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Melodie Peet

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Commissioner of the Department of Mental Health and Mental Retardation, Melodie Peet, stands at the center of a revolution in how mental health services are organized, administered, and delivered. Since February, 1995 Commissioner Peet has been working with providers, families, and consumers throughout Maine to reinvent the state's mental healthcare system from one that is dominated by state government and large institutions to one largely comprised of community-based systems of care. These changes match national trends yet have stirred great controversy in Maine.

In a fall interview with Maine Policy Review, *Commissioner Peet discussed the changing role and shape of her department as well as articulated a new vision for Maine's mental healthcare system--one focused on the integration of services, local governance, and shared decision-making between providers, consumers, families, and state government.*

Maine Policy Review: How is mental health policy changing, in Maine and nationally?

Commissioner Peet: One of the most profound changes in mental health policy was identified recently in the *New York Times:* nation-wide consumers and family members are taking a more central role in developing mental health policy. In Maine we have tried to acknowledge this trend in our planning for the establishment of local service authorities. We've involved parents, family members, and consumers of mental health services in the planning process. Even more, we want them to have a continuing role in the governance of these local service authorities through local board participation. Their involvement represents a *sea change* in the way that mental health services are constructed and offered nation-wide. Mental health has really been one of the last bastions of rigid power relationships between the people who provide services and the people who get services. These relationships are changing dramatically--in similar ways to how most provider-patient relationships in the medical care field started to shift a long time ago. In the mental health field we'll be seeing the implications of this trend for a long time to come. It will continue to push us not only toward a healthier balance but also toward a more cost-effective healthcare delivery system. Ultimately, it will cost less to provide people with what they want and need than to construct our unilateral vision of what they "need" and then struggle to get them to accept it. So called "noncompliance" with services offered in this manner is a costly waste of resources for everyone.

Another way that mental health policy is changing is reflected in the growing acknowledgement and awareness that when we talk about services for people who are mentally ill, we have to put them in a broader social policy context. People who are mentally ill are often among the poorest in society; we can't just focus on the delivery of clinical services; we have to think about them in a whole life context. Not doing so was one of the fundamental failures in the first wave of de-institutionalization. Initially we thought that if we moved people out of hospitals and gave them an after-care appointment then everything would be fine. When this didn't work we became more focused and developed comprehensive case management and crisis services thinking that

then people would be fine. These attempts, however, disregarded the fact that many, many people who have major mental illnesses are living on an income of about $5,000 a year. Unless we keep that reality at the center of our thinking about how to support people in the community, we're doomed to failure. You've probably noticed in the last few years a much greater emphasis on housing, for example, for people with mental illness. We have to look at all of the fundamental elements of existence for any human being--housing, adequate money for food, social contact, etc.--and really try to figure out ways to make sure those things are in place. These types of community supports have to be considered in tandem with the array of programmatic offerings that we're going to put in place. So thinking more broadly is a critical reality shift if we're going to be successful in helping people have successful lives in the community.

A third trend is toward the integration of systems that provide services for people with mental illness and systems that provide services for people with addictive disorders. Here Maine is following a national trend. In the context of managed care, these systems are being blended under the term "behavioral health services." A decade ago most states were separating those services because of the very different kinds of treatment orientations and ideologies that had developed around each discipline. It will be an interesting challenge to move back on that continuum. As of this week the governor's office has indicated that they want my department and the Office of Substance Abuse to develop a plan for putting the agencies together. Our challenge will be to honor the separate histories and treatment orientations of these two fields and to figure out ways to gain from the synergies available from this kind of a blending and unified organizational structure.

A fourth policy issue for the future is how the healthcare system can be more explicit about strategies for resource rationing. Most parts of the healthcare delivery system have not done a very good job at this. We always have had many ways to implicitly ration, but significant opportunities are offered by a diminishing resource environment. We now have to step back and say, "Okay, we're not going to have the same kind of resource pool that we used to have, so how can we re-think the who, what, where, and how of service delivery?"

MPR: How can we do a better job of making those decisions?

Peet: Well, we have a lot of historical artifact in terms of what we do and why we do it. The fundamental assumptions that underlie these artifacts haven't been examined for decades. Our current environment offers a wonderful opportunity to question these assumptions. In Maine we have gained momentum by beginning to build a real consensus process that brings together providers, consumers, and family members. With everyone at the table we can struggle with how to cut up the pie.

MPR: Does the current structure of your department represent one of those historical artifacts you mentioned earlier? Is it time to re-think organizational structure as well as the systems of service delivery?

Peet: I think so. I have spoken with many people throughout the state and asked for their impressions about what we need to change in order to improve care for the people we serve. People are saying that bureaucratic structures and categorical funding streams are huge impediments to service and that we have to get out of our own way by creating structures and

systems that are accessible to people and families at the community level. Right now, we've got one door that you come in if you're a child; another door if you're an adult; and so on. If an individual has both behavioral problems and developmental disability, where do they go? Too often, they go around in circles.

The theme of integration into natural communities is one that we have to come back to as a touchstone in almost everything that we do. We in the Department of Mental Health and Mental Retardation have a lot of work to do on that one--starting at home. We have three separate bureaus right now here: Mental Health; Mental Retardation; Children with Special Needs; and potentially the Office of Substance Abuse. Each bureau has a separate delivery system, admission criteria, and licensing requirements. One thing we hope to do through the Productivity Task Force process is to figure out how we can function as an integrated entity and make access to services at the community level much simpler.

MPR: Can you say a little bit more about the separateness between the fields of substance abuse and mental health?

Peet: There are some interesting origins to the separateness. One of them is stigma--something we struggle with constantly. It is unfortunate that people who are oppressed in various ways start looking for the pecking order of disabilities and oppressed groups. People with mental illness and people with addictive disorders have fallen prey to that and often you will find that those individuals don't want to be associated with the other. Each will think that it's worse to be labeled with the opposite label.

This has probably been a little more of an articulated viewpoint for people with addictive disorders. Often, they feel badly treated in the psychiatric care system and inappropriately labeled as mentally ill. I think one of the current concerns is that somehow, if there's an administrative umbrella over both agencies, this departmental blending will imply that services for people with addictive disorders may be dominated by the medical model. I also think that the self-help movement in substance abuse has been out front of the self-help movement in the mental health field. They feel that the progress they've made and a lot of what really works in recovery is reliant on that kind of ideology; so, if they get pulled into a system that uses the medical model, they feel more at risk for being devalued and consigned to second-class citizenship. There is, unfortunately, historical validity to those concerns. On the other hand, I would say that the self-help movement in mental health has really been gaining momentum in the last few years and there's a lot to be gained in sharing between the two systems now. Notions of recovery are becoming much more central in the treatment of mental illness than was historically true. More similarities exist in how rehabilitation is approached now than was true a decade ago. I believe that having a single administrative structure does not mean that you have to do violence to what is unique and special about each discipline--it becomes the responsibility of the central management core in a structure like ours to make sure that we protect the best aspects of each approach.

MPR: There has been some criticism of the development of decentralized local service authorities. Specifically, there has been concern expressed that too much control is being shifted to consumers and families. How do you respond to this concern?

Peet: That issue is still alive. But, the question is: what is the best balance point for Maine? I believe we are getting a lot closer. Certainly, we are far from the old days where families were blamed for mental illness and everything was kept secret from them. We once used the term "non-compliant" to characterize family members or patients who didn't do what we wanted them to do. We spent a lot of time and energy coming up with strategies that didn't matter because people weren't taking our recommendations or taking the medication. We need to work in partnership with consumers and family members to better understand their needs and how we can best support them. However, there has been some fear from the professional side that if consumers and family members are let in as partners, they will want to run the whole show. Many providers were initially nervous this year as consumers and family members began to take a much more active role in planning. They have been worried that they were going to be dismissed or not as important a part of the process, but it isn't unfolding that way. The family members and consumers I speak with are very clear that they want and need the professional expertise of providers to help them develop a programmatic package that meets their needs. For example, I met this morning with people from the Alliance for the Mentally Ill and then later with a woman from Gaining Empowerment Allows Results, an organizing group for parents of kids with serious emotional disturbance. The issue we talked about was one of how do we make sure that we continue to build strong partnerships with the provider community as we move forward in building community systems of care? I think it's the best of all worlds when we get representatives from all of the affected groups in a room together, kicking ideas around, trying to forge solutions together.

MPR: Are you finding the families ready, willing, and able to take on these new commitments? Are you having any trouble getting them organized and involved?

Peet: First, we are breaking new ground here; nobody has the perfect model. When I first started talking with families in Maine, they were extremely suspicious and basically said: "You know, people have promised us participation before. They've promised partnership and it never materializes. Why should we take a risk again? Why should we get involved?" But that really didn't last very long. As a group, these families are incredibly resilient and hopeful. They have come to the table and are giving us enormous energy and enthusiasm. But, they are also cautious; they worry that we're trying too much, too fast. They're very good at setting limits and saying things like: "We need more time and more training." We have stopped a few times and brought in training consultants. Managed care is a good example. What's more technologically obscure than managed care jargon these days? They nailed it right away by saying: "If you want us to participate in these conversations, you have to give us the vocabulary." So we brought in some people to do just that. While I wouldn't have identified the request a testing behavior, in retrospect, it probably did have the effect of a test. When they made a direct request, we stopped and gave them what they needed. Therefore, our relationships are developing. As providers we have been trained to make all of the decisions and then to disseminate them. Historically, consumers and family members have been socialized to be passive participants. Now, everybody is struggling with how to do it differently. But we're definitely getting there.

MPR: How about providers? Are you finding them willing and ready to change? Are you having any difficulties in getting them organized and involved?

Peet: The provider community throughout the state has been extremely active and engaged in the planning process for local service authorities. They have been particularly important at placing other reality contexts into the mix of things that have to be considered simultaneously with local accountability structures if we are to have a final strategy that works--things like managed care technology and federal Medicaid policy. Most providers are in this field because of a deep commitment to the people they serve. That value base is an extremely important component of a change strategy of this magnitude.

MPR: Tell us more about the long-term goal. Where are we going and what are we striving for? How will we know when we get there?

Peet: Well, probably by the time we get there we'll have to change again. That's the challenge these days. The ultimate goal for us is to create a system of care throughout the state which is organized around local service entities that manage a broad spectrum of services so that people can go to one place and get services for themselves and their families. These local entities must have active and involved participation of family members and consumers on their boards. As a department we will establish the policy context, provide oversight, and help make new technologies available. The everyday dialogue will be at the local level, with the people who are most affected contributing as active participants.

MPR: Can we achieve this level of community integration goal in a relatively poor state like Maine? Will lack of financial resources affect our attempts to change?

Peet: Ultimately, it's not an issue of money. It is an issue of strategy and values, and in that context, I think Maine is better positioned than most states. One of the things that has struck me time after time in this state is the degree to which communities are intact. Many people still take enormous pride in their communities and are very participatory in community life. This is an extraordinary strength. Once someone is identified as being a part of a particular community, people just do things in a very natural way to make sure the fabric of that community is reinforced and underscored. Most places in the country would just die to have that situation. In Maine we have a wonderful base to build on. We have to work with communities to support them. Certain parts of this illness need professional management, consultation, and treatment; we're not abandoning the care of people to communities. However, we need to be more supportive to communities rather than trying to control service delivery. Our historic efforts to do the latter have contributed to the perception that people with mental illness are "different," thus making it much harder for them to assimilate into their own natural communities. We at the department have to take a leadership role in working with communities to dissemble the myths about mental illnesses that continue to keep people prisoners of stigma and discrimination.

MPR: Where does Maine stand in comparison to other states? Are we in the same place, ahead of the curve, or behind?

Peet: In general, I don't think the experience in Maine is much different than it is in most states. I have read about many wonderful things that are going on in almost every state. However, when you look more closely, seldom do you see a truly comprehensive model project or program. What most states have not done, including Maine, is think about a whole system of care. Maine has some excellent programs, but we need to build integrated systems of care. For example, we still use an extremely high proportion of our budget for in-patient care; that's an indicator that we

haven't thought enough about systems development. If you haven't set up good community systems of care, then you're caught in the overuse of in-patient beds which is exactly where we are now. We're trying to figure out how to move some resources away from the hospitals in order to set up more intensive kinds of community services. That in turn will allow people to rely less on inpatient care as their only safety net.

MPR: If there was one thing you'd like to be able to change immediately, what would it be?

Peet: I wish that we could resolve all of our consent decrees so that the department could get back to focusing on what makes sense--the organization of our operations around our policy themes. The plaintiffs for each consent decree do a very good job of advocating for their discreet populations. My job is to look out for the interests of a much broader population. So trying to balance appropriate attention to the consent decrees and maintain the resources and energy of the department to attend to the larger set of populations is a tough job. I often end up feeling that the various groups without consent decrees lose in that equation. Having a strategic plan to drive the department's development over the next few years will move us in a coherent way toward a comprehensive community-based system of care for all populations served by the department--which is really the goal of each of the consent decrees as well.

MPR: Are the institutions in Maine changing much? How do we balance community-based systems of care with the growth of psychiatric hospitals? Are there important changes occurring in how institutions deliver services?

Peet: All healthcare institutions are changing radically under the pressure of managed care. In mental health, we are trying to learn how to use shorter, more clinically focused in-patient stays as part of the client's overall treatment plan.

MPR: Are we able to provide adequate transition services for people as they move from childhood to adolescence to adulthood?

Peet: No. At this point I would say that we have not found consistently good ways to help families move from a children's system where many services are entitlements to the adult system of care which for the most part is not a true "entitlement" system.

MPR: Are there other partnerships that state government needs to look to and are there institutions in the state that need to be more involved to make this paradigm shift take place?

Peet: I think so. Whether it's chambers of commerce or professional organizations or social and civic clubs, we need to figure out how to interface with all of these institutions. These organizations can then advocate for this group of people who for 100 years have been systematically excluded from communities. We used to exclude people who were "different" by putting the poor farms way out of town, and now we do it attitudinally. My experience has been that once you get people sensitized around this issue, they really do want to think about how to change it.

MPR: Is there a positive role for colleges and universities to play in addressing these kinds of issues?

Peet: Yes. However, many schools of professional education have not really caught up with the way the field has changed over the last decade. We continue to train people in a paternalistic manner and out of real life context. It just doesn't work. Most people get out in the field and through trial and error develop strategies that are more pragmatic. But we haven't figured out how to translate our experiences in the field back to academic curricula. I can tell you that whenever you talk to those in the mental health field who are responsible for managing big systems, the human resource issue comes up. Somehow we haven't figured out how to take our field reality and translate it back to universities in a way that has an impact. I think this reflects the general separation between practice and academe. There are wonderful opportunities for both sides to benefit if we can learn how to work better in concert.

MPR: How are you finding your leadership role in Maine State Government?

Peet: It's been an incredible experience in my life. I often think of it as being similar to the first time I ever got on a roller coaster. It has that mix of experience that's exhilaration and terror and not knowing what's around the next corner. I knew it was going to be a tough job before I got here. The governor did not sugar coat it. However, I think I underestimated what having the consent decrees in place was going to add. That was an experience I had not had before. Having so many forces with a legitimized role that are external to the department makes the job much more complex than I could have imagined. We have three consent decrees and the Productivity Task Force reaching into what would normally be the management domain of the department. Maine's legislature is also much more inclined towards management than the one I used to deal with. So it's a much more complex environment within which to manage. It's also been characterized by crisis ever since I got here. On the other hand the governor is a wonderful leader and very supportive. The cabinet is full of very talented people, and that makes a big difference in terms of job satisfaction. The fact that the state is small is also a big plus from my perspective. It makes the hope of changing some things in a positive way feel like it's a realistic goal.

Commissioner Peet received her B.A. in Political Science from Connecticut College in 1971, followed by a M.P.H. in Health Services Administration from Yale University in 1978. Prior to becoming Commissioner of Mental Health and Mental Retardation, Peet spent 16 years in Connecticut where she was involved in the administration, development, and delivery of mental health services.

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