

# ISSUE BRIEF

The Massachusetts Health Policy Forum

## MENTAL HEALTH CARE IN MASSACHUSETTS

Thursday, December 16, 1999

8:30 to 9:00 – Breakfast

9:00 to 11:00 – Discussion

**Swissotel**

**1 avenue de Lafayette**

**Boston**

A Discussion Featuring:

Professor David A. Rochefort  
*Northeastern University*

Laurie Ansorge Ball  
*Massachusetts Division of  
Medical Assistance*

Commissioner Marylou Sudders  
*Massachusetts Department of  
Mental Health*

Jessica Henderson Daniel  
*Children's Hospital*

Lisa Lambert  
*Parent Professional Advocacy  
League (PAL)*

Moderated by: Professor James Callahan  
*Heller Graduate School  
Brandeis University*

**Registration: Please call Sue Thomson at 617-338-2726 as soon as possible**

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**NO. 6**

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## Executive Summary

During recent decades, mental health care in Massachusetts has undergone a profound shift from a system centered around large public institutions to one based primarily on community services delivered by a variety of public and private sources. Still another wave of change has arrived over the past few years, stimulated by such forces as managed care, privatization, and health care cost-control. The purpose of this Issue Brief is to review the historical development and contemporary organization of mental health care in Massachusetts, as well as to analyze a series of issues which are currently on the agenda of mental health policy reform in the state. Key findings from different sections of this report are as follows:

### History and Organization

Between 1960 and 1985, a process of rapid deinstitutionalization took place in Massachusetts as the census of public mental hospitals fell from around 20,000 to 2,000 inpatients. Driving this trend were a host of influences, including new drug treatments, the increased availability of alternative services, legal advocacy, and public policy decisions.

By the mid-1980s, there was a widespread realization that the state needed to improve its system of community care for individuals with severe and persistent mental illnesses. A Mental Health Action Project developed by the Dukakis Administration, and backed by the Legislature, sought to address this problem with an expanded continuum of care and augmented mental health funding. This initiative was curtailed, however, by the state's fiscal problems during the late 1980s and early 1990s, as well as by the administration of Governor William Weld, which advanced a privatization

strategy for mental health services in common with other areas of state government.

Over time, a number of important changes have taken place in the operations of the Massachusetts Department of Mental Health (DMH). These include a heightened emphasis on serving adults and children with the most severe mental disorders, a shift from direct service provision to contracting, and a decentralization of many planning and monitoring functions.

### Medicaid and Managed Mental Health Care

In 1992, Massachusetts became the first state to implement a statewide federal waiver program to deliver mental health and substance abuse services to its Medicaid enrollees. Under this initiative, the majority of MassHealth recipients receive their mental health services through a "carve-out" program operated by a for-profit specialty provider.

Since the creation of the carve-out in 1992, the program has undergone various changes resulting from the transfer of corporate management, an expansion of responsibilities to include clients of DMH who need acute care, and an evolution in the state's own approach to contracting, including the use of performance standards.

Appraisals of the Massachusetts Behavioral Health Partnership, the for-profit entity currently holding the Medicaid carve-out contract, range widely. Concerns also exist that the level of administrative monitoring of the carve-out program by state government has been insufficient.

### Regulation of Managed Care

Despite the extensive penetration of the health care market by managed care, Massachusetts is one of only a few states not to have adopted a broad framework of protections for individuals enrolled in private managed care plans. During the current legislative session, lawmakers once again are considering managed care regulatory proposals, but disagreements exist as to the desirable scope and stringency of possible new requirements.

Although there have been many complaints about abuses under managed mental health care in the state, mental health care issues have received little attention in the current regulatory policymaking process. A series of measures that might improve the protection of mental

health consumers under managed care are outlined in this Issue Brief.

### Mental Health Parity Insurance Coverage

Another legislative area where Massachusetts lags behind many other states is in the enactment of a parity statute mandating equal coverage of health and mental health problems under private insurance. Although widely supported by mental health advocates, providers, DMH, and other groups, current proposed parity legislation has drawn criticism from insurance and business interests who fear its impact on costs. Other disputes concern the relationship between mandated benefits for mental health care and managed care gatekeeping. At the time of this writing, it is unclear what type of parity law, if any, will emerge from the Legislature under the pressure of these divergent views.

### Deinstitutionalization and Community Support

As a result of the work of Governor Weld's Special Commission on Facility Consolidation in 1991, three of seven existing state hospitals, and the only public psychiatric treatment facility for children with serious emotional disturbance, were closed in Massachusetts. In conjunction with this initiative, DMH launched a new "comprehensive community support system" (CCSS) model for people with serious and long-term mental disorders.

Since the announcement of CCSS, there has been notable mental health program development on the local level and the institution of a broad-based planning process across the state involving mental health consumers and family members. However, in many locations there are gaps in the spectrum of community care and long waiting lists for crucial services such as case management.

### Children's Mental Health Services

A series of reports over the past year have documented serious problems in the delivery of children's mental health care in the state. Specific concerns cited include the impact of managed care and deinstitutionalization, lack of coordination among different state departments serving this population group, and a high level of unmet need for treatment and social supports for children with mental disorders.

During the summer of 1999, very high occupancy levels in hospital psychiatric units for children became a major news item, adding to the perception of a crisis in

children's mental health care in Massachusetts. For many observers, this situation signaled the urgency for a variety of new resources and system-level reforms.

### Homelessness

It has been estimated that as many as 9,000 homeless adults are living in Massachusetts at any given time, of whom approximately 2,000 have severe and persistent mental illnesses. According to DMH, these numbers continue to rise and the shelter system is being strained beyond its capacity.

Although persons who are homeless and mentally ill are a priority problem for DMH, and substantial new state resources have been directed into this program area in recent years, such efforts are dwarfed by the magnitude of the state's homelessness challenge. According to a study by the Massachusetts Association for Mental Health earlier this year, more than 3,000 adult clients of DMH and over 100 children were awaiting housing, residential services, and rental assistance.

### "Reinventing" the Vision

In the final section of this Issue Brief, a trio of broad policy actions are proposed to strengthen the state's mental health system:

- Injection of additional funding for public mental health services to stem the erosion of state mental health funding and to reduce the discrepancy between documented needs and service availability
- Establishment of a Mental Health Legislative Caucus to help counter the fragmentation of policymaking for mental health issues within the Massachusetts Legislature
- Convening of a Mental Health Policy Summit to focus high-level attention on mental health policy issues in Massachusetts and to set the agenda for system reform leading into the new millennium

## **Overview**

The picture of mental health care in Massachusetts is one of contrasts.

Historically, the state has led the nation with important developments in the original mental hospital movement of the early 1800s, in the establishment of

general hospital psychiatry during the early 1900s, and in the postwar adoption of policies fostering deinstitutionalization and community-based care (Grob, 1973, 1983, 1991). Massachusetts was among the earliest to recognize the value of supportive services like case management and housing in implementing the concept of community care. Most recently, Massachusetts was in the vanguard of a sweeping movement by the states to reorganize the delivery of behavioral health services to Medicaid recipients (Wieman, 1998). Under Chapter 203 of the Acts of 1996, the state also expanded eligibility for Medicaid, which contributed to adding more than 225,000 people to the program between 1997 and 1999 (Hsu, October 4, 1999).

Yet despite this record of leadership, the state lags behind in other ways. So concluded a highly-publicized series of reports by a national advocacy group that rated the states for the adequacy of their services for people with the most serious mental disorders. In 1986, Massachusetts was ranked 41st of all states by the Public Citizen Health Research Group, which pointed to a "painful downhill slide...in caring for those who cannot care for themselves" (Torrey and Wolfe, 1986, p. 69). By 1990, when the group's third and last report was issued jointly by Public Citizen and the National Alliance for the Mentally Ill, Massachusetts had climbed to a ranking of 16, edging it into a place among the top half of states (counting ties). Notwithstanding this gain, the researchers put Massachusetts into the general category of "trying to improve, but major problems impede progress" (Torrey, Erdman, and Flynn, 1990, p. 43). Questions have been raised, and properly so, about the methodology used for these studies (see, e.g., Mee, 1989). Still, there is no denying the importance of the system characteristics selected for discussion in the analysis, such as service funding levels, community support activities, and the extensiveness of children's services. When University of Massachusetts author Jay Neugeboren published Transforming Madness in 1999, a survey of knowledge and treatment programs in the mental health field, the state's reputation remained mixed. Neugeboren reported how knowledgeable local providers and consumer advocates advised him against transferring his brother from a hospital in New York to Massachusetts considering, among other factors, the "unstable political and economic situation" for public mental health services here (p. 81).

Massachusetts is blessed with an exceptionally rich health care infrastructure to support its mental health services. Located in the state are some of the most respected hospitals, health plans, universities, and

mental health researchers in the nation. Few states can rival Massachusetts for its supply of mental health professionals practicing in different disciplines (Peterson et al., 1998).

However, as this report will show, accompanying this excellence and abundance are concerns about the quality of mental health care for groups such as children and the homeless. Further, thousands of individuals face lengthy waiting lists for mental health services around the state. As a recent "Fact Sheet" from the Massachusetts Department of Mental Health succinctly described the situation: "DMH still has more clients than service availability" (DMH, 1999, p. 2). In the area of private insurance, Massachusetts is currently one of twenty-three states not to have adopted "parity" legislation guaranteeing equal coverage of mental and physical illnesses. It is also one of the last states without a comprehensive framework for regulating private managed care practices.

One of the very strongest assets for mental health care in Massachusetts is the variety of model mental health programs which have been developed in Boston, Worcester, western Massachusetts, and other locations, as also discussed by Neugeboren (1999) (see also DMH, 1999). Consumer clubhouses, Assertive Community Treatment, McKinney homelessness demonstration projects, the Boston University Center for Psychiatric Rehabilitation—all are innovative undertakings well known to students of the literature on best practices in mental health. Addressed by these programs are wide-ranging needs of consumers, including vocational training, job placement, housing, recreation, social integration, and continuing care and treatment. Whatever their particular focus, a common feature of such programs—and a generally recognized key to their success—is the emphasis they place on services that are at once flexible, comprehensive, and well-coordinated. Steps are also being taken in Massachusetts to improve the access of mental health consumers to primary health care, both through DMH's service planning and Medicaid managed care.

Yet relatively few of the Commonwealth's mental health consumers currently benefit from model programs. For most, the reality is a system frequently marked by fragmentation and lack of care. The last major attempt to reform the public mental health sector in Massachusetts through funding expansion was The Mental Health Action Project of 1985. Its basic finding that "Because the mental health service system lacks a fully developed continuum of care, it is unable to

achieve the goals for which it was designed" remains generally applicable today (p. 8). Although The Action Project advanced an ambitious policy agenda that was accepted by the Governor and Legislature, implementation was cut short by the state's worsening fiscal problems in the late 1980s. The economy has since undergone a vigorous recovery, but subsequent service growth for mental health care has tended to be halting and limited to a few program areas.

As a matter of course, this report will refer to the Massachusetts mental health "system." As used here, this term has a broad meaning that encompasses both governmental and nongovernmental activities for the prevention and treatment of mental disorders, as well as for the social support of persons with mental illnesses. In its strict sense, the notion of a system implies "a tightly organized, finely tuned, interdependent, and smoothly functioning collection of elements" (Reamer, 1989, p. 22). Not many observers would claim that mental health care in Massachusetts fits this definition, given the often disjointed relationship between public and private sectors, or the bureaucratic problems that emerge when it comes to serving consumers whose needs transcend the jurisdiction of a single agency. Recognizing this latter issue, DMH has begun targeting program improvements for such groups as those dually diagnosed with mental health and substance abuse problems (Massachusetts Association for Mental Health [MAMH], January, 1998a). Sometimes, however, one state agency may actively strategize to shift clients to another, as in the attempt to maximize federal Medicaid funding for mental health care in Massachusetts. No unified authority exists for planning and resource allocation across the myriad public and private pieces of this system. Perhaps it is true, as has been suggested, that "we...use the term [mental health] system because we like what it suggests and wish the world would operate accordingly" (Reamer, 1989, p. 22). Still, for a loosely connected set of parts, Massachusetts' mental health providers, programs, agencies, administrators, and public policymakers do exhibit in the aggregate certain qualities typical of complex organizational systems: Change is difficult, and there is recurring uncertainty about where to assign responsibility for the most burdensome and difficult service challenges (Perrow and Guillen, 1990).

Whatever other ambiguities exist, one thing is plain: Mental health care in Massachusetts is a system under stress from many sources. Widespread privatization activities of the early 1990s, including the closure of several major public institutions, launched a contro-

versy that has persisted for several years, and the outcomes of those public policy decisions have yet to be carefully determined. "Managed care," the latest new framework for mental health services delivery in Massachusetts, has been described as much as "a crusade as a management tool" (Koyanagi and Bevilacqua, forthcoming). Its methods for containing costs are demanding extensive adjustments on the part of all system participants, but especially patients, providers, and family members. There are also intense differences of opinion regarding the relevance of the general managed care paradigm for the specialty area of mental health care. Finally, the state's mental health system is strained by numerous long-term unresolved issues and needs arising from incomplete insurance protections for mental health care, a community mental health revolution still in progress, and limited knowledge in regard to effective mental health promotion and mental illness prevention.

The purpose of this Issue Brief is threefold: (1) to explain the evolution of the Massachusetts mental health system and describe its current organization; (2) to examine a number of pivotal policy issues that are currently on the agenda of mental health care reform in the state; and (3) to focus attention on overarching questions of strategy, resource allocation, and public philosophy for mental health care in a way that might contribute to a renewed vision of system development in Massachusetts. Thus, the report will provide an overview of mental health care in the state that is both historically-based and policy-oriented.

Because this *is* an overview, not all significant topics can be included. For example, the Boston Globe (July 21, 1999, p. A14) recently highlighted a deficiency in the provision of mental health services within the state's prisons. The problem is an important one in Massachusetts and nationally, with many unfortunate consequences. However, it will not be examined further here, because the tangled issues of criminal behavior and mental illness, as well as the interagency complications of the problem, would overstretch the boundaries of this analysis. Similarly, all of the particular mental health policy issues that will be discussed—managed mental health care, parity insurance coverage, children's mental health services, homelessness, and deinstitutionalization—easily merit treatment in their own lengthy reports, and the level of detail supplied for each may be insufficient for advocates and experts on these matters. This paper is meant to be a single accessible document spanning a variety of mental health concerns in Massachusetts and showing their interrelationship. Value was

seen in the idea of a general guide that, analytically at least, overcame the fragmentation of the system.

## Historical Background

Many forces have shaped the historical development of mental health care in Massachusetts. Ideas about the causes of mental illness have changed tremendously over the years and, with them, approaches to mental health treatment. The salience of mental health and mental illness as public concerns has also risen and fallen, sometimes in sync with, and at other times independent of, broader social and political movements. Developments within general medicine have served to define the place of mental health care as a specialty service, including the kinds of settings, providers, and payment sources available in the private sector. Last, the mental health system has been directly affected by the operations of state government, both in matters of resource availability and in the application of contemporary administrative and policy tools.

The history of mental health care in Massachusetts can be traced back to the earliest days of the settlement (Grob, 1973; Jimenez, 1981; Bachman, 1994; Remar, 1974). Without any formal system of mental health care during the pre-Revolutionary era, people with mental illnesses usually were cared for by family members or ended up in local jails and almshouses. In time, overcrowding in these public facilities, combined with a movement known as "moral treatment" to develop more specific, humane care for individuals with mental disorders, led to the founding of mental hospitals. The private McLean Asylum opened in Boston in 1818, and Worcester State Lunatic Asylum was founded in 1833. Massachusetts was also home of the greatest psychiatric reformer of the 19th century, Dorothea Dix, who launched her campaign to improve the nation's mental hospitals with a "memorial" asking the Massachusetts Legislature in 1843 to add to Worcester State's already strained capacity (Gollaher, 1995, chap. 5).

An institutional approach remained the hallmark of the mental health system in Massachusetts as elsewhere for more than a century to come. By 1875, there were six state mental hospitals in the Commonwealth with more than 2,000 residents (Mental Health Action Project, 1985). By 1910, the number of facilities more than doubled to 13, with an inpatient census of approximately 10,000. Not until the mid-1950s did this

institutional trend peak in the state, at 14 hospitals housing more than 23,000 patients (Upshur et al., 1997).

A number of noteworthy mental health reform movements, which aimed at upgrading institutional care or developing alternatives to it, originated or were active in Massachusetts over this long period. Included were the mental hygiene movement, psychopathic hospitals, outpatient clinics, and various new therapeutic regimens (Grob, 1983, 1991; Caplan, 1969; Rothman, 1980). None, however, ever seriously threatened to displace the mental hospital from its dominant position in public mental health services, nor did the battle for improved quality gain much ground in the face of worsening overcrowding, insufficient public budgets, and a service philosophy favoring custody over treatment. According to one official assessment, "In 1960, the public mental health system in Massachusetts consisted almost exclusively of overcrowded and severely under-staffed state mental hospitals...People with serious mental illness had few alternatives to state hospitalization as community services were limited to a small number of inadequately funded child guidance clinics and a single state-run mental health center. Virtually no residential care or day programs were available in the community" (Mental Health Action Project, 1985, p. 5).

Mental health care in the private sector remained under the shadow of the public system throughout these years. Yet important changes were beginning to lay the groundwork for an eventual shift in this pattern. Outpatient clinics represented the first faltering steps toward the broadening of community-based mental health services for the general population (Grob, 1991, chap. 7). The private practice of psychiatry slowly expanded with the influence of Freud, who made his only visit to the United States in 1909 at a conference at Clark University in Worcester (Grob, 1983, p. 117).

Beginning in the early 1900s, general hospitals also began to create specialized psychiatric units, offering to both patients and medical practitioners a new setting for inpatient mental health care. As Dorwart and Epstein (1993) noted in their study of the Cambridge Hospital, it took decades for this movement to become firmly established. By 1960, Massachusetts still had few psychiatric wards in general hospitals. However, the rapid expansion of public and private insurance coverage in the 1960s and 1970s gave a tremendous boost to private office- and hospital-based mental health care. Significantly, a new law taking effect in Massachusetts in 1976 required all private insurers to cover sixty days of inpatient mental hospital care, an equivalent amount

of general hospital care for psychiatric problems as for other medical conditions, and outpatient mental health benefits of \$500 per year (McGuire and Montgomery, 1982).

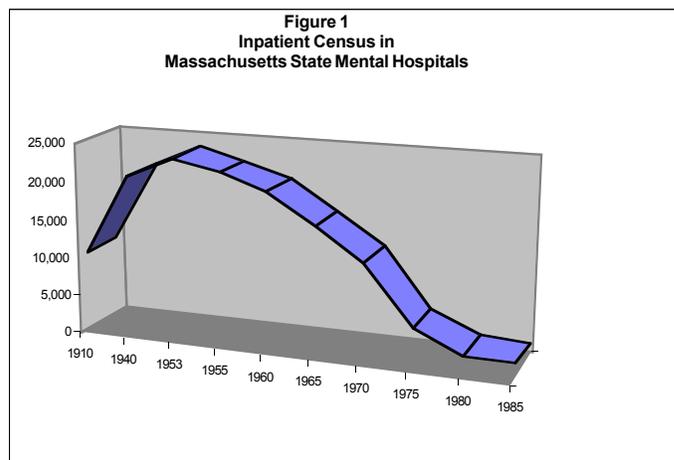
In general, the past few decades in Massachusetts have been a continuing effort to move from a mental health system dominated by public institutions toward one centered around a variety of public and private community-based services. This has meant responding to numerous managerial, organizational, and financial issues, many of which were poorly anticipated at the time this strategy first was adopted.

After reaching its apex in the mid-1950s, the census of public mental hospitals in the state began to decline, slowly at first and then more sharply (Mental Health Action Project, 1985, p. 7). From 1960 to 1985, the count fell from around 20,000 to 2,000 inpatients (Figure 1). Between 1971 and 1981, Massachusetts closed the doors of four state hospitals (Bachman, 1994, p. 119). By July 1992, after further downsizing of the system, the state operated just five mental hospitals in total, with fewer than 1,100 patients. In part, this dramatic transformation was driven by powerful new drug treatments, the growing availability of community services, and changes in civil commitment statutes. But deinstitutionalization was also a public policy choice in Massachusetts enabled by a series of legislative enactments and planning projects. In addition, the pace of deinstitutionalization was accelerated by civil liberties advocates who won agreements, such as the 1978 Northampton State Hospital Consent Decree, for the elimination of substandard hospital facilities and expanded treatment in the least restrictive setting.

In 1985, a Mental Health Action Project initiated by Governor Michael Dukakis highlighted the fact that deinstitutionalization in Massachusetts had failed to be accompanied by an adequate system of community care. As Governor Dukakis stated in a special message to the Legislature: "Many areas of the Commonwealth lack emergency screening and crisis services; housing opportunities for chronically mentally ill persons remain extremely limited; and little support is provided for families caring for mentally ill relatives. Hospital care for those needing acute or long-term psychiatric treatment does not in many cases meet even marginally acceptable standards. We are well aware of the tragic plight of homeless mentally ill" (Mental Health Action Project, 1985, p. 2).

Galvanized by the "painful awareness" of such failures, the Dukakis administration proposed a four-point plan focusing on: (1) providing emergency and support services for all persons with chronic mental illness in the state; (2) improving the quality of inpatient care at state hospitals and community mental health centers; (3) increasing residential care and treatment options; and (4) improving management in the state Department of Mental Health (DMH). The implementation time frame for the plan was five years, with a price tag of \$151.2 million in capital funds and \$110 million in operating dollars.

Massachusetts legislators supported the recommendations of The Mental Health Action Project with the passage of Chapter 599 of the Acts of 1986 and increased appropriations for DMH. Local service enhancements began, using public as well as private providers, and a process of institutional upgrading was set in motion, albeit without a goal of further reducing



Data Source: Department of Mental Health, 1999 (June 18), p. 17.

the number of inpatient beds in the public system. As a result of this effort, Bachman (1994, pp. 122-123) writes, "by 1989, services available through the local areas included emergency, case management, outpatient, day treatment, clubhouse, support programs, supported employment, residential, family support and inpatient (both acute and other)...Although not all services were available in all parts of the state, DMH was gradually developing a comprehensive system of community-based care."

Two key factors in the late 1980s and early 1990s, however, brought this period of resource expansion to an abrupt end. First was worsening state budgetary problems that choked off the flow of augmented mental health funding. Second was the election of Governor William Weld, who sought to revamp Massachusetts public policy in areas including mental health care by applying a "reinventing government" approach based on extensive privatization. Both factors and their impacts will be taken up at greater length in the policy issues section of this report.

## Organizational Setting

The forerunner of the current Massachusetts Department of Mental Health was the Department of Mental Diseases, created in 1919 to consolidate numerous offices primarily concerned with administration of the state's public mental hospitals (Grob, 1983, p. 211). In 1938, the Department of Mental Diseases was reorganized as the DMH in a move by the Legislature to centralize control over a troubled hospital network (Bachman, 1994). As a result of subsequent restructuring legislation, DMH was geographically decentralized into six regional offices and twenty-four area offices to facilitate planning and delivery of community-based mental health services; mental health and mental retardation services were separated into two departments; and DMH acquired explicit responsibility for consumers with long-term and severe disorders.

Largely in response to budgetary strain in the early 1990s, DMH regrouped its six regions and twenty-four areas into nine areas, and then simplified the system further into just six geographic areas with no regions (DMH, 1998). Situated within these areas are a total of thirty-three Local Service Sites in which DMH provides individualized case management services for the agency's clientele while monitoring an array of adult and children's services.

DMH describes its current mission as follows:

"The mission of the Department of Mental Health is to improve the quality of life for adults with serious mental illness and children with serious and persistent mental illness or severe emotional disturbance. This is accomplished by ensuring access to an integrated network of effective and efficient services that promotes consumer rights, responsibilities, rehabilitation, and recovery."  
(DMH Bulletin, Summer 1996, p. 3)

Implicit in this official statement are three keystones for the department's operations. First is the identification of a group of "priority clients," defined in practice according to the severity of disorders, degree of functional disability, and/or the length of illness. Second is the categorical recognition of children as a population group meriting special attention and resources within the department's activities. Third, the mission statement reflects the long-term transformation of DMH beginning in the 1970s from a direct provider of services to an agency that indirectly assures service delivery through contracting and monitoring. Indeed, as one researcher has described it, "Massachusetts is so reliant on contracting that policymakers and staff do not think of it as a special tool, but as the primary way the state delivers services" (Bachman, 1994, pp. 127-128).

Structurally, the public mental health sector of Massachusetts is concerned with three broad types of services (DMH, 1998, 1999). Acute or short-term services, once provided by DMH's own inpatient facilities and subsequently arranged through contracts with various community hospitals following the closure of state facilities in the early 1990s, are now being purchased by Medicaid on DMH's behalf through a private managed care organization. Long-term hospital services are supplied both by the department's remaining inpatient facilities, including four state hospitals and nine community mental health centers (CMHCs), and by public health hospitals. Community-based care, encompassing a full spectrum of community services and supports, are delivered as a mix of state and contracted services. Planning and management for these services occurs primarily on the Area-level with consumer and family participation.

Complementing these main programmatic interests, DMH also provides support for special homelessness initiatives, for eligible target groups within the courts and correctional systems, and for two "Centers of Excellence" devoted to research on diagno-

sis, treatment, and rehabilitation of patients with serious mental illness. Pilot programs applying an integrated treatment model for DMH clients with dual diagnoses of substance abuse and mental illness have been developed for selected areas of the state, and a joint Task Force between DMH and the Department of Public Health has also been created for the issue (DMH, 1998).

DMH's role as "State Mental Health Authority" entails a number of additional activities through which it seeks to assure the welfare of all individuals receiving mental health care, whether under public or private auspices. As one key example, DMH performs an important regulatory role in regard to the licensing of inpatient psychiatric facilities in Massachusetts, and it exercises oversight of both private psychiatric facilities and general hospitals with psychiatric units. For the department, "licensing is a powerful tool to require certain standards [concerning] staffing, use of seclusion and restraint, medical coverage, etc." (Sudders, 1999b). In 1997, DMH succeeded in enacting legislation guaranteeing the same basic human rights for mental health patients in private as well as public facilities.

Within the private institutional sector, there are currently eight private mental hospitals with 842 beds in the state (Massachusetts Hospital Association, 1999). Forty general hospitals have specialized psychiatric units containing 1,186 beds. However, the number of private-sector admissions for psychiatric disorders in Massachusetts exceeds those made specifically to psychiatric hospitals and specialized hospital units. Nationally, researchers have found the volume of in-hospital psychiatric care provided by general hospitals without psychiatric services to be the largest of all types of hospital facilities (Kiesler and Sibulkin, 1983; Kiesler and Simpkins, 1993). According to recent evidence, there is also a tendency in Massachusetts toward increased use of medical units for psychiatric hospitalizations as admissions criteria for specialty units have tightened and bed occupancy has climbed (see, e.g., Hudson, Dorwart, and Wieman, 1998).

The mental health system of Massachusetts has undergone many periods of rapid organizational change. Whereas the changes of past eras focused on new types or philosophies of care, today the critical shift concerns public and private roles. For most of the Commonwealth's history, these two sectors operated virtually in parallel fashion, with their own distinctive clientele and funding sources. With arrival of the large-scale public health insurance programs of Medicaid and Medicare, plus the combined movements to deinsti-

tionalize and privatize public mental health services, the public and private sectors are now much more interdependent. Simply defining what's public and what's private within the mental health system is no easy matter, depending as it does on questions of service financing, program design, program administration, and service delivery. Of necessity as a result of this transformation, the political process for mental health care also involves more stakeholders than ever before with divergent interests and public policy perspectives.

## Current Policy Issues

With this brief historical and organizational description as backdrop, the focus of this report shifts now to an analysis of six major mental health policy issues in Massachusetts touching on diverse groups in the mental health system.

### Medicaid and Managed Mental Health Care

Massachusetts' Medicaid managed care initiative, MassHealth, was implemented on January 1, 1992. Its stated goals were to expand the accessibility of preventive and primary care services; to improve the quality, continuity, and appropriateness of health care delivery; and to improve the cost-effectiveness of the Medicaid program (Cohen, 1994).

Although several goals were involved, one of these concerns appears to have been at the forefront in Medicaid's shift to managed care, many observers agree, and that was cost-control (Cohen, 1994; Wieman, 1998; Beinecke et al., 1996). By the late 1980s, state spending for Medicaid was increasing at a rate of 16 percent per year (Beinecke et al., 1996, p. 6). Over fiscal years 1988-90, the state's Medicaid program grew 80 percent, from \$1.5 billion to nearly \$2.7 billion (Wieman, 1998, p. 36). Policymakers identified the program as a "budget buster" and a prime contributor to the state's fiscal woes. With other areas of the health system coming under increasing constraints due to private managed care, Medicaid, a comparatively uncontrolled program, invited cost-shifting in its direction. Rather than stem the inflationary spiral by cutting benefits or eligibility, state officials chose to reorganize (Wieman, 1998, p. 17).

Under MassHealth, Massachusetts became the first state to implement a statewide federal waiver program

to deliver mental health and substance abuse services to its Medicaid enrollees (Callahan et al., 1995; Frank et al., 1996; Wieman, 1998). The program gave participants two options: membership in one of a specified group of health maintenance organizations (HMOs); or, enrollment in a new state-run Primary Care Clinician Plan (PCCP). The HMO group would receive their mental health and substance abuse services within the HMO. Those in the PCCP group would receive mental health and substance abuse care through a private for-profit specialty managed care organization (MCO). Thus, in writing a contract for these services, the state Division of Medical Assistance (DMA) was creating a "carve-out" in which general medical care and mental health services would be provided by different entities. Of the two program alternatives, PCCP with the mental health carve-out was much the larger, enrolling about two-thirds of all eligible MassHealth recipients, or approximately 375,000, when the program commenced in July 1992.

Like its parent program, the mental health initiative was associated with several objectives. In general, state Medicaid officials around the country have become concerned with a perceived imbalance within mental health and substance abuse spending favoring institutional care (Frank et al., 1996). Simultaneously, the spread of managed care for general medicine has stimulated an increase in the size and number of mental health and substance abuse units in the private hospital sector. Also supporting the carve-out approach in Massachusetts was "a recognition that primary care clinicians rarely had sufficient training and skills to appropriately assess mental health and substance abuse problems, and might make poor decisions about needed care" (Beincke et al., 1996, p. 7). Last but not least was the crucial element of costs. Expenditures for mental health and substance abuse services within the Massachusetts Medicaid program soared from \$70.1 million in fiscal year 1989 to \$184.5 million in fiscal year 1992 (Beincke et al., 1996, p. 7). Although the specialty area of mental health accounted for only a small part of the Medicaid budget overall (about 5 percent), it was one of the fastest-growing components.

Mental Health Management of America (MHMA), a for-profit entity based in Tennessee, won the carve-out contract. According to the terms of the contract, the MCO would become responsible for authorizing care for its enrollees; reviewing utilization of services; negotiating reimbursement rates for a selected network of hospitals and clinics; and expanding existing diversionary services such as crisis stabilization and residential

care. MHMA agreed to payment on a pre-paid, per capita basis for enrollees, with a "risk corridor" in which it shared savings or losses with the state. By June 1993, the MCO had built a network including 34 adult psychiatric hospital units, 15 child adolescent psychiatric hospital units, 129 mental health clinics, 56 hospital clinics, 516 psychiatrists, and 471 psychologists, as well as various adult and children's substance abuse programs (Wieman, 1998, p. 21).

The U.S. Health Care Financing Administration (HCFA), which granted the necessary federal waiver for MassHealth, also required an evaluation of the mental health/substance abuse program after its first year. Carrying out this evaluation was a team of researchers based at the Heller School of Brandeis University (Callahan et al., 1995). Results of the study showed dramatic cost-savings of \$47 million, or 22 percent, compared to projected spending without the program. Use of services increased overall, reflecting a slight decline for inpatient care which was more than offset by an increase in outpatient care. "Rapid readmissions," or those occurring within 30 days of hospital discharge, fell for those in the disabled category but increased for other adults. For children, readmissions rose from 7.5 percent to 10.1 percent. A survey of providers involved with the program found perceptions of increased severity of clients, increased administrative tasks, and some small improvement of coordination between state agencies. On average, the providers favorably perceived quality of care under the carve-out, although as many as one-quarter viewed clinical decisionmaking as "usually inappropriate." Providers of children's services were more dissatisfied than other providers, with many of them feeling that the MCO authorized insufficient treatment for the assessment and evaluation of complex problems.

Subsequent evaluation studies have added to the amount—and complexity—of information about the performance of this carve-out program. For example, Frank et al. (1996) examined the two-and-a-half year period from July 1992 to December 1994 following creation of the carve-out. They found a sharp reduction of nearly 30 percent in spending per enrollee for inpatient care as a result, principally, of reductions in hospital care for persons with disabilities. "The magnitude of such changes," Frank et al. wrote, "calls for caution in the application of the powerful tools of MBHC [managed behavioral health care]" (p. 145). Geller et al. (1998) studied frequent users of inpatient treatment between 1992 and 1995 and discovered substantially longer lengths-of-stay when these patients were not

admitted to the same hospital as before, something which occurred for about 22 percent of all admissions in this group. Research by Dickey and associates (1995; Norton, Lindrooth, and Dickey, 1996) provided some evidence of cost-shifting under the carve-out program from services for which MHMA was responsible to the general medical and pharmacy areas. In an analysis of child and adolescent emergency mental health screening episodes before and after the state's contract with MHMA, Nicholson et al. (1998) found that patients covered by Medicaid became much less likely to be admitted to the hospital than patients covered by HMOs.

Yet what is most notable about these evaluations is what was missing, namely, solid information as to managed care's impact on the quality of mental health services. The potential trade-off between quality and cost-savings is self-evident in a contractual relationship featuring resource constraint, sharing of financial risks, and for-profit management. The Massachusetts program's surprisingly large first-year savings only serve to underscore the significance of this concern. As noted in the Brandeis study, surveyed providers felt quality of care had stayed constant for adults but fallen for children. Yet the kinds of empirical data needed for a more definitive quality assessment—detailed information for individual enrollees on the content of care delivered and clinical outcomes achieved as measured against an objective standard of care—were not available (Frank et al., 1996; Sabin and Daniels, 1999; Callahan et al., 1995; Wieman, 1998).

A second phase in the managed care program began in fall of 1995, when DMA invited a new round of bids for its mental health/substance abuse plan. At this point, the program was also significantly expanded as a result of an agreement that DMH would purchase all of its acute care inpatient and emergency services through DMA (MAMH, December 1996). In this way, DMH sought to create a single set of acute care options in the private sector, regardless of payment source. The agency also hoped to enroll more of its clients in Medicaid, thereby gaining federal reimbursement for their care. The initiative would add about 5,000 DMH clients to DMA's managed care program, and, if successful, would generate savings which DMH stated it would use for improvement of its community-based service system. By the nature of its service agreement with DMA, DMH acquired far-reaching management and oversight responsibilities over the entire carve-out program (Sudders, 1999b). DMA awarded the new contract to the Massachusetts Behavioral Health Partnership, a

joint venture between Value Behavioral Health, Inc., and FHC Options, Inc.

Appraisals of The Partnership range widely. Various stakeholders interviewed for this report gave the MCO high marks for general management efficiency and timely claims payment, for the effectiveness of its crisis intervention services, for giving greater access to information, and for general attention to public and legislative relations. Reflecting a priority of DMH, The Partnership has required hospitals in its network to expand the level of free inpatient psychiatric care provided to indigent patients (MAMH, January 1998b). Studying the evolution of management and contracting practices under the Medicaid carve-out, Beinecke and DeFillippi (1999) credited The Partnership with numerous successes where "it retained and, when necessary, improved upon MHMA's positive activities or when it identified and corrected a major problem area" (p. 497). In his continuing series of provider surveys, Beinecke also tracked a general increase in satisfaction with issues of quality, access, aftercare, and service integration, after an initially rough transition from MHMA to The Partnership. Yet it was noted that many of providers' early concerns with the carve-out under MHMA have persisted:

"The issues that providers are most concerned about have changed little since they were first reported in the Brandeis survey. They include treatment of persons with dual diagnoses of substance abuse and mental health and persons living with other physical disabilities such as HIV/AIDS, linkages of mental health/substance abuse care with primary medical care, meeting the complex needs of children and adolescents, providing an adequate supply of community facilities, integrating state services, and serving persons who are unemployed or homelessness, or who are not directly covered by The Partnership such as persons in prisons. Some providers were also concerned about the use of medications and perceived greater reliance on medical models of care." (Beinecke, 1998, p. 2)

Another survey of mental health clinicians from all regions of the state in 1997 meted out harsher criticism for The Partnership (*Psychiatric Services*, September 1997). Among the key findings: 52 percent of respondents reported one or more of their clients had been placed in "life-threatening danger" due to an early hospital discharge; 53 percent cited problems with getting approval for hospital admissions on a timely basis; and 45 percent complained that The Partnership did not

communicate adequately in regard to clients' treatment and discharge planning. Along similar lines, some family members of mental health consumers have also spoken out publicly against The Partnership for denials of needed care, inappropriately short hospital stays, and an overreliance on medication-based treatments (see, e.g., Kong, June 10, 1998).

The Mental Health Legal Advisors Committee is an arm of the Massachusetts Supreme Judicial Court and a participant on DMA's own behavioral health program advisory council. Its summer 1998 analysis of the Medicaid managed mental health program spanning MHMA and Partnership management highlighted several trends for concern (Fendell, 1998):

- A sharp reduction in outpatient therapy by The Partnership
- A decline in inpatient hospital utilization, both numbers of admissions and length of stay
- An elevated hospital readmission rate for children

In July 1997, the Massachusetts Legislature mandated that DMA and DMH submit detailed quarterly reports presenting information on utilization trends, quality of care, and costs under the carve-out program. Reviewing the results of this new requirement, MHLAC characterized the reports as "scant and late" (Laski, 1998, p. 1). The Committee also pointed to a recurring pattern of difficulty in securing DMA's response to various data requests.

The most extensive recent study of utilization patterns under the Medicaid managed care program was carried out by Hudson, Dorwart, and Wieman (1998), who examined acute inpatient psychiatric care over the period October 1, 1995 (nine months before The Partnership's taking over) to September 30, 1997. Trends under the carve-out were also compared with Medicaid HMOs. For patients served by The Partnership, there was found to be relatively low continuity between psychiatric and medical care. Due to shortened periods of hospitalization, the researchers judged that "Mental health professionals have hardly time to complete their intake assessments before discharge, let alone discharge plans" (p. 37). About one-half of all patients of The Partnership were rehospitalized within six months, an increase of 20 percent since reorganization of the program. The researchers also reported that roughly one-half of admissions to general medical hospital units by The Partnership were actually for mental health or substance abuse diagnoses. A general conclusion from

the study was that it was impossible to state whether The Partnership or HMO programs provided the better approach to managed mental health care, but "Both programs create multiple causes for concern" (p. v).

It should not go unstated that DMA finds fault with this study for a number of methodological reasons. Although a lengthy technical discussion would not be appropriate for this Issue Brief, in general DMA's reservations pertain to the measurement of continuity of care in the study; the reliability of the data set used; and the absence of "case-mix" controls for the service population examined (Ball, 1999). Such research issues are emblematic of the disagreements that exist about this program's impacts.

Seven years have now passed since the Commonwealth began refashioning its mental health services through the use of private managed care. Considering the developments of the period as reviewed here, several facts are noteworthy.

First is the long-term programmatic adjustments and readjustments that have been associated with the policy change. Creation of the carve-out, a major departure from the status quo, was soon followed by a difficult administrative transition from MHMA to The Partnership in 1996 (Fendell, 1997). Simultaneous with this shift was the addition of an important new program element for management by DMA, namely, responsibility for DMH's clients needing acute care. In July 1997, another kind of management uncertainty arose when the pending acquisition of Value Health, parent company of one of two corporations in The Partnership, by Columbia/HCA, the nation's largest for-profit hospital chain, created a conflict of interest under the rules of the DMA contract (MAMH, August 1997a). That matter remained unsettled until Value Behavioral Health, Inc., was forced to leave the carve-out program under pressure from a suit by its partner, FHC Options, Inc. Currently, DMA is reportedly considering expanding its private managed mental health program to include physical health services as well. One mental health activist interviewed for this report exclaimed: "Everything is constantly changing. You feel you just have your grasp on something and then they change it." Parallel to these changes in the PCCP, there have also been unsettling developments in MassHealth's HMO option, with Tufts Health Plan and Blue Cross Blue Shield deciding to withdraw from the Medicaid managed care initiative (Pham, August 21, 1999).

Second, despite varied studies, there are still many more questions than answers about performance and results under the managed mental health care program. The body of completed research comprises a very heterogeneous group of studies centering on different program elements, populations, and time periods. All of this makes it extremely difficult to aggregate the findings or to reconcile incongruent results. Further, as pointed out by the researchers themselves, the studies have not applied the most rigorous methods. For example, none includes a control group. Surveys of program providers assess the carve-out program on the basis of perceptions, not independent performance measurements, and can easily be influenced by positive or negative biases, depending on the nature of the group polled. Little consumer satisfaction data were collected between 1992 and 1998 (although a significant consumer-run initiative is now under way at The Partnership owing to the influence of DMH) (ADVISOR, Winter/Spring, 1999; Sudders, 1999b). Most significantly, the quality of care experienced under the program remains elusive, even as researchers document dramatically shifting service patterns and program costs. As one DMA administrator has commented, "We are in great need of a comprehensive and empirical study of the program, so that we may have more valid and reliable data towards our efforts at continuous quality improvement" (Ball, 1999).

Third, there has been inconsistent administrative monitoring of the program by the state. This was the conclusion of a review by the Health Care Financing Administration after the initiative's opening year (Beincke et al., 1996, p. 30), and HCFA itself has provided relatively little expertise and assistance to the state related to the oversight process (U.S. GAO, 1999). By June 1998, when The Partnership's contract was renewed and expanded to include new administrative duties for the PCCP, it remained a main bone of contention for program critics. As an attorney for The Mental Health Legal Advisors Committee stated, "The fact that [monitoring information] hasn't been produced sets off real alarm bells for me....Either DMA is not doing its job properly in monitoring the program, or they're withholding the information that the public should have" (Kong, June 10, 1998, p. B4).

In fairness, the state agencies involved have not been indifferent to the issues raised by such complaints. Monitoring has been strengthened by DMA over the duration of the carve-out program, and now includes a spectrum of activities, including, but not limited to, the use of three advisory councils; extensive reporting

requirements; biweekly meetings with DMH and DMA senior staff; and various management reports. In all, the "Division believes that given available staff and systems resources, we are monitoring this program as closely as possible" (Ball, 1999).

DMA and DMH together with The Partnership have also worked to formulate an increasingly specific list of managerial performance standards for inclusion in the managed care contract (MAMH, August 1997b). Attached are sizeable financial incentives and penalties aimed at curbing the vendor's incentive to maximize earnings through denials of care (Ball, 1999). The process has included a diverse group of advocates, state officials, service providers, and researchers. Yet it is ambiguous whether certain standards—e.g., limiting the number of hospital readmissions—will yield improved quality or just reduced services (MAMH, August 1997b). As Sabin and Daniels (1999), two strong supporters of the performance standards effort, assert, "Showing that incentives are aligned with central clinical goals and that earnings correlate with achieving performance targets, not withholding services, does not in itself prove that Massachusetts is purchasing wisely or that Massachusetts Behavioral Health Partnership is performing optimally" (p. 40).

From an administrative perspective, the Commonwealth's entry into managed mental health care has been an opportunity to try to improve service delivery, as well as accountability, for a population group often poorly served in the past. Compared to the prior fee-for-service coverage, a broader range of community mental health services is now available in Massachusetts (U.S. GAO, 1999). Also spawned by the program have been other changes which DMA views as supportive of the principles of rehabilitation and recovery. These include, for example, the development of peer support/self-help groups; a Foster Family Support Program; increasing involvement of consumers and other advocacy groups in program management; and the work of the new Consumer Satisfaction Teams, already noted (Ball, 1999). DMH has contributed a new plan for involving consumers in the development of individualized early responses to psychiatric crises (Sudders, 1999b). These are all positive efforts in a situation that is constantly evolving, and may help to win over more stakeholders to the overall policy framework of the managed care initiative.

From a public policy perspective, however, there is one sense in which the Commonwealth's managed mental health program was a "success" from the outset.

Desired outcomes of privatization and Medicaid savings were built into the design of the program. In this way at least, the service changes entailed by the program have been politically-determined and their actual clinical value for consumers will continue to be debated. Thus, one of the bills submitted for consideration in the 1999-2000 legislative session asks for a full-scale review of the carve-out program. The bill has been referred to the House Committee on Post-Audit and Oversight for further study.

### Regulation of Managed Care

Over the past decade, managed care has grown rapidly to become the dominant transforming force in American medicine and health insurance. More than three-quarters of U.S. workers with insurance coverage are enrolled in a managed care organization—either a health maintenance organization (HMO), preferred provider organization (PPO), or point of service (POS) plan (Jensen et al., 1997). With more conventional health insurance plans also adopting various managed-care administrative techniques, the proportion of the group insurance market affected by managed care is nearly universal (Starr, 1994). Stimulated by this tremendous expansion, a widespread regulatory movement has also developed, fueled by professional and consumer complaints. According to the Blue Cross Blue Shield Association, 42 states passed managed care regulatory legislation or benefit mandates in 1997 (MAMH, February 1998).

In Massachusetts as elsewhere, the spread of managed care techniques has been controversial, and perhaps nowhere more so than in mental health. As early as 1993, the Boston Globe began reporting front-page stories of HMOs and other managed care plans limiting access to care for enrollees experiencing serious psychological problems, including eating disorders and depression (Bass, April 28, 1993). Patients and providers also complained about the extent of confidential information required by insurers before authorization of treatment. In 1994, the state Attorney General's office initiated a study of gatekeeping procedures by HMOs and other managed care companies in the state amid charges that insurance practices were violating the 1976 law affording Massachusetts residents a minimum of \$500 in outpatient benefits (Bass, November 16, 1994).

In March of 1995, the issue of confidentiality for mental health care consumers hit the front pages with revelations that Harvard Community Health Plan was

entering detailed psychiatric notes into computerized records accessible to hundreds of physicians and staff members (Bass, March 7, 1995). The report captured the attention of the Attorney General's office, which promised an examination of the problem (Bass, March 11, 1995). Later this same year, another front-page Boston Globe feature focused on local therapists' claims that insurers were retaliating against them for discussing with patients the restrictions being placed on their treatment due to managed care (Bass, December 20, 1995).

In January of 1996, under pressure from a coalition of professionals and consumers, the Legislature responded to both these issues of doctor-patient communications and access to care (Bass, January 23, 1996). A new law, designated "Chapter 8," was passed outlawing gag rules in health insurance contracts. The existing law providing for minimum mental health insurance benefits in Massachusetts was also revised to state:

"No medical service corporation shall require consent to the disclosure of information other than the patient name, diagnosis and date and type of service as a condition to receiving services mandated by this paragraph. As used in this section, the term diagnosis shall mean a condition sufficient to meet diagnostic criteria specified within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association."

In practical terms, the change would restrict the ability of managed care plans from undertaking aggressive "benefits management" until a patient had first accessed the \$500 of state-mandated coverage.

For many issues, the enactment of legislation is not an ending point, but an interim step leading to a difficult process of implementation. So it has proved with Chapter 8. Already by the spring of 1996, it was learned that two MCOs serving central Massachusetts were informing psychotherapists in their network that protections of the new confidentiality law did not apply to them (Bass, April 23, 1996). Insisting on the right to ask detailed questions about patients' psychiatric status from the beginning use of outpatient mental health services, the president of the Massachusetts Association of HMOs stated publicly, "We would not have agreed to this law if we thought it would conflict with doing utilization review" (Bass, May 7, 1996).

To date, managed care regulation in Massachusetts has remained piecemeal and confined to such limited interventions as these and a mandatory minimum 48-hour hospital stay for mothers and newborns. Lawmakers have tried but failed repeatedly to move toward a more comprehensive approach. Thus, one of the states with the highest penetration of managed care organizations, Massachusetts is also among the last to enact a broad framework of patient protections (Pham, March 14, 1999). The state has also been overtaken in this arena by the federal government, at least in regard to patients covered by federal health programs, for whom President Clinton established a "Consumer Bill of Rights" by executive order in 1998 (The White House, 1998).

In April 1997, Governor Weld signed an Executive Order creating an advisory commission to review managed care practices in the state and to advise on any needed new regulations (MAMH, October 1997). Its findings, released the following autumn, included a recommendation for a new position of state ombudsman to assist and advocate for patients in managed care plans. During the second year of the 1997-98 session, two contending managed care bills became the focus of legislators' attention (MAMH, January 1998c). A package of proposals submitted by Acting Governor Cellucci was based on the Weld commission's report. A stronger "omnibus bill" was based on legislation earlier reported out by the Joint Health Care and Insurance Committees (Pham, January 8, 1998). The session ended, however, before lawmakers could reconcile differences in House and Senate regulatory bills (Pham, March 24, 1999).

Shortly after the start of its 1999-2000 session, the legislature had before it several managed care regulatory proposals originating with the Governor, individual legislators, and various interest groups, such as the Massachusetts Medical Society and HMOs (Pham, March 14, 1999; Pham, March 24, 1999; Powell, April 8, 1999). Key differences separating the bills included the scope and independence of new appeal mechanisms, whether patients would be given the right to sue their HMOs for malpractice, and the extent of information disclosure required of the plans. By summer, the Senate and House had each closed ranks on their own plans, with the former favored by health care consumer advocates and the latter backed by business and insurer groups (Kamins, June 24, 1999). At this juncture, no one can be sure if a compromise acceptable to enough legislative and interest-group factions will be possible.

Whatever that outcome might be, the level of concern with mental health care issues in this policy making process has not been great, according to various observers interviewed for this Issue Brief and as evidenced by the content of leading policy proposals. Although it is true that general managed care regulations implicitly encompass mental health consumers and providers, circumstances surrounding the receipt or delivery of mental health services often are distinctive in a way that merit distinctive protections. Mental health treatment issues have played a prominent role in managed care regulatory policymaking in some other states. For example, in Rhode Island a wave of negative publicity and patient complaints concerning improper gatekeeping and utilization review decisions by a managed behavioral health care company helped spearhead a comprehensive patients' rights proposal enacted in 1996 (Rochefort, 1996). In Vermont, managed care consumer protections began with the passage of legislation in 1994 establishing tough standards for mental health utilization review and creating an independent appeals panel for mental health treatment denials whose membership is appointed by the Department of Banking, Insurance, Securities, and Health Care Administration (Rochefort, 1996). This mental health law then provided a springboard for a more general utilization review law that was adopted in 1997 (Libertoff, 1999).

There are several respects in which general managed care legislation might be accompanied by, or incorporate, measures targeted specifically to the delivery of mental health services. Possible measures include:

- Guaranteed access to mental health specialists with a right of self-referral for consumers
- Establishment of a special mental health ombudsman, or a special capacity within a general ombudsman's office, for mental health consumers and their needs
- Special internal and external appeals processes geared to mental health treatment issues in which decisions are made by mental health clinicians
- Protection against disenrollment and curtailment of services and medications for mental health consumers due to compliance problems
- Delineation of mental health concerns as part of mandated access to emergency services

- Guaranteed access to all effective and potentially beneficial psychotropic medications
- Specification of a concept of "medically necessary" services that incorporates social supports and services recognized to meet standards of good practice for mental health conditions

Another issue concerns standardizing the rights available to consumers in private and public-sector managed care organizations. The issue is a complex one because of differences between proposed state vs. existing federal protections, as well as differences in HCFA's own requirements for carve-outs vs. other managed care plans (U.S. GAO, 1999).

All of these proposals have been cited as potentially valuable avenues for managed care regulation by national mental health advocacy groups or activists in other states (see, e.g., Bazelon Center, 1998; National Mental Health Association, 1999). Which, if any, make sense for Massachusetts? What are their cost-benefit implications? How feasible would it be to implement and monitor various actions? Answers to these questions are far from clear. However, the proposals merit inclusion in any broad-gauged discussion of managed care regulatory approaches.

The absence of attention to such mental health proposals is, in its way, a telling indicator of the state of mental health policymaking in Massachusetts. Consideration of mental health issues in the Legislature is spread across many committee jurisdictions—e.g., Health Care, Insurance, and Human Services. This has the effect of fragmenting mental health policy analysis. Split among many factions themselves, mental health interest groups have been unable to coalesce behind a distinctive agenda for managed care regulation and to command a place among the powerful business, insurance, and medical groups in the thick of managed care decision making. Finally, of those public agencies having an interest in mental health, health, or insurance matters, none has stepped forward to champion regulatory issues pertaining to private managed mental health care.

## **Mental Health Parity Insurance Coverage**

Insurance coverage for mental health problems developed after that for more general medical conditions and has been characterized by numerous gaps and exclusions (Rocheftort, 1997). Minimal or nonexistent mental health benefits are a main aspect of the problem of "underinsurance" affecting millions of Americans

with health insurance. Even in health plans that are otherwise quite complete, access to mental health services typically has been limited by such means as higher cost-sharing, maximum numbers of outpatient visits or days of hospital care, and lower annual and lifetime expenditure caps.

When national health care reform came under review in the early 1990s, the expansion of mental health insurance protections was an important part of the discussion. Several major federal legislative proposals included improved benefits for mental health care, and some, such as President Clinton's Health Security Act, envisioned the equalization of health and mental health insurance coverage. Once health care reform collapsed in late 1994, it seemed as though the possibility for parity legislation had also evaporated.

Yet mental health parity legislation subsequently was revived in Congress as part of a bipartisan effort to address some of the most harmful insurance industry practices contributing to the growth of uninsurance among the working population. The result was the Mental Health Parity Act of 1996. According to the law, insurance plans including mental health benefits would be required to provide the same annual and lifetime payment caps for treatment of mental illness as for other medical conditions. Subsequently, Congress extended these same benefit mandates to managed care organizations participating in the Medicaid program.

In fact, supporters of the parity concept had fought for a much more extensive piece of legislation but were stymied by strong opposition from business and insurance interests. In the form in which it passed, the new parity statute actually left intact many important sources of discrimination in mental health insurance coverage (Rocheftort, 1997). For example, it applied only to businesses employing at least 50 people; it did not restrict higher copayments and deductibles for mental health care; it did not interfere with the use of lower limits for inpatient and outpatient visits by mental health consumers; and it neglected to prohibit employers from dropping insurance coverage altogether simply to evade the law.

Far from blunting the mental health insurance parity movement, then, the 1996 federal law has stimulated a surge in parity legislative proposals on the state level. To date, twenty-seven states have enacted their own parity statutes, including all of the New England states with the exception of Massachusetts (DMH Parity Sheet, August 12, 1999). Vermont's law, passed in 1997, is

considered "the most comprehensive parity behavioral health care legislation in the United States" (Libertoff, 1999, p. 4). Although Massachusetts does not have a parity law, in 1993, the Group Insurance Commission, on its own initiative, mandated parity for all enrollees in its indemnity and PPO plans. In 1997, the GIC voted to require all HMOs to do the same (Dolores Mitchell, Group Insurance Commission, Personal Communication, December 15, 1999).

Currently, Massachusetts is one of about a dozen states considering some form of mental health parity legislation. Parity proposals have been submitted to the Legislature since 1983. Not until spring 1998, however, did a bill get as far as approval by either branch (DMH Bulletin, Spring 1998). On April 2 of that year, the Senate passed a parity measure calling for equal insurance coverage of mental and physical illnesses that applied to inpatient, intermediate, and outpatient treatment in the least restrictive setting. The bill also specified that insurance gatekeepers—those who initially authorize or deny access to services—must be licensed mental health clinicians. If enacted, the law would have overridden the 1976 legislative mandate of minimum mental health benefits in private insurance. Senate Ways and Means chair Stanley Rosenberg, whose committee gave its unanimous support to the bill, stated: "This legislation is designed to bring fairness and equity into an area of health care where a double standard has existed for far too long" (DMH Bulletin, Spring 1998).

Within the House, however, the parity concept proved more difficult. The bill drew support from a variety of sources, including mental health advocates and the Boston Globe (see, e.g., editorial, November 18, 1997). DMH support for parity has also been vigorous and visible. But determined opposition was mounted by business and insurance interests, including the Massachusetts Association of HMOs. Central to the stated objections of critics was the belief that such legislation would open the door to excessive utilization of mental health services and substantially higher costs for health insurance. Thus, both the alignment of political forces and the focus of concern within the Massachusetts Legislature closely paralleled the 1996 debate within the U.S. Congress. Nationally, parity opponents had been undermined by analyses from the Congressional Budget Office indicating that the cost increases for even full parity would be a fraction of what business groups had claimed. So, too, in Massachusetts, a Coopers and Lybrand study estimated the costs of the proposed legislation at only 1.9 percent of current employer claims, or \$2.72 per member per month (DMH Bulletin, Spring 1998, p. 2).

If program costs were a singular obstacle, this actuarial analysis might have done more to dampen objections to the bill. However, supporters and opponents of parity actually define the issue in fundamentally different, even irreconcilable, ways. For supporters, the legislation is anti-stigma; for opponents, it is anti-business. Supporters seek financial protections for individuals and families; opponents defend the financial interests of employers and insurance providers. Supporters view the expansion of insurance coverage as a way of sharing the risks of mental illness on a community-wide basis; opponents view it as further regulatory interference with the prerogatives of the private health insurance industry and its corporate customers. Supporters aim to lower barriers to mental health treatment; opponents fear new benefits as an "entitlement" that will be abused. The parity controversy also reflects a lingering historical disagreement over where to draw the line of responsibility between private and public sectors for mental illness, with the anti-parity stance assuming the state's continued role as residual provider for those dually disadvantaged by illness and lack of resources.

Pulled by these competing perspectives, the legislative process moved slowly. The House of Representatives eventually passed a parity bill in September of 1998 that was much more restrictive than the Senate measure. Before differences between the two approaches could be resolved in conference committee, the legislative session ended (DMH Parity Sheet, August 12, 1999).

At the time of this writing in early fall of 1999, parity legislation has once again reached a critical stage in the legislative process. Responsibility for drafting the bill lies in the hands of the Legislature's Joint Insurance Committee, which is working to meet an early October deadline for keeping the measure alive. The clash of group interests continues much the same as in the previous session. Participants describe the search for common ground as arduous. The scope of coverage under the bill—in particular, whether parity will apply to a limited set of "biologically-based" diagnoses or the full spectrum of mental disorders—is a central question of policy design still to be answered by the committee. Certain participants view the narrower approach as a first step toward eventual adoption of full parity. Here it must be noted, however, that in a number of other states, such as Rhode Island, which passed a "biologically-based" bill in 1994, partial parity has functioned more as a barrier than a bridge to fuller protections.

The other major stumbling block concerns the relationship between parity and managed care. The issue first surfaced during Senate consideration of the parity bill in 1998 (Kong, May 11, 1998). In effect, a legislative compromise was reached at that time coupling expanded mental health insurance coverage with elimination of the state's 1996 confidentiality law limiting insurers' access to patients' mental health records. Whether or not that remains a viable exchange figures prominently in bargaining over a 1999 statute. Insurers maintain that managing the use of mental health services hinges on repeal of the privacy law, and is implicit in low-cost estimates under the bill. By contrast, some groups have been reluctant to surrender what they view as a hard-won protection for mental health consumers and practitioners within managed care health plans.

From a standpoint of rational policy development (Parsons, 1995, chap. 3.4), the repeal of the state's privacy law is an odd intrusion in parity deliberations. Data on the access and cost impacts of the privacy statute are not under review. Nor is the law's reportedly uneven implementation receiving systematic examination. Rather, the repeal debate is spillover from the broader politics of managed care regulation, pitting against each other industry and provider interests for whom parity is the secondary issue.

According to the architect of Vermont's landmark parity legislation, the adoption of managed care regulatory controls in that state was necessary companion legislation—and indeed set the stage—for mental health parity (Libertoff, 1999). Given this formulation, it is not surprising in Massachusetts, where general managed care legislation has been stalled for several years, that parity legislation should prove so problematic. Through the twists and turns of legislative deal-making, parity may yet serve as the vehicle for (partially) deregulating the practice of managed mental health care in Massachusetts. If that should happen, it would be an ironic outcome of the parity movement. And only time will tell whether the sacrifice was justified, or if "the impact of parity legislation will be severely limited or even gutted" without "strong regulatory controls over the mental health managed care industry" (Libertoff, 1999, p. 61).

### **Deinstitutionalization and Community Support**

When William Weld took office in 1991, it was in the midst of a severe economic downturn in Massachusetts. During his campaign, Weld had embraced the

popular neoconservative themes of privatization and reinventing government, and he excoriated the public bureaucracy (Hogarty, 1996). Even as the state ran up large annual deficits, the governor pledged not to raise taxes. If the administration was to return state government to a balanced budget, this could mean only one thing—large reductions in existing services and programs.

Public mental hospitals in the state were a ready target for cuts (Hogarty, 1996; Upshur et al., 1997). After decades of census reduction leading to low occupancy levels, the annual average patient cost had risen to \$120,000. Only about 6 percent of DMH clients made use of these long-term hospital facilities, but they were consuming 47 percent of the department's resources annually. Hundreds of institutionalized patients awaited discharge for lack of appropriate community services including housing.

In April 1991, Weld convened a Special Commission on Facility Consolidation and charged it with developing a "plan for consolidation and closure of state institutions under the auspices of the Department of Mental Health (DMH), Department of Mental Retardation (DMR), and Department of Public Health (DPH), and to provide for the provision of appropriate quality care services" (Governor's Special Commission, 1991, p. i). Given the appointments to the Commission and a sharply limited time frame of six weeks under which it was made to operate, the result was for all intents and purposes assured that the governor's privatization approach would be embraced.

The Commission's report, "Actions for Quality Care," was released in June (Governor's Special Commission, 1991). It recommended "right-sizing" the system by closing eleven state-run facilities, including three of seven existing state mental hospitals. The first two of this group, Metropolitan State Hospital and Danvers State Hospital, were closed in 1992, and the third facility, Northampton State Hospital, was closed in mid-1993. A recommendation by the Commission following the issuance of its original report also led to the closure of the Gaebler Children's Center in 1992, at the time the only public psychiatric treatment facility in Massachusetts for children with serious emotional disturbance.

To replace or substitute for these lost facilities, the Commission outlined a plan for transferring patients to the community, private hospitals and nursing homes, and other state facilities. Privatization was the central element of this strategy and integral for the cost-savings

sought by the administration. As political scientist Richard Hogarty (1996) describes:

"The official clinical rationale for closing the mental hospitals was that patients do better in community settings. But the fiscal rationale was even more compelling. Although Medicaid did not cover mental patients in state institutions, it paid half the costs for patients in community care. The yield was \$21 million in federal funds." (p. 14)

The Commission vowed that all transferred patients would be moved to settings with "equal or better appropriate care" (Governor's Special Commission, 1991, p. iii). Further, it promised vigorous development of community-based resources out of the savings produced by the consolidation.

Evaluation of this policy has been limited. However, a study commissioned by the state agency overseeing the consolidation process and carried out by the University of Massachusetts, Boston, provided some encouraging evidence that the first of these objectives was met (Upshur et al., 1997). Based on information from interviews conducted an average of one year after discharge, most of the patients from two of the state mental hospitals that were closed felt conditions were equal or better in their new placements. The study fell short of being definitive because, as the authors noted, there were "major methodological problems in finding and interviewing clients and family members and in obtaining access to hospital files of clients for background information" (Upshur et al., 1997, p. 212).

Other analyses have focused on management under the policy (Wieman, 1998, pp. 33-35). For example, various issues of cost and quality were raised in regard to the privatization of acute care in particular general hospital replacement units. (As already discussed in the section on Medicaid managed care, responsibility for acute inpatient services for DMH clients was shifted to The Partnership in 1995.) According to another analysis, rapid downsizing of the number of DMH personnel disrupted continuity-of-care for consumers as less senior clinical staff were "bumped" out of their positions, sometimes by those with less training and experience for the given slot (Cohen, 1994).

Additional impacts of consolidation on children and the homeless will be discussed in those sections following. However one gauges the immediate aftermath of the hospital downsizing, the more critical long-term issue for the state's mental health system concerns the

master strategy of resource reallocation. Have community-based services been expanded for persons with the most severe mental illnesses? How adequate are these services?

Concomitant with the consolidation plan, DMH launched a statewide model of care for people with serious and long-term mental disorders known as a "comprehensive community support system" (CCSS) in 1991. Informed by concepts first promoted by the National Institute of Mental Health in the 1970s, the model aims at development of a diverse yet well integrated array of services and supports. As explained in a DMH newsletter:

"The CCSS coordinates the clinical and rehabilitative components necessary to sustain a safe and satisfying life in the community so that people with serious and long-term mental illness can live in the least restrictive and most productive environment that is consistent with their individual needs and potential." (*CCSS Bulletin*, July 1995, p. 1)

Five specific types of service delivery elements, provided directly by the department or through contracts with private agencies, constitute the building blocks of the CCSS on the local level: 1) Acute Services; 2) Support and Rehabilitation; 3) Advocacy Services; 4) Generic Services and Supports (for accessing non-mental health programs); and 5) Informal Caregiving.

Although DMH has now abandoned some of the original terminology associated with CCSS, it has worked diligently to implement this general model over a period of several years (DMH, 1998, 1999). An elaborate planning process has been set in motion at the Area-level with broad-based input from consumers and family members. Local program development is evident, with a spectrum of new services. Between fiscal years 1991 and 1998, more than 2,800 new residential beds in the community have been opened by the department. Throughout this process, efforts have been made to redress long-standing resource inequities across the state and to be responsive to variations in local needs and cultural groups. All new funds, except those for the homeless, are allocated along an equity basis by DMH.

While the system plainly is heading in a positive direction, realization of the department's community care objectives is not close at hand. Using the department's own conservative estimates, there are approximately 44,700 adults and 35,500 children in

need of public mental health services in Massachusetts (DMH, 1998, pp. 19-46). Currently, the department estimates that it serves 18,700 adults and 2,550 children in its continuing care services. DMH planners concede that, "Although a full continuum of care exists within the state, there is not a sufficient quantity of services in each DMH service Area" (DMH, 1998, p. 41).

The discrepancy between supply of and need for mental health continuing care services is well illustrated by the example of case management. A linchpin of the community service model, the process of case management operates at the level of service delivery to match individual clients with an appropriate set of services. It is also the job of case managers to monitor clients' progress and to help them overcome barriers in accessing programs for which they are eligible. Currently, DMH reports that nearly 13,000 individuals are on waiting lists for case management around the state (DMH, 1999, p. 2).

As to how well the state has backed up its promise of reallocation to the community care system, that depends on the standard applied. Since 1992, DMH has saved \$74 million from restructuring and consolidating facilities, including the use of managed care (DMH, 1999, p. 2). The department reports reinvesting \$58.1 million of this amount in community programs (with another \$12 million used for inpatient services). Compared to fiscal 1991 when the department spent 49 percent of its budget on community-based care, 66.7 percent of its resources now go to that program area.

Yet in view of the gap between services and needs, the state's level of funding for community care cannot be considered consistent with the Special Commission's recommendation for "adequate financing of the foundation of services provided by the existing community-based system" (Governor's Special Commission, 1991, p. v). In the Cellucci administration's fiscal 1999-2000 budget recommendation, DMH is the only human services agency not put forward for an increase (NAMI-MASS, 1999). Meanwhile, the amount of revenues returned by DMH to the state's General Fund due to reimbursements received for its services rose from \$5.4 million to \$92.9 million between fiscal 1989 and fiscal 1998 (DMH, 1999, p. 9).

## Children's Mental Health Services

Children's mental health care is interrelated with all of the policy issues in this report, sometimes in ways that are especially significant. For example, as already discussed, several sources suggest that the Medicaid managed care carve-out in Massachusetts has impacted more negatively on children than other groups. The continuing care needs of many children with mental health problems also dramatically underscore the necessity for insurance coverage without arbitrary treatment cut-offs; accordingly, advocates in Massachusetts are concerned that any new parity statute be written in a way that serves the interests of children by linking coverage, for example, not only to diagnosis but to behavior as well. Similarly, some proponents of managed care regulation have urged the inclusion of standards of service delivery that address the unique issues of both children's mental health disorders and care patterns, including the primacy of early intervention.

Children's mental health issues should not be seen only in relation to these crosscutting policy topics, however. The distinctiveness of children and their mental health needs is such that it demands a defined system of care capable of high quality interventions at all levels of severity. A series of recent reports documents a rash of problems in Massachusetts when mental health services are judged by this standard, and no easy remedies for the situation appear to be available.

The first report, filed in December of 1998, was prepared by a special committee established by DMH Commissioner Marylou Sudders (Committee on the Status of Mental Health Services for Children, 1998; see, also, MAMH, March 1999). Five years after closure of the Gaebler Children's Center, the committee, whose membership included family members of children with mental health problems, agency providers, department managers, professional organizations, and advocacy and trade groups, was asked to assess the mental health needs of children under age 14 with serious emotional disturbance and the services available to them.

In general, while the committee noted that the state had accomplished a successful transition from "a single-site restrictive treatment setting" to a continuum of care with less stigmatization, fewer restrictions, and greater involvement of family members, a number of crucial systemic problems were evident. Highlighted by the committee was a major "acuity shift," or an increasing level of severity in the problems seen at all

levels of care below the hospital sector. Dual causes produced this shift: deinstitutionalization in the public mental health system, and the advent of Medicaid managed mental health care. Reflecting the decreased accessibility of inpatient care, the committee heard numerous criticisms during its research about "very abbreviated lengths of stay, inadequate assessment, poor discharge planning and community linkage, and the negative impact of multiple transitions and multiple hospitalizations" (p. 5). It also found that the "medical necessity" criteria used to determine admissions and lengths-of-stay for children in acute inpatient units tended to neglect important psychosocial factors.

In many ways, the report portrayed community-based agencies for children as buffeted by forces in their environment over which they had little control. Many programs were unprepared "in mission, training, and staffing" (p. 7) for the changes in caseload which brought to their doorsteps children having "multiple medical, behavioral, as well as social problems, who require comprehensive assessment and treatment" (p. 2). The number of children and families seeking care also "far outweighs capacity" (p. 2). For example, a survey of DMH programs in different parts of the state revealed a waiting list of more than 200 children for various services. Finally, many community agencies have recurrent difficulties in recruiting and retaining skilled staff due to low salaries and competition from higher-paying areas of the economy.

Another area of discussion concerned the administrative performance of agencies involved with children's mental health issues. The committee described a common predicament of "families, schools, referring hospitals and agencies unsuccessfully attempting to engage state agencies to assist in caring for children with mental health difficulties. It is perceived that this also leads to one state agency abdicating its responsibility if another state agency becomes involved with the child and family" (p. 17). This situation disadvantages both children eligible for services from several agencies and children for whom primary agency responsibility is unclear.

The recommendations of the report called for a number of new program emphases and system-level changes. Committee members cited a need for identifying and responding to children's mental health problems at an earlier age. They called for steps to ensure planning and budgeting for children's mental health across public departments, and a clarification of the responsibilities of different bureaucracies for this program area.

For better continuity and quality of care, they recommended changes in current reimbursement practices as well as increased resources for the system.

A second report was completed by Christina Crowe, Director of Clinical Services at the Judge Baker Children's Center (Crowe, 1999; see also MAMH, June 1999). It focused on the Northeast part of the state and was requested jointly by the commissioners of DMH and DSS because of "a high level of dissatisfaction" with children's mental health and placement services in that region (p. 1). A particular issue was the large number of DSS youth "stuck" in hospitals awaiting more appropriate services at a lower level.

Findings from this "field review" were closely consistent with the preceding DMH report, albeit with a narrower geographic focus. According to the author, demands and needs for children's mental health services in the study area far outstrip resources, leading administrators and case managers "to make arbitrary decisions about who will receive the available services, as well as which situations will not be addressed" (p. 2). Shortages exist in regard to both the overall quantity of services and the types of services available. A review of case records uncovered the following service problems: children at inappropriate levels of care; delays in accessing services; inadequate clinical assessments; treatment plans lacking comprehensiveness; and poor continuity of treatment. Considering various forces of change impacting upon children's mental health care in the state over the past decade—deinstitutionalization and community care, Medicaid managed care, and DSS's own recent move to a managed care model for some of its residential programs—the report summarizes the aftermath as "a fragmented system, with unmet expectations at multiple levels" (p. 3).

Several months after the DMH report, this study underscored that lack of coordination among agencies and departments remains a critical issue. The respective roles and responsibilities of DMH and DMA are "not at all clear" (p. 3) when it comes to children and adolescents. Crowe points out that no agency views itself as providing long-term treatment, yet that is a real need for some in the system. Further, "there is no one agency clearly identified as setting the standards for publicly-funded mental health for the Commonwealth's children" (p. 3). Many groups suffer poor service as a result of this disorganization of the system, but especially children "whose disabilities are complex, multifactorial and continuously evolving" (p. 4).

Recommendations in this report cluster in three main areas: development of a full continuum of children's mental health care services; increased resources for the system; and integrative program mechanisms, such as a case management approach that spans levels of care and different agencies, to connect consumers with the most cost-effective services possible. According to Crowe, an innovative Collaborative Assessment Program developed by DMH and DSS provides some promise of better interagency cooperation, although it needs to be formally evaluated.

The third report in the series was issued by Linda Carlisle, outgoing Commissioner of DSS, in June of 1999. This last report seeks to build on the other two, plus recent analyses from Beacon Health Strategies on the use of medications in DSS's Commonworks managed care program and acute care admissions for DSS children. Based on these data, as well as related information-gathering by the department, five main problem areas are pointed out (Carlisle, 1999, p. 5):

- 1) Increasing numbers of DSS children awaiting hospital discharge, from about 10 children in 1998 to 35 children at the time of this report
- 2) An excessive reliance on psychotropic medications to control children's behavior that results from an "alarming" increase in the use of medications in recent years
- 3) Frequent use of physical restraints in residential programs
- 4) Lack of professional childcare staff, training, and clinical supports in DSS residential programs
- 5) Gaps in placement options for DSS children at the mid- and lower-levels

For Commissioner Carlisle, such trends, and particularly the issues of frequent hospital readmissions and overmedication, signal that "the current system is not working" (p. 13). The plight of children "stuck" in the hospital is emblematic of the complicated dynamic that surrounds care for the DSS population. Children in the care and custody of DSS typically have been severely traumatized by abuse and neglect. When hospitalization occurs, it is essential that careful discharge planning be completed based on a thorough psychosocial assessment. This rarely takes place, however, because of the brevity of hospital stays and insufficient collaboration between hospital and DSS staff. Accord-

ing to the Commissioner's report, increasing the acute care bed capacity of the system is not a solution; rather, there must be a process of better planning and coordination between DSS and DMA, the payer for acute care hospital services. This shift will also require program development in various areas, including crisis intervention, residential options, and outpatient services.

Noted in the Commissioner's report are many failures of an administrative nature. Dissatisfaction is expressed with the department's own managed care initiative for difficult-to-serve adolescents, a program operated by the same company that manages The Partnership. As in both other reports, interdepartmental fragmentation is criticized. Indeed, the Commissioner states that "There is great confusion at all levels within DSS about the role DMH plays in children's services" (p. 26). More than a dozen specific recommendations are made for addressing the service and administrative deficiencies discussed in the study. More broadly, however, the report seeks a new vision for a system of behavioral health care for children in Massachusetts that is both restorative and cost-effective.

In June 1999, DMH Commissioner Sudders wrote to her counterparts in DSS and DMA warning of the shrinking number of bed vacancies in hospital psychiatric units for children in Massachusetts (Sudders, 1999a; also described in Wong, June 28, 1999). Less than three weeks later, the problem emerged as a major news item. As reported by the *Boston Globe*, numbers of children were "languishing in hospital emergency rooms for hours and in pediatric beds for days" awaiting proper psychiatric care (Wong, June 28, 1999). Others were being held in medical and surgical units, or queued up in other settings seeking admission. Many children in psychiatric beds were there only because of an inability to place them at the proper level of care. Responding to the widespread perception of crisis, DMA, DMH, and The Partnership developed a plan for quick, incremental expansion of acute, transitional, and residential beds. This will ease conditions without rectifying the underlying problem, however, which reflects the increasing number of families seeking acute psychiatric care for children, unresolved hospital payment issues under managed care, and a bevy of system-level dysfunctions as analyzed in the reports above. More important in the long run for dealing with this situation may be DMA's current attempts, in collaboration with DSS program planners, to create innovative models of care, such as Placement Stabilization Teams for children in crisis and Enhanced Residential Care for children with more difficult psychosocial problems (Ball, 1999).

For a sense of perspective, it is important to note that other states face many of the same urgent difficulties as Massachusetts with their children's mental health services (Freyer, July 25, 1999; Mental Health Weekly, August 2, 1999). (Moreover, because children sometimes are placed in out-of-state hospital facilities, events such as a hospital closure in one state rapidly reverberate throughout the region.) The series of reports discussed here also convey the dedication of personnel throughout the system, whether at the level of service delivery, program management, or departmental leadership. Certainly, the reports themselves contribute much clarity to the analysis of what is not working and how things can be changed in children's mental health care in Massachusetts. That said, however, problems within this sector are deeply rooted, not easily isolated, and compounded by a chronic mismatch between resources and needs.

## Homelessness

Although some have written about homelessness as a simple matter of lack of housing, there is nothing simple about the causes of homelessness or its relationship with mental illness. Homelessness can be the product of one or more of a variety of economic, housing supply, and domestic household problems. In addition to facing such risk factors, persons with mental illnesses must also contend with a set of special difficulties arising from housing discrimination, cuts in social program benefits, and inadequate community-based mental health services (Hitov, 1992; Carling, 1992).

Contrary to popular belief, today's problem of people who are both homeless and mentally ill (HMI) is not a result of the deinstitutionalization program of the 1960s (Hitov, 1992). More than half of the decrease in the inpatient census of public mental hospitals in the state occurred before 1970, making this cohort of patients too old to match the age profile of those currently homeless. While the main societal impacts of deinstitutionalization's first wave largely have passed, concerns do exist about the contribution to homelessness from current mental health policies, in particular the absence of a well-planned, well-financed array of community services and supports. For example, in 1991, based on interviews with dozens of mental health professionals and advocates, the Boston Globe reported that the Weld administration's coupling of hospital closures with welfare cuts was driving numbers of persons with mental illness to join the ranks of homeless in the state (Bass and Locy, December 15, 1991).

The most recent major study of homelessness and mental illness in Massachusetts was completed in 1992 by the Human Services Research Institute (HSRI) under contract to DMH (Mulkern et al., 1992). According to the higher estimate adopted in this project, as many as 9,000 homeless adults were living in the state. Of this group, approximately 2,000 had severe and persistent mental illnesses, possibly two-thirds of whom suffered a co-occurring substance abuse disorder. As stated in the first recommendation of the study group, "The estimates presented confirm what has been obvious all along: homelessness is a major social problem in Massachusetts. Amelioration of this problem will require considerable additional resources as well as improved targeting of existing resources" (p. 5). Based on subsequent information, the Department of Mental Health recorded in its State Plan for fiscal 1999 and 2000 that the state's homeless population continues to increase and the shelter system "is operating beyond capacity" (DMH, 1998, p. 48).

Within the mental health field, an important shift in thinking has occurred in regard to approaches for addressing the housing needs of the homeless and other persons who have mental illnesses (Honig, 1999; Carling, 1992). The previous paradigm, which governed most program development by state mental health departments during the 1970s and 1980s, was a "residential treatment model." Central to this model is a continuum of different types of transitional residential placements, featuring greater or lesser independence and supervision, but linked in each instance to the client's acceptance of specified mental health services. Typically, facilities on the continuum are "segregated, professionally staffed, and congregate in nature" (Carling, 1992, p. 285). As became increasingly clear with time, this model had several deficits: programs were difficult and time-consuming to establish owing to a myriad of administrative, financial, and community resistance problems; the number of residential slots created was small compared to level of need; and consumers often were dissatisfied with the sorts of accommodation provided, inflexible treatment requirements, and the lack of attention to long-term housing (Hitov, 1992).

"Supported housing" is the model that has emerged in response to these problems and now enjoys broad support among both advocates and officials in Massachusetts (Honig, 1999). Contrary to the idea of residential treatment, this approach emphasizes helping homeless individuals to find long-term stable housing selected from the available range of normal housing

options. Community integration, not segregation, is the guiding principle. Since housing in the community is now viewed as the basis for creating a home, not an alternative treatment setting, maximizing the resident's control over his or her living environment is the objective. Service provision remains a fundamental element in housing planning under this approach, including treatment as well as assistance with accessing entitlement income, finding employment, and development of social skills. However, the package of assistance must be individualized while incorporating significant consumer choice.

Persons who are homeless and mentally ill are a priority population for the Department of Mental Health, which has devoted substantial resources and administrative attention to the problem (DMH, 1998, 1999). With the help of federal grant dollars, a comprehensive outreach program has been mounted that provides direct care, assistance with finding housing, literacy education, and referrals for mental health, substance abuse, job training, and other programs. DMH also operates several transitional residences, formerly shelters, in and around the city of Boston. A joint DMH and Department of Public Health project funded under the federal McKinney Act concentrates on homeless individuals who are dually diagnosed with mental illness and substance abuse problems.

Adopting the "supported housing" approach, DMH has developed or gained access to more than 700 new housing units since 1992, and approximately 1,200 homeless have received housing placements combined with support services (DMH, 1998). In a McKinney Research Demonstration Project begun in 1990, researchers from the department and area universities joined together to analyze the relative efficacy of independent living and consumer-run group homes with a declining staff presence (Center for Mental Health Services, 1994). Both programs achieved high rates of housing tenure, with only negligible differences between the two groups' successful avoidance of homelessness.

Well-conceived though such activities may be, they are dwarfed by the magnitude of the state's homelessness challenge. In December of 1998, DMH's supported housing capacity of 3,046 slots was only slightly larger than its group home capacity of 2,924 (Honig, 1999). A study by the Massachusetts Association for Mental Health, entitled "People Are Waiting" (February, 1999), found "more than 3,000 adult clients of the Department of Mental Health and over 100 chil-

dren and adolescents are on waiting lists for housing, residential services and rental assistance" (p. 1), with the greatest proportion in need of the less intensive supported and subsidized housing placements. Although only about 400 of the currently homeless were identified on this overall list, many others were included who resided in overcrowded or substandard housing and thus could be at risk of becoming homeless.

Homelessness services are one of the few areas of the DMH budget to receive large increases from the Legislature. Between fiscal 1993-1999, spending for persons who are homeless and mentally ill rose from \$1.7 million to \$19.1 million (DMH, 1999). These state funds also enabled the department to "leverage" millions in federal matching support. In fiscal 1999, the department was allocated an additional \$3.1 million for its rental subsidy program, an increase of 20 percent over the previous year. At these current levels of funding, however, DMH has little capability to attack its waiting lists for housing and residential services. In the Governor's Budget Recommendation to state lawmakers for fiscal 2000, DMH's homeless initiative and rental subsidies account were "level funded." Reacting to the budget proposal, the *Boston Globe* urged the Legislature to boost homelessness spending by \$3 million (Honig, 1999), while the Mental Health Association called for a two-year \$20 million investment covering housing, residential services, and rental assistance for its "People Are Waiting" initiative (MAMH, February, 1999).

More current investigation on the size and makeup of the state's homeless population is also warranted. Research from the early 1990s continues to provide DMH with the basis for its enumeration and demographic analysis of the HMI. Yet, according to various accounts received in the preparation of this Issue Brief, the homeless population in Massachusetts may be changing as a result of worsening deficiencies in the service system. Signs are of an increasing number of homeless children who have "aged" out of eligibility for DSS services; individuals with mental illness who have been discharged from correctional facilities without referrals for mental health treatment; and managed care psychiatric patients leaving hospitals following too-brief stays and little aftercare planning.

In 1992, Richard Ring, executive director of the Pine Street Inn, wrote that "Massachusetts, among all the states in the entire country, holds the greatest promise of ending homelessness" (p. 613). In 1999, such a

statement can only sound even more idealistic and reproachful than it did seven years ago.

## Proposals for "Reinventing" the Vision

If the pioneers of community mental health care in Massachusetts could have peered four decades into the future, they would surely have been surprised by how far state hospital deinstitutionalization had progressed, yet disappointed that community integration for persons with mental illness remains a vision only partly fulfilled. Viewed from a vantage point four decades hence, the current historical moment will likely stand as a pivotal juncture when public and private roles in mental health care underwent an historic shift. However, whether the decade of the 1990s will also qualify as the beginning point for a more effective and comprehensive system of mental health care in the state will depend largely on the responses to challenges outlined in this report.

Many policy, service, and administrative issues have been identified affecting users of mental health services from all age groups and social strata. For some questions examined, a strong consensus exists on the type of solution required. For others, opinion is polarized, or critical details need to be negotiated among competing stakeholders. In general, enough information has been provided for readers to be able to formulate their own judgments about what actions can, and should, be taken for different issues, or to monitor specific debates as they continue to unfold. Rather than detailed policy prescriptions, the concluding recom-

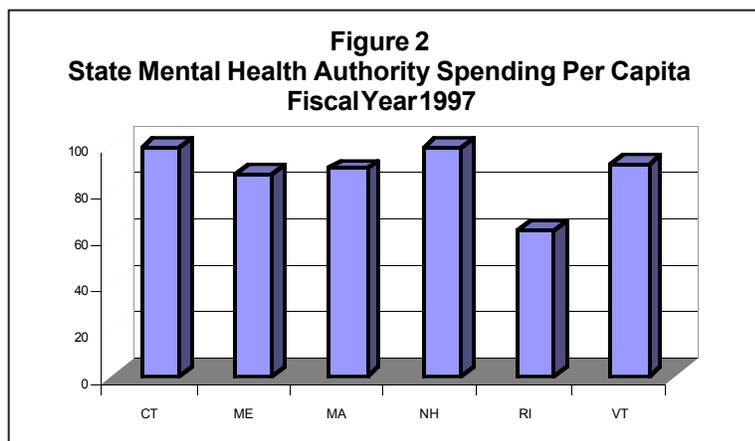
mendations offered here pertain to the basic capacity of the system, as well as the process of political decision-making for mental health care. Three proposals are set out in turn: 1) an injection of new funding for the public mental health sector; 2) formation of a Mental Health Legislative Caucus; and 3) a call for a Mental Health Policy Summit.

### I. The Need for Additional Funding

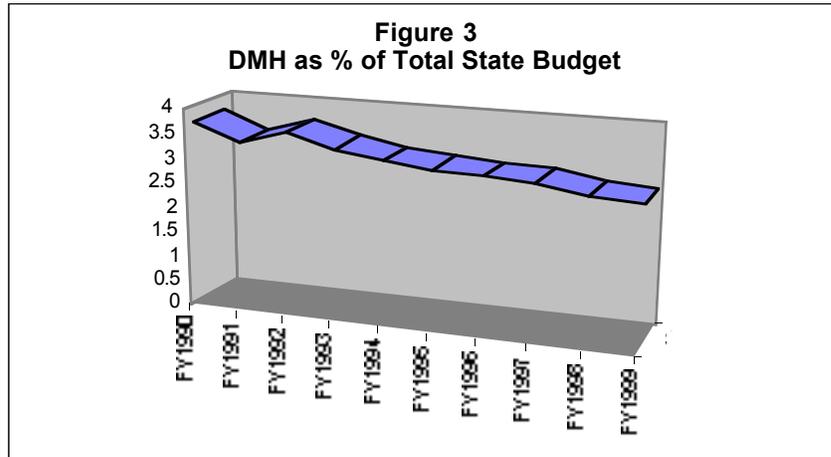
Little more need be said at this point about the glaring discrepancy between documented need and service availability within the public mental health sector. Ample statistics, often based on conservative estimates, are presented in the sections on community support, children's mental health care, and homelessness. For substantial numbers of individuals and families dependent on state programs for treatment and care, a lengthy waiting list is the best response they can hope for. Three additional analyses serve to emphasize the low relative standing of the public mental health sector in Massachusetts over recent years.

Figure 2 presents per capita mental health expenditures by the State Mental Health Authority within each of the New England states in fiscal year 1997, the latest year of data available. Massachusetts ranks fourth in this group of six. Meanwhile, Massachusetts had the second highest income per capita within New England in this same year (U.S. Bureau of the Census, 1998).

Figure 3 displays the funding for DMH as a percentage of the total state budget in Massachusetts between fiscal year 1990 and fiscal year 1999, based on data from the Massachusetts Taxpayers Foundation (1999). The trend is unmistakable. Compared to other



Data Source: Lutterman, Hirad, and Poindexter (1999), Table II, p. 36 .



Data Source: Massachusetts Taxpayers Foundation, 1999.

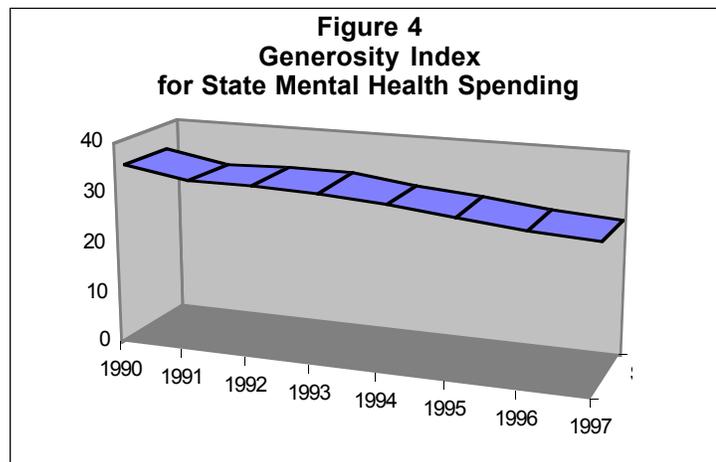
budget items overall, mental health care has declined as a policy priority in Massachusetts during this period.

Finally, for Figure 4, a "generosity index" has been calculated using the method developed for the 1990 rating of state mental health systems by Public Citizen and the National Alliance for the Mentally Ill and using per capita income data prepared by the U.S. Bureau of Economic Analysis. Dividing per capita mental health spending by per capita income, then multiplying by 10,000, the index represents the number of cents Massachusetts allocates to the DMH budget for every \$100 of income. Results again show a sharply declining commitment to mental health care.

This brief analysis, of course, is just a first step toward the more thorough examination of mental health spending in Massachusetts that is needed for effective

public policy planning. In a more complete study, it will be necessary to factor in, for example, the impacts of the growth in Medicaid eligibility in the state, as well as the possibility, suggested by national data (Associated Press, May 8, 1998), that spending for behavioral health services by private health insurers has fallen sharply over the past decade. Such trends must be viewed against a standard of need for community-based mental health care in Massachusetts that is truly comprehensive in regard to services and population groups considered.

Underfunding of mental health services is not only a failure of the system. Because of the needs of children and many other consumers for early identification and treatment, underfunding results in a "system of failure" which neglects opportunities for cost-effective prevention of more severe illnesses and disability (Committee



Data Sources: Bureau of Economic Analysis, 1999; Massachusetts Taxpayers Foundation, 1999; U.S. Bureau of the Census, 1998, Table No. 26, p. 28.

on the Status of Mental Health Services for Children, 1998, p. 15). Expanded resources are also required to address the continuing need to attract, and retain, well-qualified and well-trained staff to the public mental health sector. A reversal of mental health funding trends within the state budgetary process is thus a prerequisite for moving the public system toward its stated goals and for lessening the "political stigmatization" felt by mental health constituency groups (NAMI-MASS, 1999).

## **II. Establishment of a Mental Health Legislative Caucus**

Earlier sections of this report focusing on parity insurance and managed care regulation described the extreme fragmentation of deliberation for mental health concerns within the Legislature. Indeed, considering the total number of mental health-related bills submitted in the 1999-2000 session, more than half a dozen committees are involved, including Human Services, Insurance, Health Care, Judiciary, Criminal Justice, and others. Although these multiple jurisdictions can be rationalized on the basis of the concept of legislative specialization, the overall impact, as noted, is to hinder the institutional capacity for mental health policy analysis from a system-wide perspective. Advocacy for mental health issues is also undermined by the requirement that monitoring and lobbying occur within so many different venues featuring a large number of legislative actors. In general, this situation tends to advantage those interests such as insurers, provider organizations, and professional groups already blessed with a strong resource base, while disadvantaging the representatives of consumers and their families.

To help counter this fragmentation, it is proposed that a Mental Health Legislative Caucus be organized. Typically, such a caucus would include a Steering Committee composed of the chairs of relevant committees and encourage the participation of all legislators and staff members with an interest in the policy issue. Caucus groups create the opportunity for legislators, department officials, and issue advocates to convene outside the committee process, but with a clear focus on legislative aims. They also can provide a means for information-sharing, bill-tracking, legislative strategizing, and coordination of lobbying, both in regard to specific legislative proposals and the state budget. A variety of legislative caucuses already exist at the State House for the concerns of women, children, and other interests, so procedural models are not lacking. Especially with the support of high-level legislative

leadership, a Mental Health Caucus could emerge as an important force in the legislative arena by sponsoring public forums; building connections among legislators, administrators, advocates, and academic and industry experts; and even establishing Task Forces for special study assignments.

This recommendation for a Mental Health Caucus arises from the recognition that mental health policy development is inherently a political process. Information and analysis have a significant role in legislation, but few decisions seem to hinge on these elements as opposed to the play of political influence. A recent report on keys to effective legislation for children and families arrived at the following findings (State Legislative Leaders Foundation, 1995):

- State legislative leaders tend to be more focused on managing the legislative process and on the state budget than specific policy issues.
- State legislative leaders tend to learn about issues in terms of anecdotes, not systematic policy analysis.
- When confronted by a plethora of individuals and organizations advocating on an issue, legislators perceive mixed and confusing messages.
- State legislative leaders are often unsure about the role issue advocates play or the constituencies they represent and may be suspicious about working closely with them.

All of these observations are, if anything, even more relevant for mental health policymaking than for issues related to children and families. The institutional device of a Mental Health Legislative Caucus could offset each of these tendencies to some degree while building support behind a coherent mental health policy agenda.

## **III. A Mental Health Policy Summit**

Finally, the time is ripe for a mental health policy summit in Massachusetts. There is no question but that leadership on certain mental health issues has been lacking over the past decade. Significantly, the dominant contemporary forces shaping mental health care provision in the state have come from external forces—managed care, privatization, and budgetary limitations. At the same time, the Department of Mental Health, the state's principal repository of expertise and administrative experience for mental health, has undergone a

transformation reducing some of its functions, which are now being discharged primarily through contracts with other public and private agencies. A series of public meetings around the state, involving top-level officials as well as other key members of Massachusetts' mental health policy network, could do much to bolster a true "mental health perspective" on program and resource allocation decisions affecting persons with mental illness, filling a vacuum abhorrent to the political process.

A summit of this kind, coinciding with the start of the millennium, would have enormous symbolic value. More than this, however, important issues have come to the fore which merit review, at least initially, outside of the usual legislative and bureaucratic channels. For example, as University of Massachusetts political scientist Richard Hogarty (1996) has written, "The policy jury is still out on the quality and consequences of privatization" (p. 60). Rather than continue with routine extension of the for-profit mental health carve-outs created earlier in the decade, some question whether DMH itself might reassume management of these services and do the job "more humanely and less expensively" (Fendell, Summer 1998, p. 26). There is also need for a comparative assessment of the current carve-out and "carve-in" (i.e., HMO-based) models of mental health care delivery in use in the state.

A different set of concerns has crystallized over the past several months in response to Littleton, Colorado, and other tragic episodes of youth violence. Observers have begun to wonder what role the mental health system might play in helping to prevent such events, recalling an earlier and much more ambitious version of community mental health planning than currently prevails (NMHA, undated). In some other states, formal mechanisms have been instituted to examine the changing mission of public mental health services within a framework encompassing concerns as diverse as managed care and prevention of mental illness (see, e.g., Rhode Island Department of Mental Health, Retardation and Hospitals, 1999). Massachusetts so far has neglected this step, yet an innovative deliberative process is warranted and would be welcomed in many quarters. A good illustration of the broad educational role that a state mental health agency can play is DMH's "Changing Minds" campaign. Initiated in 1997, the project aims at increasing understanding and reducing the stigma of mental illness, with a current focus on the school setting (DMH, 1997).

Mental health care belongs to a certain category of public policy issues for which political and popular interest is cyclical. Historically, aside from periodic punctuations of high-level visibility leading to major new policy proposals, the mental health sector has resided on the "back-burner" (Rocheft, 1997). Special commissions and policy summits are often the means by which long-neglected problems in this area are brought into view for analysis and correction. Examples on the national level would include the Joint Commission on Mental Illness and Health in the 1950s and early 1960s, Jimmy Carter's Presidential Commission on Mental Health, and the Clinton Administration's one-day national mental health conference held in June of this year. Examples from Massachusetts history include the Dukakis Administration's Mental Health Action Project and Governor Weld's Special Commission on Facility Consolidation. Such efforts usually are organized by government leaders within either the executive or legislative branch. Lacking action from these sources, however, the initiative could be seized by a private foundation, university, or a consortium of relevant actors. Whatever the scenario, the objective remains the same, that is, to cast a spotlight on mental health issues and to stimulate an interaction among diverse stakeholders transcending interest-group politics.

In this way might the future course of mental health reform in Massachusetts be set and forces mobilized to assure its success.

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