Comments on Zhang, "Strategies Used by Managed Behavioral Health Organizations to Reduce Hospital Care" A Literature Review Submitted to the Myers-JDC-Brookdale/Brandeis Collaboration on Mental Health

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The avowed goal of managed care is the provision of mental-health services at a high level and low cost. However, the data and arguments presented in the review point mostly to the principle of containing costs at the expense of quality of care. For instance: while virtually all patients referred to hospitalization do receive hospital care, the number of hospitalization days utilized – subject to the approval of the insurance company – is only a third of that recommended clinically; a considerable portion of discharged patients do not initiate contact with community ambulatory services for purposes of monitoring and follow-up; the managed behavioral health organizations (MBHOs) selectively choose inexpensive service providers, i.e., of a type known to employ less intensive treatment patterns and to negotiate on reducing costs; patients are sent to hospitals known to adopt aggressive treatment methods in cases of acute mental episodes. In fact, the mechanism at work here is economization: service providers face a real danger of expulsion from the network working with the MBHOs if they do not operate according to quantitative-economic standards, which, often, are inconsistent with qualitative-professional standards. As a result, they are compelled to deny access to more substantive services for patients with severe mental illness or to substitute medication for psychotherapy.

My impression is that managed care is completely system-oriented rather than patient-oriented. If patients are not permitted to stay in hospital for the duration required to sustainably stabilize their mental condition, they are discharged without mechanisms of coordinated care to ensure their re-adjustment to the community. In any case, they receive minimal care in clinical terms – even if in the short term the goal of reducing the duration of hospitalization is achieved, in the longer term, the probability of repeat hospitalizations increases, much like the familiar "revolving door" in the treatment of people with severe mental illness (PSMI). Consequently, the attempt (if not manipulation) to save on costs acts like a boomerang: ultimately, the MBHOs are obliged to invest more than would have been necessary had they provided incentives for, or at least allowed, proper treatment.

The one ray of light I found in the review was the special programs for people at high risk of hospitalization, such as Assertive Community Treatment (ACT), a one-stop center manned by professionals from different disciplines. Apart from managing the illness, they provide round-the-clock services in a variety of areas, including housing and employment (to a large extent similar to the "rehabilitation basket" anchored in the

Rehabilitation in the Community of Persons with Mental Disabilities Law). Such interventions, however, involve enormous financial resources and talented, skilled human capital and therefore do not appear feasible – certainly not on the scale required to provide such responses to the entire target population.

As regards Israel, upon the implementation of the structural and rehabilitation reforms, the number of hospital beds decreased by half and is currently 3,500. Although most of the PSMI live in the community, the rate of occupancy of psychiatric hospital beds is 100% and more. I therefore consider it important to retain the option of hospitalization; say, a minimal amount of active hospital beds at any given time. But to this end, I do not see the point of adopting the strategy of managed care, the by-products of which outstrip the potential benefits. The preferred alternative, in my view, is to advance the gradual closure of psychiatric hospitals alongside the expansion of psychiatric wards in general hospitals. The comorbidity of mental and physical illness is common among psychiatric patients. The mind-body connection, which is the main focus of the insurance reform, is the motivation for unifying ambulatory services in mental health with primary medical services at the health plans. Why not adopt the same system for psychiatric hospitalization services by situating them under one roof with other hospitalization services, i.e., in the general institutional framework rather than one directed at the mentally ill? Such a step would enable patients to receive an appropriate response to all their needs – mental and physical alike, would improve the conditions of their stay in hospital, and perhaps even reduce stigma.

The answer to "why not" as I know it, is the vigorous opposition of the directors of psychiatric hospitals who control the money and therefore have the last word. Their argument about harming employees' rights is legitimate, but surely it is possible to reach some sort of fair accommodation with them (one option that comes to mind is employing them in the psychiatric wards of general hospitals on the basis of geographic proximity). Transferring the focus of service provision in mental health clinics from the state to the health plans was a comparable measure, adopted in the face of struggle and protest to the point of strikes on the part of state-clinic employees. If, despite all the professional conflicts and the bureaucratic maze, the procedure was implemented in the ambulatory system – why not also in the hospitalization system?

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