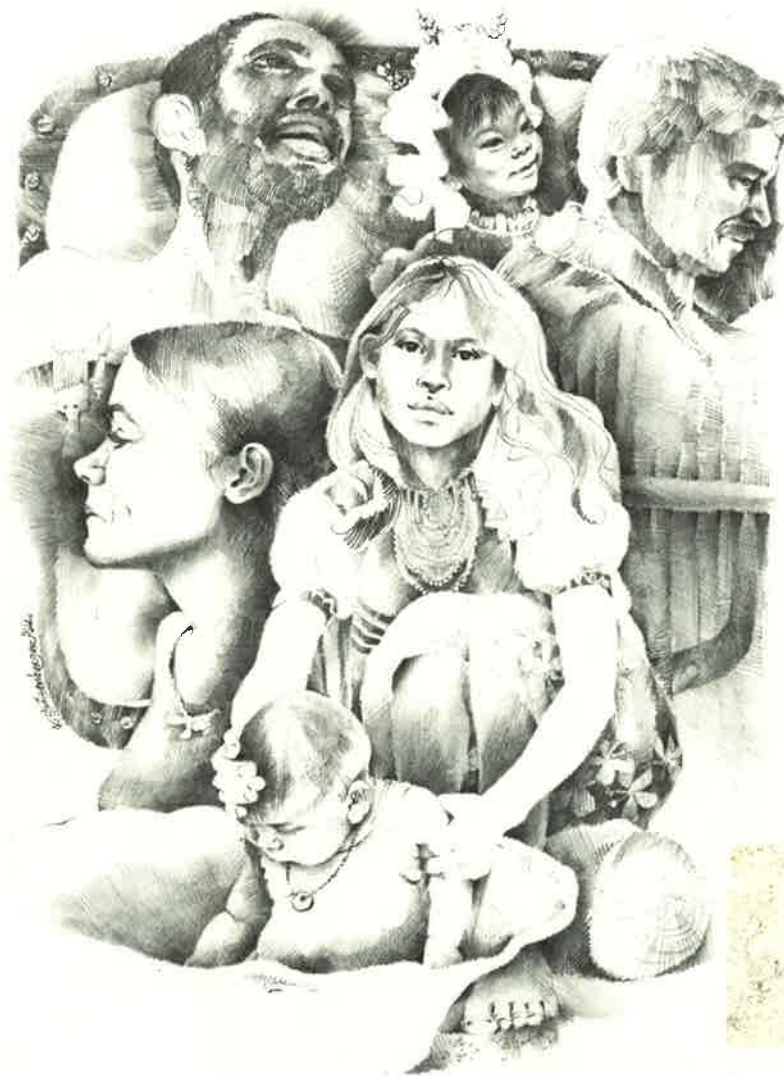


Within Community

New directions in the effort to create an improved system of services and delivery for those affected by mental illness, mental retardation, and addictive disorders, and their families



The Report of the First Annual Rosalynn Carter Georgia Mental Health Forum
October 2, 1995 • The Carter Center • Atlanta, Georgia

Within Community

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The First Annual Rosalynn Carter Georgia Mental Health Forum was supported by an educational grant from Solvay Pharmaceuticals with additional support from:

- Georgia West Mental Health Foundation
- Hillside Hospital
- Charter-Laurel Heights Hospital

Scholarships were provided by:

- Georgia's Department of Human Resources
- Governor's Council on Developmental Disabilities

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Our Continuing Task

Progress has been made in Georgia, but much remains to be done to improve the quality of life for people with mental illness and their families.

By Rosalynn Carter

Chairperson, The Carter Center Mental Health Task Force

More than 20 years ago, when I was campaigning for Jimmy for governor of Georgia, I became involved in mental health issues. My interest was piqued, I recall, by the many people who asked me: If your husband is elected, what will he do for my emotionally disturbed child, my mentally retarded brother or friend?

Jimmy and I were on different schedules then, trying to reach as many people as possible, and one evening, when I was in Swainsboro, I was surprised to learn that Jimmy was going to be there that night. So I went to his rally. He did not know I was there. When he was through speaking, I went with everybody else to shake hands with him.

As often happens in receiving lines, he reached out to take my hand before he focused on me. Then when he saw who I was, he grinned and said, "What are you doing here?"

"I came to see what you are going to do about people who are suffering from mental illnesses and mental retardation when you are governor."

He smiled. "We are going to have the best system in the country," he said, "and I am going to put you in charge of it."

He did not put me in charge of it. But I did become a member of the Governor's Commission he formed to improve services to the mentally and emotionally disabled.

That began my education about mental illnesses.

Later, when we were in the White House, Jimmy established the President's Commission on Mental Health, and we worked for the whole

four years to pass the Mental Health Systems Act of 1980. Unfortunately, much of what was recommended was not implemented by the administration that followed us. But I have always been pleased about the President's Commission and its recommendations, for they have served as a guide for many states forming more humane, up-to-date policies.

And, because my interest has not waned, I have continued to speak out about mental health issues in our annual national symposium at The Carter Center and in other forums.

Much has improved over the years—many perceptions have changed. Yet so much remains to be done if we are to continue improving the quality of life for all people with mental illness, mental retardation, and addictive diseases, and for their families, friends and loved ones.

I am pleased to have this opportunity to convene consumers, family members, advocates and professionals from all over the state to explore the needs and challenges facing our local mental health community.



"Much has improved over the years—many perceptions have changed. Yet so much remains to be done."

We Are All Responsible

Implementing House Bill 100's positive changes requires total involvement.

By Tommy Olmstead

Commissioner, Department of Human Resources

Not since then-Governor Carter created the Department of Human Resources in 1972 has there been this much positive change in the area of mental health in Georgia. Georgia has been attempting for more than eight years to build a comprehensive, community-based mental health system. Now, House Bill 100 promises progressive legislation in that direction.

In fiscal year 1997, the Department and the Board of Human Resources is redirecting \$11.5 million to community mental health services for severely emotionally disturbed children and for adults with mental illness. The DHR has requested \$8.3 million to expand these services in fiscal year 1997.

Yet, reform will be challenging in the face of state budget limitations

and the likelihood of federal cutbacks in funds for mental health services. None of us will be prepared to deal with the problems facing us if we cannot get a deeper understanding of the issues, a deeper appreciation for the assistance available, and a deeper commitment to make the necessary changes.

It is critical that we share what we know, and what we do not know, about how to be productive coalitionists and collaborationists so that we can improve the delivery system of mental health services in Georgia.

We are all responsible.

We are responsible to make sure that any new system will work and that it will provide the best service possible for those who need mental health services in Georgia.



Looking Ahead

An overview of the conference, some observations, and a few remaining questions

By Judy Fitzgerald and John Gates

The first Rosalynn Carter Georgia Mental Health Forum, "Moving Toward an Improved System," convened consumers, family members, advocates, professionals and policymakers to focus on mental health issues in Georgia. The forum, complementing Mrs. Carter's annual Symposia on national mental health issues, explored the needs and challenges facing the mental health community by increasing understanding about ideal systems of care for children and adults, and by assessing the policies, resources, and structures necessary to ensure an adequate system of care in Georgia in light of the reform which has occurred over the past three years.

The meeting proved informative, stimulating and challenging. A preview:

In her opening remarks, Mrs. Carter challenges participants to continue their efforts toward improvement through ongoing dialogue. While noting the tremendous strides that have been made in the past decade, she reminds the audience that much still needs to be accomplished to improve the lives of people with mental illness and their loved ones.

Following Mrs. Carter, Tommy Olmstead, commissioner of the Department of Human Resources, acknowledges the difficulties ahead for the mental health community in light of anticipated state budget limitations and federal cutbacks.

House Bill 100 provides opportunity for change and local planning and decision-making, but it will require continuing cooperation to improve the service delivery system for our most vulnerable population.

Where Are We Going?

Two guest speakers describe an ideal system of care for people with mental illnesses: Karl Dennis, executive director of Kaleidoscope, a Chicago-based child welfare agency, and a national expert in community-based care and wraparound services, addresses the issue of care and treat-

ment for children and adolescents. Henry Harbin, M.D., chief executive officer of Green Spring Health Services, the fourth largest behavioral health care company in the country, offers a perspective on services for adults, and the managed care environment which public and private agencies are operating in.

Dennis points out that between 5 and 14 percent of all children in this country will need services other than regular education. Yet, we spend one-third of all dollars on 1 percent of the population. These are children who are in high-priced hospitals and correctional facilities. The second one-third of our dollars are spent on 12 to 13 percent. That leaves the remaining one-third for categorical services and prevention. Dennis' wraparound initiatives change the way services are provided to this 14 percent so to be more cost effective. In addition, he has adopted a policy of unconditional care, never denying treatment to a child or adolescent in need. He offers the following as critical elements of WrapAround services:

- interagency collaboration
- all treatment and services based upon a team approach
- services should be unconditional
- services should be community-based
- services need to be individualized
- services should be strengths-based
- services should be culturally competent
- services should be outcome-driven.

Henry Harbin analyzes the behavioral health market, a \$53 billion dollar industry including state, federal, and private sources. Growing rapidly, it is expected to nearly double by the year 2000. Managed care is described as a tool for controlling escalating health care costs and quality problems. Essential techniques of a managed care program include referring patients to the appropriate level of care; setting up a preferred provider

network; matching the patients' needs with the most effective provider; and individual case coordination.

The response to ongoing questions about future financing of Medicaid and Medicaid has been to begin to enroll these populations into some form of managed care. There is concern about what this will mean for the mental health population, considering the long history of limitations on benefits and a lack of experience by HMOs in managing care for people

By preserving what is best about the public system while making the changes the private system needs for efficiency and economy, and paying careful attention to patient satisfaction and outcome measures, we can create a system that offers both professionalism and compassion.

with serious mental illness. States are experimenting with both “carve-in” and “carve-out” strategies. Georgia will use a “carve-out” approach, in which behavioral health dollars are separate from all other health dollars, and funds will be kept at the regional board level. Strengths of both the public and private sector in administering mental health care should be recognized. The public sector has much more experience in managing long-term care. It has involved consumers and family members in determining policy and planning, and has a long-term view of providing services. On the other hand, the for-profit private sector is more efficient, and more flexible, and—without government constraints—able to shift money and personnel quickly. It also has a greater ability to take risks and manage large accounts, and maintain a sophisticated information systems infrastructure.

By preserving what is best about the public system while making the changes the private system needs for efficiency and economy, and paying careful attention to patient satisfaction and outcome measures, we can create a system that offers both professionalism and compassion.

How Do We Get There from Here?

Three panels composed of individuals from all stakeholder groups address what needs to be done in Georgia to improve systems of care following the implementation of House Bill 100 (see page 5 for more information on this bill). Panels are structured around policy, structure, and

resources. Several observations and questions are repeated by panelists throughout the afternoon:

Observations

- Consumer and family-member participation has been essential to the change process and must continue if House Bill 100 is to succeed.
- Regional Boards must strive to provide a comprehensive array of services.
- The needs of consumers are not so different from the general population: they want jobs, safe, affordable housing, transportation, and relationships. Professionals must focus particularly upon creating employment opportunities for consumers.
- All stakeholders must continually be brought to the table as decisions are made. This includes consumers, family members, advocates, professionals, government officials and managed care organizations.
- Some progress has been made in streamlining the budget and resources. We must continue to look for ways to maximize efficiency and increase flexibility within the delivery system. This may require changes in the law to move toward a single stream of funding.
- Special populations will need ongoing attention and advocacy (e.g., children, rural populations, forensic population.)

Questions Remain

- Can the regional boards function as the single point of accountability if they remain understaffed and undertrained? Can they be structured to function autonomously?
- How will the dilemma of the executive directors of the Regional Boards reporting both to their board and to the state be reconciled?
- What is the relationship between Community Service Boards and Regional Boards?
- How do we measure “quality of life” outcomes for consumers and families?
- As we refine the development of a consumer-driven system, can we find out what consumers need, then develop an infrastructure to support those needs?
- Where lies the responsibility for ensuring that a safety net exists?

- Is it possible to blend the best of what we know from the private sector with the best of what we know in the public sector to create an integrated system of care?

- Can we reconvene stakeholders to directly address some of these unanswered questions and proceed with a plan of action that continues the movement toward improved care initiated by House Bill 100?

Susan McDonald, conference chair, follows with a road map for local advocacy. Carl E. Roland, director of the Division of MHMRSA, con-

cludes the Forum with a summary of the day's events. He acknowledges the expertise offered by guest speakers and the observations and questions offered by panelists, and urges the audience to continue to foster an environmental habit of respect and appreciation so that continued discussion can take place.

He notes that reform is not easy, and that Mrs. Carter's significant contributions in the field of mental health have been essential in creating an environment that makes reform possible.

House Bill 100

Since its passage in 1992, Georgians have worked to implement this radical reform in the delivery of mental health services. Their struggle continues.

In 1992, the Georgia General Assembly created the State Commission on Mental Health, Mental Retardation, and Substance Abuse Service Delivery to recommend improvements in the public MHMRSA service system. Chaired by Stan Jones, this Commission, known as the 811 Commission, offered several recommendations which served as the basis for progressive legislation that passed the General Assembly in 1993. House Bill 100 called for the following major changes:

Decision making and accountability move closer to the local level. New regional boards, appointed by county commissioners, are responsible for assessing local needs, planning and coordinating hospital and community services, and allocating funds to support services.

- Consumers and their family members have a strong voice in deciding what services

are needed and how available dollars should be spent. They make up at least half of the membership of regional boards.

- The new organization attempts to resolve long-standing governance and coordination of services problems. Before the reform, state hospitals were operated by the Department of Human Resources's Division of MHMRSA; community services were operated by boards of health. Now community services are managed by new community service boards, which also have consumers and family members as board members. Regional boards contract with state hospitals, community service boards and other public and private providers for needed services. Regional boards coordinate all publicly funded services.

- Regional boards will make it easier for people to get into the system and get contin-

ued care when they move, for example, from hospital to community programs.

- Regional boards also have more flexibility to arrange services that meet individual needs rather than force people into a "one size fits all" category of services.

The system has been phased in over a two-year period. Since July, 1995, regional boards—following a year of planning and needs assessment—have assumed responsibility for allocation of state and federal funds. In addition, community service boards now have the authority to petition to change the boundaries of their service areas.

The new legislation remains in effect until 1999, when the General Assembly has the option of continuing the new system created by House Bill 100 or reinstating the old system.

WrapAround with Love

In Chicago, Kaleidoscope has demonstrated that community-based services offer potential for improving the lives of those with mental and emotional disorders.

By Karl Dennis

Fifteen years ago we provided few services for children in mental health. Children could either be seen in a hospital or in an outpatient clinic. Today, it is different. It is different because of the high cost of hospitalization—this year, I was invited to a hospital in an eastern state that charges \$2,000 a day to keep a child. The juvenile justice system spends \$38,000 on average each year to keep a child in a “junior jail.”

Due to these high costs, and in many instances, few long lasting results we are changing and we are moving in new directions. A lot of mental health systems around the country have developed treatment foster care, in-home services and independent living services. For example, one county in Ohio, by pulling together its service systems, has been able to reduce its dependency on hospitalization by 98 percent in 18 months.

All of the systems in this country—mental health, juvenile justice, child welfare, special education, private foundations—seem to be moving into the community and looking at providing services in a different way.

Parents are moving it out of the shadows and starting to partner with professionals in making decisions about how their children and families are going to be served. Many family advocacy groups become so strong that no child or family legislation is passed without that organization giving its stamp of approval.

About Kaleidoscope

Our agency, Kaleidoscope, started in the mid-1970s, at a time when our state had close to 1,000 kids in out-of-state placement. As we looked at this group of children that very few agencies in the state were willing to



serve, and as we searched for a philosophy, we looked at ourselves, our needs and our own families. Because we would never deny services to our own children, we decided that no matter who was referred to our agency, we would find a way to care for them.

We also believed that the family was the best environment for children to prosper. So, we decided that whatever services we developed would be as much like a family as possible.

We looked at the children who had been in institutions, who had been moved from one place to the next. The agency needed to find a way to break this cycle of rejection. So, rather than change children from system to system and service to service, we would simply change the services to meet the needs of the children. Under no circumstance would we punitively discharge anyone from our system. This is our unconditional care philosophy.

We determined to provide the same kind of services for children we served as we did for our own family, and never develop anything that we were not willing to have our own children be a part of if the need arose.

When the State of Illinois discovered that there were some people who would be willing to serve anyone, of course, we got the most difficult and the hardest to serve. We moved from zero children to 69 in a few short months. We took care of these children in group homes, but soon discovered that you can't provide unconditional care with only one service environment and that we couldn't individualize services enough in a group home setting. We closed the group homes and developed the environments

of intensive in-home services, therapeutic foster care, and independent living for young adults.

Some of the children coming back from out-of-state placement were older adolescents. We used the independent living environment; placed one child per apartment and surrounded them with people and services, and maintained them in their communities.

The state sent some of the children who were coming back from out-of-state placement back home to their parents. What we learned was incredible. If the services we provided to those families were intensive enough, if they were long-term enough, if there was 24-hour crisis intervention, and most important, if we listened to the families tell us what they needed and provided those services, then we could keep more than 80 percent of those children, who no one wanted to care for, in their own families.

In 20 years, we have never turned anyone away because of his or her previous behavior, and we've never punitively discharged anyone from our services.

In 1985, Alaska—which was in a budget crunch—reexamined its practice of sending children to high-priced institutions and hospitals, and to out-of-state residential treatment centers. Its social service people came to us and said, “This unconditional care philosophy, do you think it would work in Alaska?” We said, “Yes, we think so.” And then we explained: if they would allow the dollars that they were spending on these out-of-state children to follow them back into community-based services, we could not only care for this group of children, but would have enough money left to prevent further out-of-state placements. In the first year, we brought every child, except one, back to the State of Alaska, and placed him or her in the community. In five years, we not only had changed the system and created a lot of local jobs, but we had also saved the State of Alaska \$10 million.

That was the beginning of “WrapAround initiatives” in this country.

Today, there are more than 700 projects with just about every state having at least one initiative.

Between 5 and 14 percent of all the children in this country will be in need of special services beyond regular education—many will become known to more than one system.



This is how we spend our money serving this group of emotionally unique children.

One percent of the children will receive one-third of our dollars (these are the children with the most severe complex needs.) The next 12 to 13 percent of the children will receive the next one-third of the dollars. Leaving only one-third to be spent on categorical services and prevention.

When states start to run out of dollars, the first thing that tends to disappear, of course, is prevention. Then, they start to eat into categorical services. But they never seem to affect that 1 percent, and that 12 and 13 percent, at the top. In a WrapAround initiative, we change the way services are provided to the top 14 percent and make it more cost effective.

Elements imperative to WrapAround services

The first is interagency collaboration. I firmly believe the cliché that interagency collaboration is an unnatural act between unconsenting adults. It is very, very difficult to pull people together from different systems to collaborate on the provision of services. But I believe that our problems have become so complex that one system cannot meet the needs of our most difficult children and families.

In addition, collaboration is so difficult because we are not trained to respect the way other people provide services. For example, if I get a master's degree in social work, it would never teach me what a spe-

Where Are We Going?

Part I: This overview provides a comprehensive look at the array of needed services for children and adolescents who are emotionally unique.

The Author:

Karl Dennis is executive director of Chicago-based Kaleidoscope, a child welfare agency. He is a national expert in community-based care, a pioneer of WrapAround services, and one of the first to begin a foster care program for children with AIDS.

cial education teacher does. It would never teach me what a probation officer does. It only teaches me social work skills. It helps to create systems where people are very entrenched with what they do and territorial about their dollars.

At the state level, we need to be more flexible with our dollars, and we need to look at regulations to see if they truly fit the needs of the families and children.

At the community level, we need to make sure local people are allowed to make decisions about the services they need, and that they are able to control the dollars.

Second, are strength-based services. It is unfortunate that most of the information that we gather on families and children in this country is pathology-driven. We do not talk about the strengths of families; we only talk about what is wrong. To effectively provide services, we need to look at strengths as well as weaknesses.

Third, services need to be family-focused. Children do not exist in a vacuum and I believe that until we become more wholistic and serve the entire family, as they define themselves, we cannot possibly get the best results. Families are best served when they are an integral part of the decision-making process.

There's a wonderful piece of research done by Dr. John Whitbeck from Seattle, Washington., who looked at what elements were important to the process of children and families getting well.

What he found worked was this:

- **Access.** The parent(s) and child were given options and were included in decision-making. No one from a service agency came with a prepared treatment plan.
- **Voice.** Families had a voice and were listened to at all junctures of planning and services.
- **Ownership.** The families had a sense of ownership and were committed to their family plan.
- **Consistency of service.** The parent(s) and child were served by a consistent team of professionals for both services and crisis. In some systems, one group provides service but when a family enters a crisis, another group takes over. It seems to be common sense that the last thing a family would want to see in crisis is a stranger.

Fourth, services need to be unconditional. We need to take people into

our services and continue to provide for them, regardless of their need.

An example: At age 11, Sandra was assigned to the Illinois mental health system. For seven years, she stayed in hospitals and institutions, where she attempted suicide more than 14 times. She once was held in restraints for seven days in a row, turned from one side to another every four hours. She was transferred to an institution out west, where she had a birthday party. Someone invited her mom to the birthday party but neglected to inform her. She hadn't seen her mother in seven years, and she did not respond well. She attempted suicide again; officials of the institution decided she had maximized her stay in their facility and they sent her back to Illinois. By this time, Sandra was considered one of the most difficult, dangerous children in the State of Illinois. For transportation back to Illinois, the state chartered a plane, kept her in full restraints, and had four big people traveling with her. The state had to protect people from her.

Four days after Sandra came back to Chicago, we placed her in her own apartment. We surrounded her with services, day and night. She had not been out of an institution in seven years. She thought we were the craziest people she had ever seen.

In the past, what had worked for Sandra was to attempt suicide. She claimed that she had made only two valid attempts; as for the rest, she knew if she made an attempt she would be moved to another place. When she made suicide attempts while she was with us, we would take her to the hospital, have her stomach pumped, and bring her back to the apartment. Finally, she got tired of having her stomach pumped, realized that we were not going to discharge her, so she stopped.

Sandra's strength was her talent for art. We got her a scholarship to the Art Institute of Chicago. We got her a job working with children because she liked them. Today, she holds a job. She's a salesperson. She practices her art. She hasn't made any more suicide attempts. She still has a ways to go. But what is scary about Sandra's scenario is that if we had heeded all of her psychiatric evaluations she would have spent the rest of her life on the back ward at some institution.

Fifth, service needs to be community-based. We need to keep children in their own communities, where they can develop resources, where they have ties, where they understand the culture and where they can develop roots. When we send children away, families close up and often lose contact with their sons and daughters. We do not work with the families while their



child is gone. Yet we discharge them back to their homes and wonder why in six months they are often back in worse shape than they were in the beginning. And the children always come back, often angry that we sent them away, no longer eligible for services, and without a safety net of community or family support.

Sixth, services need to be individualized. One size does not fit all, and labels do not explain the person.

In the 20 years that I have been providing services, I have never met anyone who was disturbed all the time. I've never met anyone who was just pathological. But that is the way we tend to describe people. People become "a schizophrenic," or "a conduct-disordered person," as if that is exactly who they are.

Seventh, the services need to be culturally competent. We need to learn how to value diversity. On the West Coast, a six-year-old Native American child came into the off reservation school system. People welcomed him. They gave him a seat by the window. They thought things were going to work out. But by the end of the first day, it was obvious there was a problem. A lot of things were missing and they all showed up in his desk.

The teacher asked him, "Did you steal these things?" He looked up at her and said, "No."

The teacher thought, "Well, I should back off because this is his first day."

But it kept happening, over and over again. The teacher became very frustrated. The child was obviously very unhappy. He would come in and just put his head down. They decided to get a clinical assessment, which suggested that this child was clinically depressed and needed to be placed in a residential program.

Just before they were going to move him, they decided to call Terry Cross, a Seneca Indian who worked in cultural competence. Terry talked to the young boy on the phone. Terry said, "Look, westerners are stingy. They think they own everything around them."

The young man said, "Is that why I'm getting in trouble?"

Terry said, "Yes."

You see the child came from a band of Native Americans who all lived around a crossroads. All of the children stayed together. If they went by one house, that is where they had dinner. If they went by another house and it was time to go to bed, that is where they slept. Anything that they wanted to use or play with, they just picked it up. They believed that

everything belonged to the group.

Here was a young man about to be sent into a residential placement simply because the authorities did not understand that he had a different value system. Services need to be designed and delivered which incorporate the religious customs, regional, racial, and ethnic value and beliefs of the families we serve.

Eighth, services need to meet the needs of the family and to address basic life domains. Dr. John Burchard at the University of Vermont does a lot of the WrapAround research. He always states that when services do not work, it is because the people around the child and family, who have the responsibility of putting the plan together and providing the services, have failed to listen to the family and they have failed to get along. There is an old African proverb: "When elephants fight, the grass suffers."

Ninth, services need to be outcome-driven. We need information to be timely and given in such a manner that I and my legislator who votes on service funding, can understand. The kind of information that is helpful, is if I've got a young man who was in a hospital 30 days last year and he's only in the hospital 10 days this year, evidently I'm moving in the right direction. If I've got a child who was truant from school 15 days last year and he's only truant from school four days this year, I'm moving in the right direction. This type of information is useful to me.

Tenth, and last, services need to be cost effective. As dollars shrink and we move further into a managed care environment, we no longer have the luxury of using expensive services. In order to stretch our dollars to serve a growing population of children and families in need of services, we need to look toward the greater community for support and resources—to our churches and civic groups—back to our roots of people taking care of people.

Although the climate for service delivery is rapidly changing in this country, we need to see this as an opportunity to redesign our systems of care to provide more effective humane services.

Parents are moving out of the shadows and starting to help make decisions about how their children and families are going to be served.

Can We Preserve What Is Best?

As public and private sectors learn to work together, the result could become a better system of treatment for all those in need.

By Henry Harbin

It might be helpful to walk through the basic terminology of managed care—what managed care programs are about, and how they link to the current public mental health system in Georgia. Managed care is any program that attempts to influence or control the use of medical care resources for an individual for his or her course of care. The term, “managed care,” generates a lot of emotional baggage—it is bad to some people, good to others. But if you just look at what it is, one of the things you’ll recognize is that the public mental health system has been managed for a long time.

The public mental health system usually has a fixed budget, and not enough resources. What’s happening, in a sense, is that the private health care system is catching up with what the public mental health system has been doing for a long time.

Traditional indemnity insurance is a program where patients have the right to go to whatever provider or physician they want. The care is paid for on a fee-for-service basis.

PPO stands for Preferred Provider Organization. EPO is an Exclusive Provider Organization. PPOs are first-generation managed-care program, where an employer or an insurance company sets up a network of contracted physicians and hospitals to deliver health care. Typically, most PPO programs do not have a “gatekeeping component,” meaning they are usually a public registry or directory of providers. And, while it may be narrower than the full universe of physicians and hospitals, people have a fair number of choices from the directory to determine their service provider.

POS stands for Point Of Service programs, and HMO for Health Maintenance Organizations. Typically, both types of managed-care programs are “gatekept.” There are hundreds of variants of this, but in general,



you pick a primary care physician for general health care and sometimes mental health care. The primary care physician serves as a gatekeeper who refers you to a specialist, a cardiologist or a psychiatrist or whatever. You cannot get full access to a specialist without such a referral from the primary care physician.

POS programs have a gatekeeping component, but POS programs are typically more flexible than HMOs. POS products were an attempt to have a managed component, but where consumers still can opt out and see the provider of choice, by paying a little more.

HMOs also have a lot of variety. In a staff-model HMO, most of the physicians are salaried. The Independent Practice Association (IPA) model is a contracted network of physicians and providers who deliver services on a “capitated basis.” They are paid a fixed monthly amount to care for a group of members and patients, and they deliver that care within that capitation—*per head*—amount.

Growth of managed care

A current trend is toward integrative delivery systems, an attempt by many providers—hospitals, group practices in behavioral health, as well as general health care—to unite to manage their own care more effectively, and to create a system in a continuum of care in which the management and delivery of care are incorporated under one organization.

Let’s look at the growth of managed care as a way to deal with some health care cost and quality problems. The behavioral health market is a huge one: \$53 billion including state, federal, and private sources. It is growing rapidly. Part of this is the result of work done by Rosalynn Carter,

the Carter Center, and other consumer groups to erase the stigma of mental illness and increase medical care options. More people are willing and able to get care at an earlier stage of their problems, because it's not as shameful or as financially forbidding.

By the year 2000, behavioral health is going to be a \$100 billion industry.

Early attempts to apply managed care techniques were designed primarily to control benefits and access. In the behavioral health arena, the first focus was driven by the fact that many employers were seeing huge increases in their mental health costs, faster than the rate of medical inflation. Their response was to cut benefits. What we're seeing now is a shift to managing the care and managing outcomes.

Here are some of the essential techniques of any managed care program.

- Referring patients into the appropriate level of care. There has been some controversy as private managed-care programs have been applied to the Medicaid population too restrictively. This is particularly an issue for us in the public mental health system, where we are dealing with people with long-term illnesses.

- Setting up a Preferred Provider network. This ensures quality as well as controls costs. A lot of work goes into identifying the most effective providers, trying to monitor the quality of their care and holding them accountable.

- Matching the patient's needs—whatever illness he or she has and the stage of that illness—with the most effective provider. This is different if you are in an unmanaged, fee-for-service health care system—and is particularly a problem in mental health and substance abuse because you often don't get a lot of expert advice about how to find a provider.

- Finally, there is case coordination, individual case management, tracking patients throughout a system. These are things most community mental health centers do today.

Challenges Ahead

A word of warning: Even though we've now defined most of the major terms in the current managed care discussion, dangers still exist in our efforts to communicate. Consider, for example, the term, "individual case management." Those in the insurance world do not mean by "case management" anything like what social workers or psychiatrists mean from a clinical perspective. The insurance world uses case management terminol-

ogy to talk about flexing benefits.

The newspapers daily report the struggles around the future financing of Medicare; Medicaid is further along the continuum, already having moved significant numbers of its population into some form of managed care over the past several years. Most of that has been in the form of moving Medicaid recipients into HMOs.

That has created a number of problems for the mental health population. Many times HMOs have a limited benefit, even the Medicaid HMOs, for mental health care. Most HMOs don't have that much experience managing the seriously mentally ill. A number of states have used "carve-outs": Iowa, Massachusetts, most recently Florida in the Tampa area, where the mental health dollars spent on Medicaid are taken at either a regional, multicounty, or state level, put together and then bid out to either community health center providers, private managed care companies, or a combination of those, to manage the population.

Many states, with Medicaid restructuring, are exploring "carve-in" programs. In other states, Medicaid restructurers are attempting to—probably this is closest to what Georgia is trying to do—reorganize from a state and county level, to move the funds closer to the community level.

Ohio is probably furthest along on the government side of this. Basically, over the past several years, it moved all state hospital dollars through county boards that are now responsible for the community outpatient

Where Are We Going?

Part II: This overview discusses access to treatment through current programs of payment, from HMOs to public health facilities, and describes current models of structuring mental health services for adults with mental illness.

The Author:

Henry Harbin, a physician, is president and chief executive officer of Green Spring Health Services, with 12 million members the fourth-largest behavioral health-care company in the country. He is a professor of clinical psychiatry at the University of Maryland School of Medicine, a past director of the Maryland Mental Health Authority, and is chairman of the American Managed Behavioral Healthcare Association.

funding and state hospital funding.

Medicaid has been a major funding source for people with serious mental illnesses and kids with long-term serious illnesses. It is critical, if the block-grant shift continues (and apparently it will), that all of us try to exert influence on state governments, so that the best of what has been funded for mental health and substance abuse care will be preserved. There may be opportunities for states to better integrate what they have been doing with the public dollars, the state and county general-fund dollars, and with Medicaid funds.

Among efforts that hold promise for attracting the “new” block-grant Medicaid dollars are those attempts to shift from long-term institutionalization toward de-institutionalized, community-based programs. These are decade-long experiments and trends. When they are done well, they have been very positive for consumers. They help control costs while shifting the care further down the continuum.

Preserving the best of the public mental health system

If you were going to change your public system, and you begin to provide Medicaid restructuring as a part of that, and the private managed care companies play a role, how can you preserve the best of what you have in the public mental health system? If you want to encourage community-based programs and consumer input, what will more involvement from the private sector mean?

Clearly, the public sector has experience with coordinated care. And as managed care techniques are applied to mental health care populations, the private sector can learn something from the public mental health system. It is different from general health care, which does not have such a large government-financed and -delivered system of care. There are no state hospitals for heart patients or cancer patients, for example, but there are hospitals for those with mental illnesses.

Traditional public mental health system agencies have much more experience managing long-term care. They have developed personnel and expertise, both administrative and clinical. They also have learned to involve both primary and secondary consumer groups significantly in the delivery and the oversight of planning and services.

It has not been easy for the families to get the attention of the bureaucracy. But they have, over time, done so effectively, and in many systems and states are now a major influence in determining policy and planning.

Now, consumer groups are concerned about private sector involvement: Will we, they ask, have same level of influence on the delivery and management of services under the private sector that we have now with the public sector?

I think they will. Frankly, it may be easier getting influence in the private sector than getting through some large government bureaucracies.

But, as with public agencies, the task may not be easy. This is a new venture for most private agencies. Since public sector agencies are either nonprofit or government-run, they have a long-term view and a commitment to service. The profit motive does not enter into it. That will be a factor in the future.

So, public agencies have strengths. But there are weaknesses, too. Because money is not the bottom line, carelessness and inefficiency can too easily penetrate the system. That is where profit, if it is carefully regulated, can play a role. Profit can motivate efficiency. Another weakness for many public sector agencies, nonprofit community health centers or government agencies, is that they are often underfunded. Consequently, their management information systems are not up-to-date. In any care system today, you have to be able to track and manage large amounts of data. Profit-centered private agencies usually bring state-of-the-art information systems.

Another weakness: Many community agencies have a limited risk-taking ability. Private systems can take risks because they have the ability to raise capital, and have control over their capital. Community agencies do not have this option.

Sometimes, in traditional public sector programs, there's been a tendency to centralize too much in bureaucracy. Quality standards may be high, but are variable. Competition is going to create challenges for them.

Assessing the private sector

Many of the for-profit private companies are more efficient. They tend to be more flexible, and market-driven. Many of them do not have the same government constraints or a centralized personnel system or a centralized budgeting system; they are better able to move money around, quickly, to take advantage of opportunities and meet unexpected needs.

Typically, most private-sector companies have a greater ability to take risks. They have greater access to capital. They have a lot of experience

managing large accounts and have strong information systems infrastructure.

What are some of the weaknesses? Clearly, most of these companies don't have the same level of experience managing patients with serious mental illnesses and children with serious emotional disturbances, particularly over a long haul. They do not have the talent pool, the experienced personnel that many public sector programs do. Typically, they have a shorter-term view, often because of the bidding cycles—they may get a bid for one, two, or three years. So, they are not thinking long term in the way many public sector programs are. And, of course, you have the potential conflict of profit with the service goals of quality and access.

Profit in many public sector programs, in fact, is kind of a dirty word. But profit can be a positive influence, if it is monitored and kept from getting out of hand.

One way to keep the whole system honest, and to make sure that the savings stay in the system to expand services, is to cap profits so savings get reallocated. That creates a profit potential, but profits cannot get excessive, thereby protecting against drives for under-treatment.

Medical waivers

Earlier, I promised to discuss Medicaid waivers. Medicaid is a traditional indemnity program. You go to any provider who is certified by Medicaid. When a state wants to change its Medicaid program, it has to get a “freedom of choice waiver” because patients no longer have the same freedom and selection of providers. Most states are moving into the 1115 waivers, which offer more flexibility, than the 1915 waivers.

Waivers can include some of the more flexible services that many states have developed under traditional Medicaid, such as the rehab option, and targeted case management. Many states have tried to free up the Medicaid dollars from strict limitations on the covered services and benefits, to be able to apply them to types of services this population needs.

States are going all different ways on carve-in or carve-out. This is one of the hottest topics with mental health constituencies. There are advantages and disadvantages to both. One of the advantages of a carve-out is that the state mental health agencies and consumer groups have more control over services—their design and integration within the rest of the public mental health system.

Restructuring Medicaid

In many states, restructuring Medicaid systems has been messy. There have been a lot of lawsuits. There have been legal challenges that have taken three or four years to conclude. Let us say a state has already moved part of its Medicaid population into managed care for general health services. Given all the confusion and chaos that surrounds how to do that with mental health, these things get delayed two, three, and four years. It adds a lot of inefficiency.

If you are going to try to set up an ideal system, with safeguards and workable guidelines, there are five key areas:

First, have adequate benefits and services available, particularly for the mental health population. You need available benefits that will pay for all of the levels of services.

One problem, as Medicaid has moved its dollars into traditional HMOs, is that many HMOs were used to managing restricted mental health—30 days of inpatient care, 20 visits of outpatient care. They did not know what wraparound services were, or psychosocial rehab.

Another problem is the blurring between the traditional health care purchase and support services. How do you keep that clear, while providing adequate dollars for services? When I started with Green Spring, we sat down with some large insurers who were struggling with questions like, “How do we pay for partial hospitalization? How do we define it?”

That was settled 30 years ago in the public sector, which is on to much more sophisticated alternatives to inpatient care and how to finance and pay for it.

Second, define the role of the state oversight agencies, state mental health authorities, and others. Georgia is delegating much oversight to regional boards, as well as to the state oversight agency. The state mental health authorities move into the role of regulator, quality monitor, advocate. The point is that in many states, the state authority has not been that involved in the Medicaid initiative. So, sometimes there has been a real fragmentation of efforts.

State and regional boards can infuse competitive spirit into the procurement system. Traditionally, this has not been a market-driven area because of the nature of the funding, which is often given annually to a set of community providers. They get the same funding. You do not see three and four agencies bidding for this. As these practices get restructured, it is an opportunity to add a positive, but limited, element of competition that

may increase efficiency.

Third, determine what to expect from a comprehensive provider network.

Again, it is critical that community programs developed over the past two decades are in networks such as Medicaid and that mental health systems get restructured. State, as well as regional boards, need to be very much involved with setting standards for credentials, defining the medical necessity levels of care. There should be no barriers to access.

Many traditional managed care private programs do not have clinical

criteria for residential housing, supervised housing, referral guidelines—and for many other services. Yet if you are going to have such conditions in your network, you need to define their levels of care and requirements.

It is critical, if the block-grant shift continues, that all of us try to exert influence on state governments, so that the best of what has been funded for mental health and substance abuse care will be preserved.

The providers, I think, need to be key players in this collaborative policy development. There must be a focus on outcomes. And, as many of these providers are going to be at risk, they need to have adequate data for inpatient and outpatient care costs, or—quite frankly—they will go broke. They are dealing with high-risk populations, after all.

Whoever is going to managing the

care-giving company—a regional board or an entity contracted by a regional board, such as a Managed Care Organization (MCO)—should have an oversight role that includes setting minimum standards for the company's operations.

For example, I give you “ASA”—that is average speed of answer. Many companies agree to have an average speed of answer (by phone) no longer than 20 seconds. Can public agencies promise this? That is a performance standard the company has to live up to. There are dozens of others. To clarify the medical necessity criteria, all alternative levels of care must be included. They cannot be just the basic ones. There needs to be a clinical team approach to service coordination. Obviously, the staff—case managers, treating clinicians—need experience with seriously mentally ill children and adults.

Clearly, the managed care entity needs to have state-of-the-art information systems. A lot of what is done in an organized system of care will be driven by data—patient data, utilization data, outcomes data.

Patient satisfaction measures and outcome measures are vital. They need to be collected regularly. They need to be specific for the population. There needs to be extensive consumer and citizen input into the managing entity or the delivery. This will be a big change for some private managed care companies—having to open up their books, their procedures, to an oversight agency.

Fourth, secure adequate capital to invest in infrastructure and underwrite risk. Accountability really should be based on performance, not politics or experience. “I have always been doing this, therefore I should get a chance to keep doing it.”

Finally, develop an efficient procurement process. This is one of the most tricky areas, where a lot of states have run into problems in the waiver implementation programs that they want. Price should not be the only factor when you set up most government bidding policies or private sector bidding processes.

Recently, I checked over bids for mental health managed care delivery that ranged from a 10 percent reduction down to a 35 percent reduction. In examining the proposals, however, I concluded it was not possible for the 35-percent-reduction bidder to deliver an adequate array of services. Rather than rely solely on low bids, it is often wise to put some limits on profits, at least during the initial phase.

There is another element here: Federal law has requirements for the procurement process when Medicaid funds are applied to a freedom-of-choice waiver. Federal guidelines require that if Medicaid dollars in a waiver situation are to leave government hands—that is, be transferred to a private company in return for services—the contract for services needs to be competitively bid. If, on the other hand, the money is staying within a government entity, it may be transferred between state and local without going through a competitive process.

All this may seem confusing. But there is hope. Changes are inevitable. By preserving what is best about the public system while adding the best of the private sector—what I believe should result—is a high standard of treatment in a system that promises both professionalism and compassion.

One Person at a Time

Approaches vary, focuses shift, policies at times are undefined. But the constant emphasis on quality community treatment for individual consumers—those with mental and emotional disorders—sets the agenda.

Vickie Wilkinson

In Georgia, we are moving away from a clinical treatment model to one that develops community supports for individuals who experience disabilities.

■ What exactly is the role of the regional boards in assuming their responsibility as a single point of accountability? Most regional executive directors—myself included—spent too much time just managing the mechanisms of the change: developing contracts and doing needs-assessment and writing plans; consequently, we have not been able to focus on exactly what this new system needs to look like. In the days ahead, we need to spend much more time framing this new system of care, so that we measure real quality of life outcomes for people, rather than just numbers of people served and the array of services that are offered in our system.

■ We need to design an array of community residential options for people with mental disorders and illnesses, including programs that involve consumers in the regular life of communities, that provide jobs and wages, that increase time spent in the community versus in institutional care.

■ The function of the single point of accountability is a marriage of clinical funding and programmatic issues. Regional boards have to be answerable to all the citizens in their geographic area, as well as to all their funding sources. That can be done through an integrated network of support and service that ensures community participation for individuals who experience chronic and severe mental illness, mental retardation, and/or addictive diseases.

■ Each community boasts a unique combination of assets upon which to build its future. We in the service delivery system need to inventory those assets to help rebuild the community sense of efficiency and interdependence.

■ We need to include people with disabilities, so that we discover how they can contribute to the community. This gets to the real role of the regional boards: to become change agents that provide this leadership for rebuilding our communities.

Lasa Joiner

As we move state hospital resources toward community supervision and control, we acknowledge obstacles to over-

come. But we believe

all of the barriers can be removed, and we are committed to work together again to do that.

■ Advocates will be needed, because laws have to be changed to comply with the way we want to allocate funds and the stream of those funds. It is not a matter of just turning over the hospital dollars. Under House Bill 100, public funds must go from DHR to the regional boards as a single point of accountability. DHR is the state agency responsible for receiving and administering those funds; law requires us to provide inpatient services and involuntary treatment. The institutions are specifically named in the appropriations bill. And the money goes to specific institutions. To change that is a matter of convincing the General Assembly to do things differently. I believe they will.

■ To accommodate the new procedures, a lot of us are going to have to learn to do things differently. The best example comes in the forensic services. Regional



How Do We Get There from Here?

Part I. Six experts discuss public policy issues that influence and affect Georgia reform of mental health care.

The Panelists:

Vickie Wilkinson is executive director of the Region 16 board of directors of the State Commission on Mental Health, Mental Retardation and Substance Abuse Service Delivery (MHMRSA).

Lasa Joiner is vice-chair of the board of the Georgia Department of Human Resources and chairs its Mental Health/Mental Retardation/ Substance Abuse committee.

Jim Brice is a consumer relations specialist for mental health services with the DeKalb County Community Service Board, and supervisor of the board's Drop-in Center. In 1995, he received the Georgia Alliance for the Mentally Ill Consumer Empowerment Award.

Louise Radloff chairs the Association for Georgia Community Service Boards, and chairs the Gwinnett-Rockdale-Newton MHMRSA Services Citizens Advisory Council. She has chaired the Gwinnett County Board of Education and the Gwinnett County Board of Health.

Clair Griffin Francell, former vice president of the National Alliance for the Mentally Ill, is director for the NAMI Curriculum and Training Network, and a board member and newsletter editor of the Georgia AML. In 1994, the American Psychiatric Nursing Association named her Psychiatric Nurse of the Year.

Grace Covington-Fricks is coordinator of the Time for Change Coalition and a member of the Mental Health Association of Georgia Board of Directors.

boards are going to have to learn quickly to think differently, because you have two types of populations to treat and you have no control over the front door. The court simply sends them and the institution has a tremendous responsibility.

■ Traditionally, state hospitals have been the gateway to treatment for the forensic population and for evaluation, pretrial assessments, and working in jails. There are a lot of people in community mental health centers and the private sector who have no experience with forensic patients. Regional boards will be challenged to develop plans for a comprehensive array of services for this population.

■ Community mental health center interaction with jail and prison is certainly the most effective way to treat the forensic population to successfully move them back to the community.

■ It is going to be difficult for state hospitals to compete with private sector bids, because it costs state hospitals more to do business—personnel expenses are high, and cannot be trimmed as easily as in the private sector. There will have to be core funding to keep state hospitals open to provide services in circumstances where the private sector will not.

Jim Brice

Where are we going? How do we get there from here? I have some starters:

■ **One:** More quality jobs for consumers of the mental health

system. I do not mean minimum wage, I mean quality jobs.

■ **Two:** More consumer-oriented sensitivity from the clinical staff.

■ Communities must get involved and stay involved. Consumers must get involved and stay involved. Policies developed at the division and state level must include consumer philosophy regarding treatment, both inpatient and outpatient.

■ Georgia has the potential—only the *potential* at this point—to adopt an attitude of real change for consumers.

■ Management staff of the state of Georgia must get out in the field—visit the mental health programs, the day treatment centers, the residential facilities and workshops.

■ We need more drop-in centers. DeKalb has a drop-in center which is totally consumer-oriented and consumer-run.

■ So, we successfully staff our drop-in centers with people who have an understanding of what the consumers face, of what they go through, of what they need.

(You know, you can get all the policies in the world, all the think tanks, all the Ph.D.s devising new programs. But what it really comes down to is that novel approach, the human approach, to each person you serve.)

■ I am encouraged by the significant changes, the beginnings of significant changes in the system.

■ At this point, House Bill 100 is two years old. It comes up in 1998 for final ratification. And it is sadly lacking.

■ That is in part due to the fact that consumers have to show accountability, too. They need to show some personal initiative. Consumers must be held responsible.

Louise Radloff

There remain a number of real issues out there to be resolved. One is the relationships between regional and community service boards (CBSs).

■ Governing boards must, before they can set policy and develop goals, have a clear understanding of purposes and direction. We need to have high standards. Issues of allocation, redirection of dollars must be resolved.

■ Despite the growth in population of people with mental illnesses, substance abuse or neurobiological disorders, dollars are not quick to follow. We have an inadequate funding formula. Politics-as-usual have to be overcome, and we have got to become objective in serving those most in need.

■ The private sector currently is showing a considerable amount of interest in serving this population.

■ We in the public mental health field, like the public schools, hold the responsibility of serving the most needy clients.

■ Preserving the safety net is a

pivotal issue.

■ The availability of services is another issue. In metropolitan Atlanta, services are available. But in the rural parts of the state, it becomes a problem.

■ Governance policy goals should reflect consumer needs. Board accountability and fiscal responsibility are key issues. Micro-management between local boards, and between CSBs and regional boards, can dismantle our efforts. Our clients are our stockholders. Without them, we would not exist and we need to remember that.

■ We need to tell the story to our communities. We need to urge everyone to support us in the legislative arena as well as in the community. If America is to be strong, we will need to convince the public that mental health issues are worthy of everyone's emotional, participatory and financial support.

Claire Griffin Francell

As editor of the *Georgia Alliance for the Mentally Ill* Newsletter, I believe our role is to provoke discussion about the major issues facing mental health service delivery in Georgia.

■ A major failure of mental health systems throughout the United States has been that providers did not give families the emotional support, information, coaching, and guidance they needed to function in the role of primary caregivers to severely

mentally ill persons.

■ Families came together in 1982 to found the Georgia Alliance for the Mentally Ill for the purpose of taking action to change service delivery. GAMI members began educating themselves, mental health providers, and the general public. They organized support groups throughout the state to empower families.

■ Recognizing that research in neuroscience and research into service delivery would be the keys to convincing mental health professionals to change the way services were designed, in 1986, GAMI conducted a major study on families' perception of service delivery throughout Georgia.

■ It became apparent that the most efficient way to change the dismal status of service delivery was through advocacy in the public policy arena. The National Alliance for the Mentally Ill (NAMI) was successful in the passage of major federal laws to correct abuses nationwide. Here at home, Georgia joined with others to testify at statewide hearings and secure passage of H.B. 100 through the legislature.

■ GAMI members are concerned and frightened about the advent of managed care. The private sector has never had a commitment to the long-term care of persons with neurobiological disorders. The public sector through necessity has had to have that ethical and moral commitment.

■ In Georgia, we are now in the process of changing from a provider-driven service delivery system to a consumer-driven service delivery system. The Regional

Planning Boards and the Community Service Boards have the awesome responsibility and moral accountability for that task. The introduction of managed care administrators cannot change this legal mandate. We support efficient fiscal responsibility and oppose waste.

■ GAMI families want to have future services evaluated through measured outcomes. GAMI wants to see that Best practice Guidelines are in place and monitored by valid performance indicators.

■ Families do not care about good intentions in provider motivations. We want to see state of the art treatment through outcome measurement. We want our family members to have a better quality of life, for consumers to be satisfied with services, that their physical health is improved and their psychiatric symptoms reduced. Families want adequate, decent housing options available with respectful consumer and family education provided. We are tired of public and professional stigma. We will continue to insist upon responsible managed care.

Grace Covington-Fricks

In the last month I have had the opportunity to hear a dozen presentations. In at least six of those presentations I heard the warning: "Beware of simple solutions to complex problems." I have concluded that number one, we as humans tend to complicate problems which further confuses the

issues and number two, that simple solutions are different from simplistic solutions. A simple solution is not necessarily easy to implement.

■ The problem as I see it is we are trying to create a system to meet consumer needs, instead of identifying and meeting consumer needs and then developing the infrastructure to support that work.

■ I offer that we must dedicate more of our energy and efforts directly to the consumer and less to the system. What this means is that we need to help the seriously mentally ill or most in need one at a time. We know that we have approximately 80,000 people who are most in need and those people use 75 percent of the systems resources. This 80,00 is where we should direct our energy one person at a time.

■ These are not nameless, faceless people. They are known by name to community service boards, hospitals, sheriffs, and private providers. If we begin in a small way to address these folks one at a time we can learn and begin to apply the learning in a larger way.

■ An example of this is Margaret in Athens. She lived in state hospitals most of her life, until she was selected to move into the community. The provider built the supports around her and now she lives in her own place, has a paid live-in companion, and has a part-time volunteer job and hopes for a paying job. At first, Margaret returned to Augusta State Hospital frequently for medication stabilization, but now she has not returned to Augusta for over two years. Margaret did not change, the supports around her changed, includ-

ing a community physician for medication treatment.

■ Another example is the ACCESS service at GR-Atlanta which reports serving 52 persons who had four or more hospital admissions per year. They have reduced those folks admissions by 40 percent and their days in the hospital by 37 percent. They did this by identifying the people, helping them decide what they needed and then building the ACCESS system.

This one person at a time approach is the foundation of good service coordination and it is a major tool of managed care organizations by which they control costs and services, one person at a time. Service coordination means helping the person and the family when appropriate to choose, get, and keep what is needed to live meaningful lives in the community. Ratios have to be reasonable and service coordinators have to have training on a value system of support, respect, and empowerment.

■ In conclusion I would say beware of complex answers when more simple solutions are at hand.

We need to help the seriously mentally ill or most in need one at a time. There are about 80,000 people who are most in need.

A Tremendous Situation

In concluding their revamp of Georgia's mental health system, reformers must remember that the glass can be half empty, or half full.



Richard Fields

Why are we talking about structure? Does structure properly come in our discussion before we sufficiently understand the needs and the services that are required by the folks this reform is supposed to serve? Can we adequately address structure without having first done that?

- Let us talk about decreasing structure and increasing flexibility in the system so that patients and information can flow properly through it, and those who must manage the new system have, in fact, the flexibility to do it effectively and efficiently.
- Let us talk about structuring the resources so that we do not lose them, but that we redirect them within the system, which was never adequately funded to begin with.
- Let us not throw out the baby with the bathwater as we restructure, but design structure in the experience with the expertise of almost a quarter-century of this system's activity.
- Let us not focus on doing old things in a new way, but really entering into new paradigms in which we describe systems of care that are comprehensive and wrap-around.

Clif DuBois

Several reforms are occurring simultaneously. When House Bill 100 was written, the public system in this state was changed, forever and fundamentally.

- Consumers and families and officials of counties were invited right into the boardrooms, to sit at the board tables, and play a significant role in the public policy decision-making process. That is one reform.
- Another reform is the new way of managing our system, a decentralized planning and coordinating role for regional boards—moving the action closer to where the consumers and families and most-affected citizens are.
- The third reform is a new kind of service delivery—a consumer-driven service system, a system that starts with the needs and the desires of the consumers and their families, and takes those into full account.
- While we have been implementing those three reforms, there is a fourth reform that has found its way to Georgia, which has been sweeping the country: *managed care*.
- If House Bill 100 had not passed when it did, Medicaid already would have contracted

with the private sector to go to a capitated payment system and managed care in Georgia. House Bill 100 bought us time to do careful planning and consensus-building in this state, so that if we are wise and if we stick together, we can avoid some of the chaos and some of the disasters that have been occurring in other states.

- We are trying to avoid creating two separate, and inequitable, public systems of care. There would be problems of dumping, cost shifting, and continuity of care between the systems that would actually be incentives in the Medicaid system to overuse state hospitals. Regional boards would not be the single point of accountability for all of the system, only about half of the public system.
- How do we take the best of the new governance structure in Georgia while at the same time benefit from recent experience, growing expertise and developing infrastructure patterns? How can we blend the best of the public system and the best of the private system to achieve the best?
- We came up with the idea of the third-party administrator—two third-party administrators, in fact—major managed care organizations that would come into Georgia and provide certain func-

tions in support of the regional boards.

- We have to move forward slowly, and we have to skillfully craft the kinds of functions that the third-party administrators will carry out and the continuing public policy role, the governance role, that the regional boards would continue to have. That cannot be contracted away. The policy-making role must stay with the regional board.
 - We believe that we can bring in the private expertise to undergird the public policy role of the regional board and create a much better system of care.
 - Wayne Gretsky, one of the greatest hockey players ever, once tried to explain his phenomenal success. He said, "I never skated to the puck. I always skated to where the puck was going to be."
- That is the kind of strategic thinking we have to engage in as we create the new systems of delivery and service our people need in Georgia.

Priscilla Cascioli

Early on, the regional boards saw the need to meet together to share our ideas, to learn from each other, and to become educated and knowledgeable about

How Do We Get There from Here?

Part II. *Six experts discuss the structures that challenge and influence reform of mental health care in Georgia.*

The Panelists:

Richard Fields, M.D., a physician board-certified in psychiatry and administration, is superintendent of Georgia Regional Hospital in Atlanta, which in March 1995 was re-accredited by the Joint Commission as a creative array of inpatient, outpatient, and case management services for people who are severely disabled. The new organization, the Metro Atlanta Psychiatric Care System, emphasizes consumer employment. Fields also is a member of the 811 Commission, the Governor's Commission on MHMRSA Service Delivery.

Clif DuBois, Ph.D., heads the Transition Implementation team of MHMRSA, and directs its Office of Reform, Evaluation and Strategic Planning.

Priscilla Casciolini is chair of the Region 7 MHMRSA Regional Board, which includes Gwinnett, Newton and Rockdale counties.

Jim Ledbetter, Ph.D., is executive director of the Health Policy Center at Georgia State University in Atlanta. Previously, he was commissioner of the Georgia Department of Human Resources.

Lee Kyser, Ph.D., chairs the Georgia Coalition on Mental Health Managed Care, serves on the board of the Georgia Psychological Association, and serves on the executive board of the National Coalition of Mental Health Professionals and Consumers.

Sue Smith is president of the the Mental Health Association of Georgia and executive director of the Georgia Parent Support Network. She received the National Mental Health Association's 1995 Tipper Gore Remember the Children Award for her volunteer work on behalf of severely emotionally disturbed children.

■ I, after leaving the DHR as its commissioner, would like to review some of the issues that cause dysfunction because putting principles and values into operation is laborious.

Four conditions, I believe, are beginning to cause dysfunction:

■ *The separation of functions.*

The regional boards from the community service boards, the regional boards from the state office. The conflicts when monies are provided, the contradiction, the apparent duplication of functions, are all issues that must be resolved.

■ *The understaffing/underfunding of the regional boards.* Their number, the adequacy of their members, the number of staff that carry out the functions assigned by law. The apparent conflict of the regional directors serving two masters, and ultimately the amount of work required of voluntary board members to carry out their judiciary responsibility, not only for the people they serve, but also for the monies they manage.

■ *The cumbersomeness of the bureaucracy.* The promise of no new resources has lain heavily on many people; the need to carry the existing work while trying to implement a new system has been difficult. More significant, developing the cultural change required so that form can follow function requires time-consuming effort.

■ *The poorly defined role of the state hospitals.* How do you move those resources that reside within the state bureaucratic system—the state bureaucratic system in which we operate? Regardless of how

■ No one can function well with two bosses, which was one of the problems of the previous system.

■ The community service boards do not have this situation. They hire and fire their own executive directors. They also have been free to form their own association to help board members become knowledgeable, become professional, share ideas, and move forward. We need a similar association for the Regional Boards.

■ Another point in favor of such a Regional Boards forum is that the 811 Commission, which is legislative, will not be around forever. A forum would be a good place to deal with ongoing issues into the next century.

■ I would like to urge that we regionalize the matched funds, the troubled children's funds, that are administered to send kids to residential facilities.

Jim Ledbetter

After the passage of House Bill 100, Ted Gaebler, one of the co-authors of Reinventing Government, described the reform effort and what was facing us, he referred to the undertaking as monumental. Monumental in the sense of the resources that we had allocated to that task. Monumental in response to the time frame for implementation.

■ He did say there were some positives: strong legislative support; the executive branch advocates and the staff involved; the strong partnership served well in the passage of the legislation

the issues with which we have to deal.

■ We still see the need for some form of formalized structure, which would give the regional boards a statewide forum for training, and for validation of our collective ideas, concerns, and recommendations, particularly as we are entering into a whole new area of managed care.

■ I do not believe we should build more structures. Instead, we should restructure the four formalized volunteer boards we have.

■ The only opportunity we have for reconfiguring the structure that conserves the regional boards is the Governor's Mental Health, Mental Retardation, and Substance Abuse Advisory Council, which deals with all of the disabilities related to mental health. There might be some interest in reconfiguring, restructuring that organization that will convene the regional boards as a statewide forum.

Consider this—not unreasonable—scenario: At a meeting, members of Regional Board X discuss pending legislation. They decide that this bill would greatly affect the consumers in their region, and that it should be passed or defeated. They vote to instruct their executive director to follow this legislation, to attend community hearings, and to keep the board informed. They seek to influence the legislation.

At a meeting with the division director, who hires and fires the executive directors, the executive director of Region X is told not to attend such meetings.

What should he or she do?

much we wish to change the bureaucratic function, it exists and we must manage it.

■ The challenge for the structure is to reconvene the collaborative consumers, staff, political leadership and agency leadership to begin resolving the tensions, then to hammer out the details necessary to create the form, so that the function and body and principles of House Bill 100 can be carried out.

Lee Kyser

As a representative of the private practice voice, I want to discuss how important it is for the private and public sectors to collaborate.

■ The private sector has been evolving structures that address concerns raised by the shifts toward managed care.

■ During this debate, the private practice professional and the consumer have had little voice in how health care delivery has changed. Decisions have been made, for the most part, by the corporation, the purchaser, and the managed care company, the deliverer of service in the private sector.

■ A much more effective system would be developed if there were four places at the table: the managed care company, the professional provider, the consumer and, from the public sector, the regional board.

■ Private practitioners of all disciplines are joining together and working to transcend turf issues and speak to the common concerns, and thus was born the

Georgia Mental Health Coalition on Managed Care.

■ As a coalition, we are primarily concerned with the quality of care and ethical issues that have been eroded by decisions made primarily for corporate profit.

■ The coalition understands that efforts must be made to contain health care costs. However, we have seen in the private sector that in this opportunity for businesses to make a profit, mental health services—unfortunately—are being bought and sold like a commodity, like soybeans and cotton.

■ The private practice professionals are worn out.

There are some realistic limitations. Managed care has put the squeeze on people in private practice.

There will be a bulge of people squeezed out of each system. Where will they go?

We must not operate as two separate systems, but rather develop an inter-relationship. We need to work together. The regional boards are the corporation purchaser in the public sector. We need a structure to keep communications flowing back and forth among the consumers, the practitioners, the administrators, and the managed care companies.

Sue Smith

As I was thinking about opportunities, they became interchangeable in my mind with challenges. I could not figure what would be an opportunity and what would not be a challenge. This reform offers us opportunities and

challenges.

You have all seen these wonderful bumper stickers, “My kid’s an honor student?” We wanted to have one made up that said, “Our kid’s hanging on.” We thought that on a good day.

■ From a family point of view, the bottom line is: can you take care of my kid? Can you take care of my kid at home, or as close to home as possible? And can you do it in a caring manner?

■ But as we reshape the services we provide, we need to ask the people consuming those services, whatever their age, what they think about the services they are getting, how they think they should be delivered, and what they and their service providers can do to work together to make a better quality of life.

■ Consumers have probably the best opportunity ever. They have an opportunity to belong to a consumer network on jobs. There is a presence and there is a voice, which is absolutely the most important thing that could happen.

■ How do I assess the various players in the new structure?

■ **Regional boards.** The challenge of the regional boards is absolutely astronomical.

■ **Community service boards.** You have served our families for years and years and years, and you have done a really good job. You have been there when nobody else was there and you have been there when you were tired, and you have been there when you did not have any money. Today, with the implementation of House Bill 100, you are given an opportunity to make

the changes you always wanted to make. If you provide good services, that is where our family members will be.

■ **Local government systems.** House Bill 100, with the restructured shift of power to the local county commissioners, moves the responsibility for our families right where it should be—at home.

Now, I can call someone in my own community who can give me some answers about my services. That is really good.

■ **State systems.** State systems have the biggest challenge of all because it is really hard to see the things that you have done for so long look, worked at so diligently, seem to be devalued. It is hard to have to change the way you are doing things. Nevertheless, state agencies and institutions should, in a timely manner, make the precise decisions necessary for us all to get on with the changes that need to be made.

■ **Federal opportunities.** Social Security, welfare, block grants. Basically, if you are looking for opportunities, everything that we have worked for, and hold dear, is up in the air at this moment and we all should be involved in any efforts to rewrite the script.

■ **Advocates.** When I thought about advocates, I thought, “The doctor who treated my daughter all those years was an advocate. The person in the community is an advocate. The schoolteacher was an advocate.” Everybody who came into her life was an advocate in one way or another.

So I think we are all advocates, we all have the responsibility of advocacy to carry out that role.

People Can Make a Difference

In the effort to reform delivery of mental health services in Georgia, the best and most important resource continues to be us.

Bob Hawes

In light of our progress and the reform we undertake now, our attention moves from past experience to future requirements. What will be needed and what resources do we have to get us there?

■ At the top of any list of resources is money. There are intense forces at work throughout our society that can cause a serious reduction in the money available for our work with in the immediate years ahead.

■ For the first time in my lifetime, there is intense pressure at the federal level to stop the addictive process of spending more money each year than we receive from taxes and other sources.

■ Money for social programs is and will continue to be under serious attack.

■ Our ability to obtain increased levels of funding, not to mention keeping funding at present levels, is in serious question.

■ In this difficult environment, new strategies are needed. So what do we do differently as we petition our legislative bodies for funds?

First, we must develop a well-

thought-out position and strategies to support our claims on both federal and state budgets. To be effective as we ask for funds for mental health consumers, we must make our case in terms that are well reasoned and persuasive.

We can strengthen our cause and our case by emphasizing the relative worth of our services compared to any and all other non-people things in government budgets.

Second, we must eliminate all jobs between the source of funds and the consumer that are unnecessary or of marginal value. This is both practical and prudent. Some will see this as a threat to personal job security, which will lead to

strong arguments to save jobs. Keep in mind that while these measures may cost a temporary loss of jobs, the reduction in the cost of services and increased efficiency in delivering these services to consumers will more than justify these changes.

Third, we must clearly establish accountability and responsibility at the local regional board level. House Bill 100 has given us a good start to reform delivery of services. However, to some extent, we have inserted the new regional board concept into the old system without fully accomplishing the objectives of the reform.

■ Regional boards function through a staff that is under the



How Do We Get There from Here?

Part III. Six experts discuss the resources necessary to execute community-based reforms of mental health care.

The Panelists:

Bob Hawes, retired CEO of Melloco Inc., and currently vice chair of its board, is a member of the board of directors of the MHMRSA South Central Regional Board, Region 13.

Larry Fricks is director of the Consumer Affairs Division of MHMRSA and a founder of, and first statewide coordinator for, the Georgia Mental Health Consumer Network. He received the Clifford W. Beets Award from the National Mental Health Association for fighting the stigma of mental illness and improving conditions for people with mental illness.

Jean Toole is executive director of Community Friendship, Inc., a psychiatric rehabilitation program in Atlanta. She is a member of at least six councils and coalitions concerned with mental health issues.

Annette Maxey is chair of the Medicaid Waiver Oversight Committee, and executive director of the Clayton Regional Mental Health/Mental Retardation/Substance Abuse Board.

Rachel Davis is the Assistant Commissioner for Budget and Financial Services for the Georgia Department of Human Resources. She has extensive experience in public budget management and development, finance, contracts and grants management, and auditing.

James Carroll Crutcher, M.D., is a member of the Governor's Commission on MHMRSA Service Delivery and district health director for Gwinnett, Rockdale, and Newton counties. He is a professor at the Emory University School of Medicine in Atlanta.

direct supervision and control of state officials. The executive director of the regional board should report to, and be an employee of, the regional board. At this time, the executive director and the staffs of the executive directors have two bosses.

It has been said many times that shared responsibility and shared authority creates a situation where neither responsibility nor authority can be pinned down.

■ Although regional boards should always be constrained by official policy and by official oversight, this feature of the reform should be changed.

■ Although the bill describes an independent regional board, these boards have been fitted into a system filled with procedures and rules that can, and must be, simplified and made more flexible.

■ Efforts are underway to consolidate and simplify the flow of funds from the state and federal governments to regional boards. Therefore, I suggest three specific actions.

First, develop a new strategy with which to petition and advocate the Congress and legislature for funding.

Second, eliminate staff and procedures that are either unnecessary or of marginal value.

Third, have the executive directors of the regional board made direct employees of the regional board.

These three goals will improve flexibility at the local level, assure that our limited resources are best used to fit local conditions and circumstances, and that more of the available funds

are spent on consumers and not on overhead.

Larry Fricks

The best resource is *us*. Most important is self-help, which is using consumer empowerment and natural supports. Under self-help comes taking responsibility for our illnesses.

I will never forget when I was hospitalized for the first time. I was communicating with God and thought I was an apostle. I got in the pital and staff just kept saying, "You've got bipolar illness." Did not mean anything to me.

Finally, another consumer with manic depression came up to me and said, "You know, Larry, I'm an apostle, too, and I've been talking to God. But I think you had better take your lithium."

■ Build on our strengths.

■ Prevention. I do not think many parents would appreciate someone saying, "You might have been able to prevent your child having schizophrenia." But, I do feel that prevention is critical in setting up supports and realizing what triggers our illnesses.

■ Spirituality is essential and so is planning our crisis.

■ Important, too, are natural supports, such as employment.

■ The pulpit is a very powerful

place, especially in rural areas, and we must educate organized religion about mental health.

■ The greatest resource is us. Please help us help ourselves.

Jean Toole

As providers, we cannot get there from here if we do not believe in consumer choice.

Are we talking to consumers about what they want and need from us? If

we are not doing

that, we

are not going to get there. I

heard about this staff person who was asking a group of consumers what they wanted. "All I

want is chow." The staff person said, "You mean like food?"

The consumer said, "No, c-h-o-w—car, house, occupation, wife."

■ When the consumers are asked what they want, jobs are number one. So, are we doing things to help people go to work?

When I first went to Community Friendship, I did job development. I had done my best sales pitch at this one company. The guy looked at me and said, "Well, how many of those people y'all got working for you?" And I said, "We don't have any." He



responded, "If they're so good, why don't you hire them?"

Aside from being one of the most embarrassing moments of my life, it was an eye-opening experience, because I thought, "Why don't we?" Now, 23 percent of our staff people are consumers. They are wonderful employees and it sends a message that you value them and that you think they can do a good job.

Another thing about helping people go to work and set goals is that, for a lot of people, they have not been asked what they want in so long that they do not know how to go about saying it. So we have to help people dream.

■ Bill Anthony describes how the concept of recovery is so important in physical rehabilitation. He defined recovery as "a personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying life that's hopeful and has purpose, even with limitations caused by an illness." That is something that we need to think about in our vision of mental health services.

■ That is what we need to be for consumers. We need to help them find the triggers. We need to give them experiences that will let them see that there is hope, that they can grow. Their illness may not go away, but that does not mean they cannot go to work. That does not mean they cannot have an apartment. That does not mean they cannot have relationships. That does not mean they cannot live a productive life. They can have all of those things.

■ As providers, we have got to

broaden our vision and our role with consumers. We cannot just do therapy. We have got to help them dream.

■ To make sure that our services grow and change and meet the intent of House Bill 100, we have got to start by listening to consumers.

Annette Maxey

I have had to realize, as do all of us who have worked within a large, cumbersome, multilayered system, that we have worked hard and honed our skills at manipulating the bureaucracy to get what we want. It takes a lot of concentration, a lot of learning, and a lot of honing.

■ The rules and procedures also serve as handy excuses. As managers, we all can find ways to say no or to stall something, not make a decision, because the Merit System will not let us do it. So, we have a handy reason for not doing many, many things.

■ We have to realize there is a very real reason we have the private sector in our country and a very real reason we have government. We need together to think carefully about the purpose government serves best, and how government can best do that service.

■ The answer is not with all those layers, nor with all those rules and procedures. However, there are ways government operates quite differently from the private sector that are very important—like government has always been the part of our society that assures some attention and a safety

net to those that others do not choose to serve. That is a critical function. The private sector, at least until now, has never been willing or able to do that.

■ Government also makes decisions, albeit clumsily, that keep in mind stewardship of all people and constituencies, not just a narrow constituency. And government makes decisions in public, open arenas, which the private sector has not done.

■ Together, as we face the next reforms, and as the lines between public and private begin to blur, we need to define accurately and clearly those things the private sector has done better than government, and adopt those, and determine, with equal clarity and insightfulness, those things that government does better and adopt those.

Rachel Davis

In Georgia, progress had been made in funding programs in DHR for severely emotionally disturbed children, as well as adults with chronic mental illness.

■ We have also made progress in flexibility and streamlining—granted not where we need to be, but still progress. Extensive progress was made this past year in minimizing the number of budget line-items that we deal with, yet we still have a long way to go to be able to move money from hospital to community or vice versa.

■ The evidence is that our sys-

tem is workable now, but still we need to take it a couple of steps forward. We went as far as I thought politically possible this past session. There is still opportunity to do more by working through the system.

■ Through the new redirect process, we are reinvesting monies in other areas of the system. State government as a whole, as well as the mental health reform, is heading in the same direc-

tion.

■ There never will be enough revenue to meet our needs, particularly as human services compete with other interests.

■ In working with the Board of Human Resources in public forums throughout the state, we found just the basic functions of life—transportation, jobs, housing, things that you and I want—are basically the same things that our consumers need. And we have got to modify programs to get to that.

■ As we move into the federal fiscal year, there is a lot of uncertainty—what form we get the money in as well as how much we get. So it will be a challenge for us to fold in federal directions with state directions.

Jim Crutcher

It was the advocates, the resources of people with needs, who actually brought House Bill 100, Senate Bill 49, to conclusion.

■ Three things have become clear.

First, people given the opportunity, regardless of their disabilities or their backgrounds, will generally rise to the occasion.

Second, we have 286 new, non-paid mental health, mental retardation, substance abuse employees. They are called regional boards. The boards are full of creativity. We ought to allow them to go for it. Giving them the fiscal responsibility, we will be able to develop their potential as regional board directors whose priority is planning.

Third, whenever there is major change, leadership emerges, sometimes in unusual ways. One of the leaders who has emerged is Eddie Roland, director of the Division of MHMRS.

■ Obviously, it is structure. It is form. It is money. But ultimately, it is those of you involved in mental health work, in mental health issues, who are going to bring this to fruition.

■ The people's voice still can make a difference in our society.



House Bill 100 bought us time. Not a lot of time, but enough time to do some careful planning and consensus-building, so that if we are wise and if we stick together, we can avoid the chaos others have experienced.

A Road Map for Local Advocacy

The challenge is to keep on pushing until the goal is reached.

By Susan McDonald

I grew up in a minister's family, and at the end of our special religious events, you were always encouraged to come down and take the pledge—agreeing that after Sunday is over, you will continue to do some things the rest of the week. Today has been our “Sunday”—a time to gather wonderful ideas; but ideas are all they are unless you commit to do something on a personal level, day in and day out.

Central to all our suggestions, all our actions, seem to be five things that consumers say will help: jobs, housing, transportation, day treatment activities, and stigma-busting. These are concrete outcomes upon which all of us can focus, and all of us can use as we define our roles as advocates, as workers, as family members.

I think it was Bill Cosby who talked about being able to take over the world with an army of one hundred 2-year-olds. The way 2-year-olds influence behavior is through persistence and the willingness to fall on the floor and throw a tantrum if necessary. As advocates, we might learn from some of their strategies. They know what they want and they are persistent. They can articulate their ideas, at least in their own language, and we can, we hope, articulate much better about our vision.

In the Appendix, you will find two assessment tools to help you take stock of your community-based services and perhaps organize your planning about future directions in a more concrete way.

I have been a consumer. I have been a family mem-

ber. I have been a provider, and I have been an advocate.

I tried to think about all of these roles as I was going through the assessment tools, and I ask you to do the same. One of the tools was put together by Karl Dennis' Kaleidoscope Project. It is “The Checklist for Community-based WrapAround Services.” This is a checklist that you would use in developing and assessing child services. Let me remind you though, it is really good even if you are in child services to know a little bit about what is happening in adult services; you can be instrumental in making a smooth transition for the older adolescent into adult services or you can help family members find supportive services they may need. And the reverse is also true for those looking at adult services.

We have developed a second instrument called “The Checklist for Quality Community-based Adult Services.” This, again, is a tool for you to use in thinking about yourself as either a consumer, a provider, or family member or advocate who is involved primarily with adults. This checklist has a summary page that will allow you to pinpoint areas of challenge and strength in your existing services.

As you work with these tools, think of them as a road map for your advocacy. You do not have to change everything today. Develop your vision—be able to share it clearly. Prioritize what you will advocate for and above all, persist. That is what is most important for the future of those we love.



The Author: Susan McDonald, Ed.D., is chair of the Forum and its planning committee, and a member of the board of directors of the Mental Health Association of Georgia.

Reform Is Not Easy

Despite the obstacles remaining, the goal of improved services for those with mental illness, mental retardation and substance abuse diseases is worth the effort.



By Carl E. Roland Jr.

The agenda has been the future of House Bill 100, but more than that: the future of the way we treat, as a society and as a profession, those with mental illness, mental retardation and substance abuse diseases. You have now read about the issues around structure and resources. You have read about issues that we need to address differently in our reform in Georgia. You have read about the opportunities that the reform brings.

Often, as I face each day, I realize again the challenge brought on by this reform. It is a changing world for all of us in the mental health community—a changing world in terms of who I am as a person, in my job; whether what I do as a community service board member is important or not; whether what I do as a hospital worker or administrator is really what people really want and need. Am I truly responding to consumers and families?

This reform causes us to search, not only our hearts, but also our minds for new visions of ways in which to do business. Karl Dennis' report has been provocative: I could not help but think there are many days when I wish some of the staff could come and “wraparound” me. I am sure you have felt some of the same, because all of us are being challenged in ways that we never expected, as we attempt to implement HB 100. Henry Harbin walks us through the maze of new programs and private care plans; I thought how many of us would like for Henry to manage our care, because oftentimes we feel like we do not get enough.

And still there looms another challenge: what's happening on the federal scene—how will the actions of Congress change us yet again? Will it hasten, alter, reduce or accelerate what we see happening in terms of a managed care environment in health care?

As health providers, we are particularly challenged at this time to look

beyond the old way of doing business, to look beyond simply inserting new ideas into old systems, or old systems into new platforms—to find a way to create new systems.

The watchword for all of us must be one of “do no harm, but do not stand still and do not forget to keep the eye on what this system is really about.” It is about improving services for consumers. Rosalynn Carter warns us, “Reform is not easy.” It takes work. There are lots of barriers. It takes patience to go about the work of improving our system of care.

Where are things headed? The big questions are related to financing issues. What is going to happen at the federal level related to dollars? Will the safety net be pulled? If, in fact, that safety net begins to have holes burned in it, then fortunately Georgia is positioned, through its regional boards, through its community service boards, through its families, its advocates, and its consumers to bring the message to local communities that the safety net is being pulled and it will not work.

How shall we address the financing

Future Directions

This summary wraps up the reports from forum speakers and challenges participants to follow the commitment of Rosalynn Carter in serving the mental health needs of their fellow Georgians.

The Author:
Carl Roland Jr. is Division director of MHMRSA.

issues in our state at a time in which our taxpayers have looked at the number of people that we employ, have continued to criticize the cost of government, and then asked us to do better, to be more cost-effective?

We live in a time in which privatization is being looked at by the governor and others as one of the methods to begin addressing the cost of government. We must try as best we can in the management of the privatization issue, and in our own arenas, to bring costs down, to be prepared for managed care, to give great attention that the cost savings goes back into our system and that we do not lose what we have saved.

Managed care challenges not only our state hospital system in terms of what it should be, needs to be, and ought to be, it challenges our hospital management staff to look at, in a very different way, cost.

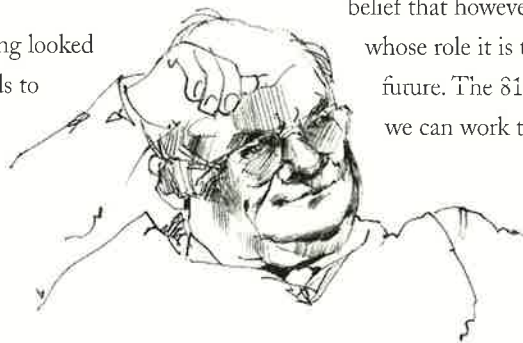
service boards and their executive directors to assess in a businesslike way how we can deliver services and be competitive.

We will all struggle as we continue through the reform in trying to understand better the role of the Division, the community service boards, and our regional boards. But I hope as we challenge one another in understanding that role, we will develop, if you will, an environmental habit about how we conduct business and appreciate one another—that we will do that with great patience, with pride for what each can offer, and with-

out pointing to the other as the enemy.

We must continue to work, and work hard, to provide the improved system of care that consumers and families look to us to provide. It is my belief that however one might define the role of who is in charge, or whose role it is to do what, that partnership is the way of the future. The 811 Commission offers to all of us a forum in which we can work to improve upon our reform.

We also must give attention in the future to outcomes. Have things really improved for the consumers and their family? If we do not do that, then we have failed in a major way in bringing this reform about.



How does a state prepare for a managed care system?

Where do we begin?

We begin in forums like this and in training sessions. We begin by looking at ourselves, and trying to decide how can we make a difference—a difference in which we can deliver a service at a cost that is efficient, yet allows us to continue to be a safety net for those who are most vulnerable in our system.

Managed care, I believe, challenges not only our state hospital system in terms of what it should be, needs to be, and ought to be, it challenges our hospital management staff to look at, in a very different way, cost. Before, cost did not make any difference; now it will. It challenges, I believe, the community

I appreciate Rosalynn Carter's lending her name and The Carter Center's to this particular forum. She has made much difference in the lives of people nationally, and in our state, and I feel honored to have been a part of that. In fact, I feel if it had not been for the pioneering work that she has done, we would not have had the opportunity to work toward this new reform. I do not know how familiar you are with the way in which she has touched lives and changed systems in small and large places. I would like to tell you a story.

I was a mental health center director working in Dublin, Ga. Dr. John Gates was the superintendent at Central State Hospital. Dr. Sam Heaton, who was a public health director, and I were riding down the road in June, to a little town called Rochelle, for a public health board meeting in Wilcox County. On the way, I explained to Dr. Heaton, for whom I worked, how we needed to try to get the county to come up with some additional funds for mental health because of the additional services we were trying to provide.

Dr. Heaton told me, "You know, Wilcox County is an awfully poor county. I would not hold out much hope."

We went into the meeting and the chairman of the board, Shotgun Coleman, called the meeting together. The Board of Health began its deliberations, and we explained how we had tried to bring additional services into the community. The Board of Health, to my surprise, approved the small increase. I left feeling very good, and Dr. Heaton said, "Now wait, son. You realize because the Board of Health approves this, this does not mean that you get it."

I said, "What do you mean?"

He said, "You have got to come back and talk to the county commissioners."

The following week we came down to meet with the county commissioners in an old courthouse. We used what I presumed to have been the jury room. In the room were a few chairs spaced about and a few Coca-Cola crates. No air conditioning. We met Shotgun coming into the courthouse, went up to the room, began opening the windows and began to take our seat. Some of men who were members of the county commission began to come into the room. There were men who obviously had come right out of the field, with overalls, dusty shoes. They took their places, some sat in chairs and others sat on the Coca-Cola crates.

I looked at the group and I thought, "How am I going to ever

explain what it is I want, much less mental health?"

Shotgun opened the meeting and introduced us, "Here are some boys from Dublin that need to talk to you all about some money."

I began to speak to them about mental health, but I did not feel like I had a chance at all. But much to my surprise, one of the gentlemen sitting on a Coca-Cola crate spoke up. He said, "Well, Shotgun, I think we ought to do it. You know, me and my wife, we spent the night last week with Jimmy and his wife at the White House. I know this is a favorite program of Mrs. Carter's." With that, they agreed to give us the money. I can only imagine how many others over the years have become concerned about mental health and people with mental illness because of your leadership.

So thank you, Rosalynn Carter, for making such an impact on so many lives.



Check Lists for Self-Evaluation

Developed by Karl Dennis of Kaleidoscope, Chicago, Illinois

[RANK ITEMS BY CIRCLING A NUMBER, WITH 1 BEING LOW AND 10 HIGH.

IF YOU HAVE COMMENTS ABOUT ANY QUESTION, PLEASE MAKE THESE ON A SEPARATE SHEET OF PAPER]

For Community-Based WrapAround Services

We hope this check list will facilitate your thinking and planning for community-based services. Rate your state and agency's service implementation for these items:

■ **Interagency collaboration** on state/community level facilities sharing of financial and personnel resources across systems and ensures access to a comprehensive array of services that address the child and family's physical, emotional, social and educational needs. Interagency collaboration ensures smooth transitions to the adult service system as emotionally unique children reach maturity. *To what degree does Georgia facilitate and/or provide interagency collaboration?* 1 2 3 4 5 6 7 8 9 10

To what degree do agencies provide for cross system collaborative training? 1 2 3 4 5 6 7 8 9 10

■ **Community teams** incorporate public and private service providers, parents, cultural, religious, business, civic and legislative leaders facilitate resource development and system change. *To what degree does your agency participate or organize interagency community teams?* 1 2 3 4 5 6 7 8 9 10

■ **Strength-based services** include the positive aspects of the child, family, and community. They are the driving force of planning and service delivery. *Are strength-based services used by your agency in planning and service delivery?* 1 2 3 4 5 6 7 8 9 10

■ **Family focused services** include the development of plans and the delivery of services which center on the strengths and the needs of the family (as opposed to focusing on the child only) and will include the family as part of the decision making process. *Are family focused services an integral part of your agency philosophy?* 1 2 3 4 5 6 7 8 9 10

■ **Unconditional care philosophy** mandates that agencies agree: to never deny services because of the severity of disability; to change services as needs of the child and family change; and to never reject a child and family from services due to behavior or lack of appropriate environments. *Does your agency provide unconditional care to all of its clients?* 1 2 3 4 5 6 7 8 9 10

■ **Individualized services** are based on specific needs of the child and/or family, and not on a categorical intervention model. They respond to the unique needs and potentials of each child and family and are guided by an individualized service plan. *How individualized are the services provided by your agency?* 1 2 3 4 5 6 7 8 9 10

■ **Community-based services** are delivered in the area where the child and his/her family live. They are the least restrictive, most normative environment that meets the needs of the child and family. Restrictive or institutional care should be accessed for brief stabilization only. *Is your agency committed to providing community-based services to all of your clients?* 1 2 3 4 5 6 7 8 9 10

■ **An inter-disciplinary child and family team** includes the parent and/or surro-

gate parent, the child and a group of four to eight who serve this family and best know its strengths. Child and family teams allow for full family participation in all aspects of the planning and delivery of services. This team plans, monitors and evaluates the family plan. *To what extent does your agency use inter-disciplinary child and family teams?* 1 2 3 4 5 6 7 8 9 10

■ **Culturally competent services** are designed and delivered to incorporate the religious customs, regional, racial and ethnic values and beliefs of the families we serve. *To what extent does your agency provide services which incorporate the principles of cultural competence?* 1 2 3 4 5 6 7 8 9 10

■ **Life-domain needs**—residential, family, recreational, educational and vocational, psychiatric/psychological and medical, legal, spiritual and safety—are areas of basic human functioning that most experience. *To what degree does your agency take life-domain needs into consideration when creating family plans?* 1 2 3 4 5 6 7 8 9 10

■ **Cost effectiveness** means that every attempt should first be made to utilize available community services and that the total cost should not exceed that of a more restrictive setting. *To what degree does your agency provide for the most cost effective services?* 1 2 3 4 5 6 7 8 9 10

For Quality Community-Based Adult Services

Use this checklist to help you identify strengths and challenges in the current agency/system where you work or in the agency/system which serves you as a consumer.

AGENCY

The agency I work for, or go to for services, demonstrates:

1. A clear understanding of and experience with mental health issues (including substance abuse, if appropriate). 1 2 3 4 5 6 7 8 9 10
2. A range of services tailored to consumers' individual needs. 1 2 3 4 5 6 7 8 9 10
3. Adequate arrangements for locating referral for non-health services such as housing, social services and job training. 1 2 3 4 5 6 7 8 9 10
4. Prompt, affordable access to appropriate treatment. 1 2 3 4 5 6 7 8 9 10
5. Responds promptly to phone calls in a timely manner. 1 2 3 4 5 6 7 8 9 10
6. Has a 24 hour a day, 7 day a week on-call clinician or mobile crisis capacity. 1 2 3 4 5 6 7 8 9 10
7. Encourages consumer advocacy from both consumers and families. 1 2 3 4 5 6 7 8 9 10
8. Offers ongoing training and consultation for staff. 1 2 3 4 5 6 7 8 9 10
9. Has good, cooperative relations with other agencies and the community. 1 2 3 4 5 6 7 8 9 10
10. Facilitates coordination between hospital and community services. 1 2 3 4 5 6 7 8 9 10
11. Provides adequate administrative support for staff and consumers. 1 2 3 4 5 6 7 8 9 10

12. Has a reasonable caseload with a good fit between consumer and clinician in experience, attitudes and beliefs about recovery. 1 2 3 4 5 6 7 8 9 10
13. Has appropriate accountability system, particularly in terms of consumer outcomes and satisfaction. 1 2 3 4 5 6 7 8 9 10
14. Routinely evaluates both clinician and consumer satisfaction and uses this information to improve systems. 1 2 3 4 5 6 7 8 9 10
15. Has consumer-friendly appeals procedure which provides speedy results. 1 2 3 4 5 6 7 8 9 10
16. Respects confidentiality. 1 2 3 4 5 6 7 8 9 10
17. Keeps current about political issues which affect directions in resources/services. 1 2 3 4 5 6 7 8 9 10
18. Has adequate financial reserves to accommodate at-risk contracting. 1 2 3 4 5 6 7 8 9 10
19. Routinely does follow-up medication and other treatment. 1 2 3 4 5 6 7 8 9 10
20. Has a service care coordinator for each consumer, with responsibility for assisting with assessment, planning, creating linkages, self-advocacy and getting services. 1 2 3 4 5 6 7 8 9 10
21. Shows respect and caring for consumers. 1 2 3 4 5 6 7 8 9 10

ADVOCACY

1. Do you have a local MHMRSA advocacy coalition? Yes No
2. Does your coalition meet regularly? Yes No
3. Do you have effective consumer and family representation on your Community Service Board and Regional Board? Yes No
4. Is your local coalition in touch with the state Time for Change Coalition? Yes No
5. Have you received encouragement and training in being an advocate? Yes No
6. Does your local and/or state coalition have access to key decision makers and informational resources? Yes No

7. Does your coalition have a relationship with your state, local and national legislators? Yes No
8. Does your local/state coalition keep anecdotal and statistical data for education, advocacy and planning processes? Yes No
9. Does your coalition have a relationship with local media? Yes No

SYSTEM MEASURES

1. Are local contracts accessible to a wide range of providers? Yes No
2. Do you have Target Area funding? Yes No
3. Is consumer satisfaction significant in your system outcome assessment? Yes No
4. Does your agency have a long-term plan, and does this plan reflect both consumer, provider and payer concerns? Yes No
5. Are there out-of-clinic services such as assertive community treatment, in-home support, family support, mobile crisis? Yes No
6. Are there long-term support services for people with severe disabilities, severe mental illness and addictions? Yes No
7. Is purchase of service based on individual need and what is valued by the consumer, rather than payment incentives for more expensive and intrusive services? Yes No
8. Is eligibility for services based on individual need and income, not on whether a person has previously been institutionalized or is in danger of institutionalization? Yes No

SUMMARY

On a separate sheet of paper:

1. List your areas of *strength* (items you ranked 7 or above, or answered "Yes").
2. List your areas of *challenge* (items ranked 4 or less, or answered "No").
3. Write out your action plan to improve conditions or reinforce the quality work that is being done in the agency in which you work/use services.

Sponsors

The Rosalynn Carter Georgia Mental Health Forum is grateful to its sponsors:

The Carter Center Mental Health Program

Former First Lady Rosalynn Carter has been the driving force behind the development of The Carter Center Mental Health Program. Her long career in public service as an advocate for mental health began when President Carter was Governor of Georgia and continued with her appointment as active honorary chair of the Presidential Commission on Mental Health 1977-1978. In collaboration with the Emory University Department of Psychiatry, Mrs. Carter spearheaded the creation of the Annual Rosalynn Carter Symposia on Mental Health Policy, convening leaders of national mental health organizations representing advocates, providers and consumers to focus upon issues of common concern. This led to

the establishment of the Mental Health Task Force and Program. Priorities that have been targeted by the Task Force include: 1) the equitable inclusion of mental health in health care reform; 2) early childhood education and prevention programs; 3) the importance of the media in appropriately representing mental health issues; and 4) the furthering of treatment services and supports to people with mental illness and their families.

Mental Health Association of Georgia

The Mental Health Association of Georgia is a private, non-profit organization with 19 chapters throughout Georgia. Their services include: Public education, individual and system advocacy, family and

peer support, residential facilities, and promotion and research support. The Mental Health Association of Georgia is affiliated with the National Mental Health Association.

Georgia Parent Support Network, Inc.

The Georgia Parental Support Network is a statewide support system for families of disturbed children, assisting parents by providing support, telephone information and referrals, advocacy training, group organizing assistance, and linkage with other parent organizations across Georgia. The common element among members is that our children present behaviors at home, school, and in other environments that are puzzling and difficult to handle.



*Our goal is to renew our sense of the potential to improve
the quality of life of people with mental illness, mental
retardation, and addictive disorders.*

*Our focus is upon Georgia's efforts to improve services. While managed care
is one issue having a profound impact upon health-care delivery,
our work encompasses the much broader issues of improving services
to Georgians, especially those Georgians who are most vulnerable.*

John Gates, Ph.D.

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