. Still they represent a significantly underserved population from a mental health perspective.

Seniors represent a growing share of the managed care population, currently about 12% but growing steadily. Addressing senior mental health care needs early on will help improve quality and manage costs for the future, especially if, as some argue, attending

to mental health needs such as depression and its complications, we can further lower overall expenses.

Finally, as I will note in my conclusion, we can take a meaningful step to improve the quality of life for older people and make a statement to society at large.

Mental Health Needs of Seniors

Seniors face many of the same kinds of mental health problems as does the general population. However, here are some situations more common among the older population and more specific common diagnoses, with confront seniors, their families, and the caregivers who attend to them. Consider some of the common situations, which create the need for mental health care. They include bereavement, disability, the implications of other physical health problems, loneliness, and isolation. In fact, the most commonly identified problem which seniors themselves designate as impacting their lives are loneliness and the lack of transportation to address their mobility.

Let me start with dementia of which there are many forms. While most families tend to group them into the “Alzheimer’s” category, there are, in fact, other forms of dementia, some of which may be managed more or less effectively with proper diagnosis and treatment, including mental health therapy.

In addition, seniors confront depression, anxiety disorders, and confusional states all of which can respond well to treatment. Similarly, substance abuse among older people who misuse alcohol, medicines, or controlled substances is identified regularly.

A more common problem, which is associated with mental health, is the complication associated with contraindicated prescription drugs. While many older people suffer these complications because they rely on multiple providers, not all of whom speak directly with each other before they prescribe drugs, other seniors fail to comply with the prescription directions out of confusion.

Finally, there is suicide which may be a complication growing out of any of the elements listed earlier.

Common Issues with the Population in General

The senior population relates to the mental health clientele at large in that there are a number of common experiences that argue persuasively for an intergenerational approach to improving quality and access to care.

Older people have, for example, experienced a form of deinstitutionalization. In recent years, heavy emphasis has been placed on shifting the focus of care from the institution in the form of the nursing home to more community-based settings. We have

seen a growth of a unique program of state funded support for home-delivered social services for elders. As a result, we have fewer nursing home waiting lists.

At the same time, the support network and the case management issues that revolve around them raise many issues and concerns. There is also the question of the adequacy of the budget for elderly home care. Also, there remain alone and unidentified in the community clients in need who do not enter the system at all or only when they experience medical crises that require acute care.

Seniors, like clients of the mental health system, lack sufficient coverage for many legitimate needs. Medicare, for example, does not cover most routine care and wellness services. Long term care, including institutional care in nursing homes, or ongoing care for chronic illness that is not related to accepted acute medical services is also largely uncovered except under the Medicaid system. (In order to become eligible for Medicaid, clients must be virtually impoverished.)

And, most significantly, seniors, like clients of the mental health system, are skeptical of managed care services for their particular needs.

Key Developmentts in Mental Health Which Will Impact Seniors

I would like to cite some specific factors, which give us reason to be optimistic about the future of mental health care for older persons. Among them is the modest growth, but growth still of the Medicare benefit and the recognition among policy makers that mental health is, in fact, a medical issue. Medicare, for example, covers about 50% of outpatient mental health care costs, as opposed to 80% for other medical services. Inpatient care is restricted to a 190 day maximum over a patient's lifetime, whereas other medical inpatient services, while subject to deductibles, copayments, and other restrictions, are not capped. Also, Medicare does not cover outpatient prescription medication for mental health or most other medical problems. We at AARP have taken the position in support of parity. Others are following suit.

Here are some other reasons that can be optimistic. First, there is the emergence of quality measures and the public's appreciation of and demand for developing outcomes data for different treatment modalities, caregivers, health delivery systems, and institutional providers. We are still at the early stages of such a development, but it is clearly inevitable that reasonable measures of quality will be standardized for all aspects of health care. Further, the public will use them in making treatment and coverage decisions.

Second, we see a greater respect for community-based care which means increased resources for community mental health centers and other outpatient services, accesible and convenient to consumers.

Third, there is a fast evolving trend toward strengthening the role of case managers and care managers for seniors. In fact, a growing industry is the case management business, which can also assist family members who are distanced from their older relatives. This will mean greater coordination of services to improve quality and control costs.

Fourth, we have recognized the incidence of substance abuse among seniors, including alcoholism, and we are seeing more emphasis on reaching out, identifying abusers, and offering services.

Fifth, as "baby boomers" age (and as they begin to care for their parents), we will have a generation which has much less hostility to mental health services turning to behavioral health providers to assist them and their older relatives. Seniors themselves, therefore, will have a greater appreciation for the value of mental health services with each year.

Not all the trends are positive. We are very concerned that threatened cuts in reimbursement to academic medical centers will impact mental health providers.

Finally, managed care represents both a positive and potentially negative trend for seniors.

Medicare, Managed Care, and Seniors

Medicare is our nation's universal medical care system for people over 65 or who are disabled, or who are victims of End Stage Renal Disease. Most seniors have Medicare. Medicare is expensive—to consumers and to Americans in general. Medicare Hospital Insurance (Part A) is free for eligible older people. Still, it is not unusual for a senior citizen to pay not only the more than $46 per month for Medicare's Medical Coverage (Part B), but also to spend as much as $150-200 for a supplementary policy to fill in the gaps our federal program leaves. Moreover, the trust fund that has managed that portion of the payroll tax for Medicare's hospital insurance program, is running low. As Congress grapples with a solution to the current Medicare funding crisis, a situation which threatens to deplete the Hospital Insurance Trust within the next 3-4 years, many public policy makers are turning to managed care as a solution. Many of us view managed care, not as a panacea, but as part of the solution which offers this concept as an option—never a mandate. However, we also fear that the lower cost managed care options may become to attractive on one hand, and the fee-for-service alternative so expensive on the other, that the HMO, PPO, or their various modifications may become a de-facto program of necessity.

Seniors, their families, and members of the advocacy community have a number of concerns about the evolution and growth of the managed care system as an alternative to the traditional fee-for-service mode. Here are some of them:

- Mental health care may not fit well into the managed care industry's quest for predictability, risk sharing, and cost control. While it may be reasonable to predict the average annual cost for such procedures as some forms of cardiac surgery, mastectomy, or gall bladder removal, such skill in estimating treatment course and cost for many complex mental health diagnoses with so many more variables than traditional physical medicine cannot be expected.
- Primary care physicians in general may fail to appreciate and therefore identify mental health problems as distinct, treatable diagnoses. This is not unique to managed care, but, given some of the methods plans use to reimburse physicians, many of them adding pressure to caregivers to resist the temptation to refer to specialists, it is not unreasonable to fear that physicians might fail to recognize the symptoms of mental health disorders as such.
- Systemic problems of referrals under "capitation" methodologies can create situations where primary care physicians in managed care organizations do not see value in referrals to mental health clinicians. Or, they may attempt to treat those situations themselves, overestimating their own abilities to work with the diagnosis.
- Provider quality is a major concern, and quality has many meanings. Critics of mental health care in managed care programs have raised serious questions about the possibility of reconciling the demands for predictable costs with the less quantifiable treatment courses for mental health diagnoses. As a result, some have relied on less expensive providers or individuals with lower levels of training. For example, we might see a heavier reliance on "supervised", but not necessarily licensed individuals, or upon less experienced psychologists, social workers, or psychiatric nurses rather than more experienced individuals. Members of the psychiatric community have complained that accessing the physician/psychiatrist for care other than for an evaluation for medication is unreasonably withheld. I make no declarations as to the validity of these claims, only that they are being made with increasing frequency. Also, patients have argued that certain forms of care are offered at inconvenient hours, or that there is a heavier reliance on less expensive group therapy rather than individual counseling.
- The method Medicare uses to reimburse managed care plans is in question at this time. Currently, Medicare reimburses plans at 95% of the average adjusted per-

capita cost (AAPCC) for individuals of certain age cadres in individual counties. For example, there is a separate AAPCC for a 75 year old woman in Middlesex County and another one for her twin sister living in Suffolk County, and it is based on the average cost of a Medicare patient in their cohort in each district. Congress is considering reducing the 95% rate to as low as 90% in order to make reimbursement more equitable and accurate, according to those who think it is currently too high. Should Congress reduce payments, plans must either raise premiums to members or reduce benefits. Advocates for the mentally ill fear their services will suffer the most. They also fear that plans will seek out low risk applicants and discourage enrollment of individuals with complex diagnoses, mental health needs, or at risk in general.

- Finally, they fear that seniors will lose their options: first the option of managed care vs. fee-for-service care; and second, the choice of providers including the individual of choice and the treatment mode they prefer.

Managed care has its plusses and minuses for seniors. It offers them guaranteed access to a primary care doctor and assures them a greater measure of case management among multiple caregivers. There is coordination of care. There is also the potential of coordination with the long term care system, especially in light of the development of joint Medicare and Medicaid, "dual eligible" programs for seniors who have exhausted their resources and rely on the medical assistance program.

Because managed care is less expensive, it can represent good value and far improved quality over care that is self-managed by older people or their family members who are trying to put together the pieces of the care giving puzzle on their own.

In fact, managed care can help focus mental health care better if there is a quality program in place.

Public Policy, Values and the Future

We are at the threshold of a critical period in American social and political history as the generations face off against one another. Advocates for Medicare, Medicaid long term care services, senior housing, transportation, and Supplemental Security Income for low income older people and disabled individuals are facing off for limited resources against those who are fighting for children, public education, family nutrition, health care for the younger uninsured population, and others. It can be embarrassing to see seniors object to the placement of younger, disabled persons into public housing for the elderly resident. It is further embarrassing to see seniors voting against school budgets on one hand, but in favor of senior programs on the other.

A call for intergenerational collaboration is appropriate. Seniors, for example, have outstanding advocacy structures in place, especially in Massachusetts. Seniors have won major victories in the state legislature in stabilizing funding for home care, transportation, combating elder abuse, access to Medicaid, and state supplements to SSI. Our agency to serve elders, the Executive Office of Elder Affairs is a cabinet level department, one of only three in the United States.

At the same time, societal changes will have significant implications. We have heard much about that generation of people in their 50s and 60s who are caring for an older parent while at the same time supporting their own children. This is the “sandwich” generation.

But in recent years we have also seen this same cadre caring not only for their own very aged parent and their own children, but who also have financial or care giving responsibilities for their grandchildren. Consider the case, not uncommon, for a 55 year old person who cares for an 80 year old parent. This same individual may have a child who has borne them a grandchild and who is in economic distress. This 55 year old falls into what my friend, former State Representative Saundra Graham has labeled the “Club Sandwich Generation”. Who will help those people?

Vision for the Future

I offer the following recommendations as part of a master plan to improve mental health services overall and address some critical issues in American health care delivery.

1. Promote the concept of interdisciplinary assessment teams and case management entities to oversee a full range of health care services for seniors and, in fact, for all. Managed care may be part of the solution here.
2. Develop a more effective curriculum in geriatrics in training caregivers, including physicians.
3. Into these curricula, incorporate cultural and ethnic sensitivity, particularly where mental health care bears a stigma for older, more traditional patients in the health care system.
4. Eliminate the 190-day cap on Medicare inpatient services and establish outpatient services for mental health care at the same level as other medical services.
5. Address more effectively the impact of substance abuse including alcoholism and contraindicated medications.
6. Expand community mental health services and outreach to identify seniors who will not self-refer.

It is a fact that many seniors live lonely and isolated lives. Without such outreach services, many older Americans remain unidentified or unserved.

Conclusion

This discussion, including the issue of Medicare, Medicaid, and overal funding for health care, involves a debate about money. And, to be sure, this is about money. But it is also about values. Former Secretary of Elder Affairs Thomas H.D. Mahoney, himself a distinguished historian, biographer of Edmund Burke, and professor at MIT for more than 45 years. Tom Mahoney passed away last month, but I can say with great pride that he was a strong advocate for mental health care. In fact, he was awarded the 1983 Humanitarian of the Year Award by the Massachusetts Psychological Association. He raised dramatic issues in a statement he made fifteen years ago. He said "If we do not take the deliberate step of stating our values clearly and articulating them in our public policy now, while it is within our power to do so, the 'invisible hand' of time, events, and economics will write its own value statements for us. And when it does, we are likely to be powerless to edit them".

We Americans have made powerful value statements with the creation of Medicare for seniors, Medicaid for poor people of all ages, SSI for the disabled and blind population, and very broad social welfare programs.

I suggest to you that a commitment to mental health services reflects our own statement values.

Discussion

David Satin:

Seems to me at least that there are really two things that we have to address. One is the resources, the restrictions, the other is the values and the needs. How do we deal with both of them? Which one is real, which one is not real, which ones do we have more flexibility to deal with, which ones do we have less flexibility to deal with: values and resources. I wonder if people had some thoughts and reactions to hearing one another?

Paul Barreira:

Let me just make one issue that I thought was going to come up but didn't, and it speaks both to values issue and the issue of economics and that has to do with the parity law. Before the state legislature, and it's also been looked at in other states, and I think the parity bill, the effort should stay with mental health services deserve the same treatment, whether it's adequate or not, the same treatment that the…There has been an opportunity, at least in the department, to get different stakeholders who usually don't get together on a common issues, and make reasonable compromises, they come out in support of this legislature, and it seems to me it serves as one example, albeit small, of various consumers, families, patients, professional groups. They come together and make a small advance, and it has never been an easy battle.

Bruce Bird:

I don't think we as professional…some of our standard requirements for…state house… The fundamentally important issue would be…

Peter Gumpert:

There are some people in the circle that I've talked to who feel that the parity legislation is sort of a Trojan horse for managed care, and it would simply allow people to redefine what is medically necessary and what is not, and it wouldn't change the picture much at all…

Paul Barreira:

I think that probably…

Peter Gumpert:

…and that sort of has to be answered.

Paul Barreira:

I think that's probably an overcynical reaction. My vision of what will happen for profit managed care companies, and with most, not all, but a marked number of managed care companies involved in mental health care services for profit is that they will be unhappy with their narrowing market share, and once that happens they'll get rid of it.

I mean if you're a stockholder what you look at is, I guess, a margin derivative, and you look at the margin, and it doesn't matter what product. but when the margin gets too narrow, you get rid of it. Well, the margins are getting narrower and narrower. There's little left. At some point you won't be able to squeeze out any more profit, and they'll dump those services and when they do, the only people who will be willing to pick them back up will be the providers or the government.

One route to socialized medicine is to watch the for-profit managed care companies squeeze out the profit, then get rid of their business. I really think this is a very short-lived experience, painful and highly wasteful of a lot of hours providing necessary services, but it has a trajectory that's already going down. The issue for me, and I want to restrict myself to the sort of seriously persistently mentally ill psyhciatrically disabled population, as I said earlier, that's really where the Department of Mental Health sees its responsibility, I think that the likelihood is that we will see not-for-profit organizations. It may take a little bending, maybe different from the community mental health centers that currently exist. Well, neither one said weíll step to the plate, said 'I'll take the risks involved in trying to provide the services', but what it fundamentally has to do is to get enough money to do it well… used to have with the not-for-profit people were they're not giving us enough money because you've got to pay the cost of living increase…

Discussant:

That's really the same?

Paul Barreira:

I wish we had more money left. But the not-for-profits won't argue for enough money to make the margin bigger. When you talk, I don't know what goes on, but when you talk to the managed care company you get this thing where the money isn't big enough for the company to feel comfortable…to be a non-profit. It's a whole new different world.

Glenn Koocher:

Except that you can't separate the managed care line of business from the rest of the line of business for some of the for-profits, and I think that there are those single-payer health policy advocates who are laying in wait for the end to happen as the margins get

smaller everywhere and people reconvert to other lines of business and get back to the life, property, casualty.

Paul Barreira:

My concern from a public policy point of view is that there isn't any way to yet identify the dollars that have been lost to profit to reinvest in care, so I find it mind boggling that the citizens of the Commonwealth are willing to let their tax dollars go to a for-profit company without any concern about those dollars might get reinvested in services. At least if your organization…

Glenn Koocher:

Our organization is based…

Paul Barreira:

…had an reserved account to be reinvested and you didn't put it in somebody's pocket…

Discussant:

The mental health care providers…as the general corporations in Massachusetts provider division, and just to make it clear to everyone, I believe it wasn't clear enough, the issues that you will eventually shake down to provide sponsored organizations to …the providers for part of managed care…We believe that networks of providers who are more likely there will be large degree..regional systems such as…health care.. Now I'll joke about this that sooner or later on we'll belong to…

Paul Barreira:

I'm sure I'd feel comfortable with that.

Discussant:

And I know there's an alternative at the other end of the table, but the current permutation in managed care, which is managing by amounts-limited service, based on very poor data. is a very painful…and it's also partly because…

Paul Barreira:

One of the more radical proposals was to give the money to the patient, you know that table you had… psychiatrically disabled? So there's a certain amount of money appropriate for…give it to that person and let them work with providers, whether it's an individual person, figure out how to get the services they need. This was sort of taking the consumer movement, the empowerment movement and the capitation contract to one logical conclusion.

Discussant:

Like the voucher system?

Paul Barreira:

It would be, I suppose it would be equivalent to the voucher system.

Glenn Koocher:

Or a medical savings account.

Paul Barreira:

Or a medical savings account. I'm not sure if anybodyís ready to get there yet, but I would think that that's one model that's…What we don't do is use the word you've used at the DMH. This whole thing's been a social experiment without even calling it a social experiment, and the data on whether the… private sector you save money or provide better services, which you're suggesting. If you look at a recent… on public, not managed care, there's no data to support anything that they've provided better services at a cheaper cost. In many other ways it's a social experiment, but unfortunately it's driven by the economics, and not necessarily somebody saying, 'I've got a vision of better care'. Having said that, there are things that happen in our practice that I would say are valuable, sort of define criteria for care, people's health care. Having it more objective is helpful, but finding with patients, with them, what's the outcome that's reasonable, that they want, is health care.

There are ways of looking at data across the state that's helpful, and I would like to know, and you had a circle here which is a function assessment tool, which… The reason the Department of Mental Health would like to have a tool with all these communications is that you get a group out in western Massachusetts that says …population… program that's working. Well, I don't know how to compare that with someone else in another part of the state. We have this program that's working, well, unless I have something beyond the individualís subjective sense, might be different. It's very hard for me hanging onto your tax dollars to know which one works more effectively. We've got to figure out a way to get data that's a little bit more objective that we can use uniformly across the Commonwealth.

Discussant:

That's useful.

Discussant:

That also goes to the clinician level, and part of the tension from our position is the need, according to more than one clinical operation in our history in which… people

doing things to clients that turned out to be very inappropriate, so if we don't have some prescribed mechanisms to train people on, how you train has to have some standards of quality. The trick is how do you do that? Where do you set those limits, and how do you do employ the best clinician do what they can do in a period of time, not doing some practice protocol template. I also…use therapy also…but the other side of that is are we doing this…to cut corners…substandard…

Peter Gumpert:

I think you all raised my consciousness about thinking about where we put our resources. You said, was a little bit distressing to me, which was that we may not be paying as much attention to the patient as we should be in making these kinds of decisions. We're sitting here on the sidelines from Mount Olympus trying to figure out what people need without spending a substantial amount of trouble and effort and money on asking them what's important to them about their care and about the consequences of care.

Paul Barreira:

I think we could do more. I feel like one of the largest contracts that DMH has is clubhouses, where the patients…We've put in, I forget how many million, but it's $10,000,000 or more in the clubhouses with very little data to support that a clubhouse is an effective…proven socialization in the clubhouse is better than some other… But the reason they have been in place is we're listening to people in the communities saying that 'we want this', and 'we think this is effective'. One interesting…that I've seen in parking lots that have been used in newer emergency groups that are run by patients, survivors, and they've proven to be enormously helpful in DMH's… maybe a crisis hotline. I think there are efforts that I didn't see ten years ago and modified programs.

David Satin:

What concerns me is the values, goals, the criteria. We can make up programs, we can develop protocols and not be aware that they're driven by, that they are predicated by certain goals. If you say, 'ee only have $400,000,000 to spend; therefore let's be objective about how we should spend it', or if you say, 'our goal is to reduce the number of clinicians by so much, therefore let's be objective about who we reduce, and when we do it', the question is getting people's input about what they need. This used to be done in the olden days, there were community mental health districts, and there would be a health advisory board where people said, 'this is what we want', but they had a different thing in mind. They looked at what did people need? where are people suffering? what would prevent people from suffering? Now we have advisory groups which think, what do people need that can demonstrate that they really need it? That they want, within the

limits of eight sessions of therapy per year and dealing preferably in groups, and given by under master's level social workers. If you have your choice of any black car on the lot, what color would you like?

Paul Barreira:

I must say...

David Satin:

We aredriven by some criteria, with some goals, which are not accidental. They may or may not be conscious. I wouldn't go so far as to say there is this group in the back that is doing it, but they are not accidental, and I wonder why we don't stop and say, why are we doing this? Can we get outside this set of criteria?

Paul Barreira:

My sense is that there are groups that are trying to get out of this box, to look at it. I feel it's hard not to acknowledge that we're talking about a population, and I'm not really clear that the issues that ...psychotherapy, somebody that's not just legal. How much does she have...try to ...population not ready to...those populations you have, which is why I kept on saying public dollars to public clients. There may be an overlap, but I'll give you one example. There was a conference this morning that had to do with violence and how logical violence in the forensic system is us, it's the Department of Mental Health--nobody else is running in there, trying to deal with issues, commitment and people who are criminals that have mental illness. I'm not prepared to bring it together. I think I still have...

David Satin:

What happened to the concern for the people who are going to...Remember the study in Wellesley, of the preschool study of children who looked like they were going to get in trouble at school but hadn't done it yet. Who do you give to? Is that a legitimate expenditure of resources? Or are you going to wait for the kids who have gotten into trouble in so many schools...

Paul Barreira:

Interesting... One of the effects of trying to use health maintenance organizations is they are very interested in preventive care, and if you look at the way they spend dollars, you'll see a lot more dollars trying to ...

Glenn Koocher:

No, they used to be. When they first started they were, and now they're cutting up…right and left and the only ones they are keeping in are the ones that are either extremely inexpensive, or the ones that…the press, for example smoking cessation programs, in which they send people letters saying smoking is bad for you.

Discussant:

I think if you review the provider responsibility information, and if the market forces and the public data really start kicking in, eventually… The only impression…always lose how much resources are we going to have around for the current… everything out and how far will we have to come back? Because we honestly are not spending the kind of resources we should be…organization, there are other aspects of the community in line…

Paul Barreira:

There are three..

Discussant:

…but at some point we are going to realize that we've been failing both in terms of the quality of the services we provide and to the broader community, not just the currently eligible, and the question is how far down will we be when…

Discussant:

I have actually two questions. One is a managed care question, I guess, for lack of a better descriptor. With the partnership now managing I guess the acute care, I'm wondering when and how you see that happening to continuing care, to residential and non-acute care, because…

Discussant:

Okay, alright, we out in western Massachusetts are really thinking that it's inevitable, as probably a lot of people are, but within a couple of years, and we're trying to position ourselves for that and doing outcome studies of our own, and so forth, and I don't know what that would look like.

Paul Barreira:

Let me separate the managed care companies from the… I think it's highly unlikely that a for-profit managed care company will receive a contract to provide all the managed care services that are currently running through the state mental health services. I just don't see it happening, partly because people are fed up with profits and the loss of reinvestment of dollars in services, partly because I think the legislature was asleep during the MHEA contract, they were asleep during the writing of the MBHP

contract, and they woke up last summer, and it's a little bit like waking up from sleeping. I don't believe that the legislature wants the state mental health authority to disappear. I want to believe they want a public debate about how public dollars could be used to serve public disabled folks to be done without a public debate, and I think it's …force in terms of for-profit managed care companies seeking profit.

Will we come to a system with state mental health authority? Will we write a contract? Will we do it with a large provider group or community mental health center or some collections of providers? I think we'll come to that, and at that point we should integrate with community services. The insanity in this program is that we've got the acute services going in separate contracts, separate dollars, through separate entities. You've got the continuing care over here. Whenever you split something at the top it's everybody else in the field who feels…of not bringing in patients. The patients go back and forth. We've got a system that isn't unified.

It reminds me, those of you who remember a long time ago, DMH used to have a deputy commissioner for outpatient services, and that person would have a pot of money, and a deputy commissioner for inpatient services, and they'd get a pot of money, and it was the same split. You'd go out to the field and you'd have to figure out which deputy commissioner to hang around with to try to get services, so nobody in their right mind would design it this way from the start. Most of these designs, not only in Massachusetts, you hear about this throughout the country, most of these designs occurred because of political pressures, economic pressures, all kinds of expediencies that lead to something that we looked at and say itís irrational. So one answer to your question is yes, I think there will be, I don't think we want two contracts for services that fundamentally should… I think that there will be… want contract with us because…

Discussant:

I think it would be great if there were a single source of funding, but I donít think that's going to happen. But also, related to that I am wondering about some of the outcomes, projects, and the infancy of the outcomes. We know that managed care companies will love this, but we're not using our outcome study in that way, we're really saying this is our own internal management tool, and we're just going to go for it because DMH hasn't specifically said, 'use this tool', or 'use that tool', so we're just doing it, and some of the preliminary results are really fascinating. Clients are self-reporting high levels of independence, in all sorts of domains, but the other thing, too, is that I think that ultimately we might come to see, at least in residential, that what the hospitals were doing is the same thing in a lot of ways as far as what the community-based programs are doing which is really containing people, and I know that's cynical, but….

Discussant:

I think thatís exactly what you should be doing. You've given, invested a lot of time and energy to.. measured by ourselves…do a better job treating patients and figuring out what works. Eventually that will all become public, but we needed to do that job better. The second issue is that you need much more resources than we have right now for management information systems. I have all these managers and clinicians who are, 'let's work and see', and I don't have the ability yet. We're spending a lot of money investigating that infrastructure…you have to finally, we can give our clinicians and managers the tools…

Paul Barreira:

My simple-minded way of thinking about is in which tools to use. Ideally, what you do is get…and people who are helping provide the services sit down and say, 'what is it that we want to accomplish?' Write it down, put it in some format that's somewhat standardized, and then use it to do a self-evaluation of both, the recipient, participant person and the provider or worker, and then use it to make things better. What happens in managed care companies is that they wanted to restrict networks or to cut services or to somehow tie it to dollars, and once that happens a whole different dynamic that gets involved, and rather than seeing it at a local level, that locally all sorts of funding sources, it becomes some kind of paranoid, conflicted, who's trying to do what to us. That permeates a lot of states. The perception is diminished care…. take the contract away and bring it somewhere else, and you need to do it objectively, you need to see that the reason, a justifiable to get rid of… and that dynamic doesn't help…this conference which is figure out how to collaborate to bring this together.

Discussant:

Especially I think when client choice is factored in. You know, there are a lot of clients in our agency in programs that are saying, 'yeah, I'm really satisfied, I like where I live, things are great', and you sit down to do a treatment plan and the client doesn't necessarily specify goals. I think that really does conflict with the more systemic view of change and progress and movement to more and more independence, but I think that…

Paul Barreira:

One of the largest fights I have with managed care companies around this is my belief that in the system that we're working in you can't use the term that clinicians don't pay attention to what's really important, which is the person is really functioning, which is number one, how do they view what they want for themselves? I saw a wonderful presentation in England that had to do with… not psychiatric. They basically said, you know, you ask somebody, 'what's important in your life?' they'll say, 'my family, my

religion, sex, my golf game, making money', something like that. You'll get five things like that. And they say, 'well, you're one week to post-cardiac surgery. Of those five things that are most important to you in your life, what are the most important three things?' 'My health, my family, and my job', and so they've organized their rehab services around those priorities. Then they come back a month later, and they say, you know, or two months later, 'whatís next?', 'golf, my family, money, job, sex is last' . But they streamlined their rehab intervention not based on the year's worth of what's your priority, but a much smaller time frame, recognizing that we do this all the time. Moment to moment, day to day, month to month, how we organize our time, what's our priorities--it varies. You may have five that are always there, but some are more important to us in our life than others.

Discussant:

Issues around managed care, and I think one of the…that I… much attention was the clinical maintenance, mentioned earlier, when I think of it now…managed care, Massachusetts having had six years in that contract, I'm kind of going back thinking about the political power or political belief system of the state government that is fighting to hire the… that reach for profit, versus another type. I'm not saying it's good or bad, I'm just raising that the political pressure at that time was cut back spending, cut down salaries, and for-profit company appeared to be…

Discussant:

Because I've been in other states where Medicarid deficites were a billion dollars…

Discussant:

You said it. The red ink, the tide of red ink, when that comes to us again, it's huge. What's happening at the federal level?

Discussant:

So the first managed care wave was… the ball financially last time and we have historically shown that, left to our own devices, we will tend toward those values and incentives that say, 'give us as much care as we can'. You know, we'll err on the side of giving more care, and society is telling us, back to the issue that you raised, consumers can't limit the choice because society gives us limited resources. We haven't found a way to argue that through and advocate for more resources so the choices can be broader, so…

Discussant:

...start moving consumers to our residential programs to make room for others because they need it, they need, there's a waiting list, homeless people that need homes. What am I going to do? I've got to encourage these consumers to try to move on, be a little more independent, have a little less care. I understand that, and part of that has to do with a fixed amount of resources...

Discussant:
Just one element that creates part of the problem. Just as your delivery system is fragmented so your advocacy network is also fragmented, and a unified advocacy network which could deliver a consistent message under a coherent strategy, as a good part of the aging community has, could be particularly helpful, and the one thing I'll say in support of regulators today, by the way, that if they had been watching New York more closely and had stopped Governor Pataki from paying prison guards with his Medicaid money, maybe that deficit would have been $1.2 billion instead of $1.3.

Paul Barreira:
Two examples that will support your observation: in New Hampshire, because it's New Hampshire, they've been worried about fairness, so what they did was that they were one of the first states to pass the... bill. If you know, itís a fiscally conservative, politically conservative state. There's another part of their value system that says you've got to treat people fairly, this isnít fair ...pass it...because theyíre moving slower in coming to managed care. They basically said, 'we're going to be damned if weíre going to give our money to some big corporation in Vermont, we're going to figure out how to be a managed care driven system with whatever is useful from that world, we're going to do it ourselves'. They said, 'screw them.we're going to have consultants come up, we'll pay them, we'll figure out how we, through our system in order to make sure we use the public dollars effectively and get the most that we can for whatís fair, but weíre not going to ...'. So every state has done something different, and it depends on the character of the state and the administration of the state.

Discussant:
I guess that's what I was thinking about, was that, you know, a little piece of the pie broke into...what kind of services are we going to have, how we're all going to be able to work together. The only other point I want to make is that the decision of the state to actually give a contract to a for-profit company for about the past four or five years, which was pretty much enough time to get it to start working, to actually start doing the same thing that was mentioned earlier about 'if you donít what I need you to do, we're going to be going with someone else'. Then thatadministration goes to someone else, and the impact of that. Well I actually work for the other managed care company, and I know

that I, again…process…going on to provide…thinking about all of these other things, but the impact and the loss that has been, just a number of times, I mean I'm just thinking, and I'm not saying things are perfect, and I'm not saying I think it's the way to go, but to think about the impact and loss of dollars, and the loss of the quality of the client, and you hope that these things don't impact on the client as much as they have, as they potentially could have.

Paul Barreira:

What this year proved to me, because of previous reports seeing the transition from one managed care company to another… six months before new company…start, and maybe a month ago things started up ago, but basically you will find they do… and get it up until maybe a month or two ago the attention to providing quality clinical services to… population was absent. However, having said that, it is remarkable to me that the provider community has stuck with providing services and stayed faithful to the patient population through this time.

Glenn Koocher:

At their own expense.

Paul Barreira:

I don't want a disaster, by the way, I don't want to see people dying …but it is a testimony to the fact that the provider community in Massachusetts is very sophisticated, incredibly dedicated and lets the system work even if it's dysfunctional.

David Satin:

From the providers point of view, it sounds like this is more cost containment, because the contract in many managed care organizations says that you, the provider, guarantee to continue the treatment even if the managed care company goes bankrupt. We are legally obligated to do it for nothing if you can't do it…

Discussant:

I can discriminate values and operating styles… I felt I only have a year or so of experience…values and approaches…

Paul Barreira:

For a position of …the beginning has been that we inherited this contract, and we are obligated to make it work because the consequences of not making it work would be catastrophic. And so we didn't design it, but we've got it, and we've got it for a few years,

so we’ve got to make it work, we have to make it work, step forward and recognizing that more clinical responsibility.

David Satin:

It’s interesting watching a trial. One of the questions that came up for one of the witnesses was… “you were a lot of people--you were 15,000 people and why didn’t you do something?”. Essentially the answer is, “where…”. I’m afraid that’s… mental health providers. We’re stuck with the system.

Glenn Koocher:

I’m going to have to disagree with some of that. The mental health corporation in Massachusetts provider groups…back together… legislature a number issues and just said, “we’re going to take whatever comes”…manipulations of managed care, because there were certain limits, you know this story, that just could not… so we took a very conservative vote and said we have to go in and advocate for this, whatever it costs us. A small victory, a small victory, a small victory.

Discussant:

I’m not sure this is a question, but I think my observation that this whole ..prepare to serve the long-term needs of people who are necessarily…You look at models that can be…where people… and what has really struck me in this whole thing is that it reflects the economics about power which is, who knows who and those who simply doesn’t.

Paul Barreira:

The other way of measuring: we are probably spending hundreds of millions of dollars in mental health services that arenít being accounted

Peter Gumpert:

Absolutely.

Paul Barreira:

And so this computation about how much it’s really costing providing all these service is really a total farce.

Peter Gumpert:

I talked to professionals and asked how many of your patients are not using their managed care insurances, the hands go up everywhere, it’s everywhere.

Discussant:

I meant to ask how many of you prefer to work with patients who don't have managed care?

Peter Gumpert:

A lot of the self-pay is also tied to the issue of confidentiality. Quite frankly if I had a very, very delicate family mental health issue and I had the capacity to pay privately I certainly would, because I would receive an improved quality care and I could be sure that the confidentiality that could be promised by my clinician could be held firmly.

Glenn Koocher:

And thatís also true in medicine. Lots of people--my wife one of them--switched physical therapists because she knew there would…financially…and it's playing out, the choices--we have two-tiered counseling.

Peter Gumpert:

If I had a wish… I spoke in Missouri maybe a year or so about… who reached people who were organizin… and I use the word "provider". Somebody in the audience said, "hey, will you please quit using that term?"

Discussant:

There were a couple of comments I wanted to make, mainly from a research point of view. One: there was a mention of a client as a positive thing, a … in health services. Back in the late '50s, early '60s ,and then in the mid-'60s I switched over to Boston City Hospital service, I helped with two projects. One was to help with a halfway house program --male alcoholics and the chronic disease hospital, and this was funded by the Vocational Rehabilitation, a federal agency that I think no longer exists. And so of course we gave attention to employment, made ratings of the level of employment of some of the people who'd gone through the program, and a matched… alcoholics and not matched …

Anyhow, it turned out that was that it was a negative indicator, and the one most significant that distinguished between the halfway house people and… was that the men who achieved the highest ratings on vocational,had the best jobs, the best employment, were the most likely to revert to alcoholism. In those days, people got arrested for drunkenness, they had the highest rate of drunkenness arrest, and the greatest rate of relapse and the highest death rate, so I think one can… some of that the stress that they underwent in …rather than the ones…