UNDERSTANDING PRIVATIZATION THROUGH THE LENS OF DORWART AND EPSTEIN'S *PRIVATIZATION AND MENTAL HEALTH SERVICES*: A WARNING FOR LATIN AMERICA AND THE DEVELOPING WORLD

ENTENDENDO A PRIVATIZAÇÃO ATRAVÉS DAS LENTES DE DORWART E EPSTEIN *PRIVATIZAÇÃO E OS SERVIÇOS DE SAÚDE MENTAL*: UMA ADVERTÊNCIA PARA A AMÉRICA LATINA E O PAÍSES EM DESENVOLVIMENTO

ENTENDIENDO LA PRIVATIZACIÓN ATRAVES DE LOS LENTES DE DORWART E EPSTEIN PRIVATIZACIÓN Y LOS SERVICIOS DE SALUD MENTAL: UNA ADVERTENCIA PARA LA AMERICA LATINA Y LOS PAISES EN DESARROLLO.

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Abstract:
This essay analyses the encroachment of for-profit corporations on the mental health services delivery system in the United States, which may provide importance insights to development and social welfare practitioners and scholars internationally. For the purposes of clarity and focus, the article explores this issue through the vehicle of Dorwart and Epstein's classic text, *Privatization and Mental Health Services*. The author explores the history of privatization in this context, and discusses how the context of treatment services was changed due to the dictates of the privatized environment. This discussion serves as a warning for social welfare practitioners and social scientists in the developing world, who have witnessed the encroachment of privatization through the process of globalization.

Keywords: Privatization, Mental health care, social development, globalization

Resumo: Este ensaio analisa a intromissão das empresas lucrativas no sistema de entregas dos serviços de saúde mental dos Estados Unidos, o qual pode fornecer

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insights de importância para médicos e estudantes do desenvolvimento e bem-estar social, internacionalmente. Visando clareza e enfoque, o artigo explora esta questão usando como veículo o texto clássico de Dorwart e Epstein, *Privatização e Serviços de Saúde Mental*. O autor explora a história da privatização neste contexto e discute como o contexto dos serviços de tratamento foi modificado devido aos ditames do ambiente privatizado. Este debate serve como advertência para médicos do bem estar social e cientistas sociais no mundo em desenvolvimento, que tenham testemunhado a intromissão da privatização através do processo de globalização.

Palavras - chave: Privatização, cuidado da saúde mental, desenvolvimento social, globalização.

Resumen: Este ensayo analiza la intromisión de las empresas lucrativas en el sistema de entrega de los servicios de salud mental en los Estados Unidos, el qual puede fornecer *insights* de importancia para médicos y estudiantes de desarrollo y bien estar social internacionalmente. Con el objetivo de conferir claridad y objetividad al tema, este trabajo toma como base el texto clásico de Dorwart e Epstein, *Privatización y Servicios de Salud Mental*. El autor explota la historia de la privatización en este ámbito y discute como el contexto de los servicios de tratamiento fue modificado por los dictámenes del ambiente privatizado. Este debate sirve como advertencia para la medicina social y para los cientistas sociales del mundo en desarrollo que haya sido testigo de la intromisión de la privatización a través del proceso de globalización.

Palabras clave: Privatización, cuidado en la salud mental, desarrollo social, globalización.

The purpose of this essay is to analyze the encroachment of for-profit corporations on the mental health services delivery system in the United States, which may provide importance insights to development and social welfare practitioners and scholars internationally. For the purposes of clarity and focus, it will analyze this issue through the vehicle of Dorwart and Epstein's (1993) classic text, *Privatization and Mental Health Services*. Over time, the authors have been able to anticipate many of the changes that have occurred in the social welfare systems due to privatization. The author of this article finds it lamentable, that seminal texts have lost their importance due to our current obsession with "progress" and technological advancement. It is the author's contention that good social commentary can transend time and place, and may help those in other social contexts view their own reality with fresh eyes.

While the effects of privatization in the United States may seem remote to scholars in Latin America, the pattern of privatizing social services is transnational in scope and impacts most developing countries through the World Bank's neo-liberalist structural adjustment policies (Danaher, 1994 & 2001; Kaseke, 1998). Indeed, in the age of the global economy, human service workers and development specialists must develop an international perspective in the analysis of social problems and social institutions. Social policy change in the United States often impact the poor and oppressed in the developing world even more so than those in the United States (Gerster, 1994; Prigoff, 2000). The ideas presented here serve as a warning to advocates for the mentally ill and other vulnerable populations throughout Latin America and the developing world, and demonstrate the deleterious effects that privatization can have upon the most vulnerable.

Therefore, this paper will explore several questions to illuminate the problems and dilemmas of privatization. First, how have divergent philosophies about and definitions of mental health impacted the provision of services in the United States? That is, what are the historical, theoretical and cultural factors that have lead to the privatization of mental health services? Second, how have these conceptions impacted mental health care in the United States. Stated differently, how do different philosophies of social provision impact the definition of mental health, and how do these definitions effect the provision of services? Third, what are the effects of privatization on the delivery of mental health and other relevant services?

Historical events and cultural norms play an important role in the nature of the provision of mental health services. Dorwart and Epstein (1993) conceptualize four models of mental health current conceptions of mental health and social policy Vis a Vis mental health. Viewing the history of mental health from each of these perspectives, and showing how they mix with other social factors gives us a powerful analytic tool for understanding the nature and context of the mental health system. In each of these models, mental illnesses are viewed as: a social abnormality requiring social control; a condition in need of social support; a long term disability; and, a medical problem.

The social control model stems from ancient views of the mentally ill as evil. Throughout much of colonial America people with mental illness were treated as criminals and punished (Dorwart and Epstein, 1993). In the early part of the 1800s, this earliest model dictated treatment. As the views of the Enlightenment in France and England crossed the Atlantic, more humane institutions designed to treat the mentally ill were established. Early mental health reformers saw mental illness as a condition created by social factors and in need of social treatment. Social treatment sought to create nurturing family-like institutions for the mentally ill. Still, the religious nature of treatment suggested a moral etiology of mental health disorders. However, these changes led to the creation of a permanent place for the second model; mental illness as a condition in need of social support.

Medical breakthroughs in the treatment of syphilis, which accounted for many of the mentally ill in hospitals at the turn of the century, led to the attribution of mental illness to biological factors. Concurrently, the Freud's views led many to attribute mental illness to sociological and psychological factors. The influence of the medical model to treatment lead to a strong push to find biologically based cures. In the 1940s frontal lobotomies came to the fore as a popular treatment modality. Not until the development of phenothiazines in the 1950s did the medical model begin to hold a place of prominence in psychiatry.

The Community Mental Health Act of 1963, an expansion of entitlement services, more humanistic philosophies of the 1960's, along with the development of more effective pharmacological treatments, brought the long term model of mental health care into prominence.

The social control model stems from ancient views about mental illness being derived from evil or sin. Throughout much of colonial America, people with mental illness were treated as criminals and punished in repressive institutions (Dorwart and Epstein, 1993). In the early part of the 1800s, this earliest model dictated treatment. As the views of the Enlightenment of France and England crossed the Atlantic, more humane institutions designed to treat the mentally ill were established. Benjamin Rush, a Philadelphia Quaker physician, was the first to treat the mentally ill in the United

States in this manner. Many early mental health reformers saw mental illness as a condition created by social factors, and thus in need of social treatment. Social treatment sought to create nurturing family-like institutions for the mentally ill. Still, the religious nature of treatment suggested a moral etiology of mental health disorders. However, these phenomenon lead to the creation of a permanent place for the second model, mental illness as a condition in need of social support. Medical breakthroughs in the treatment of syphilis, which accounted for many of the mentally ill in hospitals at the turn of the century, lead to the attribution of mental illness to biological factors. Concurrently, the views of Freud and others lead many to attribute mental illness to sociological and psychological factors. The influence of the medical model to treatment lead to a strong push to find biologically based cures. In the 1940s frontal lobotomies came to the fore as a popular treatment modality. Not until the development of phenothiazines in the 1950s did the medical model begin to hold a place of prominence in psychiatry.

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A profound shift in services to the mentally ill occurred in the 1970s. In the 1960s, 95% of the psychiatric hospital beds were government operated. By the mid 1980s, fewer than 50% of the beds were government owned (Jellinek and Nurcombe, 1993). In the 1980s indemnity insurance plans began to have more generous mental health and substance abuse benefits, and for profit psychiatric hospitals took advantage of this trend. From 1980 to 1986, adolescent admissions to private psychiatric hospitals increased four fold (Jellinek & Nurcombe, 1993). By the late 198's, managed care was called on to reign in excessive and often inefficient admissions. Jellinek and Nurcombe (1993) state it well when they comment "it was profit that filled psychiatric beds in the 1980's, and it is profit that empties them in the 1990's" (p.1741). This perceived need for the cost containment of mental health services, occurring within the context of the

privatization movement of the Regan era presidency, was one of he most immediate factors that lead to the privatization of mental health services.

How a society, and sub-groupings within a society, views the provision of social services, (including health and mental health) affects the nature of service provision. Such views can be understood by asking what are, according to each perspective, people entitled to. Whose responsibility is it to provide these services? Several models of analysis can be useful in clarifying these issues.

Wilensky (1985) notes that social welfare systems can be characterized as either residual or institutional in nature. In the residualist system, services are seen as being needed only when people fall through the cracks of more traditional systems. Society is seen as inherently sound and capable of handling problems without the creation of specialized institutions. In many local and state jurisdictions, mental health care "takes on the nature of a residual system" (Dorwart and Epstein, 1993). That is, mental health care is forced to handle social problems that are unresolved though other mechanisms. Since the mental health care system is often forced to adopt this residual function, the development of mature systems and structures can be hindered.

Part of why the mental health care system has been forced to adopt a residualist way of operating is due to social ambivalence about the nature of mental illness. The residualist model of social provision can be most strongly associated with the social control model of mental illness. Callahan and Boyle (1995) note that unlike persons suffering from physical illness, those with mental illness are likely to be seen as being the cause of their problems, and thus in need of shaping up or being controlled. Thus, they're in no right or entitlement to such services. This "blaming the victim" as the root of their own illness is a powerful dynamic operating in modern societies (Titmuss, 1959).

The institutional view holds that the creation of social institutions is a natural and integral component of highly complicated modern societies. An individuals' dependence is seen as normative, not pathological (Wilensky, 1985 & Titmuss, 1959). The community mental health centers (CMHCs) provide the institutional dimension of the mental health system. CMHCs cover a geographical region and serve all those who live

within the area. However, as we will discuss later, the trend towards privatization is moving CMHCs towards a more residualist way of operating.

Paulson (1994) suggests an alternative schema. He shows that managed mental health providers can take one of two paths, the "wellness" model or the "profit" model. In the wellness model, managed care providers are invested in the long-term health of the clients that they serve. MCOs characterized by a wellness approach see themselves as partners with other service providers in the community, and see themselves as part of the community.

Those operating under the profit model do not see themselves as members of the community, but as providers of marketable services that others can purchase for a profit. It would be interesting to see how the mission statements of MCOs correlate to one of these models.

Dorwart and Epstein (1993) assert that they do not see privatization as the primary policy direction that the mental health care field should go, but instead see it as one direction that can solve several problems that have been endemic in the system. These problems, and their potential solutions, can be analyzed by seeing how privatized care responds to five central issues (Dorwart and Epstein, 1993). Will privatization:

1) increase or diminish access to care?

2) lead to higher or lower quality of care?

3) be more or less costly?

4) be more or less community responsiveness?

5) lead to better accountability within the system?

6) create greater or lesser administrative efficiency and flexibility?

The authors note that the answers to these questions are in large part dependent on the design and implementation of privatization. Policy makers need to contend with what the authors refer to as the four C's: capital, competition, contracting and capitation. Essock and Goldman (1995) also see states' careful monitoring and enforcement of contracts with managed care organizations as a key to successful privatization. They additionally note other keys to quality mental health subcontracting including provisions

against client "dumping", strong negative consequences for non- performance, and incentives to identify and properly treat persons with complicated and severe conditions.

In his analysis of the effects of privatization on mental health care, Brotman (1993) discusses several relevant issues. First, he notes the concern of many mental health advocates, that privatization will become a code word for the abandonment of the chronically mentally ill. While others believe that privatization may spell the end of mental health advocacy, Brotman believes that the private sector's concern with the bottom line could lead for-profit entities to lobby government effectively on behalf of the mentally ill. Clearly, this would only come to pass if these entities were invested in the long-term well being of the clients they serve.

Brotman provides a vision of what many states are already doing, setting joint venture between managed care and county mental health authorities. In this capitated managed care model, the county authority would receive a capitated pool of mental health dollars, and would contact with private organizations for services. Not constrained by ponderous categorical services, the public entity could design flexible, cost efficient services. The local mental health authority could force providers into providing the types of services that would be most useful to consumers. One concern is that since the local authority shares financial risk, they would only support low cost care and contract with providers that offer the cheapest rates. This could lead to low quality care that fails to meet the real needs of the seriously mentally ill.

The importance of contracting and oversight, discussed previously, cannot be understated. If not carefully crafted, behavioral health organizations are certain to adopt a residualist perspective. One of the dilemmas that has not been sufficiently addressed by the above stated articles is how the nature of some large behavioral health organizations effects the provision of services (Geller, 1996). Large corporations, for the most part, see their primary responsibility being to their shareholders. This natural allegiance can lead towards a push to maximize profits in each fiscal quarter. This pressure can lead behavioral health organizations towards adopting philosophies of care that combine aspects of the medical and residual models. In order to counteract these tendencies, several questions will need to be addressed throughout the

contacting process. First, how will the managed care organizations be forced to be invested in the long term well being of the community in which they are providing services? Two, how will penalties for non-compliance be enforced in a meaningful way?

Perhaps an even more salient question would be to ask if these entities are capable of providing the type of care that will lead to long term mental health prevention, and thus savings to society as a whole. The medical, residual model of most for-profit behavioral health care organizations leads to the treatment of discreet mental illness, not a provision of wellness related services.

The effect of different characteristics of behavioral health organization on the clinical outcomes of clients constitutes a major gap in current research. In all the articles reviewed that either support or criticize behavioral health care organizations, most information is philosophical or anecdotal. Dorwart and Epstein (1993) give us a hint at a powerful tool to investigate this problem. In their study, one of the key variables in analysis is the type of organization that is providing services. A natural extension of their work would be longitudinal studies that look not merely at the types of structural and internal changes that Dorwart and Epstein reviewed, but at the effects on client populations.

Given the lack of empirical data, an additional exploration of anecdotal, experiential and theoretical critiques of managed behavioral health care will be explored. Boyle and Callahan (1995) list six common criticisms of managed behavioral health care:

1) Managed mental health care could adversely affect quality of care.

2) Managed mental health care could limit access.

3) Managed mental health care could adversely affect the provider/ patient relationship

4) Managed mental health care could adversely affect patient choice.

5) Benefit design within managed mental health care could be capricious and unfair.

6) Managed mental health care could create problems because responsibility is inappropriately shifted to management.

Dumont's (1996) observations of the events that transpired in Massachusetts since privatization provide us with some provisional answers to some key issues. The author notes adverse effects in the access, quality, community responsiveness and flexibility of service provision. The closing of small, community based clinics has meant that many chronically mentally ill adults are forced to attend distant (physically and emotionally) institutions. Many of these clients do not have the ability to get to where they are now required to go. The author cites a 40% increase in admissions of chronically mentally ill adults to local homeless shelters.

Also, the nature and quality of service has been adversely affected for this population. Since therapists are now more commonly paid on a fee-for-service basis, the types of informal contacts and home visits that have helped keep chronically mental ill clients in treatment are now unavailable. It is also unclear if privatization has lead to savings or cost shifting, as emergency rooms and the court system may be seeing an increase in mentally ill adults. Also, as state hospitals have been rapidly closed, families are responsible for the care of their mentally ill adult family members. The financial and emotional costs on each of these families cannot be overlooked.

There are those who see the privatization and corporatization of mental health services in a far more positive light. In his discussion of Cumming's (1995) work, Geller (1996) shows us another view of how this phenomenon is seen. Cumming's six effects of the "industrialization" of mental health services are:

1) The providers of goods (psychiatrists, social workers, and other mental health practitioners who provide psychotherapy and/or psychopharmacology) lose control of the production of the goods and services.

2) Since industrialization grows and blossoms on cheap labor, there will be a progressive de-professionalization of the professions. Less trained practitioners will replace better trained ones. For example, MSWs, who replaced MDs, will themselves be replaced by BAs.

3) Greater efficiencies will be repeatedly achieved, meaning there will be a perpetual and progressive decrease in the numbers of providers, i.e. practitioners. The

ranks of those with more training will decrease at faster rates than the number of those with less training.

4) Quality will suffer at first. Then, as the industry matures, quality will improve, and should surpass its earlier levels.

5) Greater efficiencies will mean that more people can receive the goods and services (mental health treatment). Successful companies will take over less successful ones. The small practitioner, will disappear.

What is interesting to note, is that many of these potential effects would be seen by most social workers as negative. However, for many proponents of managed care, the controlling of what is perceived as run away costs is the primary consideration. Consequences for professionals working within the system are seen as ancillary.

Feldman (1992) sees managed mental health care as acting as a mediator between the interests of professionals, clients and a society paying for services. In managed mental health, the safeguards against improper practice are far more extensive, better developed and therefore much more likely to insulate the care of patients from the self-serving behaviors of providers and managers (p. 16)

Other commentators note that many of the arguments against managed care are from professionals whose hegemony will be impinged upon. One of the major dilemmas in the provision of mental health services is the lack of integration of systems of care. How privatization deals with the integration of diverse systems will be a key factor in its success. An example of how privatization can adversely effect the integration of services can be taken from the author's past position as the administrator of children's mental health programs. The program provided community-based intensive mental health services to children in their homes and schools. All of the children were covered by medical assistance. 10% of the children that were served had their mental health care coverage provided by a for-profit, behavioral care organization. The rest of the children are paid fee-for-service by the state Office of Medical Assistance.

The medical model philosophy of the managed care case- manager prevented an integration of services. Children were seen mechanistically and not systemically. Therefore, referrals to community based resources, coordination with school personnel,

the involvement and empowerment of parents, were not included in their treatment. Additionally, services were denied to children who were not medicated.

The concept of privatization is a central analytical component of Dorwart and Epstein's work. While the authors' conceptualization of privatization is useful, they do not draw a distinction between privatization and corporatization, or the "HMO'ing" of mental health services. In their defense, much of the data used in their study was collected before Massachusetts began to subcontract with managed care agencies for the provision of services to the chronically mentally ill. Still, the trend towards the carving out of mental health services to specialized corporate subcontractors has been evident since the 1980's. The authors even discuss these trends, noting that utilization review and other managed care techniques were utilized by self insuring companies to reduce mental health expenditures. One explanation is that the authors see managed care as other commentators have, as merely a set of management techniques.

In conclusion, it is clear that to analyze changes in mental health service provision by using the concept of privatization is far to narrow. Privatization does not take into account the way care is managed or by whom. What is also certain is that the effects of managed mental health care are greatly unknown. Future research will need to define broad-based outcome criteria that measure cost, access, and quality of care. It will need to determine how managed mental health care effects not only the populations they serve, but also communities and other systems within each community.

In Latin America and much of the developing world, the policies of privatization sponsored by the World Bank are analogous to the privatization of mental health services. It is the hope of this author that this account will serve a warning regarding the potential deleterious effect of this often insidious, global trend.

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