



# The Center Page

Newsletter for the  
Center for Behavioral Health

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## *What's Happening to the Non-Profit Sector?*

Dr. Dennis Morrison, CEO

The State's financial crisis has forced politicians to look again at cutting Medicaid benefits—an action that threatens to decrease or eliminate funding other services for the public. While this appears to be an isolated and recent occurrence it is actually a symptom of a larger trend occurring in the non-profit sector. Consider the following events that have affected the non-profit community:

- Center for Behavioral Health has 20% of its contract withheld by the State Department of Mental Health and Addictions to allow for any cutbacks implemented by the State Legislature;
- Bloomington Hospital announces its Ambulance Service may have to be cut back because of insufficient funding;
- Pleasant Run Children's Home closes abruptly leaving several hundred children without a place to live;
- Bloomington Hospital announces reimbursement decreases that may affect the delivery of health care services to the indigent;
- Monroe County United Ministries experiences a five-fold increase in the number of people per month asking for sustenance and heating funds;
- Shalom Center opens to provide services to the underserved in the community but numbers are increasing so quickly that they are running out of space;
- Stone Belt Center announces cutbacks because of decreases in reimbursement;
- Center for Behavioral Health announces a reorganization due to decreased funding;
- Public Health Nursing Association announces cutbacks to the CHAP Program, a primary source of medical care for the indigent in Monroe County;
- United Way identifies 5% cuts to funding of 26 non-profits last year with more cuts anticipated next year;
- Backstreet Mission is forced to turn away men needing shelter because demand exceeds capacity.

We all like to feel good about organizations that help those among us in need. Non-profit businesses are often seen as the community's "life boats" for those who have no other resources. But only a certain number of people can be accommodated before the life boat itself sinks, taking with it all who would have been saved.

The part of the picture that we often don't want to discuss is how those organizations pay for "doing good." The obvious but unstated fact is that these organizations are businesses that must follow the same

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***Adolescent Substance Abuse:  
When Parents Use***



Cindy Houston, LCSW, LMFT

The fact that teens are using substances is not news. Media sources frequently announce statistics stating that in the past year teens using one substance is up and another substance is less popular. In Bloomington, for instance, there has been much publicity about the use of Ecstasy among younger people. (Ecstasy is a “club drug” meaning that young persons often use it in connection with partying. It is methylenedioxymethamphetamine or MDMA and creates a rush in the user that may be experienced as pleasurable. Many describe it as mildly hallucinogenic with a hit of speed. Initially, it was thought to be harmless. There is now clear evidence that it depletes levels of serotonin in the brain which impacts on mood regulation, affects memory on a permanent basis, and may destroy the body’s ability to regulate its temperature, leading to death.) Regardless of which study one reads, it is clear a substantial portion of teens, and most particularly teens who are displaying significant problems in life areas, are often also using substances in a problematic manner.

What may be news is that there is clear evidence linking the pattern of use of parents to the child’s substance use.

The genetic predisposition to addiction is well established. Long-standing studies of identical twins separated at birth having extremely high correlations regarding the presence or absence of addiction in both twins, despite different environments, have been corroborated. The increased risk if one side of a person’s family has issues with addictions, and an even higher level of risk if both sides of the family have members with addictions, is a standard part of risk assessment.

Other predictors of problematic use include the addictability of the substance used, i.e., it is easier to get addicted to nicotine, crack, and heroin than to marijuana, and the age of onset or first use. One troubling fact is that teens are starting to use at earlier and earlier ages, even before their adolescence begins, and that means they have a longer time to “practice” usage—increasing the odds of becoming problematic users. It also means they are using at ages when they have fewer alternative tools to affect judgment, moderation of use, peer selection, impulse control, etc. Drinking before the age of 15 gives one a four times greater chance of being alcoholic than if one waits until 21 to drink. Forty-seven percent of adults who report drinking at the age of 13 meet criteria for chemical dependency.

Aside from the above factors, there is much social learning that goes on in a household. What do teens learn from parents who are problematically using substances? They learn it is okay to medicate oneself. If life is hard, if life is painful, the option to reduce that pain by taking a substance is perceived as an acceptable choice. Problematic use by definition starts to affect life areas such as work, home, school, and family relationships. Parents who are problematically using set

(When Parents Use...  
Continued)

standards for the teen that such disturbances are acceptable. We tend to surround ourselves with people who use substances like we do. The social network of problematically using parents is likely to be full of other problematically using adults, reinforcing the message that problematic use is normal. The clear message is that “everyone does it.” Since



marijuana and many other substances are illegal and less than complete honesty is practiced by the significant group of people who doctor-shop for continuing access to pills, parents are teaching the teens that adherence to some laws is optional; it is acceptable to exaggerate or fabricate stories to get new prescriptions. Certainly parents who use with, and/or supply, their children are breaking the law with every use.

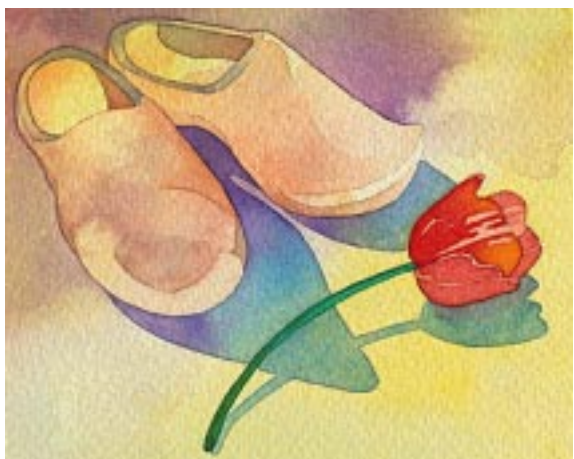
Another major issue is the correlation of problematic substance use and child abuse/neglect cases in this country. The National Center on Addiction and Substance Abuse at Columbia University in New York estimates that 70-90% of all cases of child abuse and neglect accompanies problematic use of substances by parents. If this figure is even close, imagine the impact on the generation of children impacted by abuse/neglect if parents would change/stop their usage. In families where parents problematically use there are higher rates of use by teens and abstinence by teens. There is not a model of responsible use. Patterns that we know help teens transition into successful adults are often missing. There is a noticeable lack of quality communication, consistency, and parental supervision. Teens in these families report a perception that the parents are less concerned about the teen’s welfare.

There has been a recent trend of emphasizing parental use in interventions. One can easily imagine the difficulty in suggesting to a teen to change his/her use when s/he returns home every night to a parent who is using problematically. A recent APA report states that one of the most helpful things a community can do is to support parental non-use in situations where teens are using. Since all empirically validated interventions with teens in trouble with substance use involve some form of family participation, imagine the difficulties trying to impact a family where one or both parents are continuing problematic use while encouraging the teen not to. Thus, the APA recommendation seems commonsensical.

CBH is trying to implement that approach by creating a parenting group for adults caring for teens that are problematically using. Along with exploring parenting challenges to this population, we help parents investigate whether their usage is a part of the problem. This group, called “Parent’s Brief Intensive Group,” is open to any parent in the community regardless of whether or not the teen is in treatment.

*What may be news is that there is clear evidence linking the pattern of use of parents to the child’s substance use.*





## Social Anxiety

Juliet Matthews, M.A., L.M.H.C., &  
Cathi Norton, Community Relations Specialist



People with mental illnesses are too often disregarded, and at worst, shunned, by their communities. They face discrimination in health insurance, housing and employment, and struggle in the face of continuing stigma associated with psychiatric disorders. Mental disorders vary in intensity, duration, and social acceptance, but misunderstanding and fear are best battled through educating ourselves and learning how important good mental health is to an individual and the whole community. **May--Mental Health Month**, is a chance to focus on the fact that *mental health really matters*.

We are perhaps more aware of illnesses like schizophrenia, or bipolar disorder, but many other disorders, like depression, or panic attacks, are often not regarded as serious enough to be treated. They are also commonly regarded as personal weaknesses and therefore unadmitted though their impact on quality of life is profound.

For example, you might get very nervous or uncomfortable around other people, being the center of attention, or talking in front of a group. Such feelings may keep you from doing things you want or need to do. You find yourself blushing, sweating, shaking, or plagued with difficulty swallowing, an upset stomach, or a pounding heart. When these reactions are intense and prolonged, you may be experiencing *social anxiety*, characterized by excessive worry about what others might think of you—in particular, that you might act in a way that would be embarrassing or humiliating. Most commonly reported situations arousing social anxiety are public speaking, conversations with unfamiliar people, or situations requiring assertiveness. Other situations include talking with authority figures, fear of eating or drinking in front of others, or using public restrooms.

At what point does social anxiety become a disorder? Anxiety is a very normal emotion and cannot be completely eliminated, nor would we want it to be. A healthy amount of worry helps us meet deadlines, complete tasks, or study for tests. However, when anxiety interferes with life in important ways, such as causing problems at work, school, or in relationships, it may be more serious. You might notice you are avoiding situations that cause anxiety or that you are enduring those situations with great distress and discomfort. According to the National Institute of Mental Health, about 5.3 million Americans between the ages of 18 and 54 have social anxiety disorder in a given year. Social anxiety disorder occurs twice as often in women as in men, though more men seek treatment for the disorder. Social anxiety disorder typically begins in childhood or early adolescence and rarely develops after age 25. For people with social anxiety, thoughts and feelings of anxiety *persist* and seem to show no signs of going away—despite the fact that often their “fears are faced” every day of their lives.

Fortunately, effective treatment exists. Cognitive-behavioral therapy is an effective approach in which the person systematically begins to face their fears, and uses cognitive, or “thinking,” techniques to help control the anxiety and change the dysfunctional beliefs that underlie it. This is a well researched approach, with studies citing 75-80% of treatment participants reporting significant improvement in their symptoms. In more severe cases, certain medications can also be a useful adjunct to therapy. The brain is continually learning, and irrational thoughts and beliefs can change as a result of cognitive restructuring. Clearly, the pervasiveness and effects of this disorder warrant attention. Yet the stigma associated with “nerves” can easily derail any efforts to get help.

It requires little effort to imagine the improvement that might be seen in the lives of those affected by social anxiety, and other mental disorders, but our understanding of how mental health care can alleviate such conditions typically remains rudimentary. People with mental disorders can, and often do, recover when given the chance. Not only must we commit ourselves to making the needed resources available to help, we can change the way mental health disorders and illnesses are viewed in our society.

Please take the opportunity during May—National Mental Health Month—to work together to end the discrimination people with mental illnesses face everyday; support policies that fund mental health services; help individuals in their recovery; and encourage those in need to seek treatment. Good mental health matters to everyone.





## Washington D.C. and the Pentagon Catastrophe

Bethany A. Murray, MSN, RN, CS

Disaster Mental Health Service Technician and CBH Nurse

On September 11, 2001 a small group of terrorists attacked the United States. That date will go down in our history as a tragedy of horrific proportions. It is also the day that the citizens of this country united in a way that we haven't seen for many years. People of all nationalities, religious groups, ages, and regions of the country pulled together in unity to respond to these events and to care for our wounded brothers and sisters.

When American Airlines flight 77 was intentionally crashed into the Pentagon building, 189 people were killed and scores were physically injured. Over 6,000 were lost in the World Trade Center attack. Of smaller scale, but just as tragic were the innocent lives lost in Pennsylvania from the hijacked airline crash there. Emotional wounds are more difficult to detect. We will likely never know the extent of damage done to our people in terms of the loss of a sense of safety and security, grieving, ongoing fear, and anger.

I was called out on September 13<sup>th</sup> – two days after the attacks. I knew that emotions would be at a peak during the next few weeks. The Red Cross has always been there for victims and survivors, and the mental health function of the Red Cross would be more important in this disaster than perhaps in many of the past “natural” disasters where we have served. Initially, I was deployed to Somerset, Pennsylvania where a United Airlines jet had been crashed into the countryside, in a heroic act that aborted a larger scale path of destruction. The Somerset site was well under control at the time of my arrival and I had only 24 hours to debrief some of the local volunteers and other Red Cross staff before I was sent on to Washington, D.C. There, I was assigned to an Integrated Care Team that was given the task of making visits to local hospitals to meet survivors and their families, and provide Red Cross services as appropriate.

My team had an assignment of 10 survivors and their families at the Washington Hospital Center, a large metropolitan hospital with a state-of-the-art burn center and rehabilitation unit. Seven of our clients were in the Intensive Care Unit. We made initial contacts and helped the families with temporary housing (hotel rooms), transportation (including airfare), food, other daily living needs, and emotional support. By the second day, one of our clients passed away and another was discharged. We visited the discharged client and helped her process some of her fears over the recent events. We maintained regular contacts with our client families up until the end of my tour of duty. Other Integrated Care Teams were assigned to identify and locate nonhospitalized survivors, and to help families of those who died in the attack.

In the final two days of my time, I was assigned to work at the Pentagon site. A large “camp” was set up with first aid, ERV's with snacks and drinks, hot food, haircutting facilities, supplies, a chapel, and other necessities to support the rescue and recovery workers. I could never have imagined the number of different organizations working together, unified in a common goal! I saw Red Cross workers, Salvation Army volunteers, Southern Baptists, FBI, EPA, and ATF agents, the Army, Marines, U.S. Marshals (who were the federal security), local and state police officers, Pentagon employees, the construction crew who had recently remodeled the building, dump truck drivers carrying out the rubble, and many more. My job was to provide a “safe” emotional place for anyone who needed to talk about his or her experiences while working at the site.

I came home on Tuesday, September 25<sup>th</sup>. People back here ask me things like, “How was it?” and “How are you doing?” I can only say that this experience has allowed me to step outside of myself and my life, to gain a better perspective on what is really important to me. My spiritual self is renewed and I look at my family with a greater appreciation of the blessings I have received. My personal freedom is a concept that is less abstract to me now. I have seen what oppression and poverty can breed in the irrational and cruel attacks by these terrorists on our brethren. As a country, we will heal and we will recover. But we will never forget. I will never forget.



Reprinted from *American Red Cross Newsletter*, 11/2001.





## *Changing Treatment Models in Behavioral Health Care*

R. Gordon Gibson, Ph.D.

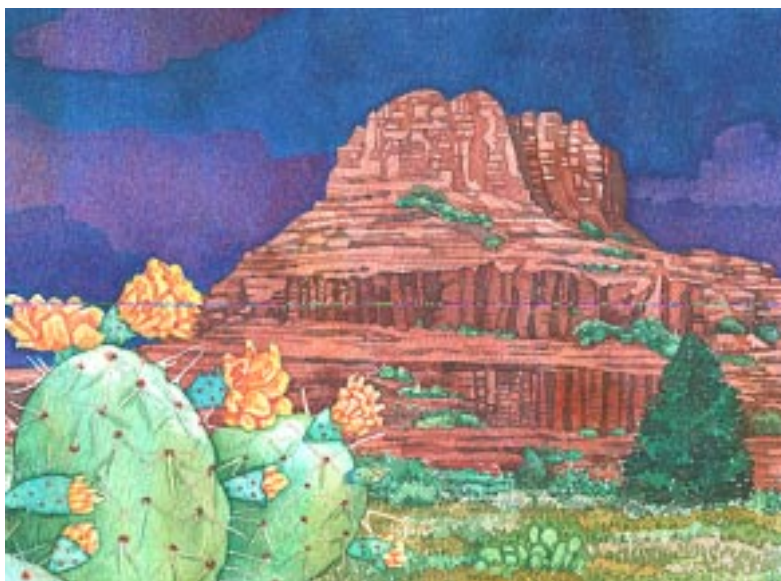
Historically, behavioral health care has been provided in an *expert* model where a professionally trained and licensed practitioner uses clinical measures and assessment methods to determine a diagnosis. Given a particular diagnosis the practitioner then provides a current *best practice*. In some treatment settings like the Center for Behavioral Health, there is a stronger emphasis upon using scientifically supported treatments and measuring the outcomes throughout and following the course of treatment. This type of expert model is used in most practice settings where the consumers present primarily mental health problems. In the case of substance use problems the model becomes more of a *mixed* model with both professional practitioners providing the behavioral treatment protocols and individuals in recovery utilizing peer support through Alcoholics and Narcotics Anonymous.

**Challenge of the Dual Diagnosis Condition:** Behavioral health care systems have not functioned as effectively when the individual presents both a mental health and substance use problem. In many treatment settings, the secondary diagnosis will not even be documented. Straightforwardly, if an alcohol and drug treatment program does not have practitioners qualified in mental health care they cannot acknowledge the disorder for liability reasons. They either provide their substance abuse treatment protocol and hope the mental health symptoms will also be reduced or refer to a mental health treatment setting. Conversely, when an individual with a persistent and severe mental disorder is known to be abusing alcohol and/or other drugs, the individual is often referred out to a sub-acute detoxification program for brief treatment. The consumer with both mental health and substance abuse symptoms presents a challenge to the practitioner for both assessment and treatment of the dual diagnosis condition.

**Assessment of Dual Diagnosis:** Assessment of dual diagnoses for consumers with serious mental illness disorders has been problematic. Providers in either mental health or substance use treatment settings are generally not trained in the assessment of a dual diagnosis condition. Unlike the standard assessment packages available for diagnosing either mental health or substance use disorders, practitioners do not have readily available standardized measures for the assessment of consumers with dual diagnoses. In consumers with persistent and severe mental health disorders, symptoms that are related to either experimentation or increasing use of substances, may go unobserved and/or unassessed until clearly elevated over the consumer's usual level of functioning. In some cases the symptoms observed are more related to non-compliance with, that is discontinuance of, their anti-psychotic medication rather than the substance use.

Most substance use-related assessment measures are ineffective in measuring the level of substance use or the impact upon functioning for consumers with serious mental illness disorders.

Assessment measures of substance use problems have not been sensitive to the lower levels of consumption that may have significant interaction effects with anti-psychotic or other psychotropic medications. Some of these consumers are functioning at quite low levels requiring assistance in many life skills areas including personal self-care, unrelated to the effects of substance use. The standardized measures used are effective for assessing either the symptoms related



(Changing Treatment Models...Continued)

to serious mental disorders alone, or substantial substance use alone, but not for the more complex behavior of the dual diagnosis consumer. The most promising assessment has been New Hampshire-Dartmouth Psychiatric Research Center's development of a *Toolkit for Evaluating Substance Abuse in Persons with Severe Mental Illness* (Drake, et. al., 2001).

**Treatment of Dual Diagnosis:** Similar to the limitations of assessment, there are best practice treatments readily available for either mental health or substance use disorders, but not for both conditions. The Association for Ambulatory Behavioral Healthcare has focused upon the research and development of integrated treatment of the dual diagnosis condition. They have recently published standards and guidelines for dual-diagnosis patients receiving partial-hospitalization level of care (AABH, 2001). The Center for Behavioral Health has examined the effects of an integrated treatment model of the dual diagnosis condition adapting the Motivational Enhancement Therapy (Hickman, 1999; Miller, 1992). This model has been effectively used in the treatment of substance users and involves the use of cognitive dissonance, self-efficacy, and cognitive behavioral interventions. Information is provided to the consumer in a non-confrontational manner and then matches the level or intensity of treatment with the consumer's interest and level of readiness. While this integrated treatment model was effective with 40 dually diagnosed consumers, the treatment program required a level of training resources and commitment that significantly exceeded what the Center has been able to make available.

**Changing Models for Provider Organizations:** The Substance Abuse and Mental Health Services Administration, that administers the federal block grant funding for community mental health organizations, has been reviewing the results of a six-year study of the usefulness of a set of performance measures that indicates the effectiveness of provider groups in meeting the behavioral health care needs of consumers. The task force working with this review has been struggling with the strong reaction of consumer groups who reject the longstanding (expert) model, describing it as an internal, bio-medical, disease-based treatment that inhibits the consumer from being involved in his/her own recovery. From an external socio-political position mental health service delivery systems create conditions whereby individuals experience a loss of control. One of the few behavioral healthcare delivery systems responding to these concerns is the Wisconsin Department of Mental Health. They have been experimenting with the integration of hope, healing, empowerment, and external conditions that facilitate recovery including implementation of human rights, a positive culture of healing, and a collaborative orientation among providers, individual and family consumers, peer support, and community support systems.

**New Direction for the Center for Behavioral Health:** Based upon Epidemiologic Catchment Area studies (Center for Substance Abuse Treatment, 1994), the estimated prevalence of dual diagnoses for those currently diagnosed with persistent and severe mental health disorders or substance abuse disorders is as follows for this past year:

Serious Mental Disorders (Psychosis. . .) with Substance Abuse Diagnosis	47%	392
Substance Abuse Disorders with Serious Mental Illness Diagnosis	4%	85

Of these 477 individuals, only 26 percent (123) were assessed with a dual diagnosis and received treatment. While all received medication and case management services, only 20 participated in the Center's integrated group treatment program for individuals with dual diagnosis.

In the Fall of 2002, the Center for Behavioral Health will be participating with five other Indiana Centers using the New Hampshire-Dartmouth Psychiatric Research Center's Integrated Services Model for the assessment and treatment of individuals with dual diagnosis conditions. The challenge will be the ability of the Center staff to shift to more of a collaborative resource model with the recovery concepts that empower the consumer.

*"...mental health service delivery systems create conditions whereby individuals experience a loss of control."*





## *Mental Health and Schools: Mind the Gap*

Robert Slisz, M.S., School Therapist

The relationship between communities and schools is tightly interwoven. Without synergy the complexity of such relationships may leave a gap between service providers and those in need of mental health services. When focusing on mental health in the educational system the gap between availability and need is often all too evident.

Indiana's licensed school counselors are on the front lines and face daily challenges. In primary and secondary schools counselors

typically oversee 350 to 500 students and have numerous responsibilities. Their job responsibilities are: assisting students with class scheduling, ISTEP administration, career selection, and countless administrative tasks. Support for special education teachers and their students are coordinated through the counseling department. Additionally, the needs of students with learning disabilities and emotional or behavioral problems have become increasingly prevalent. When a crisis arises in a school or in the life of a student, whether on a grand or small scale, it is the school counselor who is called upon to rectify the situation. This becomes more challenging when one considers that a large percentage of school counselors have had their primary training in guidance counseling with limited training in mental health.

When a student is experiencing an emotional problem or a psychological disorder the condition must be addressed. Students suffer needlessly if help is not provided. Frequently parents or guardians are unable or unwilling to deliver the child for services at a site away from the school. Sending mental health professionals to the school is a first step toward meeting the mental health needs of a growing number of students. Through a collaborative venture between the Center for Behavioral Health (CBH) and Forrest Hills Educational Cooperative (FHEC), just such a program is now available.

In July of 2001 a colleague approached me with information about a newly created position designed to offer mental health services in Owen County schools. During the prior two years I worked independently as a counselor/counseling educator in the Owen Valley and Richland Bean Blossom School districts, so the position intrigued me. Within a month I interviewed, was offered the school therapist position, and set out to define a new role.

The first months as a school therapist were filled with rewards and challenges. During my second week of employment I was asked to present anger management classes during ISTEP testing week at Owen Valley High School. Midmorning on September 11<sup>th</sup> I was interrupted with notification about the events taking place in New York City. Guidance counselors and mental health professionals were gathered for advisement, and decisions were quickly made on how to inform the students of the morning's horrific tragedy. Although no one can prepare for an event of such magnitude, the school had a crisis protocol, and it became the task of the administration and school counselors to implement that emergency plan.

As therapists, we enter into the profession knowing we will deal with crisis, but when working in a school setting, there are many other issues that also must be addressed. Mental health professionals are specifically trained to offer support when students struggle with grief, the abandonment by a parent, or face the challenges of a psychological disorder.

When working with students a CBH school therapist must follow a set protocol. Each student becomes a client of the Center for Behavioral Health and follows the same initial procedure as any other CBH client. The intake involves an evaluation, followed by a recommended treatment plan that is formulated after the diagnosis. The treatment plan is agreed upon by the client/guardian and therapist, and reviewed by a CBH

## Center for Behavioral Health

(Mental Health and the Schools, Continued)

psychiatrist. A major difference in this program is that the client can be seen at the school rather than the office. In addition to therapy provided at school, appointments can be made at the Center where a complete array of services are available. Included in treatment might be individual and family psychotherapy, partial hospitalization programs, case management, and pharmacological services.

As a school therapist I navigate a special set of challenges. Faculty and staff welcome me into their schools and assist in countless ways. Temporary meeting areas are carved-out of otherwise underutilized space; counselors share their personal offices; and teachers adjust schedules to accommodate my sessions with students. My cell phone keeps me tethered to the office, and in crisis situations I can relocate to any Owen Valley school within 15 minutes. There are days I feel like a vagabond traveling from school to school, working out of an attaché case filled with scribbled notes and a calendar full of meetings, but the rewards of working with students, families, and school staff make the inconveniences tolerable.

I've come to realize that no two days are alike. A "typical" day may begin with a response to a principal's concern that a student is failing his classes because he comes unprepared and does minimal work. After a conversation with the principal, several of the student's teachers, and the school guidance counselor, a course of action is agreed upon. CBH clinicians review cases weekly in a staff meeting and consultations with the psychiatrist may follow. Even staff meetings are susceptible to interruption. I might be called to another school for crisis intervention to console an agitated, aggressive student. After staff consultation, a decision might be made to release the student to class or to a parent/guardian, recommend him or her for hospitalization, or release the student to law enforcement. To help students remain in school, Forest Hills staff formulate behavioral plans. Working lunches with a social worker from Forest Hills help monitor clients and assess the effectiveness of their treatment plans.

The afternoon may include a case conference for a student with an attention deficit/hyperactivity disorder, or a consultation with a parent about a daughter who is experiencing severe depression. When I return to my CBH office, I assist with a life-skills group for high school students, and later return telephone calls. Finally, I'm greeted by what seems to be an overwhelming amount of paperwork, but charting must be completed. Some days, while rushing to schools or meetings, I wonder what keeps a school therapist motivated. But when I am able to reflect with colleagues about success stories, the reason becomes evident—therapy helps students face the world in a more positive and effective way. This is quite a reward.

A gap does exist between students who need mental health services and agencies that provide assistance. It is my belief that programs like the one created by CBH and FHEC reach students who might otherwise suffer needlessly. Communities build schools to nurture and educate future leaders, and I feel fortunate to be part of a collaborative effort to mind the gap between mental health services and the educational system.



### Children's Trust Fund

*As you renew your license plates this year, please consider purchasing a "Kids First" plate to support the Children's Trust Fund. This fund supports the Center for Behavioral Health's "Nurturing Program," a family centered, evidence-based program for adolescents and their parents. The Program is designed to improve communication, problem-solving, nurturing, conflict resolution, and behavioral management, to prevent child abuse.*



(Non Profit Sector...continued from page 1)

economic rules faced by all businesses. The common theme for those listed above is that demand is increasing and reimbursement is not.

The term “non-profit” is an unfortunate and misleading one in that it suggests these organizations do not and perhaps should not make a profit. A basic fact of economics is that revenue must exceed expenses if the organization is to survive. Granted, revenue for non-profits takes many forms: donations, grants, insurance reimbursement, and direct payment for services. However, the source and type of revenue is irrelevant. It is still revenue and it must exceed expenses, i.e., there must be a profit.

One key difference between for-profits and non-profits has to do with where the profit goes. For-profits distribute profits to owners and shareholders while non-profits reinvest them in their organizations. Another key difference is that non-profits are expected to provide some added benefit to society, and in return for doing so, they are granted tax-exempt status. For some non-profits, the societal benefit they provide is caring for the indigent. For others, it is education or some other public good. However, non-profits’ contract with society is that they meet their mission requirements only to the limits of their capacity. In other words, there are limits to what a non-profit is expected to absorb under the heading of “mission” or “public good.” For health care providers it means the cost of caring for the indigent must be figured into the expenses of the non-profit business such that they remain sufficiently profitable to stay in business. It does society no good if non-profits start up, lose their financial shirts by not managing the business well, and then close their doors. Nobody wins when this occurs.

Historically, charitable giving, contracts, or other public sector sources such as grants, funded these organizations. Health care companies like Bloomington Hospital and Center for Behavioral Health are able to bill private insurance companies and public payers such as Medicaid and Medicare. The margins from more profitable endeavors can be used to help unprofitable lines. This practice is known as *cost-shifting*, and for many non-profits it was a primary means of meeting their mission of caring for the underserved. However, this source of funding has decreased significantly, allowing less opportunity for cost shifting.

The health care industry provides a clear example of this change. In the 1980’s, corporate America responded to the skyrocketing costs of health care benefits by negotiating reduced rates from health care providers either directly or, more frequently, through the introduction of various forms of “managed care.” Managed care was a euphemism for cost cutting. While this helped the payers get control of their expenditures and reach their bottom line, it effectively removed a funding source for the indigent. Public payers such

as Medicaid and Medicare responded to the same pressures by either decreasing or holding constant their reimbursement rates. This means that as private payers decreased the opportunity for health care organizations to subsidize care for the indigent, the government has not moved in to make up the difference. In fact, Medicaid and Medicare programs began the same process of negotiating lower rates, not increasing rates to keep pace with inflation, and implementing managed care programs. From the perspective of those who pay the bills, this all makes sense, but



(Non Profit Sector...continued )

the needs of the indigent do not magically go away just because there is no one to pay for their care.

Besides decreasing the amount they will pay, public purchasers of health care are also trying to economize by limiting eligibility for services. For example, the Center for Behavioral Health's contract with the State of Indiana used to be much less restrictive. Money received could be used for a variety of purposes including indigent care for anyone who needed services. Now our contract targets three specific populations and provides no money for those who do not meet those criteria. From the State's point of view, this is prudent purchasing for the citizens of Indiana. That is, if you have less money to spend, it makes sense to spend it on those who need it most. But the need for others does not disappear; it is just not funded. Those who are not "covered" but still need help seek it from other social service organizations, contributing to the backlogs described above.

Non-profit social service providers are not the only ones who have become the *de facto* responsible party for the indigent. Private health care providers also share the burden. Clinical professionals are required by their Codes of Ethics to do some work for free. However, it is unreasonable to expect private practitioners to absorb the cost of providing huge amounts of free care simply because the government chooses not to pay for it.

An example of shifting the burden to private practitioners can be seen in the much-publicized area of health care for children. Much has been written recently about the successes of the Children's Health Insurance Program, or CHIP, a national initiative developed to assure that kids who need health care can be covered under Medicaid. Monroe County deserves to be proud of the excellent work done by the Covering Kids network in enrolling eligible children in CHIP. The city, county, and state legislators serving Bloomington and Monroe County have been very supportive of this program (and other health care initiatives as well). In fact, Monroe County leads the State, and Indiana leads the Nation, in enrolling kids in the CHIP program.

We all agree that enrolling kids who previously had no health insurance is a good thing. Unfortunately, the Medicaid reimbursement rates for pediatrics are generally inadequate. In one local pediatric practice, the actual cost for a visit to a pediatrician is a little over \$43. Yet, the Medicaid reimbursement rates for three of the most common visits to pediatricians are: \$18.20, \$25.98, and \$37.00. Before you assume that those "rich doctors" are just whining, consider that this is only for things like light, heat, and staff salaries, and does NOT include any payment for the physician. So, pediatricians lose money every time they see a Medicaid patient, while through CHIP more and more kids are becoming Medicaid eligible. This is particularly problematic for physicians that serve Medicaid patients in rural areas since Medicaid may comprise 30-50% of the patient population in those areas. The situation is similar for Obstetrics and Gynecology offices where services

## Center Profile



**Leslie Robison**

CBH welcomes new staff psychologist, Leslie Robison, a Washington State native. Robison earned her Bachelor of Science (BSc) from U. of Victoria (BC) in 1992; followed by an MSW and PhD from Washington State in '95 and '99. Following graduation, Robison spent two years as a therapist and consultant with the Seattle Department of Veteran Affairs, before moving to Bloomington.

Both Leslie and her husband (a post-doctoral quantitative geneticist at IU) love college towns, and Bloomington seemed a great place to land with their one-year-old son Jacob. "We looked for employment that suited our dual careers and Bloomington was just perfect. I liked the people I interviewed with --that's what brought me here."

Robison marvels at the changes she's seen in her short time here. "You don't know what's happening from week to week—but that's not bad!" she laughed. She feels the Center's greatest strength is its willingness to experiment to meet the needs of clients. "If things work, they go for it; if they don't, it's back to the drawing board." Personally, she keeps a healthy balance between work and home life, and has a philosophy for handling work stress. "I make sure I talk to other clinicians; download problems; and don't leave issues hanging. I also realize that there are some things that must wait for a solution." When asked about her hobbies, she saucily replied: "They consist of diapers, bottles, and child-chasing." Welcome Leslie!



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are reimbursed between 1/3 and 2/3 of their actual cost.

Another tactic to manage costs is to simply stop reimbursing for whole classes of diseases. In behavioral health care, Medicaid does not typically cover treatment for chemical dependency. This is a travesty since it effectively denies treatment to people who are suffering from a disease that is chronic, progressive, and deteriorating. That is, the addicted person gets worse without treatment even though the treatments available are about as effective as those used to treat other chronic illnesses.

This places addictions treatment providers in an ethical bind since it is difficult to deny treatment to someone who needs it. The result is private practitioners and social service agencies must choose between serving an uninsured client or going out of business. In essence, by either underpaying (as seen in the example of the pediatricians), or refusing to pay at all (as in the case of addictions), State and Federal payers have shifted the responsibility for serving the indigent to those caregivers who, for ethical reasons, are unable or unwilling to refuse care for this population. It is important to note that private clinicians do not mind providing some free care. Most do so without complaint. It is entirely different to develop public health care policy that purposely shifts the responsibility for indigent care to private practitioners by taking advantage of their ethical commitment to their patients.

Another way to control costs is to pay for only part of the cost of care. Approximately five years ago, the State initiated a program called Medicaid Rehabilitation Option that allowed community mental health centers, such as the Center for Behavioral Health, to bill for services for persons suffering from chronic and debilitating disorders like schizophrenia. This was a new source of funding that was particularly helpful for the treatment of these serious illnesses. The catch was that the State of Indiana puts no money into the program. It is, as they say in the halls of politics, "revenue neutral" to the State. Since Medicaid is made up of approximately 62% federal money and 38% state money, the 38% had to be paid by someone other than the State of Indiana. Who picked up the tab? The community mental health centers. Is this a bad thing? Perhaps not. After all 68% of something is better than all of nothing. Unless of course the cost to provide the care is 69% or greater.

These concerns are not news to our state legislators. The ones I have spoken with are sympathetic and acknowledge that providers are not sufficiently reimbursed under Medicaid. The state legislators serving Bloomington and Monroe County have been very helpful in countering this trend when they can. However, many times they are clearly swimming against the legislative tide. Some legislators have noted that nothing will be done unless a crisis occurs and history has shown them to be correct. It is very difficult for health care providers to refuse to treat patients because of money. Nonetheless, for some providers, the economics become untenable.

A few years ago, many dentists in Indiana realized they could not afford to continue treating Medicaid patients for the reasons listed above. Soon, it became very difficult to find a dentist who would accept Medicaid as a payment source. No health care provider likes making such a decision but sometimes there are few other choices. Eventually, there was an increase in the Medicaid reimbursement rates for dental procedures and Medicaid patients again had dental services available. Providers do not like refusing to provide care but the fiscal issues are real and can have dire consequences.

Pleasant Run Children's Home went out of business in part because their contractors could not or would not pay their bills. Pleasant Run provided a needed service to the citizens of Indiana. The problem was not

(Non Profit Sector...continued )

their mission nor their intention to do good. It was economics. It is simply impossible to stay in business if your expenses exceed your revenues. Some believe the problem lies in the managerial competence of those running non-profits. Perhaps Pleasant Run's management should have done something different. Does the private, for-profit sector have any potential solutions to this problem? Probably not. An under-funded system will be under-funded regardless of the tax classification of the provider. While there have been privatization successes seen in some quarters, health care has not been one of them. The national landscape is littered with the debris of public systems of care that were destroyed through the unsuccessful attempts of private for-profit companies attempting to manage public sector programs such as Medicaid. Indeed, we have even begun to see the whiplash effects in the private sector as employees rebel against the constraints of their HMOs and other managed care programs.

The problem is not with managerial technique. Certainly there are non-profits that could be managed better. The same can be said about for-profits. Consider Enron for example. No, the problem is that demand is outstripping resources. Effective management will only help to a point. After all the efficiencies are found and all the "fat" cut out of the system, there is nowhere else to look to find savings, and services must be curtailed. This is precisely the position Bloomington Hospital was in relative to its ambulance service. Like Nancy Reagan's ill-conceived response to the problem of addictions, providers will have no choice but to "Just Say No" when asked to provide more services without funding.

What happens then? As private providers limit the amount of unreimbursed care they can provide, the problem will "roll down" to the public sector, usually at a local level. For us, that means county government will be forced to respond to an increased demand for services. Consider the cost of health care in the county jails. There has been a direct relationship between decreased funding for the treatment of addictions and increased numbers of jail occupants with addictions problems.

So, what is to be done about this predicament? We don't need to do anything if we regard the less fortunate among us as unworthy of adequate access to food, shelter, and health care, or if we believe that health care providers should pay for the privilege of seeing under-reimbursed patients when legislators know that the reimbursement system is inadequate. We don't need to do anything if we believe that government will magically fix this problem.

As HL Menkin observed, "For every complex problem there is a simple solution—and it's wrong." These complex problems require more than short-sighted, parochial solutions. Like the proverbial balloon that pops up elsewhere when you squeeze it here, this problem will only be fixed by looking at it systematically.

Indigent care is not just the government's problem—or maybe it is. After all, WE are the government. So it ultimately is our responsibility. Controlling costs for one specific area or one particular diagnosis pretends that the lack of reimbursement in that area will make the problem go away. It does not. Employers who want to pay only for the services their employees receive presume they will not have to incur the hidden costs of indigent care either in the form of higher health care rates or higher taxes. The health care and social service system, public and private payers, providers of care, and the community at large all participate in a single system that is more like a web than a group of isolated silos. Legislators have to understand the effects of legislation and politics that in the short run attempt to control immediate costs without regard to the long-term implications. I don't have the answer to this problem but I do know that it's bigger and more interconnected than many of us thought. We have seen the symptoms in our community and I am concerned about the long-term effects. When the life boat that holds ten people is full, what happens to the eleventh person?



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## CBHBreakfast LearningSeries

The Center for Behavioral Health continues to offer its free monthly “Breakfast Learning Series”—informative sessions on a variety of mental health topics. Each session is held on a Friday morning, from 8:00–9:30 a.m., at the Unitarian Universalist Church, 2120 N. Fee Lane (Bloomington). Attendees may be eligible for 1.5 CEU credits (Category I), and no reservations are required. Breakfast is free. For more information, contact Cathi Norton (812-330-2887; [cnorton@the-center.org](mailto:cnorton@the-center.org)). Upcoming topics include:

May 17, 2002	“Child & Adolescent Psychopharmacology”	Melody Gongwer, M.D. Center for Behavioral Health
June 21, 2002	“Assessing Suicide Risk”	Frank Stevens, Ph.D.