

Living the Reform for Twenty-five Years

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MY CONGRATULATIONS TO Dr. Swartz and Dr. Morrissey for the eagle eye of the researcher on the topic in question. Please accept this ground level view from someone who has lived through the reforms of the MH/DD/SA public system in North Carolina.

The reader is most likely familiar with the careers of the researchers. Allow me to give a brief review of my own experiences as I address the issues of reform. I began work in the MH/DD/SA Area Program of Vance, Granville, Warren, and Franklin Counties (VGFW) in 1978. At that time there were few full-time career psychiatrists in the public system. The previous chapter of reform led to an exodus of the original psychiatrist pioneers.

My experiences taught me that, if programs were to be successful in treating the patients that came to them, an investment in career development of psychiatrists, and other highly trained professionals such as nurses and psychologists was vital. I watched and lived this process for over two decades. While 60-75 percent of my work time was always in direct clinical service delivery, I also wore the hat of Medical Director, the duties of which evolved over time. I served on the local top management teams, had a key role in the QA/QI process, and from time to time held membership on various state- and regional-level task forces and committees.

I served as the Area Program leader in our affiliation with the NC Area Health Education Centers program. This program placed student psychiatrists in local programs and was perhaps the key element for some programs in recruiting and retaining psychiatrists. Through this involvement I learned a great deal about Area Programs other than VGFW. Some of these programs learned that psychiatrists are not interchangeable, and do not come out of training programs prepared to be good community psychiatrists. Those programs made the career development investment in their most expensive resource, and were rewarded.

One Continuous Reform

Reform was on the table when I began in 1978 and gathered steam in the 1980's. The issues then are the issues now. It is about governance, mandate, funding, and the task of recruiting,

motivating, and rewarding clinicians, administrators and support staff who do the work.

I commend the work by Dr. Swartz and Dr. Morrissey in delineating the details of the reform, especially recent concepts. I would argue, however, that all the various individuals, names of programs, initiatives, task force reports, legislative efforts, and reports by consultants are variations on the above common themes.

Why each of the previous iterations of reform failed, or rather evolved into the next version of reform, depends on whom you ask. The rest of this writing will examine why the current reform has gone very wrong.

Mandate of the Public System

Of the four key elements of reform, I will not address funding or governance. Mandate and resource development are, in my opinion, the key issues available for influence. Funding has to be sufficient and governance has to be intelligent, but a true review of these issues is beyond this writing.

The mandate of the public system has until now been unlimited. No one is to be refused treatment, regardless of ability to pay. Since funding is not sufficient to be all things to all people, services are rationed. With no mandate to ration, decisions are made by default rather than by design. Area Programs have handled this issue in various ways leading to no uniformity in services among programs.

Area Program leaders have always wanted a more focused mandate, and a general consensus has evolved that they should focus efforts on the most severely ill. Parameters for "target and priority populations" are specified in the current reform. Disagreements at this point are based on who deserves to be included and what are the appropriate mechanisms of denying care to others. Much work remains, there are real problems here, but it is intelligent and appropriate for the public dollar to be spent within a framework of conscious choice about who will benefit. Rationing by design rather than default is overdue. I believe issues such as the correct number of hospital beds and the choice of "best clinical practices" will fall in line once these disagreements are settled.

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Resource Development: The Flaw in the Reform

The current evolution of the reform has added one new strategy, namely, privatization. Area Programs are to become a different sort of “Local Management Entity” and divest themselves of clinical service delivery staff. They are to seek out a provider network of private for-profit or not-for-profit providers and engage these resources through contracts.

A full discussion of the rationale behind this strategy and the problems with divestiture is beyond this writing, but this writer sees the strategy as unworkable as far as the psychiatry resource is concerned, as well as the other highly trained professionals whose services and skills are needed.

Simply put, divestiture and privatization strategies show a fundamental misunderstanding of the marketplace for professionals. The practice of psychiatry does not need the target populations to earn a living. There are easier and more prestigious jobs that pay more money. It is only through thoughtful investment of time in career development for professionals that can bring these resources to the public system.

It is also true that professionals who serve seriously ill individuals leave their training programs not fully prepared to do the work. The key to necessary additional training is that this work is true “bio-psycho-social” medicine. Understanding the biological science and basic psychological dynamics is vital, but is not enough. There are a potentially great number of “third parties” to the treatment relationship that will influence the delivery of care. The role of family, friends, schools, jails, and many other

community organizations that help or hinder the work must be a topic of teaching and learning for the practitioner. Local and cultural variations within communities make this a lifetime learning issue, not one that can be taught in a degree program.

The overall matrix of relationships needed to deliver care may be compared to the electric power grid that recently failed in the US Northeast. The “power” of biological and psychological interventions needs a way to flow to those in need. Our lack of attention to building a capable workforce trained in bio-psycho-social principles is akin to neglecting the electric power grid. We should anticipate blackouts.

Programs that divest themselves of their career professionals will be squandering vital intellectual capital as well as deleting priceless organizational memory needed to develop an adequately trained workforce. The belief that “market forces” will somehow produce such clinicians is simply wrong.

What Now

I am a long-term optimist and believe that we are a smart enough people and a rich enough society to eventually get reform right. I look forward to the day that governance structures find the right mix of funding from federal, state, local, and volunteer sources. We will figure out what we can and can't contract out, and will eventually make an organized investment in career development for the clinical, administrative and support staff to serve the public patient. In the short term, however, it looks rather dark for the people served by the public system of care.