

Community Support Systems:

**Lessons
for
Managed
Care**

William A. Anthony, Ph.D.

CENTER FOR PSYCHIATRIC REHABILITATION
Sargent College of Health and Rehabilitation Sciences
Boston University

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Phone 617/353-3549
Fax 617/353-9209 or 617/353-7700
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“IN RECOVERY, WITH PLACES TO BE AND SYMPTOM FREE”

We're Baaack!

Community Support Program Reemerges in a Managed Care Context

William A. Anthony

*William A. Anthony, Ph.D.,
is Executive Director of the
Center for Psychiatric
Rehabilitation at Boston
University, Boston,
Massachusetts.*

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About 20 years ago the destructive aftermath of deinstitutionalization stimulated the growth of the Community Support System (CSS) initiative. Professionals, family members, and consumers planned a system of community-based services designed to help improve the quality of life of people with serious mental illness. Important conceptual, empirical, and technological developments related to the CSS initiative have occurred during this 20-year time span. The Community Support Program (CSP) of the National Institute of Mental Health, and now the Center for Mental Health Services, provided the federal guidelines and resources to further the CSS initiative. In essence, CSP defined the range of services that a service system (CSS) must have in order to effectively help people with severe mental illness. These essential services included such interventions as case management, rehabilitation, family and peer support, housing, and crisis response—services which heretofore had received little to no emphasis in traditional mental health systems.

In the decade of the 1990s, proponents of managed care have speeded up the design of managed care systems for people with serious mental illness (and now particularly for the public sector consumer). Prior to managed care companies'

involvement in the public sector, most of the professionals, consumers, and family members who helped to create and nurture the philosophy and knowledge base of CSS watched the developments of managed care from the sidelines. We listened at their conferences, read their material, and observed their actions.


We learned.

We learned, and now we understand.

For example, we understand that with respect to services for people with serious mental illness:

- *Utilization review case management as practiced in managed care, is in so many ways deficient to case management as practiced in a CSS.* In utilization review case management, the case manager controls expenses by requiring professionals to gain approval before accessing or continuing to use certain kinds and amounts of care. In contrast, CSP type case managers attempt to form an ongoing working alliance with the consumer, making joint decisions on what services the consumer wants and needs.
- *The values of cost containment need not be preeminent over CSS values.* What CSP values, such as consumer and family involvement, empowerment, and the vision of recovery are quintessentially important whether the service system is publically or privately managed.
- *The conceptual model underlying managed care systems is relatively non-existent as compared to the conceptual model underlying a CSS.* CSP has identified and organized the required components of an effective service system—for the most part managed care companies have not.
- *The managed care empirical base for people with severe mental illness pales in comparison to the empirical base of CSS.* For over 20 years CSP has been collecting data and trying to understand its implications for designing effective service programs and systems—managed care systems for people with serious mental illness, as new as they are, have of course developed no such comparable data base.
- *The understanding of interventions such as psychiatric rehabilitation and self-help is rudimentary at best in managed care as contrasted with the understanding in a CSS.* Compared to CSP, managed care's non-existent track record in implementing such programs is reflected in their understanding of them.

Unlike the early
deinstitutionalization
efforts, the CSS initiative
will influence how
managed care for people
with severe mental
illness is implemented.
We will influence how
outcomes are identified
and measured, how state
RFPs are prepared,
how state contracts are
written, and how systems
are designed. We will do
this from the inside
and the outside.



Now that we are immersed in our learnings about managed care, now that we understand some of the important distinctions between managed care systems and a CSS—it is safe to say *we're baaack!*

We are back—to ensure that, unlike the early deinstitutionalization efforts, the CSS initiative *will* influence how managed care for people with severe mental illness is implemented. We will influence how outcomes are identified and measured, how state RFPs are prepared, how state contracts are written, and how systems are designed. We will do this from the inside and the outside. From the inside we will influence managed care strategies in our roles as managed care administrators, as providers in agencies owned by managed care companies, and as consultants to managed care organizations. From the outside we will influence the managed care field as state bureaucrats who develop the RFPs and the contracts, as providers and agencies who partner with the managed care organizations, as consumers and family advocates, as researchers of managed care, as educators, and as citizens. Deinstitutionalization was a nightmare—managed care must not be. Two decades of CSS knowledge and experience can no longer sit on the sidelines.

We are back.