Regular Articles

Managed Care in the Public Sector: Lessons Learned from the Los Angeles PARTNERS Program

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Abstract

PARTNERS is the Los Angeles County Department of Mental Health's capitated managed care treatment program. To explore the context in which public sector managed care reforms are occurring and to understand the obstacles to implementing such programs, qualitative data were collected from administrators, case managers, and clients. Administrators were found to need assistance in negotiating managed care contracts and in tracking costs. Case managers, although concerned about increased clinical demands, enjoyed the flexibility and creativity their new roles allowed. Clients were satisfied with their increased independence, even though many had to change their site of care. Beyond considering these concerns, the range of community stakeholders who may be affected by such interventions must be addressed.

High health care costs have been an increasing problem in both private and public sectors of health care. In response to fiscal constraints, public mental health systems have implemented various types of managed mental health care.[1–4] While the public sector has a long tradition of emphasizing the

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importance of management of care through coordination and integration of services,[5] this tradition has reflected primarily a clinical goal rather than a budget management goal. Increasingly, however, the new forms of managed care in the public sector emphasize cost containment. Capitation and other forms of risk contracting have become an increasingly common way of financing public sector managed care.[6,7]

The introduction of these new forms of managed care have created novel sets of demands on public mental health systems and on the agencies with whom they contract to conduct managed care programs. For example, to an increasing extent, clinical case managers are being asked to blend their traditional clinical roles with that of allocating scarce resources; public mental health administrators are, more than ever, being forced to become more familiar with the often sophisticated economics involved in risk contracting.[3] Further, in some instances, clients are being required to change case managers or otherwise alter their usual care. While a number of public sector managed mental health care programs have been evaluated and described in the literature,[1–4,8,9] little has been published that more qualitatively describes the impact of such programs on administrators, case managers, and clients.

The PARTNERS (People Achieving Rehabilitation Together Need Empowering Respectful Support) program, conducted by the Los Angeles County Department of Mental Health (LAC DMH), is a model of managed care in which resources are shifted from inpatient care to a capitated, community-based treatment program in an effort to make better use of existing treatment funds and to improve health care for high-cost service utilizers. Prior analyses of the PARTNERS program have investigated disenrollment rates and treatment costs.[3,10] Because PARTNERS uses a full-risk contract, shifting much of the financial responsibility to community organizations, there is a strong incentive to disenroll high-cost utilizers.[3] In addition, client empowerment was recognized as essential to the success of PARTNERS.[11–17] For example, services were designed to emphasize client participation in setting goals, planning services, and evaluating the outcome of these goals and services. While PARTNERS did not uniformly reduce treatment costs, it did successfully transition clients from unstable clinical situations involving frequent hospitalizations to ongoing community care.[10] This article presents the results of a qualitative study of the PARTNERS program that was intended to expand the understanding of obstacles and benefits of program implementation from the perspectives of participating administrators, case managers, and clients.

Methods

The PARTNERS program

In the fiscal year ending in 1993, the LAC DMH oversaw a treatment network that included two state hospitals, two county hospitals, 28 directly operated adult programs, and 410 mental health contracts with 100 community organizations and funding of over $275 million.[18] In the decade leading to the PARTNERS initiative, the LAC DMH experienced repeated budget cuts that resulted in the closure of numerous programs at a time when the population of Los Angeles County was growing. Hospital costs were a particular burden, despite efforts to increase the proportion of care provided in community settings. In 1993, an opportunity emerged for the LAC DMH to shift funds from the support of 200 hospital beds to a new, intensive, community-based treatment program for 500 high-cost clients. Due to the county budget process and concerns regarding political opposition, the implementation of PARTNERS had to proceed quickly, allowing limited time to plan or to assess clients clinically before enrollment.[3]

Community-based treatment organizations submitted proposals in response to an LAC DMH project announcement. Six private, not-for-profit organizations were selected. Each was paid a fixed rate per client with no risk sharing between the six community-based treatment organizations and the LAC DMH. Organizations were called integrated service agencies (ISAs) because they agreed to either facilitate, directly provide, or contract for mental health care, medical and dental care, social

and vocational rehabilitation, and housing, all within a model that emphasized client empowerment. Client empowerment was defined as increasing consumer involvement in care and in clinical decision making. In addition, mental health care was to include transportation, active family participation, substance abuse treatment, and 24-hour crisis response.

The ISAs were to be held financially responsible for treatment across all LAC DMH outpatient, inpatient, and crisis intervention settings with the exception of pharmaceuticals and acute hospitalizations paid for by fee-for-service Medi-Cal (California's Medicaid). ISAs received between $14,000 and $21,000 per client per year depending on each ISA's bid to the LAC DMH. Clients were considered eligible for PARTNERS if they were between 18 and 64 years of age; had received LAC DMH treatment for at least 3 of the previous 5 years; and, in the previous 5 years, had LAC DMH annual health care costs averaging more than $30,000. In total, the six ISAs included approximately 40 to 50 mental health professionals and administrators who provided or supervised care to these 500 clients. Also involved were three administrators from LAC DMH. Because PARTNERS utilized a fixed rate or capitated reimbursement model, the ISA organizations—not the individual providers—were essentially "at risk" for those clients who incurred high costs. In most cases, front-line providers were not required to alter their documentation procedures for PARTNERS. Additional details about the structure, implementation, and cost of the PARTNERS program is described in previous work.[3,10]

Data collection

Qualitative data were collected from March through July 1997. Data collection techniques, which included both focus group discussions and key informant interviews, targeted four perspectives: LAC DMH administrators, ISA administrators, ISA case managers, and clients who received PARTNERS services. Interviews were conducted with three LAC DMH administrators (who represented senior management, planning, and contracts functions) and two key, middle-level management personnel (who were responsible for administering the PARTNERS program).

To gather data from ISAs, interviewers met with at least one senior administrator (eg, executive director, chief operating officer) and the PARTNERS director from each of the six ISA sites. In addition, four focus group discussions were conducted with a total of 28 case managers from four of the six ISA sites. An additional four focus group discussions were conducted with a total of 24 clients at three of the six ISA sites. Case managers from each facility were responsible for recruiting clients into focus group discussions. Key informant interviews as well as focus group discussions lasted approximately 1 hour. Participation was voluntary.

Data collection was designed to best document the conflicting perspectives of all parties involved.[19,20] Interviews were conducted by a team of two individuals. One team member had primary responsibility for conducting the interview. The second team member monitored the progress of the interview, ensuring that all topics were covered and taking comprehensive field notes using a laptop computer. Interviews were guided by protocols containing suggested questions and an outline of the specific areas in which information was to be gathered. As such, the semistructured approach ensured comparability for the data collected across all sites, while allowing respondents flexibility in the order and perspective of reporting information.

While separate interview protocols were developed for the LAC DMH and the ISA administrators, all interviews and focus group discussions contained a common set of core questions covering topics pertinent to program implementation and the kinds of problems or experiences they underwent with start-up, such as staffing; locating, enrolling, and retaining clients; providing services that met their mandate; financing issues; and interactions with one another. Interviewers also asked about how problems were handled; what services were provided; how services were organized, supervised, and monitored; how difficult it was to integrate the services of multiple agencies at the client level; and what gaps existed in the service system.

Clients were interviewed in focus group discussions to gather information on their expectations, participation, and satisfaction with PARTNERS. Research shows that focus group discussions are particularly useful in situations where the perspectives of many members of a target population are being sought and a high degree of prior knowledge on a topic has not yet been attained.[21–23] While the results are not necessarily generalizable to a larger population, they have the advantage of being more detailed than most quantitative survey results. In addition, using a group format elicits comments and interactions that would not occur in dyadic interactions, and it provides quality controls on the data by allowing respondents to identify false or extreme views.[19]

Results

Results are separated into three groups based on interview responses with PARTNERS administrators, case managers, and clients.

Administrators

The request for proposal (RFP) for the PARTNERS program was issued on December 1992 and was awarded to the six ISAs in February 1993. This was a rapid turnaround time because the funding opportunity for this program involved transferring money from the state hospital system to the LAC DMH at the close of the calendar year. Both the LAC DMH and the six PARTNERS ISAs agreed that this rapid bidding and contractual process had a negative impact on implementing a project of this complexity and significance. For example, there was limited time for the LAC DMH and ISAs to meet with organizations in the community that would be affected by the implementation of this program. All six of the ISAs reported challenges interacting with other agencies that were unaware, unprepared, and often perceived themselves in conflict or competition with PARTNERS's efforts.

The implementation of PARTNERS represented a major change in the delivery of community-based mental health services in Los Angeles. Any challenges were amplified as a result of implementing PARTNERS with relatively little development of the needed infrastructure and outreach to the broader network of community stakeholders. For example, one goal of PARTNERS was to move individual clients from more restrictive locations (eg, hospital wards) to less restrictive residential placements. Within the community setting, this meant moving clients from locked facilities (eg, hospitals, skilled nursing facilities, and privately owned chronic care facilities called institutions for mental disease) into open board and care facilities or apartments. As the ISAs began to move toward this goal, it became clear that some locked facilities would actively resist any such effort if it meant a perceived loss of revenue for them. Likewise, when some clients were assigned to PARTNERS, there was resistance from some community mental health centers (CMHCs), especially in those cases where the clients were already actively participating in CMHC programs. "Nobody in the community had heard of PARTNERS, how it worked, and what it would mean to them," said one of the PARTNERS chief executive officers (CEOs).

In addition, community stakeholders stated that when ISAs contacted clients directly, they left the clients' current treatment staff uninformed. To resolve these conflicts, ISAs assigned community specialists to work directly with community stakeholders, such as board and care programs, to establish partnerships. The LAC DMH and the ISA agencies also clarified guidelines for engagement, transfer of treatment, care coordination, and clarification of the program's clinical and fiscal expectations for both the ISA agencies and the community stakeholders. A range of contractual business relationships was developed with external stakeholders where ISAs paid a community agency to provide care to PARTNERS clients. The LAC DMH also provided ongoing training and met monthly with program coordinators during the initial months. Once the procedures were developed, there was a continuous effort to educate providers about the ISA program and its requirements.

In addition to having difficulties caused by rapid implementation, ISA administrators had minimal experience negotiating managed care contracts. Five out of the six ISAs reported difficulty

understanding the clinical and fiscal expectations of the RFP. Due to the rapid RFP turnaround time, the LAC DMH had only a limited amount of time to help the ISAs with understanding the complicated service and funding reforms. All six of the ISAs expressed some degree of confusion over the contract funding mechanisms, such as how Medi-Cal dollars were used, how to project the cost of delivering services to a population of high utilizers, how to set program rates, and how programs would maintain their savings.

PARTNERS CEOs stated they believed that flexible fiscal incentives were to be built into the program for agencies to maintain whatever savings existed at the end of a fiscal year. They reported not being able to hold on to savings, either because it was not possible to have savings at the end of the year or because savings needed to be returned to LAC DMH. Second, the ISAs were frustrated because they had little control over some of the costs for which they were ultimately responsible. They found themselves at a significant disadvantage because there was a lack of risk sharing by the LAC DMH. As a result, the ISAs were legally and financially responsible for a range of events that they felt they were not directly authorized to manage. For example, ISAs were not in a position to manage or influence various hospital costs for which they were billed and often could not afford. Influence over hospitalizations would not occur until approximately 1 year after the state of California transferred the responsibility of the private, fee-for-service Medi-Cal acute psychiatric hospitals to LAC DMH. This shift in responsibility was considered Phase I in consolidating the private, mental health fee-for-services Medi-Cal sector with the then Short-Doyle/Medi-Cal mental health sector.

Moreover, while ISAs provided case management services, duplicate case management was provided by other community organizations and billed to the ISAs. Some of the duplicate case management activities were simply an overlap of services due to a client's cultural and linguistic needs that required a coordinated effort from ISA staff and another agency's bilingual treatment staff. Generally, ISAs lacked the critical mass to provide the array of bilingual services needed for some clients and an ethnic-specific agency usually did not possess the resources and expertise to provide intensive ISA-type services.

It was essential for ISAs to have a monitoring system to ensure services were coordinated, approved, tracked, and billed appropriately. All six of the ISAs initially planned to use only the LAC DMH's system. There were problems with the accuracy, usefulness, and timeliness of existing data, and ISAs eventually developed monitoring systems at their own expense. However, these efforts produced mixed results, creating double data-entry efforts and disparate data when compared with the LAC DMH management information system (MIS). The MIS was important since it was the basis for processing claims, finding utilization data, and coordinating care and client information. For example, when the client's information was accessed, the LAC DMH MIS alerted non-ISA providers to contact the ISA for authorization of services.

Another unexpected problem with the PARTNERS implementation was a high rate of disenrollment. During the initial 9 months of implementation, a total of 1,332 clients were disenrolled. Of this group of disenrolled clients, 55% ($n = 739$) were found not to meet the criteria for participation because they could not be considered for community placement and care due primarily to severe brain damage or substantial and recent continuous histories of destructive behavior.[3] ISAs reported they had to expend considerable resources to locate and enroll prospective PARTNERS clients from the LAC DMH lists because clients had died, were incarcerated, or had moved to a different address. In many cases, even if the prospective client was located, gaining access to the person to make a clinical assessment and introduction was made more difficult by resistance from existing providers. Also, although PARTNERS was not funded to conduct face-to-face interviews or in-depth chart reviews prior to enrollment, this could have helped to ensure that clients met clinical criteria for participation.

All six of the ISAs reported increased rates of staff burnout. Each ISA struggled with recruiting staff and stated they did not expect to hold on to a staff member longer than a year. Although this extent of retention does not differ from that in most organizations intensively treating persons with

serious mental illness,[24–27] all of the ISAs addressed staff burnout. To help case managers, ISAs developed staff clusters where a team leader would provide planning, evaluation, and training. In addition, regular staff meetings were conducted so staff could provide support to each other and problem solve challenging cases. Nevertheless, staff turnover remained an issue at all six ISAs.

Case managers

Because client empowerment was recognized as essential to the success of PARTNERS, services were designed to encourage clients to take a more active role in their treatment. The mental health case managers within the ISAs were generally pleased with this underlying philosophy and the treatment assumptions of the program's empowerment model of care. They said PARTNERS challenged them to use creative treatment approaches that were very different from those previously practiced. Generally, adult outpatient caseloads ranged from 15 to 20 cases per case manager compared with 75 to 125 in usual care. Because caseloads were smaller with this treatment model, case managers reported they had a greater opportunity to assist clients with their families and communities in meaningful ways.

However, some described great difficulty transitioning to this new treatment approach. For example, staff were no longer merely expected to provide "office-based" mental health services in the traditional 50-minute model of care. Instead, staff needed to be available 24 hours a day/7 days per week to provide intensive case management, most often in the form of teaching independent living skills and providing overall assistance and support. Therefore, while case managers expressed satisfaction that PARTNERS allowed for more flexibility and time with clients, they described this type of work as demanding and echoed administrators' view of staff burnout and turnover. Most case managers stated that their traditional professional training had not provided the skills necessary to be successful in a treatment model such as PARTNERS, and most thought that additional training would have been helpful.

Clients

Approximately half of the clients learned about PARTNERS through their case managers or family members while they were either getting out of the hospital or moving to a different living situation. Clients hoped PARTNERS would help them become more independent, increase their education, find employment, save money, and live on their own. Many reported they found PARTNERS difficult to adjust to, but, over time, their comfort grew. Initial discomfort seemed to be related to changing to a new set of providers and leaving their usual mental health providers and clinics. Clients said they especially liked that staff were available on weekends and evenings. "If I have a problem, no matter what time of day or night, there is someone to call," said one client. Still, clients reported they wished staff had more time to participate in day treatment group activities.

When asked about setting goals, many clients reported that it helped to have someone assisting them. However, some found it frustrating when their opinions about goals differed from those of their case managers. Several clients reported that vocational classes needed to be more challenging, and some wanted more assistance finding a job. Clients also reported a need for more organized social events, especially when holidays resulted in having too many days off.

Virtually all of the clients who participated in the focus group discussions agreed that PARTNERS allowed them to increase their satisfaction with their living situations. In particular, they stated they were able to be more independent and to rely less on family members. They also believed that they were better able to take their medications as prescribed, and they were especially satisfied with the assistance received in learning new vocational skills.

Discussion and Implications for Behavioral Health Services

Managed care interventions often represent a radical departure from the conventional organization of public sector mental health services. In any public health system, managed care, especially if

broadly implemented, can entail a basic restructuring of the system, and such restructuring may affect all stakeholders in the system in both obvious and subtle ways. The LAC DMH PARTNERS program provided an opportunity to explore the content in which public sector managed health care reform will be occurring and to understand the obstacles to implementing such programs. Stakeholders in this system include not only the administrators, case managers, and clients (which were addressed in this article) but also many other participants in the traditional care network for persons with serious mental illness, such as families and other caregivers, community mental health clinics, skilled nursing facilities, and locked psychiatric facilities.

The success of PARTNERS, and of any managed care program implemented in the public sector, depends not only on the kinds of programs it fields and their economies, but also on the pressures and incentives it imposes on the stakeholders in the health care network. Some stakeholders may perceive themselves as benefiting from this realignment and may aggressively attempt to facilitate its implementation. Others may be threatened by these changes and, in some instances, may actively try to resist them. Public mental health systems that are initiating managed care programs can likely benefit from anticipating these reactions, to the extent possible, and preparing stakeholders in advance.

Clients in PARTNERS reported great satisfaction with a program founded on principles of client empowerment. The benefits, especially greater independence and assistance with vocational skills, appeared to outweigh the discomfort of changing to a new set of providers. However, since participants were invited to join these innovative programs and could refuse to enroll, this group of clients may have consisted primarily of those most likely to welcome change.

Both case managers and administrators identified staff burnout and turnover as concerns, even when measures were taken to minimize these problems. If intensive case management is utilized in managed care programs, it is possible that smaller caseloads may be needed. Alternatively, the most intensive case management could be targeted to those most in need. Many case managers who have been trained in traditional office-based practice may need additional training to perform optimally in other community treatment settings.[12] For example, providers may need more teaching regarding the very seriously mentally ill, management of violence, treatment of mentally ill persons with substance use comorbidities, and in the principles and practices of assertive, rather than passive, treatment. More direction also may be needed in the increasingly common dual role of balancing clinical needs with the demands for cost containment. Due to attrition, the case managers interviewed were those with the longest track records in the PARTNERS program. It is, therefore, unlikely that they are a representative sample of all case managers involved in PARTNERS and may, in fact, view the program more positively than those who left the program earlier.

Researchers have found that individuals with serious mental illness often receive poor quality care.[28] Rates of inappropriate treatment are high, and outcomes appear to be much worse than those that are found in programs delivering state-of-the-art care.[29,30] It is possible that many current clinicians do not posses the clinical competencies required to provide high-quality care for serious mental disorders.[12] LAC DMH management clearly stated that one goal of PARTNERS was to improve the quality of services provided to the most severely ill clients under their care. The comments of stakeholders reflect the extent to which PARTNERS changed the organization and delivery of care to this population. However, stakeholders commented on challenges of the PARTNERS implementation much more than on the quality of clinical care or improvements in care. It is possible that interviewer questions focused more on the challenges than on the advantages of the program, despite efforts to allow respondents to determine the direction of the interview. Changes induced by PARTNERS, such as increased access to important community and rehabilitative services, may have had a positive effect on quality and outcomes. Future efforts to improve the delivery of mental health care may benefit from an increased focus on the measurement of quality and should target specific domains for measurable quality improvement.

Finally, many of the most challenging obstacles in implementing the PARTNERS program were organizational in nature. Administrators from both the LAC DMH and the ISAs attributed challenges

during implementation to a short timeline, having little experience with managed care contracts, and having problems with client disenrollment. Clearly, lessons were learned from the PARTNERS implementation. Such lessons can provide valuable information to administrators preparing to contract managed care mental health services. For example, like the ISAs, many traditional public mental health provider organizations are poorly prepared to negotiate or even to appreciate fully the implications of risk contracting. Further, many lack the infrastructure, especially comprehensive data management systems, to track cost data effectively and efficiently, a component often critical to managing the economies of risk contracting. Knowing which data to have available, how to get them, and how to use them are all issues that health care systems across the nation are struggling to resolve. As many public mental health authorities decrease the extent to which they are directly providing care and increasingly contract for care, it will be necessary to develop additional expertise in these areas.

Implementation of managed care programs, including PARTNERS, tends to be turbulent; stabilization of the initial PARTNERS program was not complete until early 1995. Despite the many obstacles discussed in this article, the PARTNERS program must be considered a success in that it resulted in more care being delivered in community settings using a more assertive treatment philosophy. These changes are not directly the result of a different funding mechanism (ie, capitation), and could have been implemented by a mental health system without the introduction of a new reimbursement mechanism. However, in this case part of the intent of the PARTNERS contract was to alter the treatment approach and philosophy. PARTNERS not only encouraged innovation but also targeted high-cost clients. Since the quality of care usually provided in public mental health systems is often poor, especially for these clients, more innovative programs such as PARTNERS are needed.

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References

1. Hoge MA, Jacobs S, Thakur NM, Griffith EE. Ten dimensions of public-sector managed care. *Psychiatric Services*. 1999;50(1):51–55.
2. Essock SM, Goldman HH. States' embrace of managed mental health care. *Health Affairs*. 1995;14(3):34–49.
3. Young AS, Sullivan G, Murata D, Sturm R, Koegel P. Implementing publicly funded risk contracts with community mental health organizations. *Psychiatric Services*. 1998;49(12):1579–1584.
4. Chang CF, Kiser LJ, Bailey JE, et al. Tennessee's failed managed care program for mental health and substance abuse services. *Journal of the American Medical Association*. 1998;279(11):864–869.
5. Lehman AF. Strategies for improving services for the chronic mentally ill. *Hospital & Community Psychiatry*. 1989;40(9):916–920.
6. Mechanic D, Aiken LH. Capitation in mental health: potentials and cautions. *New Directions for Mental Health Services*. 1989;43:5–18.
7. Lehman AF. Capitation payment and mental health care: a review of the opportunities and risks. *Hospital & Community Psychiatry*. 1987;38(1):31–38.
8. Dickey B, Norton EC, Normand SL, Azeni H, Fisher WH. Managed mental health experience in Massachusetts. *New Directions for Mental Health Services*. 1998;78:115–122.
9. Lurie N, Christianson JB, Gray DZ, Manning WG Jr, Popkin MK. The effect of the Utah Prepaid Mental Health Plan on structure, process, and outcomes of care. *New Directions for Mental Health Services*. 1998;78:99–106.
10. Kapur K, Young AS, Murata D, Sullivan G, Koegel P. The economic impact of capitated care for high utilizers of public mental health services: the Los Angeles PARTNERS program experience. *Journal of Behavioral Health Services & Research*. 1999;26(4):416–429.
11. Geller JL, Brown JM, Fisher WH, Grudzinskas AJ Jr, Manning TD. A national survey of "consumer empowerment" at the state level. *Psychiatric Services*. 1998;49(4):498–503.
12. Young AS, Forquer SL, Tran A, Starzynski M, Shatkin J. Identifying clinical competencies that support rehabilitation and empowerment in individuals with severe mental illness. *Journal of Behavioral Health Services & Research*. 2000;27:321–333.

13. Rogers ES, Chamberlin J, Ellison ML, Crean T. A consumer-constructed scale to measure empowerment among users of mental health services. *Psychiatric Services*. 1997;48(8):1042–1047.
14. Greenfield S, Kaplan S, Ware JE Jr. Expanding patient involvement in care: effects on patient outcomes. *Annals of Internal Medicine*. 1985;102(4):520–528.
15. Greenfield S, Kaplan SH, Ware JE Jr, Yano EM, Frank HJ. Patients' participation in medical care: effects on blood sugar control and quality of life in diabetes. *Journal of General Internal Medicine*. 1988;3(5):448–457.
16. Liberman RP, Kopelowicz A, Young AS. Biobehavioral treatment and rehabilitation of schizophrenia. *Behavior Therapy*. 1994;25:89–107.
17. Mueser KT, Glynn SM. Family intervention for schizophrenia. In: Dobson KS, Craig KD, eds. *Empirically-Supported Therapies: Best Practices in Professional Psychology*. Thousand Oaks, CA: Sage; 1998:157–185.
18. *Annual Report to the Los Angeles County Board of Supervisors*. Los Angeles, CA: Los Angeles County Department of Mental Health; 1993.
19. Patton MQ. *How To Use Qualitative Methods in Evaluation*. Newbury Park, CA: Sage; 1987.
20. Lincoln YS, Guba EG. *Naturalistic Inquiry*. Newbury Park, CA: Sage; 1985.
21. Krueger RA. *Focus Groups: A Practical Guide for Applied Research*. Newbury Park, CA: Sage; 1988.
22. Morgan DL. *Focus Groups as Qualitative Research*. Newbury Park, CA: Sage; 1988.
23. Stewart DL, Shamdasani PN. *Focus Groups: Theory and Practice*. Newbury Park, CA: Sage; 1990.
24. Young AS, Grusky O, Sullivan G, Webster CM, Podus D. The effect of provider characteristics on case management activities. *Administration & Policy in Mental Health*. 1998;26(1):21–32.
25. Ben-Dror R. Employee turnover in community mental health organization: a developmental stages study. *Community Mental Health Journal*. 1994;30(3):243–257.
26. Gillespie DF, Numerof RE. Burnout among health service providers. *Administration & Policy in Mental Health*. 1991;18(3):161–171.
27. Oberlander LB. Work satisfaction among community-based mental health service providers: the association between work environment and work satisfaction. *Community Mental Health Journal*. 1990;26(6):517–532.
28. Lehman AF. Quality of care in mental health: the case of schizophrenia. *Health Affairs*. 1999;18(5):52–65.
29. Young AS, Sullivan G, Burnam MA, Brook RH. Measuring the quality of outpatient treatment for schizophrenia. *Archives of General Psychiatry*. 1998;55(7):611–617.
30. Kissling W. Compliance, quality assurance and standards for relapse prevention in schizophrenia. *Acta Psychiatrica Scandinavica Supplementum*. 1994;382:16–24.