MENTAL HEALTH SERVICES IN THE 21ST CENTURY: THE ECONOMICS AND PRACTICE CHALLENGES ON THE ROAD TO RECOVERY

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Abstract: *Since the program was initiated in 1963, little has been stable in Community Mental Health. Not only has this important quasi-public utility fought for survival, but the primary models and philosophies that shape the mission and delivery of services have undergone cycles of reform. There is much to be optimistic about in the mental health treatment arena, particularly in services focused on those with most challenging and debilitating conditions. However, all is not well. As states began to deemphasize institutional care and incrementally build a community infrastructure to care for those most in need, savvy administrators relied less on internal fiscal resources, and more on programs such as Medicaid to accomplish their agendas. Faced with budgetary crises in general, and in the Medicaid program specifically, many states are increasingly forced to consider processes to restrict eligibility, place limits on benefit packages, and cut rates to service providers. Indeed the worlds of economics, policy, and practice are on a collision course. This article explores some of the challenges of providing mental health care in the 21st century, and the continuing quest to address fiscal realities while offering high quality services.*

Keywords: Mental Health, Medicaid, Managed Care, Mental Health Policy

INTRODUCTION

A generation of Americans cannot imagine a world void of Community Mental Health Centers. The availability and accessibility of mental health services, along with a reduction in the stigma associated with seeking care, has resulted in an increased demand from the general population that has stretched the capacity of vendors, and left practitioners gasping for air (Gumz, 2004). Despite the perception that Community Mental Health Centers are a permanent fixture on the healthcare landscape, in reality, the turbulent fiscal and policy context in which they operate, keeps them in a constant state of peril. Indeed, the survival of the community mental health system as we know it remains uncertain.

Since the program was initiated in 1963, little has been stable in Community Mental Health. Not only has this important quasi-public utility fought for survival, but the primary models and philosophies that shape the mission and delivery of services have undergone cycles of reform (Mechanic, 1999; Mechanic, 1998; Foley & Sharfstein, 1983). Indeed, as Mechanic (1998) notes, "these changes often have been more a response to changes in financial structures, social ideologies, and new technologies than they have been to internal practices in the mental health sector itself" (p. 83-84).

Today, there is much to be optimistic about in the mental health treatment arena, particularly in services focused on those with most challenging and debilitating condi-

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tions. Pharmacological breakthroughs continue to offer new hope to those who gained little benefit from an older generation of psychotropic medications, and worse, suffered crippling side effects from an intervention intended to offer relief (Pomerantz, 2001). Rebounding from harsh criticism from all fronts, the last quarter century has seen dramatic improvements in the quantity and quality of community-based services intended to address the psychosocial needs of consumers trying to find their way in a post-institutional world (Mechanic & Bilder, 2004). Furthermore, the concept of recovery, once viewed as wishful thinking at best, has been firmly embraced by consumers, and continues to inform providers and policymakers (Anthony, 1993; Sullivan, 1994).

However, all is not well. The newer psychotropic medications, while effective, are expensive. Given the vast numbers of Americans who are uninsured or underinsured, and resurgent increases in healthcare costs again garnering headlines, difficult choices loom ahead (Zuvekas, 2005). As states began to deemphasize institutional care and incrementally build a community infrastructure to care for those most in need, savvy administrators relied less on internal fiscal resources, and more on programs such as Medicaid to accomplish their agendas. Faced with budgetary crises in general, and in the Medicaid program specifically, many states are increasingly forced to consider processes to restrict eligibility, place limits on benefit packages, and cut rates to service providers (Boyd, 2003). Attempts to maximize Medicaid and Medicare reimbursements, seemingly a wise strategy, can also create difficulties. When organizational behavior is driven solely by available fiscal streams, the range of services offered, as well as the breadth of populations served narrows. Moreover, when an increased percentage of an operating budget is dedicated to providing the match needed to leverage Medicaid, the inherent flexibility of providers is hindered. In turn, chasing the dollar may alter the broad-based mission that has characterized Community Mental Health (Frank, Goldman, & Hogan, 2003). Finally, as the direct federal role in mental health services has been primarily limited to a relatively small block grant to the states, and as providers have depended on Medicaid, Medicare, and private sources to remain afloat, the policy role of State mental health authorities has been reduced (Buck, 2003).

While some professionals would choose to remain blissfully ignorant of these developments, they have a profound impact on how and what kinds of services will be offered, and who will receive them. While veteran practitioners may long for days gone by, as Mechanic (1998) notes, "payment for anything professionals want to do, the long-standing traditional pattern, is no longer realistic and never was ideal" (p. 83). In short, economic realties shape practice, an implicit reality that became increasingly explicit in the early days of managed care. The challenge is to align policy, fiscal, and practice frameworks to support a vibrant and inspirational vision for mental health services. As we enter the 21st century the concept of recovery still offers a compelling vision for our work. However, a disturbing question lurks in the background: Can we continue to find a way to fund the community mental health mission?

THE EVOLUTION OF COMMUNITY MENTAL HEALTH

The birth of the Community Mental Health movement can be traced back to the period immediately following World War II. It is the story of dedicated reformers who hoped to

build on the experience they had gathered from the field of battle, and previous work in small local clinics that brought mental health services to places where none had existed previously (Foley & Sharfstein, 1983). Drawing from a public health model, the plan was to develop a network of community based services across the country that not only offered treatment, but also provided consultation and education services and vigorously engaged in prevention (Joint Commission on Mental Illness and Health, 1961).

Ironically, it was the American Medical Association (AMA) who objected loudly to the idea of a nationwide system of Community Mental Health. However, the AMA's energies were diverted by another policy development they considered even more threatening: Medicaid and Medicare. The enactment of these social insurance programs provided the safety net that allowed many psychiatric patients to move from the institution to the community. Through Medicaid and Medicare, mental health authorities, burdened by the high cost of State psychiatric hospitals, now had a method to reduce the census of such facilities. This movement fit hand in glove with a range of important legal decisions that protected the rights of consumers, and made it increasingly difficult to institutionalize people against their will (Foley & Sharfstein, 1983).

In the end, however, Community Mental Health Centers were ill prepared to serve people with the most serious mental health challenges, and simultaneously, the level of sophistication of rehabilitation services, and the limits of primary prevention, was exposed. Faced with a burgeoning crisis and growing criticism, Community Mental Health Centers redoubled their effort to develop an array of services directed to a population then referred to as the chronically mentally ill.

By the late 1970's, the National Institute of Mental Health proffered a new model of care known as the Community Support Program (Turner & TenHoor, 1978). Hogan (1999) suggests, that the community support model, "was the first reform model that viewed serious mental illness as a long term disability requiring both rehabilitation and treatment, rather than a problem that could be avoided by providing only short term acute treatment" (p.107). In response, wide ranging and specialized services directed to those now commonly deemed the seriously and persistently ill have been developed, with case management, housing, and vocational programs in the forefront. State mental health authorities, as always confronted with greater demand for services than were available, increasingly directed their limited funds to those in greatest need by virtue of their illness and poverty.

While no one is prepared to claim victory, it does appear that money and services are being directed to the intended target population, as those in greatest need currently are enjoying greater access to specialty mental health services than ever before (Mechanic & Bilder, 2004). The development of these specialized services, psychopharmacological breakthroughs, the work of the family and consumer movement, as well as the existence of funding streams to support psychosocial interventions, have helped foster a more hopeful and purposeful treatment system.

However, when attention is directed to certain subpopulations, others are left behind. As Mechanic and Bilder (2004) suggest, "many people who need treatment still do not receive it, and most treatment fails to meet reasonable evidence-based standards of care"

(p. 86). In an effort to assess the current state of mental health services, and determine what can be done to improve them, on April 29, 2002 President George W. Bush unveiled the New Freedom Commission, the first presidential mental health commission since the Carter administration (Hogan, 2003). Reflecting on his role as chair of the commission, Michael Hogan noted:

The one big idea – the headline, if you will in the report to the President is that recovery is possible for anybody, But the system is too fragmented, and the services that are available are inadequate and not of high enough quality to allow recovery to be a realistic promise for many people. So the commission's vision statement for future mental health care is that recovery should be expected because of the accessibility and quality of services that are provided. (Cunningham, 2003, p. 447)

FUTURE OPPORTUNITIES/FUTURE THREATS

As health care costs grew exponentially during the 1990's, managed care programs dramatically altered the delivery of medical services in America. Historically, the unpredictability of mental illness, the lack of specificity in the diagnosis and assessment process, and the relative absence of generally accepted treatment protocols made many proprietary vendors wary of entering the behavioral healthcare market. Although there were, and continue to be some efforts to integrate behavioral health services with primary health care, more often, mental health and substance abuse services have been treated separately, or in the common nomenclature "carved out".

However, the new world of managed care impacted the organization and delivery of behavioral health care. Over a decade ago, Jacobs and Moxley (1993) implored mental health programs to prepare for managed care by adopting a business mindset. Indeed, before long new worlds of management information systems, actuarial analysis, productivity requirements, credentialing, and accreditation was upon us. On the positive side of the ledger, the pressures of managed care have forced provider organizations to be clearer about their processes and outcomes, in a continued effort to improve the quality of care, and to be accountable to the wide range of funding sources that are vital to survival. Given the current state of the economy, the rising costs of Medicaid and Medicare, and the state of individual and employer-based insurance coverage, the pressures for improved quality and greater accountability are not likely to abate. The vexing dilemma facing administrators and practitioners is how to generate needed funds, provide comprehensive services at high quality, and meet accountability requirements?

Drawing from 30 years as a Community Mental Health director, Robert Dunbar (personal communication, October 11, 2004) surmises that:

> I believe that effective Community Mental Health Center directors, and other behavioral health leaders, will need to position their organization to effectively implement evolving evidence based treatments, with very little up front financial support, will need to assess the effectiveness of services by identification and tracking of key performance indicators, will need to employ an increasing diverse and culturally competent staff despite a shortage of professionals seeking a career in behavioral health, will need to integrate services particularly with corrections and physical healthcare in part as a

> means of further revenue diversification, and will continue to seek new and diverse means of funding, particularly of a social enterprise nature. .... The future of community mental health is very uncertain.

All conversations with leaders in mental health begin and end with concerns about funding. The potential crisis in Medicaid is particularly nettlesome, as this one program serves as the foundation for community-based care. Buck (2003) notes, that by 2002, "Medicaid had become the largest single source of revenue for community providers, accounting for 38 percent of their total funding" (p.971). Significantly, non-traditional Medicaid offerings, such as the Rehabilitation Option, have funded key activities, such as case management services, and as the title suggests, this funding stream supports services directed to the broad psychosocial needs of consumers. Vladeck (2003) reports that Medicaid, often viewed as a program for poor mothers and children, actually spends more on the non-elderly disabled (including those with mental illnesses) than any other single group. In part, this is due to a social desire to help a wide range of people who have "real needs for which it is difficult or too uncomfortable to hold them personally responsible" (p.93). However, disability is an illusive term, and the process of determining disability is as much a political process as it is an objective one. As a result, the development of each State's individual Medicaid plan becomes contested turf, with seemingly slight policy adaptations having serious consequences for consumers, families, and providers.

One growing possibility is that Medicaid dollars can become folded into a State's overall block grant, offering greater flexibility, while capping spending. Hogan, the Director of the Ohio Department of Mental Health and Chair of the New Freedom Commission, views this as a reasonable option if the dollars are adequate;

> Because one of the consequences of how Medicaid is often run, given its fee-for-service orientation and categorical approach to eligibility, is that it has made community mental health care into piecework, with an emphasis by case managers and therapists on billable units of service for people who are Medicaid eligible, as opposed to clinically necessary care for people who need that care irrespective of eligibility. (Cunningham, 2003, p. 447)

The growth in Medicaid spending for mental health services will not go unnoticed, and while State and Federal Medicaid officials may be reluctant to eliminate classes of beneficiaries, there will undoubtedly be growing pressure to demonstrate that clinical necessity exists for continued care, and that services deliver a tangible benefit. Not surprisingly, these trends only add to the push to develop evidence-based services, As Terry Stawar (personal communication, October 7, 2004), a Community Mental Health director in Southern Indiana predicts, there is a "coming juncture between evidence based practices and funding, in which only evidence based practices will be eligible for Medicaid/Medicare reimbursement."

It is hard to argue against a position that practice should be supported by good science. However, Tanenbaum (2005) suggests that "controversy may reign over fundamental notions of defining evidence, applying evidence, and determining effectiveness." Larry Burch, (personal communication, October 14, 2004) approaching his silver anniversary as a mental health center director, recognizes that dilemmas do exist:

> Every provider is challenged to make sure they are engaged in evidence based practices. At the same time we are encouraged to make sure we are focused on recovery and consumer driven services. There are times when these two are contradictory. Consumers do not always choose evidence based services. This will require providers to walk a fine line at least into the distant future.

Consider the concept of recovery. Does recovery mean that a person is symptom free, holding a job and living independently? Or is it a matter of deeper personal meaning, ultimately best-judged by the person facing a challenging condition? These questions are far from trivial, as they may determine what types of services are prioritized, and if linked to social insurance policies, what services are reimbursed?

A move towards evidence-based practice, improved utilization review strategies, and even the quest for insurance parity for those facing mental illnesses leads community mental health and other behavioral health organizations to fall in line with trends seen in the world of physical medicine. If successful, the integration of systems of care for physical and mental health may not be far behind. The specific approach such an integration plan would take is far from clear. Certainly, the primary care gatekeeper model has conceptual coherence, but it will only work to the degree that this system can adequately assess behavioral health challenges, and has secured the proper specialty providers to offer effective services. Given the unpredictability of serious mental illnesses, and the attendant costs, there is always danger that a bifurcated system could return in the form of a narrowly defined medical model – reversing many of the gains of the last 25 years and signal a retreat from the psychosocial model that now prevails.

Few would see this as a desirable trend, but the troublesome question is who will fight this battle? As community mental health centers struggle to diversify funding streams, an increasingly smaller percentage of their budget is comprised of State administered funds. Accordingly, the most important actor in the life of a modern day Community Mental Health director is the not the head of the State mental health authority, but rather the State Director of Medicaid. Medicaid constitutes more than 20 percent of most state budgets, with behavioral health only one of many actors who depend who funds disbursed from this office (Boyd, 2003). Decisions made by a State's Medicaid office, dictates the course of mental health care far more than any other entity. Consider the costs of prescription drugs alone. According to Zuvekas (2005), between 1996 and 2001 prescription drug costs for mental health and substance abuse grew at a rate of 20 percent a year. Remarkably, 80% of this growth was accounted for by selective serotonin reuptake inhibitors and newer antidepressants, and atypical antipsychotics. Few disagree that these newer medications are often critical to the recovery process for consumers, but many wonder if these drugs will remain on a state's Medicaid formulary.

Complicating the lives of mental health directors is that while the press of managed care, and other third party payers, has required the adoption of an insurance model of care, vestiges of the public health, or population-based model remain. State directed funds may support a portion of the cost of serving the most seriously ill, while self paying clients and those with adequate insurance also contribute. Other clients fall into an entirely different group. The working poor, often underinsured, depend on reduced fee schedules to receive

services, resulting in a net loss to the provider. Given the pressing demand, practitioners face high productivity standards as all try to maximize their billable units. The worlds of care and finance have collided. The challenge facing administrators is to help guide their organizations through these challenging times without inexorably compromising the primary mission. As Larry Burch notes (personal communication, October 14, 2004):

> It is critical to get the entire organization to buy into a healthy bottom line. The purpose of this bottom line is to serve the mission. But, in order to enhance and protect the mission you must have the capacity to respond to emergencies and opportunities. The final major change in my job has been to develop the skills and organizational commitment for philanthropy/fundraising.

Burch and his peers have been forced to become social entrepreneurs (Eikenberry & Kluver, 2004). Eikenberry and Kluver (2004) contend that to understand the behavior of a non-profit organization it is first necessary to understand the threats and pressures that emanate from the external environment. Social entrepreneurship requires these leaders to leverage their understanding of the world of business and the market to help improve the lives of consumers while simultaneously respecting the primary mission of the organization (Dees, Emerson, & Economy, 2001).

Adopting a social entrepreneurship model could increase mental health centers' legitimacy with key stakeholders, and consistent with the promise of evidence-based practice, rend organizations more effective, efficient, and accountable. But there are risks. Eikenberry and Kluver (2004) argue that non-profit organizations have been vital to society by serving as "value guardians, service providers and advocates, and builders of social capital" (p. 135). When a non-profit organization unconditionally adopts a market mindset, and becomes driven more by the demands of funders than consumers, these important contributions may be abandoned.

THE UNCERTAIN FUTURE

By virtue of the increased demand for services for problems ranging from interpersonal difficulties at home, to the most difficult psychiatric conditions, Community Mental Health Centers have developed a loyal constituency that should bode well for their survival. The threat of managed care forced even the most traditional of providers to take necessary steps to modernize operations in the area of management information, contract management, and accreditation. In addition, many provider organizations developed networks to share these management functions and fiscal risk, as funding moved from grant-based to a contract-based environment. These centers retain a wealth of expertise in serving the most severely ill, and should be welcome partners should the worlds of physical and behavioral health care merge.

The trends, long sent into motion, have obvious implications for social workers and other mental health professionals. The world of practice has changed. Evidence-based practice, manualized treatment protocols, group modalities, and brief helping techniques have become the rule, not the exception. Increased interdisciplinary work in community settings is on the horizon. For some these changes are unsettling, but as Mechanic (1998) asserts, "mental health professionals have to stop lamenting the changes and devote their

energies to better defining good practices and putting into place disease management approaches that are informed by evidence" (p. 93).

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