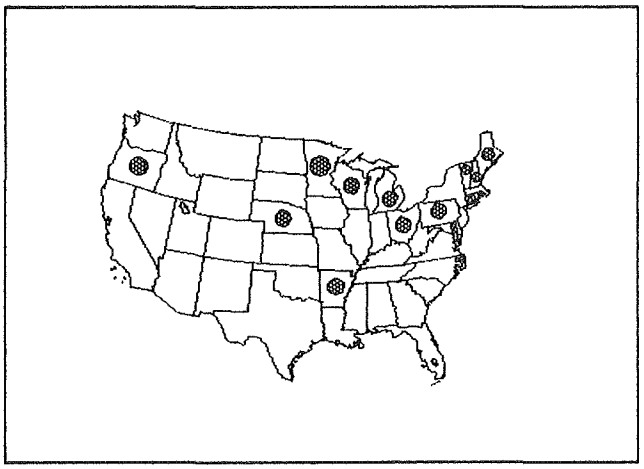
MENTAL HEALTH SYSTEMS REFORM IN SELECTED STATES



A Report to the Maine Systems Assessment Commission

November 1990

FOREWORD

This report was prepared for review by the Maine Systems Assessment Commission to assist it in its deliberations about mental health issues in the state. The information included in this document was obtained in a series of telephone interviews conducted in the summer of 1990 and through a review of written reference materials provided by other states. The findings are presented individually for each state, as the study states have had widely different issues with which they have to contend. To enable readers to use the document and to make comparisons between the states, an index is provided at the end of the report.

I would like to thank Joan Lawson, Elizabeth Heath and Kala Ladenheim for their support and encouragement with this project, as well as Donald Nicoll for his supportive questions, guidance and suggestions. I would also like to thank the Systems Assessment Commission members who have shown genuine interest in the project.

In any exploratory study such as this, it is always possible that the findings raise as many questions as they answer. It is my hope that the information is clear and accurate so that students of mental health systems reform will be able to use this report to continue to ask the right questions.

Bruce H. Thomas

SUMMARY OBSERVATIONS

Study Sample

In early 1990 the Systems Assessment Commission became interested in learning about other states' experiences with mental health systems reform. To do this, the Commission entered into an arrangement with the Health Policy Advisory Council office to conduct interviews and review materials that would offer various perspectives on the dynamics and status of systems change efforts in other states. A sample of states was selected following discussions with individual Commission members, review of the 1988 Report by the Public Interest Research Group, and the Alliance for the Mentally Ill entitled, Care of the Seriously Mentally Ill, a Rating of State Programs [1] and discussions with the George Washington University Intergovernmental Health Policy Project.

The states chosen for study were further targeted for "in-depth" or routine reviews, with up to four people being interviewed in "in-depth" states and one or two in "routine" states. The states selected for in-depth review were chosen because they shared one or more surface characteristics with Maine: Rhode Island had a state level service system and uses Community Mental Health Centers (CMHCs) in its reform efforts; Minnesota has a rural service delivery system as well as urban, with a history of innovative health care delivery; Vermont is a New England state that has used CMHCs in its reform efforts and has explored getting out of the state hospital "business;" finally, New Hampshire was studied to assess how it was able to develop both community services and tertiary care for chronic mental illness. "Routine" states selected included Arkansas, Connecticut, Nebraska, Oregon, Michigan, Pennsylvania and Wisconsin. Kansas, Colorado, and Washington were also contacted, but are excluded from this report due to insufficient information.

Method

The interviews were organized around a set of values upon which the Commission had reached agreement. These value statements were sent to state contacts to illustrate the general subject matter of the interviews. Interviewees were selected on the basis of their ability to explain systems issues in mental health. Directors, advocates, planners, community program directors, legislators, legislative staff, and primary and secondary consumers were interviewed by telephone in June and early July. Interviews ranged in length from thirty minutes to one and one-half hours.

Materials were sought that would describe the systems change efforts or further an understanding of those efforts. The majority of states sent a comprehensive plan. These were often supplemented with statutes, budgets, task force reports and other documents.

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[1]. E. Fuller Torrey, S. Wolfe, L. Flynn, Public Citizen Research Group, Second Ed. 1988

Analysis

This exploratory study consisted of a review of literature and interview notes that began in August, 1989. Time pressure has made it difficult at this point to obtain feedback from the states on the draft findings; this might be impossible in some situations. Problems with the study also include possible "response bias" from states, reliability problems with open-ended interview questions which were not entirely standardized, and incomplete information. The decision was made to draft a profile of findings from each state and to integrate the findings whenever possible into the ongoing deliberations of the Commission. The draft profiles are included in this report, and surveyor impressions are provided as a summary. There may be inaccuracies or omissions in some areas, and some states that appear to have many problems may simply be at a stage of planning or development where it may not be helpful to air one's problems in public. Other states which may appear to be relatively "trouble free" may have difficulty with self analysis. Some states may have an excellent system for severely mentally ill adults and not for children. These states may emphasize positives and negatives quite differently. Finally, the number and mix of respondents may influence the findings. Interpretation of these draft profiles must be done with awareness of these factors. That said, it is possible to study each state and derive several common concerns as well as specific differences.

Systems Structure

Organizational structure or location did not appear to affect the process of systems reform, once reform got underway. One the other hand, failure to unify state institutional and service functions or to articulate a clear role for the mental health agency in the context of either executive or provider agencies made it difficult to initiate a change process. Some of the study states have attempted to simplify the focus of the agency (e.g., by focusing on just adults or on the severely mentally disabled). Other states have changed state agency leadership and have used this as an opportunity for restructuring agency functions. Continuity of political and executive leadership, combined with an incremental approach to planning that was based around shared concerns and values and which rewarded participation with concrete actions appeared to be the keys to sustaining systems change efforts during the 1980s. One recurrent theme centered around changing the role of the state institution; all study states have had only partial success in downsizing, however. Barriers to this include lack of resources to insure provider risk in the community, disputed collective bargaining agreements, lack of professionals oriented toward public psychiatric care, dogma, and lack of both technology and infrastructure. A common theme, stemming from the experience with community supports for the chronically mentally ill in the 1980s and the emergence of younger people with serious mental illness who were never institutionalized, is the need for real housing and real jobs. Virtually all states were involving consumers in helping reorient the system toward "consumer-directed" models of care, similar to what is occurring with physically disabled populations.

Flexible Response

Variety in interventive repertoires was evident: where it used to be just a monthly clinic visit or weekly contact with a caseworker to deal with problems, it now includes intensive case management, crisis teams or mobile outreach and consumer drop in centers to tailor a crisis intervention service or to prevent crises. Similarly, a wider range of housing alternatives has been found useful, particularly for the never-institutionalized population. These have the potential for helping contain General Fund costs, but the time required to develop the needed variety of community serfices in the state to achieve such cost containment in a decentralized service delivery system is likely to exceed five years and may require ten.

Accountability

The exploration of Medicaid funding alternatives for capitation/case management models is a recurrent theme, as are leveraging federal vocational rehabilitation and housing resources. The use of foundation and NIMH grants to fund demonstration projects has been relatively high in the more successful systems. The key to leveraging as well as to expanding Medicaid appears to be developing a statewide system of accountability in a decentralized system. This system is successful if its purposes are clear, and if it supports planning. An important aspect in system reform appears to be the willingness of providers (e.g. CMHCs, hospitals, and practitioners) to risk integrating the unique service needs of those with severe mental illness into their programs. The increased role of consumers and families in program planning, the use of performance contracting, and the development of clear goals all seem needed to develop a locally-based, unified service delivery system.

SUMMARY OF STATE FINDINGS

Administrative and Political Infrastructure to Support Change

Pennsylvania is a state where institutional interests are well developed and where reform involves building a local service delivery system. The reform is not yet based in statute as in Ohio. The dominance of the private inpatient system, particularly in regard to children and youth is seen as a financial problem as well as a control problem that may be partially addressed by creating a wider array of community services and by restructuring the financing system. The understanding of the human resource development issues in the state plan is particularly profound, and represents an apparently insoluble problem that will worsen. The plan for unifying the system at this time appears to be oriented toward establishing necessary administrative infrastructure to support the expansion of medicaid, to articulating a vision developed by opening up the process to families and consumers at the state and county levels, and by developing and maintaining a variety of policy, research, and program development relationships within the system.

Resolve Structural Barriers to Change

In Minnesota there was a sense of frustration that the state had recapitalized three of its six State Hospitals ("Regional Treatment Centers") and a general feeling that the efforts toward mental health systems reforms sparked by the 1986 study were in danger of losing their momentum. There was a general tone of fatigue noted in the responses, and while the philosophy and statutes are in place, the lack of adequate resources is seen as a problem. One respondent suggested that structural elements prevent mental health from being perceived with a health care mind set, and instead contribute to its perception as a form of welfare. as one example reported by an interviewee, the state has recently attempted to remove expanded coverage of group mental health benefits from state insurance policies. The assistant commissioner who Fuller Torrey described as the "Margaret Thatcher of Mental Health" brought in to lead the change has since resigned; one respondent noted that the Governor had originally sought to make this a commissioner level position, folding in the responsibility for the Regional Centers. The interviews convey the impression that the reform effort has reached a plateau and there is no clear vision of where to go next. This reflects uncertainty about the gubernatorial election as well as about the commissioner's successor and the continuation of the state hospitals. The legislative initiatives are essentially complete; the incentives for changing behavior are not all in place, however, and there is an expressed need to develop a coalition between the CMHCs and the Counties.

Maintaining Flexibility in Delivery

Wisconsin's approach to mental health systems development has been to integrate service delivery with the generic human service delivery system under a system of local governing authorities. The approach also has been to ensure that counties have a high degree of flexibility in how they

plan, organize, deliver, and finance mental health services. The trend toward maximizing federal Medicaid funds to guide service expansion to emulate models and to achieve greater uniformity will clearly require a degree of centralization, and uniformity in quality assurance efforts. The state's comprehensive approach is strongly oriented toward ensuring that civil rights are preserved as the state and counties act to intervene in ways which emphasize the least restrictive alternative for treatment. Overall, Wisconsin has made many legal and administrative tools available that should facilitate flexible intervention in people's affairs. However, this commitment to flexibility is likely to erode as funds become tighter. As a result of this probable erosion, it is unclear what will happen to the state's concept of universal entitlement.

Rural Systems Have Different Resource Needs

The move toward a community managed care system is the general direction of the Arkansas system. There are four parameters of such change: (1) systems change involves attitudinal change, and this takes time, (2) human resources requires a commitment to both training and retraining, (3) maximizing the available funds through internal restructuring to use the rehabilitation option under medicaid (to cover case management in the community) and (4) recognizing that there is limited human resource capacity to do the job.

Nebraska's adult service system appears to be orienting itself toward improving management and development of community services; however, the lack of practitioners and resources in its large rural regions makes development slow and difficult. The effort to develop a user driven, quality system could help centralize accountability and facilitate the use of Medicaid to expand services. The close linkage with vocational rehabilitation funds, and the emphasis on wrapping services around people where they are illustrates a sense that real jobs and real housing are the only possible things to develop in the state.

Planning Infrastructure and Focus Are Needed

Connecticut spends $72 per capita on adult mental health care out of its General Fund; this amounts to 3.8% of General fund expenditures. Connecticut has the highest per capita income in the nation. The success of the mental health system appears to be due to a well established infrastructure to guide program expansion, flexibility in designing and establishing local priorities, and elimination of "noise" by developing a continued policy commitment to institutional care and by expanding community funding, and by keeping administratively simple so that children's mental health care, substance abuse or MR/DD are not directly administered by the department. The system appears to be driving itself from the bottom up, and has tended to consolidate its leadership through funding a variety of community based programs and by expanding the participation of other interests in planning and services.

The Torrey Report was sharply critical of Michigan's mental health system, citing the diffuse focus as a major problem, rather than lack of funds.

This state is attempting to sharpen its focus through a long range planning process and through what appears to be an increased emphasis on demonstration grants. The elements for a managed mental health care system are in place in this state, but it is apparent that this structure will do little to correct the societal stress of this larger northern state, particularly in the housing and vocational areas. The long range planning process is an effort to build consensus at a time when there may well be increasing demands on the general fund to maintain state hospital quality.

Efficiency and Quality

New Hampshire is a state where there is a strong commitment to increasing the quality, efficiency, and accountability of services to people with serious mental illnesses who are at risk of institutional placement. The transition of the New Hampshire Hospital from an asylum into a tertiary care facility has been supported by careful development of administrative, housing, and vocational services, as well as basic crisis response capability throughout each of the CMHC regions. The most remarkable aspects of the state presented in this survey include the apparent consensus that New Hampshire has been able to achieve and the control they have been able to sustain over community development. This is testimony to the importance of executive and legislative commitment and the ability of the Department to interact with Medicaid and other parts of the human service system. It is also testimony to the effect of developing programs in a context of where -- subject to sunset legislation and increasing competition for public funds -- they must remain lean and relevant.

The Next Step: Unified Services

Ohio since the mid 1980's has been able to establish infrastructure necessary to support a balanced service system, and it has just passed an inflection point where the fiscal unification of the state and local systems of mental health is beginning. Efforts to develop real jobs, real housing, and community integration of people with severe mental illness or emotional disturbance are supported by strong executive agency collaboration, and have helped prepare the state for this major policy change. The state is strongly supportive of consumer involvement in program and policy decisions, and is attempting to use this to advocate for change as well as design meaningful services in all settings. The uncertainties over the future of State operated services as a way to help move staff into the community are offset to some degree in that there are clearly positive effects of the refinancing scheme on hospital use. The effort to develop case management in the community is portrayed as one solution. The state's apparent effort to develop quality standards for services, combined with growing funds in the face of declining federal grant revenues for mental health suggests that Ohio's tenacious focus on systems development is beginning to bear fruit.

Reform Requires a Credible Long Range Perspective

Rhode Island's Director of Mental Health identified three system strengths: (1) the system is built on a clear commitment to major mental illness by the public sector, (2) there is a strong partnership between the state and the Community Mental Health Centers, and the provider network is actively involved in developing financial and regulatory protocols, (3) there has been consistent leadership. The external planning and collaboration with other departments regarding mental health issues helps the state establish the expectation that the department is part of a system. Both the creation of a basic core of services in the community and the evolving authority the community mental health centers have in deciding where people should receive services will support the further downsizing of the state hospital. The concept of integrating the individual into the community is emphasized and the configuration of community services, vocational and residential services is expected to result in functional improvements in the population served and less cost over the long run. The long term commitment to systems evolution in Rhode Island and movement toward a balanced system of care is supported by a department that has had a clear focus on its own priorities, leadership that worked to draw on the experience of the Community Mental Health Centers to sustain a network, and a shared desire to create a single community resource that would meet the mental health needs of all the people. The system seems driven by a sense that if it can't be done in a state as small and as close knit as Rhode Island, then it can't be done at all.

Is the Fear of Change Warranted?

Vermont's system represents a model for planning that is simple, focused on developing community services that are responsive to consumer needs, and which represents a partnership between the state and Community Mental Health Centers. The regionalization concept stemmed from a crisis in state hospital service delivery in a state where the Community Mental Health Centers and the state have a history of close cooperation. The Vermont experience suggests that the provision of consumer based support and crisis response services to persons with serious mental illnesses can reduce the need for involuntary treatment and state hospital use. The transition from a state operated system to a unitary system of mental health care involved defining community based support and intervention as a technology that was better then what the state could offer in its state hospital. Much of the energy for change is due to legislative support ; however, the system's ability to gauge its success and communicate that to reinforce an ongoing process of strategic planning is an important way to sustain and broaden support. The continued need for expansion of vocational opportunities , affordable housing, and a wider range of community crisis supports represent new challenges for Vermont. There is a strong impression that the willingness to criticize and debate systems issues stems from a sense of basic trust that has been established and nurtured by state agency staff in a wide range of stakeholders. Ultimately the success of Vermont may lie in the adoption and agreement about guiding values, the first of which is an expectation that change will occur only

when consumers, providers and communities agree to change their behavior.

Leadership is Needed

Oregon provides a good example of a state that is fine tuning what it currently has but which is faced by a need for adequate resources to pay for needed community services. The transition to a consumer-driven service system appears to require a commitment to expanded local residential capacity as well as program development that is made difficult by incentives for counties not to get back into mental health funding or delivery. The shift away from a reactive planning process in mental health, where the current service crisis receives the attention to a more systematic approach to development is occurring. This may be hampered somewhat by the tendency of other parts of the state's system (e.g. corrections) to experience a crisis that will call for an infusion of general funds. Efforts to enhance consumer and family involvement and to encourage state of the art treatment practices throughout the system seem likely to provide some improvement in functioning of persons in the system and may help lay the ideological groundwork for systems change. The emphasis on long range mental health systems planning is likely to succeed to the extent that leadership is committed to change and provided that the county human service delivery system can be part of the process. This represents a major challenge.

NEBRASKA

Nebraska's Department of Public Institutions is the state agency responsible for mental health, mental retardation, substance abuse, veteran's homes and visually impaired services. It operates three public psychiatric hospitals referred to as Regional Treatment Centers, which are under the authority of the Department's medical services director. Community mental health programs operating with public funds also fall under this office's purview. The majority of admissions (60%) to the three Regional Centers were involuntary in nature, and over one third are referred to community programs following hospitalization. In 1988, Fuller Torrey ranked Nebraska as a "best buy" state with the highest ranking for services to the severely mentally ill and the least per capita expenditures. Nebraska had developed six mental health outpatient clinics before the passage of the federal Community Mental Health Centers Act in 1963.

Hospitals

Nebraska is moving toward conceptualizing their 3 state hospitals as tertiary care facilities, where security and safety is needed during treatment. The state leases crisis residential beds on the state hospital grounds, which are losing third party health insurance reimbursement because they are not hospital services. There is no promotion of a specialized, similar setting for children or adolescents; however, the state operates an adolescent care unit for high risk offenders and sexual abuse perpetrators. Recent legislation prohibits counties having "first class cities" from using jails to commit people involuntarily for mental health treatment.

Hospitals are concerned about their liability for indigent and dangerous patients, and private emergency psychiatric care for involuntary patients is difficult to develop. In the crisis beds rented from the state hospital, the substance abuser represents a major user group. In 1984 the legislature assigned responsibility for inpatient care in state hospitals to the counties. There is concern that a separate but equal tier would develop in the hospitals in this state; the state would like to move its state hospitals toward a tertiary care model. In the 1984 state plan, the position was set that there should not be two separate systems of care based on economic factors.

Community Based Care

The state does not house adults in the community, although providers are developing housing units through Farmer's Home Administration (FmHA) or HUD Section 202 Programs; however, the approach is to provide services wherever the client chooses to live, facilitated by HUD Section 8 certificates. In 1989, the Department initiated discussions with the state's Medicaid agency to establish the rehabilitation option under the state Medicaid plan and provide targeted case management under the Comprehensive Omnibus Reconciliation Act of 1985 (COBRA). There is no requirement for mental health coverage by insurers; however, the ones that do cover mental health do so at a relatively low level. In addition to the undersupply of emergency psychiatric care, there is an identified shortage of community based long term services due to a lack of

consistent funding policies, no individual client based cost reimbursement system, and financial disincentives. On the other hand the state plan for adults emphasizes rehabilitation, meeting needs where and when they occur, ensuring that the system is consumer driven and focused on quality.

One interesting proposal contained in the 1989 Draft State Plan is "consumer-based reimbursement" for people with serious and persistent mental illness who are in a case managed system. The basic approach in this proposal is to tie reimbursement to an Individual Program Plan. The state would reimburse for day programs and vocational rehabilitation for this population as well as fund start up costs and would require that case managers not be associated with direct service providers. This approach would help eliminate the disincentives for delivering long term services.

Quality Assurance

With regard to quality assurance, the state is examining whether its role is to ensure public safety or to assure quality. The emphasis on quality runs the danger of bureaucrats imposing their vision on the system, while the emphasis on safety requires that the state articulate what is the minimum it needs to know and still maintain flexibility. The state is exploring using national accrediting bodies, but is also attempting to develop technical assistance capacity to prevent problems and improve practices and to establish practice standards (using family and consumer input in both development and monitoring). All new service contracts will also contain a requirement for program evaluation.

Target Populations

The state has identified people who are disabled by severe and persistent mental illness as a priority. Four other populations needing state attention are referenced in the state plan: (1) substance abusers, representing 41% of the severely and persistently mentally ill group, (2) elders deflected from nursing home placement or requiring alternative placement, (3) minorities, and (4) homeless people. High users who are in imminent risk of hospitalization are a priority as well. The state is faced with a shortage of psychiatrists and clinical psychologists and children's mental health service providers in its vast rural areas in its western part.

Governance

In 1974, the state created 6 regional governing boards and 6 regional administrators with fiduciary responsibility; each of the state's 3 Regional Centers (state hospitals) were assigned to two mental health regions. The regions represent a collection of counties, coming together under the Interlocal Cooperation Act to provide mental health services,and represent entities of local government. These Boards typically plan and deliver services themselves or through Community Mental Health Centers, and the services mandated under this act were the range of Community Mental Health Center services: inpatient, outpatient, partial hospitalization, emergency and consultation/education services. Funds are distributed through contracts with the Governing authorities and matched with local tax dollars. Counties

share responsibility for outpatient services, funding $1 for every $3.33 from the state. The county-state partnership in mental health system is being reexamined, as there are problems with communication and the structure may not meet present needs; one option is to retain the structure, but to have it all state-financed.

Children

The children and youth service plan developed under a federal Child and Adolescent Service System Project grant attempts to develop an understanding of mental health needs of children and youth and the roles and responsibilities of the various systems and agencies involved. The plan is based upon Nebraska's Family Policy Act, a public review process, and an intergovernmental planning process. The principles underlying the ideal system were delineated: (1) fixed point of authority and responsibility for access, including planning for use of public resources, managing all financial resources, and facilitating effective linkages to ensure appropriate care is obtained, (2) flexible funding mechanism that would allow dollars to follow the client, (3) single points of access with sole authority to make eligibility decisions, (4) case management to ensure family participation in decision making, (5) structure to eliminate conflicts of interest, separating funding and case management from service provision, separating quality accountability from both funding and service provision. The Department serves as a member of the Interagency Collaboration/Coordination Team(ICCT) and has proposed jointly developing a client rights statement, a generic approach to prevention and early intervention, a multi-system case management mechanism, training non mental health professionals in mental health issues, developing mechanisms and structures to facilitate community based program development. This ICCT would also be asked to devise a plan to implement the system principles outlined above. The plan also calls for a comprehensive coordinated array of services including home based care, day treatment, and therapeutic foster care.

Impression

Overall, Nebraska's adult service system appears to be orienting itself toward improving management and development of community services; however, the lack of practitioners and resources in its large rural regions makes development slow and difficult. The effort to develop a user driven, quality system could help centralize accountability and facilitate the use of medicaid to expand services. The close linkage with vocational rehabilitation funds, and the emphasis on wrapping services around people where they are illustrates a sense that real jobs and real housing are the only possible things to develop in the state.

MICHIGAN

Michigan was selected for a review because it was examining its state responsibilities and roles and because it represented a combination of problems and issues: (1) state hospital quality, (2) multiple populations and competing priorities about resource distribution, (3) variable success in its outpatient service system, and (4) single entry point for services. The state has developed a system where it is well along in the process of assigning responsibility to counties or clusters of counties for mental health management. In fact, in 1979, the mental health code was revised to establish community mental health boards as the single point of entry and exit to the public mental health system. This was the earliest such a transfer occurred in the states examined in this study.

Service System

The state has a fiduciary role that extends to its 83 counties through 55 community mental health boards. The 45 "full management" boards are provided financial incentives to manage care across the entire community-institutional continuum. These boards are able to purchase hospital care in either general psychiatric hospital units or can contract with state hospitals for services; they are also able to evaluate appropriateness of admissions, and generally have a more direct payment and reimbursement role. For the remaining "shared management" boards, the state has a more direct financing role, although the board still serves as the single point of entry, and is required to develop procedures for screening admissions, service planning, coordination of services during inpatient care, and discharge planning.

The Michigan mental health code identifies the Department's responsibilities for people with mental illness, developmental disabilities and organic brain and other neurological conditions; service planning and delivery to these populations occur through the community boards. There are several pilot projects administered for people with senile dementia of the Alzheimer's type, and preventive efforts targeted at children and adolescents. The Community mental health Boards are statutorily required to examine and evaluate mental health needs on an annual basis; this is tied to the budget for their programs; these are incorporated into the annual management plans for the Department by the Bureau of the Budget. The state currently devotes 40% of its total expenditures for MH, MR/DD, and neurological impairments to state institutions, 35% to Community Mental Health Boards, and 22% to community residential care. This was not disaggregated information, and includes expenditures for other than mental health.

The broad emphasis of the Department on health and prevention and promotion activities has been criticized as diluting services to the seriously mentally ill. This criticism was made at a time when there were significant problems pertaining to quality of state hospital care and to patients' civil rights (Torrey, 1988). In apparent response to this critique, the state has recently started a long range planning project to define the respective roles and responsibilities of the state and the community with regard to service delivery. Specific activities center around outlining the expectations on the part of legislators, the general public, and the community; defining the

service delivery problems and desired outcomes of systems change efforts; and establishing priorities for state and community responsibilities. The overall purpose of this effort is to develop a unified community-based service system.

Mission

The mission, values, and principles for the service delivery system have recently been framed by the Department and representatives of numerous stakeholders after a full year's discussion and review. The document covers values of dignity and respect, health and ability, community participation, and sound management (which includes local decision making and stable and adequate financing). This document represents a beginning integration of viewpoints about prevention, research, equal access, and targeting resources at MR/DD or serious mental illness. The plan carefully asserts that **it does not represent a consensus about what constitutes a fair distribution of resources.** The mission statement places state hospitals in the community-based care system, and places the department clearly in an advocacy role for people who are or may become developmentally disabled, emotionally disturbed or mentally ill to maximize their participation in the life and resources of the community. The mission statement has been integrated into this current planning cycle, where local boards are required to analyze and plan, under flat funding assumptions, to address 4 issues: (1) assumption of state administered residential care and changes in utilization of state institutional resources, (2) expanding case management to the 50% of severely mentally ill and to an unknown number of developmentally disabled who don't currently receive it, (3) meeting residential needs of mental health clients by assisting them rather than providing for basic needs, and (4) establishing the purpose and direction of partial day programming.

Assertive Community Treatment

The jewel in Michigan's system is clearly the widespread use of the Assertive Community Treatment (ACT) approach in service delivery. ACT programs patterned after the successful Program of Assertive Community Treatment in Wisconsin, operate in 56 counties and provide services to obtain basic resources, promote social integration, and deliver mobile (home based) response in crises. In addition to this program, all boards are required to provide 24 hour access, and about half of the people entering the public system are diverted from the 3400 State Hospital beds, into the 4000 short term licensed psychiatric beds in community hospitals; this amounts to 1200-1300 public patients at any one time. Hospitals are required through the Certificate of Need process to provide charity care, thereby improving access by a population that has had a traditionally high degree of indigence. One problem is that police can directly transport patients to the State Hospital and circumvent the single entry point process. With regard to discharges from the 16 adult or child psychiatric state institutions, the Community Mental Health Board is notified of all non-forensic discharges, and efforts are continuing to promote liaison between the two organizations.

Empowerment

The system is also making efforts in the areas of consumer run programs, client protection, active treatment in state hospitals, psychosocial rehabilitation, and assault prevention. There are thirteen consumer drop in centers through out the state, arising from a successful statewide grass roots movement at the start of the 1980's; a food co-op is operated by consumers in Kirwood, and there is a range of self help, hotlines, work readiness and employment programs. These are typically funded at startup by the State. A training program targeted at both staff and patients in state hospitals uses a national assault prevention model, the Non-Abusive Physical and Psychological Intervention Program. This has resulted in dramatic reductions in use of restraint and seclusion and personal injuries. The Assault Prevention Training Program is targeted at patients in which clinical staff teach strategies to patients with mental illness to prevent their sexual victimization. These programs are gradually being made available through the community boards for use with hospital, residential and day program staff. A contract for supported employment with the State's vocational rehabilitation program, extensive use of psychosocial rehabilitation clubs, and several Fairweather Lodge programs are designed to help long term patients achieve greater control over their lives. Achieving the goal of "real jobs and real money" through supportive employment of people with mental illness is seen as one which educates the business community, promoting it as an economic development resource. This recent expansion of supported work for people with mental illness in Michigan has clearly built on the experiences of the Department and the community boards with advocating and developing work activity programming for people with disabilities. The community residential capacity for people with mental illness has expanded dramatically into the area of group homes for 6 or fewer people. Efforts are currently underway to develop smaller residential care programs (foster care or supported living). These efforts will be supported by the use of federal Medicaid funding for personal care in residential care settings and by a trade off where the state will pay 100% for in home programming if community boards assume responsibility for existing and new community based residential care programs. Use of the Medicaid waivers to provide home based care to people with MR/DD, coupled with a statewide family support subsidy program for maintaining mentally disabled children at home and an interesting demonstration that trains former welfare recipients to become foster mothers for severely disabled children, appears likely to achieve some economic efficiencies that would allow the mental health residential care effort to diversify from its group home base. The Torrey study suggested that housing supply was a highly variable in both amount and quality, and that large board and care facilities tended to dominate the landscape for people with mental illness.

Research and Development

The system is actively involved in both basic and applied research, and has taken steps to improve the skills of hospital and community personnel. The LaFayette Clinic, the Department's research and training hospital, is currently conducting over 100 basic studies in psychiatric illnesses, anxiety disorders, and on neurological movement disorders. There are over 100 third

and fourth year psychiatric residency positions, 66 of which are funded by the Department; there appears to be a concentration of these in the Detroit area. A stipend program to provide educational support to DMH and community mental health employees has produced over 200 mental health graduates. Demonstration projects, most notably one to serve the homeless and secure permanent housing and one for the seriously mentally ill operate out of the central office. There are also grants made to universities for demonstrations.

Impression

The Torrey Report was sharply critical of Michigan's mental health system, citing the diffuse focus as a major problem, rather than lack of funds. This state is attempting to sharpen its focus through a long range planning process and through what appears to be an increased emphasis on demonstration grants. The elements for a managed mental health care system are in place in this state, but it is apparent that this structure will do little to correct the societal stress of this larger northern state, particularly in the housing and vocational areas. The long range planning process is an effort to build consensus at a time when there may well be increasing demands on the general fund to maintain state hospital quality.

CONNECTICUT

Connecticut was selected because it was highly rated in the 1988 Torrey Report. The survey respondents included the chair of the State Board of Mental Health as well as the State's Director of Program Development. Materials were sent and included brochures, a service directory, the comprehensive mental health plan, and an operating budget. The major part of the interview data were obtained from the state office, as Connecticut was not selected for an in-depth survey.

Target Populations

Connecticut has defined its responsibility for those who are unable to access private psychiatric care due to severity, duration of illness and due to lack of financial resources. The working definition (1989) of severe and prolonged mental illness contains five criteria: (1) Age 18 or above, (2) psychiatric history with some level of supervision required, (3) role disturbance in at least 3 out of 7 defined areas, (4) lack of a support system to restore functioning or decline in function likely to result in increased restrictiveness of care, and (5) other diagnoses are not present, such as MR, alcoholism or drug abuse.

Three criteria are used to determine whether someone over age 18 is at risk of hospitalization. All of the following must be satisfied: (1) at least 2 out of 12 signs and symptoms as manifestations of psychiatric disorder, (2) sufficient symptom severity to cause role disturbance in performance or coping skills in at least 2 out of 6 defined areas, and (3) one or both social support system difficulties as in (4) above. Poverty is defined in the state plan as family income that does not exceed 150% of the federal poverty level. The Department of Mental Health is charged with the responsibility for the care an treatment of adults in inpatient and community based settings. Services for children are the responsibility of a separate authority for children and youth; linkages are made at the regional level, with joint transitional programs for youth aging out of that system.

Planning

There is a well-established network of local advisory councils in the 23 catchment areas of the state, where 25% are consumers; these are in turn represented on five regional mental health boards, with representation from alcohol and substance abuse providers. The 23 catchment advisory councils are seen in statute as the primary reviewer of 158 programs and services that receive DMH grants and contract funds. The Catchment Area Councils also serve as a source of information for planning and identifying new service needs. All municipalities across the state are assigned to one of the 23 Catchment Area Councils; Connecticut was the only state reviewed that has explicitly involved towns in its system, a feature unique to New England where towns play a role in human services delivery. A statewide directory, updated annually, appears to be a widely used resource for both planning and service access. The regional boards advise the regional director in making grants to local projects, with technical planning support from regional office staff. The

State Advisory Board includes regional board representation, as well as members of the human services cabinet and more consumers and providers, so that the State Board serves as the federally required PL 99-660 Planning Council. The planning process is structured so the regional authorities obtain input from the Catchment Area Councils which integrates expansion proposals into a consolidated statewide package for the next state fiscal year. This, combined with the solid base in the Catchment Area Councils, promotes participation and sustains interest in local planning. Regional Service System Plans to spend appropriated funds allocated to the regions by the Commissioner are prepared which include the CAC-generated proposals for the next fiscal year. This provides a view beyond the fiscal year into the next, and helps promote continuity in local planning as well as in statewide programming. This planning process seems particularly well conceived, and is testimony to how local participation can be successfully integrated into statewide policy, particularly during a period when there is expansion of community based programs.

Accountability

The regional directors meet on a weekly basis with the Commissioner and the Deputy Commissioners for Administration, Planning/ Policy Analysis, and Clinical Services on an extended executive management team to consider statewide issues. There is a uniform system of accountability across the state, regional and local levels of administration, where quarterly reports are provided to the central office. At the catchment area level, the point of accountability varies, so as to meet local needs and preferences. There appear to be three unmet needs in this state, generally articulated as nursing home residents with mental illness, geriatric patients in state hospitals who need more programming, and a need to move away from a bricks and mortar approach to programming toward more natural residential and vocational settings. In articulating these needs the state appears to be responding to recent federal regulations governing nursing home care for people with mental illness.

Operations

The state operates 12 facilities, which include four hospitals, one forensic hospital, 3 regional case management programs, one crisis intervention center in Hartford, 3 community mental health centers (two in conjunction with universities), and an outpatient treatment and support program. The community programs are grant funded in accordance with regional and local priorities. A major focus over the past several years has been to develop comprehensive crisis intervention centers in each region, where a mix of acute care units, crisis beds, mobile treatment, and outreach services are available. Three projects follow the Assertive Community Treatment (ACT) model. There is a need to strengthen the crisis intervention system, especially the link with private psychiatrists. The emphasis on acute short term care in the state hospitals and the de-emphasis on long term treatment is supported by a state hospital bed assignment mechanism that provides opportunities for community staff to meet with the patient and hospital staff in the hospital and to participate in discharge planning. The state is

examining strategies for equipping state hospital personnel to participate in a continuing treatment system under a Robert Wood Johnson Foundation grant.

From 1983 to 1989, funding for community infrastructure grew 700% from $127.3 M to $227.1 M; in the same period, the relative proportion of state mental health dollars devoted to state hospital care has declined from 72% to 55%. This shift is credited in the state plan to a new focus in the service philosophy and values that have guided present and future development. This was facilitated by a policy adopted in 1982 which emphasized the need for a **comprehensive and balanced system** of care. Discussion is occurring at a variety of management levels regarding the use of state hospital beds in the system, including some method for allocating bed days to facilitate development of a managed care approach.

The state has made intensive efforts over the past 4 years to provide help to people to apply for SSI or SSDI benefits and to secure Medicaid and Medicare coverage for people who need mental health care. The crisis intervention program is not medicaid funded at this time. There is ongoing discussion about applying the targeted Medicaid case management services option under Federal COBRA 1985 rules, as well as seeking Medicaid reimbursement through the rehabilitation option for counseling and psychosocial rehabilitation. The department is attempting to develop its ability to administer Medicaid quality assurance activities, as recommended by a 1987 study prior to tapping into federal Medicaid funds for services. Efforts to provide "user- driven" services in housing, employment and community based programs so that it is a normalizing experiences are being made as well.

Impression

The state spends $72 per capita on adult mental health care out of its general fund; this amounts to 3.8% of general fund expenditures. Connecticut has the highest per capita income in the nation. The success of the mental health system appears to be due to a well established infrastructure to guide program expansion, flexibility in designing and establishing local priorities, and elimination of "noise" by developing a continued policy commitment to institutional care and by expanding community funding, and by keeping administratively simple so that children's mental health care, substance abuse or MR/DD are not directly administered by the department. The system appears to be driving itself from the bottom up, and has tended to consolidate its leadership through funding a variety of community based programs and by expanding the participation of other interests in planning and services.

ARKANSAS

Arkansas was selected because it was a small rural state that ranked 15th in the Torrey study, and because it was recommended by the Intergovernmental Policy Project as a state undergoing systems reform. The respondent was the director of the state's Division of Mental Health. The interview lasted thirty minutes, and it had been postponed once. No written materials were submitted by Arkansas for review, although these were requested. Interview data suggest that the State has essentially defined its responsibility for all comers into the system, although its primary focus is on people with severe/persistent mental illness and children with severe emotional disturbance (SED). The priority for new state monies is crisis services for the severely mentally ill/ SED populations. As part of this effort, the state plans to restructure funding so that state hospital funds are administered through the community.

The State Hospital in Little Rock is designed for acute care, and is near the University Medical Center's Department of Psychiatry at Little Rock, which provides some limited research into mental health issues. There is essentially little emphasis on research in this system. As state hospital units close, there is a tendency to work toward using the resource as a tertiary care service and to incorporate hospital staff as part of the CMHC staff. The Department of Mental Health is focusing on upgrading its personnel to perform case management in the community. An issue of increasing importance here is salary parity between state staff and the Community Mental Health Centers, particularly in nursing, occupational therapy and physical therapy salaries. Increasing salary may well be the only way to take advantage of scarce rehabilitative resources in this poor state (49th in per capita income, 1988).(See also Torrey & Flynn).

The 15 Community Mental Health Centers (2 state operated and 13 private non profit) are defined in the State's strategic statewide plan as the single entry points for all admissions to the system. These agencies are designated receiving facilities for involuntary admissions, and they are encouraged to establish linkages with hospitals. Forensic patients are seen as the state's responsibility, although forensic evaluations are conducted in the community system. Efforts are under way to develop a way for monitoring the flow of clients through the system; the hope is that using the rehabilitation option under Medicaid will encourage this. The Department certifies Community Mental Health Centers and develops performance standards for their use of state funds. All contracts are performance based. The Community Mental Health Centers are also now conceptualized as the single point of "exit" from the state hospital system, and receive information about admissions from their catchment area at admission and at regular time periods. Using the bed buy back funds, more remote Community Mental Health Centers are hiring staff who live near the State Hospital to act as the discharge liaison. The Community Mental Health Centers all had inpatient capacity until federal staffing grants were lost. Two thirds of the CMHC patients receive Medicaid, and while the State Hospital serves as an Institute for Mental Disease, community hospital are also able to get reimbursement, with Community Mental Health Centers working out the arrangements and buying beds.

Two populations are seen as falling through the cracks: (1) children and adolescents and (2) dual diagnosed people with either substance abuse or mental retardation as a problem. The state has a Children and Adolescent Service System Project (CASSP) grant where it has identified outcomes for a children's program, and efforts are under way to develop inpatient screening under an umbrella organization that would draw funds from a designated pool to improve collaboration and increase the amount of children's resources throughout the state. At this time, there is a tendency to rely upon residential treatment centers and private psychiatric hospitals in this state for these children than is desired, primarily because community options are not available. With regard to adults, there is a "bed buy back" system that has been established to provide incentives for Community Mental Health Centers to lessen adult state hospital bed use. This system recovers money from the state resources available to the CMHC to pay for state hospital use.

The Department of Mental Health attempts to coordinate its efforts with other divisions in the Department of Human Services, where it is located. This includes written agreements as well as efforts to develop day to day interventions with Alcoholism, Developmental Disabilities, Children and Families, and with Vocational Rehabilitation. One good example of this collaboration is that the division shares staff with the Vocational Rehabilitation agency and maximizes Federal vocational rehabilitation (VR) reimbursement in this way for supported employment. Joint training with VR at the front lines to familiarize staff with mental health issues and identify barriers to program effectiveness is ongoing.

The State Hospital uses vocational rehabilitation for the forensic patients; the forensic unit in 1988 was under a court order to improve. The state reports that a menu of active treatment programs are available at the state hospital. Efforts to monitor psychotropic medication use are currently being debated, and the state is examining a model where treatment plans are incorporated into court orders. The state is making efforts to recruit psychiatrists and other clinical personnel (it hired a recruiting firm), and it is attempting to expand its residency program through raising salaries. The State also sees a need to reduce stigma associated with public mental illness in the medical profession.

Maintaining the natural support system consists of community support program groups, efforts to encourage peer case management as part of the continuous treatment team model, and CMHC efforts to educate families and train them in care giving methods. There was little evidence that this is widespread. The one survey respondent identified the move toward a community managed care system as the general direction of the Arkansas system, and outlined four parameters of such change: **(1) systems change involves attitudinal change, and this takes time, (2) human resources requires a commitment to both training and retraining, (3) maximizing the available funds through internal restructuring to use the rehabilitation option under medicaid (to cover case management in the community) and (4) recognizing that there is limited human resource capacity to do the job.**

OREGON

Oregon was selected for study because it had recently conducted a reassessment of the role of the State Hospitals in the mental health system. The Torrey report also rated the state 11th in 1988, indicating that it was improving slowly; at that time, only one of the three state hospitals was Joint Commission on Accreditation of Health Organizations (JCAHO) accredited, and all were having trouble with HCFA certification for Medicare. The major problem appeared to be that there was a lack of funding for needed services.

The analysis proceeded along two fronts: the Report of the M-ED Residential Task Force, [1] which made recommendations for housing and support services for persons with severe mental illness or emotional disturbance (1988, Skryha & Krygier) and the report Improving the Quality of Oregon's Psychiatric Inpatient Services, made by the Governor's Commission on Psychiatric Inpatient Services (Kast, 1988). Both authors were contacted and interviewed, and interviews were conducted with the directors of the Community Mental Health Directors' Association and the statewide Mental Health Association.

Structure

In the Oregon mental health service system, the Oregon Mental Health Division plays the primary administrative and coordinating role in providing services. This Division is one of ten agencies in the Oregon Department of Human Resources. It operates three psychiatric hospitals and contracts for community services with 32 Community Mental Health Programs (CMHP), which serve all of the 36 counties in the state. The State contracts with those county mental health authorities, which are overseen by the county boards of commissioners. Each county must appoint a local mental health advisory board to assist with service planning and monitoring. The CMHP can either provide services, contract for services or do both. Counties have not had a local share in service financing since 1981, and the only remaining statutory requirement for participation is that counties must pay for pre-commitment investigations and for psychiatric hospitalizations at non-state facilities.

The Psychiatric Security Review Board was created in 1978 to assume responsibility from the courts for supervising individuals found "guilty except for insanity " of a criminal offense. The Oregon Alliance of Advocates for the Mentally Ill formed a special interest support group called "Friends of Forensics" in 1988 which lobbied the 1989 Legislature for improvements in treatment services. The Forensic Psychiatric Program at Oregon State Hospital consists of 10 wards including maximum and medium security, sexual offender treatment, and transitional living.

The Mental Health Division of the DHR was renamed the Mental Health and Developmental Disabilities Services Division by the legislature in 1989.

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[1]. The Task Force focused on Mental and Emotional Disturbance

Problems

The State of Oregon has identified three major problems affecting the mental health system during the 1980's: (1) half of the adults with severe mental illness are unserved, and only about 1/4 of children and adolescents with severe emotional disturbances are served, (2) there are gaps in the array of community services and the state hospitals are beset with major problems, and (3) there is a clear need to refine the system so that continuity of services is a reality and to ensure that the system is consumer centered. (Developing Comprehensive Mental Health Services in Oregon, 1988). There was also a change in administrative leadership starting in 1987, when Kevin Concannon, Maine's former Mental Health Commissioner, was appointed and subsequently promoted to Director of the Department of Human Resources. In September 1988, Dr. Lippincott from New Hampshire became the Mental Health Division (MHD) administrator. In early 1988, Governor Goldschmidt appointed a 14 member commission to examine the provision of inpatient care to Oregonians with severe and chronic mental illness; its report was produced in September 1988. The M-ED Residential Task Force created in late 1986 released its report to the Mental Health Division in July 1988 after twenty months of study. Finally, the state is experiencing economic difficulty, and has had to revise its estimates of additional revenues for the next biennium from $400 M to $86 M.

Barriers to Change

The 1988 document, Developing Comprehensive Mental Health Services in Oregon, 1989-1995, lists obstacles faced by the current mental health system. These include: (1) mental health services are not entitlement based, (2) federal funds are underused,(3) state funding levels are constrained by an economy in recession, limits on employee levels, and a policy that requires surplus revenues be returned, (4) local funds are shrinking and are being used to meet growing school, infrastructure, and emergency needs, (5) limited private sector donations, (6) deferred maintenance and a deteriorating mental hospital physical plant, (7) lack of knowledge in the legislature, which meets every two years, (8) constraints on Medicaid eligibility including basing eligibility on long term disability, (9) lack of long range planning, (10) not enough individualization in service delivery, (11) lack of community resources contributes to inappropriate placement, lack of voluntary hospitalization stimulates use of involuntary commitment, and there is increased reliance on forensic casework, (12) the management information system is neither detailed or timely for decision making, and not able to measure service effects, (13) diversity across localities, including population density and other regional differences, make unified services difficult to develop, (14) attitudes of families, consumers, staff, and community levels all inhibit intervention, (15) unclear roles for state, county, providers and subcontractors,(16) lack of continuity and coordination of services, particularly for multiple diagnosis individuals, (17) insufficient academic support focusing on public mental health, and lack of a full spectrum of routine training for hospital and community staff, and (18) liability exposure inhibits willingness of providers to risk new service models. In addition to these problems, there is

growing concern that the state's criteria for which populations are to receive state funds is too exclusive and there have been suits regarding these criteria.

Residential Care [2]

The 1988 M-ED Residential Care Task Force report noted that all consumer groups would require a crisis respite care alternative from time to time. The service typology is provided as an appendix to this report. The Task Force also recommended several strategies, including adoption of guiding principles; implementing competitive funding levels to achieve parity between salaries, rates, and make emergency facility improvements; improving availability of training and technical assistance; developing new resources, including accessing affordable housing, incremental expansion, routine funding of startup, adopting regional development strategies; administrative/system improvements including improving protective services, addressing liability and insurance issues, promote positive zoning and community education, balanced development increasing rates, training and new resources simultaneously when new funds become available.

There has been little construction of new housing, and there has been significant gentrification of housing stock that make housing more difficult to afford. The State has HUD Section 8 subsidized housing certificates that would provide some access to housing; however, there is a shortage of units. Efforts are under way to explore how to use housing resources to leverage federal or private funds to expand the supply, and the state office has added staff to do this. Oregon reportedly uses restrictive settings which are costly; to move toward supportive housing may mean that group home resources would have to be de-emphasized.

State Hospital Issues

The Governor's Commission on Psychiatric Inpatient Services found that the three state hospitals were dangerously crowded with acute and long term patients, wards were understaffed, staff often lacked essential training, the facilities were deteriorating from years of neglect, voluntary access to hospital care was not available, local programs were insufficiently funded, and there was a "crisis" approach to planning. This resulted in 6 major recommendations with projected biennial increases in the MHD base budget: (1) establish improved long range planning and budgeting processes, (2) enhance state hospital staffing levels and provide training and continuing education to staff, (3) establish local or regional acute inpatient programs, with the state hospitals serving medium to long term treatment needs of adults and adolescents, (4) accompany development of local acute care capacity with increased residential, crisis, outpatient, and specialized services for

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[2]. The M-ED Residential Care Task Force issued its report in 1988. For a brief summary of the services categories they developed, please refer to the material in Appendix A.

patients with alcohol and drug problems, (5) coping with a forensic workload increase must include examination of community options, (6) prioritized, cost effective capital construction. The Commission also identified several measurable benefits flowing from full implementation of its recommendations: (a) reduced injuries and worker's compensation costs, drawing in increased federal funds, access to voluntary hospitalization, doubling the number of local or regional acute care programs and reducing state hospital admissions by 60%, reducing the average length of stay from 40 to 10 days, and adding 100 new individuals to outpatient services. This would require moving from $28 to $42 per capita, an increase in the biennial base budget above 1987-89 of $70.9 million. While the report of the Governor's Commission on Inpatient Facilities didn't go as far as it could have, there has been an incremental focus on developing local acute care capacity (four new regional inpatient programs), developing a physical plant for forensic patients, adding staffing, instituting a planning focus, and developing a statement of client rights. In the biennium 1989-91, state hospital funding comprises $128.2 M out of a total appropriation of $212.3 M, representing 60.4% of funds. There is a need for bridging funds that would allow the state to move from non-reimbursable forms of institutional care (as in Institutes for Mental Disease for persons between the ages of 18 and 64) toward medicaid reimbursable care in the community.

The System Management Council, consisting of state hospital, county, and central office representatives, has met since 1983 to allocate a state hospital bed limit based on historical use to each CMHP. The insufficient funding of community services has been cited as a barrier to ensuring genuine control over the rates at which state hospital beds are used. The System Management Council has played a role in developing residency and gatekeeping policies, and admission/discharge rules. It has not yet achieved the goal of increasing county responsibility for bed allocations. County turf considerations, combined with underfunding have been described as two other problems, particularly since the counties have played a role as gatekeeper, but are sometimes left out of the hospitalization process. The lack of consistent funding has resulted in crisis diversion efforts of varying quality in the counties. Utilization has increased since its downturn in the early 1980's, and overcrowding is now a problem at the state hospitals; this prompted the policy in 1986 of eliminating voluntary admissions to state hospitals. (This policy has reportedly been reversed, and the state hospitals will now take voluntary patients). The Council in 1989 adopted a policy to stem the increasing census by having the state pick up the local inpatient costs for court committed persons who are diverted to local hospitals when the state hospitals adult units exceed their licensed capacity. This may prove to be costly ($6 M) and the Council is examining ways to reduce the hospitalization rate.

Hospitals

Oregon's average daily hospitalization for adults with mental illnesses is estimated at 75% of the national average of 49 per 100,000. The state hospital remains a viable entity in the service system at this time, particularly in rural areas where community capacity is limited. From the state's perspective, the reluctance of the medical community to care for people with severe mental illness cannot be attributed to liability (tort

immunity has been extended to community physicians) or to reimbursement (the state reimburses for cost), or to a diminished perspective on public psychiatry (there is a center for training in Portland). This reluctance is especially obvious when the patient has a personality disorder or when there is also a substance abuse problem. The role of the private sector, particularly in rural areas, is seen as one where the hospital may have a small 5 bed ward as part of its contract with a county that serves as a temporary holding point until emergency involuntary placement can be secured in the state hospital. There is a financial incentive for gatekeeping counties with limited community slots to seek less expensive state hospital placement for temporary holds once state emergency hold funds are spent. The State realizes that creating a local acute care capacity will take ten years, and assumes, according to one respondent, that counties will invest their share in acute care. The gaming of the system by using involuntary commitment to gain state hospital admission is recognized as a problem by all respondents.

Adult Services

Unmet needs for homeless people with mental illness and behavioral disorders, adults in forensic programs, and people in the corrections system are the current foci of the state's adult services planning effort. Mental health needs of aging people and populations with multiple disabilities, while studied, are not yet integrated into the plan. The plan for homeless people gives a broad framework for action following use of limited McKinney Funds for projects in two counties. The state plans to improve outreach and pursue options for providing affordable housing. For persons in forensic settings under the jurisdiction of the Psychiatric Security Review Board, the state has emphasized discharge and placement planning, identified direct care staffing shortages in the face of a growing census, and has proposed program improvements ranging from statutory authority to continue liability insurance for community providers to developing a contract to provide services for inmates. Adults in the corrections system are currently under study, and the Community Corrections Centers Act allocates $1.4 M to the counties to purchase services for offenders on probation or parole status. The Oregon State Penitentiary has a special management unit that is currently being reviewed; the four unit correctional treatment program, which is referred top as a national model of voluntary treatment is underused. A subcommittee of the Mental Health Services Planning and Advisory Council developed a set of recommendations to implement consumer-centered services, that included action at the consumer, service provision, system and legislative level. Several proposals were made in 1989 that would expand the definition of who could receive case management services, develop a clear definition of the service, allow the use of discretionary loans or grants, define residential case management, and increase financial resources through medicaid.

Children's Services

The state has received a Child and Adolescent Service System Planning grant. This is supplemented by a grant from the Robert Wood Johnson Foundation for a pilot program in Multnomah County that would restructure and refinance services. The Governors' 1989 Children's Agenda expanded a range of

services and the "Great Start" proposal, which focused on prevention and early intervention for children 6 and under. In addition, demonstration projects are in progress to reduce inappropriate admissions to state hospitals, help runaways and homeless youth, expand DD screening, and establishing a children's coordinating council. A series of community meetings revealed several issues: (a) there is no firm legal mandate to provide MH services to children, (b) children's services Division programs lack a treatment focus, (c) access is often confusing, (d) financing often requires families to relinquish custody to receive services, (e) transition to adult MH service is difficult, (f) the scope of services is limited, and (g) there is often poor coordination. There are interagency screening committees at the State and community levels that develop plans based on the services available to prevent out of home placement. The state's Certificate of Need process is described as " strong, preventing overuse of for-profit psychiatric hospitalization for children/adolescents." (1989 Plan, Document II). The state plans to use the Child and Adolescent Service System Project process to develop linkages at the state and community levels, and to develop funding that would allow services to be wrapped around the client so that services are covered regardless of where the child enters the system.

Community Services

The erosion of the service base during the recession of the mid 1980's, combined with the absence of local funding have resulted in a situation where only about half of those severely mentally ill are able to receive services in the community. Access in the fee for service system under medicaid is an issue, and waiting lists for community services to children are presently the subject of a suit. The primary focus of the state appears to be on EPSDT as a screening/case management mechanism, which does not yet explicitly target severely emotionally disturbed children and youth.

State-Local Relations

There is apparent consensus that reducing dependence on institutional care needs to happen and that this requires development of community services. There is a recent study of funding equity that shows a range from $14 per capita in Portland to $.50 in Marion County; this shows a wide variation in fund allotments, and may reflect historical effects of widely different regional or local economies. One respondent indicated there was a need for an equitable distribution formula. There is a method for allocating state hospital use to the counties; however, the counties are required to encumber county funds to keep people out of the state hospitals. An Interim Commission has been established to sort out the responsibilities for the state and local governments in this area.

The state monitors its Intergovernmental Agreements with each county through site reviews, training and technical assistance, through a performance indicators information system, and through fiscal audits and research studies. Using county level needs assessment data for budgeting purposes was made difficult by different planning cycles, and efforts are under way to coordinate these processes.

Changing Roles for Localities

The legislation establishing state priorities in 1981 and 1983 for adult services used hazard to health and safety of self or others, need for continuing services to avoid hospitalization, and immediate risk of hospitalization as criteria for receiving public mental health funds. For persons under age 18, the criteria include at risk for removal from the home for treatment or display of behavior indicating high risk of developing disturbances of a severe or persistent nature. This emphasis on severity of mental disturbance suggests that counties and their local service providers may have lost some control over their traditional mental health roles due to a lack of a requirement for county financial participation in mental health during the 1980's and the dominance of state funding in their programs. The tendency of counties to integrate mental health, developmental disabilities, alcoholism and drug abuse, with more traditional public health functions of prevention and screening is somehow at odds with the state's priorities on chronicity. The state plan estimates that funding for community services has almost totally shifted to persons meeting the above criteria and that 98% of state and federal funds contracted by the DMH in 1989-91 will go to these clients. While the state wishes to encourage counties to participate in funding local services, the loss of timber revenues stemming from the "Spotted Owl" endangered species controversy makes this appear unlikely, according to two respondents. The state plans to eliminate outdated language and include a more objective measures of functional capacity in its definition of who receives priority for state funds. It should be noted that while the above criteria dominate in terms of funding for mental health services, the state has defined these as Priority I criteria, with more general criteria for non Severely Mentally Ill as Priority II.

Client Rights/Consumer Empowerment

1987 legislation that allows for civil commitment in cases where the individual has been involuntarily hospitalized twice in the past three years. This law also allows the state to provide the names of these individuals to their county of residence so that a case manager can supervise the case. In this same legislation, the state's public guardian statute was amended to require a determination that "no less restrictive alternative" is appropriate before appointing a guardian. The goal of protecting rights in accordance with Mental Health Law Project standards of one investigator/advocate for every 150 inpatients is unable to be met due to resource constraints. The Office of Client Rights and Services, established recently in the Department, and inpatient grievance and seclusion/restraint committees at the state hospitals represent the state's internal efforts. Stemming from the Fairview consent decree with HCFA, the state has hired a consumer and has two ombudsmen in this office, and their role is evolving with regard to the state hospitals. The federally funded Oregon Advocacy Center is external to the state agency. The state has established a committee to review the current system.

An explicit state goal is to increase the empowerment of consumers and their families through increasing self-help and support groups, involving them in site reviews and service decision making, and provide educational and employment opportunities. A Consumer Centered Outcome Indicators Work Group

was convened and developed a list of recommendations ranging from client rights education, improved hospital community linkages, changing from a "slot" to a unit of service system to facilitate funds flow, and developing consumer advocate lobbying skills. There are also beginning efforts to develop local consumer operated services in Portland to provide training, outreach, advocacy and social support. There are two NIMH grants for consumer projects and a third for family self help groups. The state is exploring how it can continue funding projects after grants are gone and how it can qualify consumers as service deliverers.

Training, Research and Development

Oregon has a Human Resource Development Council that is focusing on recruitment, retention and workforce development. A Psychiatric Rehabilitation Subcommittee's recommendation to implement a hybrid model of rehabilitation resulted in the use of state training funds to develop hospital and community worker skills, and to operate a demonstration on a new ward at Dammasch State Hospital. A Family Education Advisory Committee has developed a family education training manual for distribution and has facilitated statewide parent-professional workshops. Academic linkages have been pursued by the Council as well; this has resulted in establishment of field internships and specialty courses in a state university's social work program and an experimental program to eliminate duplicative coursework for AA level nurses who seek advancement. The Council has also encouraged training for community residence aides. The state has developed specialized training curricula in geriatric psychosocial rehabilitation and implementing family education programs. The state is experimenting with the use of instructional television for use in training in remote sites, and there are efforts to expand the internship efforts through social work, nursing and psychology internships and stipends and through exploring psychiatric residency linkages.

Training is funded through a federal human resource development program grant as well as by state funds. State funds cover training in the state hospitals, as well as community training in case management, dual diagnosis topics, and psychiatric rehabilitation. One cooperative project focusing on the homeless with mental illness used Portland State University and Oregon Health Decisions inc. resources to hold a live and cable TV based symposium on preparing staff for serving the homeless.

Impression

Oregon provides a good example of a state that is fine tuning what it currently has but which is faced by a need for adequate resources to pay for needed community services. The transition to a consumer-driven service system appears to require a commitment to expanded local residential capacity as well as program development that is made difficult by incentives for counties not to get back into mental health funding or delivery. The shift away from a reactive planning process in mental health, where the current service crisis receives the attention to a more systematic approach to development is occurring. This may be hampered somewhat by the tendency of other parts of the state's system (e.g. corrections) to experience a crisis that will call for an infusion of general funds. Efforts to enhance consumer and family

involvement and to encourage state of the art treatment practices throughout the system seem likely to provide some improvement in functioning of persons in the system and may help lay the ideological groundwork for systems change. The emphasis on long range mental health systems planning is likely to succeed to the extent that leadership is committed to change and provided that the county human service delivery system can be part of the process. This represents a major challenge.

OHIO

Ohio was selected primarily because it is currently in the middle of a decade of systems reform efforts, and has recently moved toward unifying services in its 53 county-based community alcohol, drug addiction and mental health services boards. Recent changes have created a separate alcoholism and substance abuse department in the state and have vested mid level management authority for this as well in the community boards. The past year has been devoted to preparing for implementing the provisions of the 1988 Mental Health Act, and a bipartisan Study Committee on Mental Health Services consisting of legislative leaders, non-providers, and mental health constituents has been established to evaluate goal achievement under this law. This committee will also advise the department on its PL 99-660 Plan and the use of federal block grant funds.

This study consisted of one extensive interview with the program support administrator and review of the following materials: (1) "A System in Transition: Meeting the Challenges of the 1990's and Beyond," Annual Report ODMH, FY 1989, (2) "Emergency Crisis Response System Discussion Paper, February, 1990, (3) State Mental Health Plan Implementation Report, September 1990, (4) Ohio Mental Health Laws, Ohio Association of Alcohol, Drug Addiction, and Mental Health Service Boards, 11/89.

State Organization

A separate cabinet level department, the Ohio Department of Mental Health (ODMH) is statutorily required to do several things: define and support the elements of a community support program, operate inpatient and other services pursuant to an approved community mental health plan, provide training throughout the system, set criteria for defining severe mental disability and for evaluation of mental health programs, promote, direct and conduct research, establish local plan guidelines, establish a program to protect client rights and to issue guidelines on informed consent, promote consumer involvement in program planning and evaluation, and foster establishment of vocational rehabilitation services and jobs. The Department is required to consult with relevant constituencies in the mental health system before it holds hearings on standards or rules.

The organization consists of the director's office, four regional deputy directors, a deputy director of program support, and a deputy director of program development. In the director's office, there is a medical director, an office of legal and labor services, and a communications office. The four regions are responsible for state operated mental health centers and psychiatric hospitals, and have planning, monitoring, and management of community and hospital programs in their geographic area. Program Support provides education and training, program evaluation and research, fiscal management and information services. Program Development is responsible for consumer services, housing, preventive services, vocational and educational services, forensics, children's services, and drug abuse. The Department employs about 6700 people, 6200 of who work in it 15 public mental health hospitals; of those in state hospitals, The state's Mental Health Act explicitly allows the Department to deploy its staff to work in settings in

the community, and about 120 state employees currently work in State Operated Services (SOS), the majority as case managers. The Office of Psychiatric Services to Corrections (OPSC) provides services to state prisons under the terms of an operating agreement overseen by an interdepartmental oversight committee with the Department of Rehabilitation and Corrections.

System Organization

The legislature established community mental health boards in 1967 to plan for and provide comprehensive mental health services through contracts with mental health agencies. This law's 1989 amendment added the new Department of Alcohol and Drug Abuse Services and allowed the State's 88 counties to consolidate these functions with their mental health effort. Larger counties elected to have separate functional boards. The boards are constituted to serve areas with populations of 50,000 or more. The majority of the 53 boards have jurisdiction over a single county. There are over 400 contract agencies, the majority having a small, single purpose scope. The state estimates that this community system serves 155,000 daily and nearly 300,000 persons a year.

In addition to the state agency and the community boards, there are several advisory bodies with mental health interests. These include the Community Support Program Advisory Committee, the Citizen Advisory Boards to the hospitals, the Consumer Advisory Caucus, and the Professional Advisory Committee. There are also several voluntary organizations, including statewide organizations representing community boards, community mental health agencies, and forensic directors. The state also has a mental health association, a statewide Alliance for the Mentally Ill office, and a consumer support network.

The system has proceeded from a period best characterized as one of service infrastructure development in the community to one where it is now developing the capacity of the community boards build on their experience with pre-admission screening to manage the spectrum of community and inpatient care. In 1988, the first year of the Mental Health Act, 38 of the 53 Boards elected to receive up to 10% of their projected state hospital costs. Those boards that did not make that choice tended to experience higher than projected inpatient use in 1990. Four more boards have gotten into the program for FY 1991. The proportion of these monies to be spent for hospital or community services must be specified in the local plan and approved by the Department. There is evidence that hospital use is declining more due to the Mental Health Act incentives to reduce long stays by moving people out of hospitals, rather than to decreasing admissions. These incentives essentially allocate funds from state hospital maintenance, personal services, and equipment to community boards for services to severely mentally disabled persons. These allocations are to be phased in over a five year period, with 10% of the total available in the first year. Appropriations for the local management of mental health services can be used by the Department as well. The boards that are participating in this program are required to contribute to a $2 Million fund that will share the risk of increased costs associated with public mental hospital use beyond a planned amount.

Inpatient Care

The system has essentially an equal share of psychiatric hospital beds in the public and private systems. There are currently 3391 beds in the state hospital system, distributed across 15 facilities, and staffed by 90% of the Department's employees. Of these facilities, two are children's hospitals and one is a forensic hospital. The remainder (3,191 beds) are adult hospitals, with an occupancy rate of 89%, serving 12,000 admissions a year and with half its beds devoted to long term care. The private sector currently has 3,212 beds, which are operating at 69% of capacity, and which have lead the state to assert that there is an excess capacity of 15% or 480 beds in this system. This situation is explained by efforts by hospitals to develop services (e.g. psychiatric) outside the scope of the DRG system to reverse declining revenues. An additional 200 child and adolescent beds were granted Certificates of Need as a result of special legislative action, but they are not yet developed. It is interesting to note that the state medicaid plan was amended in FY 1990 so that freestanding psychiatric hospitals could no longer be medicaid providers for persons under 22; this is expected to shift some of the use to units in general hospitals. The State Plan observes that "there is not a trade-off in utilization of beds between the public an private sectors, and...that inpatient services are being used in lieu of other services because of the fiscal incentives."

Community-Based Services

In its plan and Annual Report, Ohio emphasizes the principles and methods of the Community Support System (CSS) as the guiding philosophy behind systems change. This has resulted in development and expansion of case management services, adoption of a "housing as housing" model, home based care for children, jobs and vocational programs. The public's resources are targeted at people with serious mentally illnesses or emotional disturbances.

The Mental Health Act has placed the state hospital funding under the aegis of the community boards, and has made the state hospitals one of several options for services to severely disabled persons in the community. The Act's permission for the Department to be a community services provider allowed it to begin to re-use its state hospital manpower. A three year no-layoff provision in the state hospital employee contract effectively prevented the reallocation from working because per diem costs would rise as use dropped and the ability of boards to divert funds to community care would be compromised. To continue to use the experience and commitment of state staff, the state has developed an effort to use state staff in the community. The state has attempted to increase the number of State Operated Services (SOS) throughout the state, and larger boards have allocated about 25% of their transferred state hospital dollars to SOS. SOS projects include an a project through Sagamore Children's Psychiatric Hospital to prevent hospitalization, an assertive forensic treatment team demonstration, a project that uses maintenance staff and patients to rehabilitate community housing, and various community treatment team and direct skills training programs. The state plans to have 285 staff in these projects by the end of FY 1991.

The Office of Psychiatric Services to Corrections, established to provide outpatient (e.g. non-hospital) care to state prison inmates who do not require placement in the forensic hospital serves 4,000 inmates at the state's 13 prisons and the training center for youth. There has been a merging of the OPSC's services with Oakwood Forensic Services to achieve the goals of unification of services pursued elsewhere in the system. The OPSC also has developed a program to serve adolescents in Department of Youth Services facilities, which it plans to expand to include girls. A recognized service need is for additional services to inmates who are released but who have mental health needs.

Planning

The state promulgates guidelines for boards to develop community plans. This requirement includes planning for emergency and crisis services that work effectively with both mental health and other local emergency service systems. As part of its effort, it provided a discussion paper for community boards to use. Six population groups are required to have their needs addressed in the annual plan submission: (1) severely mentally disabled persons, (2) children and adolescents with serious emotional disturbances, (3) alcohol and other drug abuse clients, (4) criminal justice systems clients, (5) elders, and (6) homeless persons with severe mental disabilities. Boards are also required to submit plans for quality assurance which describe monitoring, special case review, utilization review, and participation of consumers and families in quality review activities. A residential services and housing opportunities plan is also a required component; in this plan, the boards must address how they will participate in the review of residential facility applications, and how they will approve liaison between services and housing providers. This plan component is complicated by changes in licensure and regulation of adult care facilities in the state. A case management plan, which must be approved by the Department, is a requirement for Medicaid reimbursement. All boards are further required to execute a service agreement which addresses how " the boards, hospital, agencies and probate judge(s) will interface when serving persons hospitalized in public hospitals." Boards are also required to develop agreements with private hospitals regarding pre-screening of involuntarily committed persons.

Preparing for the implementation of the Mental Health Act proceeded throughout 1989. The Department undertook to develop training in case management and to develop standards for services. The Department plans to return to its program development role to expand case management, job supports and housing. In addition to emphasizing the populations included in its local plan requirements, it is emphasizing programming for homeless persons,as well as using block grant funds for integrating mental health services into the normal support systems for the elderly, and for planning for people with deafness, physical disabilities or communication disorders.

Prevention

The State Department has an Office of Prevention and is one of 30 States to participate in the Depression Awareness Recognition and Treatment

Initiative (DAR/T). It produces information on early intervention to a wide range of users. In addition, it has stimulated and funded development of "Friends Can Keep You Healthy" support groups, a project which is currently under evaluation. Through $12 M in funds over a three year period, the department plans to fund projects in case management, crisis systems, natural supports and employment.

Housing

Housing policy has built upon several years' experience with homelessness, culminating in an effort in 1987 with the Robert Wood Johnson Foundation's Chronic Mental Illness project in three Ohio locations to develop targeted housing plans that provided scattered site, integrated housing. This has resulted in a funded Housing Assistance Program which provides individually tailored "housing supports" such as revolving loans to help pay security deposits; this project now blends ADAMH block grant monies with $4.3 M in general fund monies. To continue several homeless housing projects, ADAMH block grant funds have had to be allocated to supplement a decreased (to 16%) Mental Health Services for the Homeless block grant (McKinney funds). Housing is also a continuing focus of research funded through the Department and the Robert Wood Johnson Foundation. The Department policy is to develop local expertise in housing, and to link effective outreach to case management.

Case Management

Case Management is clearly the centerpiece of the Ohio systems change effort. The impending implementation of the Mental Health Act resulted in 68% of state hospital dischargees seeing their case manager before discharge, as compared with 22% in the previous year, indicating the importance of this service to local boards. In the 38 Boards that entered the program in 1988, over a third of the funds were spent to increase case management. Expenditures for case management increased 47% over FY 1988, and by 1604% in the 1985-89 period. Efforts are underway to reduce the caseload size from the current level of 1:46 (1989) to 1:30 for adults with severe mental disabilities (SMD). Case management is also provided to non-SMD clients, in accordance with individual service plans; however, while just under a third of consumers in the system had SMD, just over half of the 736,000 annual units of case management service in 1989 were for this SMD population. The state receives Medicaid for case management services, and all boards are required to provide 40% of the funds for this service. (State law allows for local boards and county commissioners to levy taxes for mental health services in excess of statutory limits on tax levies). The state is concerned that case management funds are not sufficiently targeted at the SMD population, but that those non-SMDs who need it should not be denied service until all SMD's are served. Guidelines to standardize the definition of Severe Emotional Disturbance (SED) for children and youth[3] have recently been promulgated across the state. The state is interested in developing a method for documenting statewide when case

[3]. Children must meet three criteria (as opposed to two for adults) to be determined as SED: (1) DSM III Diagnosis, (2) Global Assessment Score, and (3) duration.

management is provided by human services outside the DMH system. Leadership teams in many local board areas meet monthly to design local case management systems. The Department provides training in localities for intensive case management in integrated systems, skill development in the case management process and in working with other services in the system. Plans are underway to develop a statewide case manager network to and to build on local area networks.

Jobs

Work in FY 1990 has focused on developing real job opportunities, restructuring the cooperative agreement with the Ohio Rehabilitation Services Commission, and helping boards change their focus from day treatment to work. Responding to consumer interests, the state has funded five matching grants to move from day treatment toward employment services, and supported employment was developed in 9 locations. The Office of Jobs and Education in the Department has added a job development specialist to work with local boards; 18 funded projects provide seed money to private employers. Efforts are being made in conjunction with the Developmental Disabilities Planning Council to convert sheltered workshops into settings where prevailing community wages are earned.

Children's Services

Goal 5 of the 1990 State Plan reads: "Provide statewide leadership and policy initiatives which support the development of appropriate and adequate mental health services for seriously emotionally disturbed (SED) children and adolescents." There is a coordinating structure (the State and Local Interdepartmental "Clusters") of human service agencies at the state and local board levels that has helped in the Department's efforts to develop four core services statewide: (1) therapeutic foster care, (2) case management, (3) intensive in-home treatment and (4) day treatment. The problems of coordinating care following hospitalization, regional planning, and a model system for youth with SED are all examples of funded grants made available to consortia of Boards in the state. The five years during which the CASSP funds were available helped develop an approach to statewide interagency collaboration around children's issues, as well as stimulated continued interest in planning and monitoring plan implementation for children and youth with SED. Governor Celeste chaired a committee which authored a paper on children with SED for the National Governor's Association. A new project with the Robert Wood Johnson Foundation will develop a client care model project targeted at inner city youth with multiple problems and SED; intensive case management will be provided to an estimated 600 youth to provide care coordination. Children aged 6 to 12 in the 53 counties of Northern Ohio are the subject of an effort by a state hospital for children to provide intensive treatment team services at home. The primary goal of this Without Walls program is to prevent hospitalization. Statewide case management guidelines for mental health case management are being finalized this year. Other projects include training in cultural awareness for mental health staff, four transition from school to work demonstrations, ongoing technical assistance and development funding to local boards in developing interagency collaboration, and capital funding for a residential treatment program for

adolescents with communication impairments or behavior disorders and SED. The system has researched factors affecting post hospital service use, parent coping capacities with delinquent adolescents, depression and grief, service needs, stress and development, and program effects.

Consumers

Ohio has made a strong commitment to empowering primary consumers by improving access to program planning and evaluation and by refining advocacy services. The state has granted funds to both the WE CARE (primary consumer) network and the Ohio AMI to staff, direct and maintain statewide offices. The Department also provides technical assistance to primary consumers to develop consumer operated businesses, and encourages the development of leadership and organizational skills by providing conference scholarships and paying consumers for consulting with consumer groups. There is a sustained effort to ensure that consumers are actively involved in state and local advisory boards, in staff training, and in statewide conferences. The Department will only sponsor conferences when consumers are included as paid presenters, according to the state plan.

Increasing the system's ability to respect, protect and advocate for consumer rights is a major goal for the Department. This includes monitoring informed consent policy to ensure that consumers are able to participate in decisions regarding psychotropic drug use. It also includes developing and disseminating information about clients rights, including training client rights officers in community agencies that linked them with hospital advocates. Training consumers in self-advocacy in the community has been provided. There are also administrative rule revisions being planned to protect client rights with regard to behavior therapy, to minimize the use of seclusion or restraint.

Impressions

Ohio since the mid 1980's has been able to establish infrastructure necessary to support a balanced service system, and it has just passed an inflection point where the fiscal unification of the state and local systems of mental health is beginning. Efforts to develop real jobs, real housing, and community integration of people with severe mental illness or emotional disturbance are supported by strong executive agency collaboration, and have helped prepare the state for this major policy change. The state is strongly supportive of consumer involvement in program and policy decisions, and is attempting to use this to advocate for change as well as design meaningful services in all settings. The uncertainties over the future of State operated services as a way to help move staff into the community are offset to some degree in that there are clearly positive effects of the refinancing scheme on hospital use. The effort to develop case management in the community is portrayed as one solution. The state's apparent effort to develop quality standards for services, combined with growing funds in the face of declining federal grant revenues for mental health suggests that Ohio's tenacious focus on systems development is beginning to bear fruit.

PENNSYLVANIA

Pennsylvania was selected for review because it was examining ways to develop a unified services approach to achieve systems reform. The 1988 Torrey Report suggests that Pennsylvania was faced by major problems which impeded progress, although it had at the time a new, "highly regarded" Commissioner. These problems included a high proportion of funds spent on hospital care, resistance to change by the CMHCs, regional infighting, lack of psychiatrists, and generally poor coordination between outpatient care and inpatient care for the seriously mentally ill. Interviews were held with state planning staff, and the state's Mental Health Plan was received and reviewed.

The Mental Health agency is part of an umbrella Department of Public Welfare and has responsibility for institutional, community and mental retardation programming and administration. The state plan (1989) indicates that the public mental health program has evolved into three separate and unconnected systems: the State Hospitals, the Community Mental Health Program administered by the counties, and private service providers that -- since these costs are not controlled by the state or counties -- the plan suggests may be forcing the community program to be driven by available funding rather than client need.

Who is served?

The State, through the Office of Mental Health and Mental Retardation, has defined itself as responsible for everyone with a mental health need, and has placed a priority in its PL 99-660 Plan on adults with severe and persistent mental illness and on children at risk of severe emotional disturbance (SED). The state's intensive case management program specifically targets persons with a major mental illness, a history of hospital or emergency room treatment, and a global assessment of functioning score on the DSM III-R of 40 or below (or below 60 if under age 35 or has a history of aggressive or violent behavior). Children and adolescents are targeted if they are at risk of SED, under 18 (or under 22 if in special education) and have a diagnosed mental illness and disability under DSM III-R. Other criteria include if the child or youth is in another part of the human service system, currently receives service or is identified by a local interagency team as needing services. These persons are at risk of SED if they are exhibiting substantial delays in psychosocial development. Priority is established if these children at risk have parents with a serious mental illness, experience physical or sexual abuse, are drug dependent, or are homeless. The state assumes that all children or youth with serious mental health needs are served in at least one other system.

Who is underserved?

Populations that are underserved in Pennsylvania include problem children, substance abusers with mental illness, persons who resist group living arrangements, high frequency emergency room users, persons without insurance or who are receiving Medicaid and SSI, and the hearing impaired. The State Plan identifies the following need categories: (1) adults with

serious mental illness, (2) children and adolescents with a serious emotional disturbance, (3) children and adolescents at risk of developing a serious emotional disturbance, and (4) several special needs populations.

Vocational services for adults, particularly for African Americans and women, are underused due to lack of referrals. The needed variety of programs are not yet available, and the plan describes poor collaboration between the VR and MH systems at both the administrative and direct service levels. Permanent and affordable housing has not been a priority, as existing community housing has emphasized rehabilitation and transitional models. Efforts are under way to use McKinney Block grant funds in 5 funded projects and 3 additional HUD 202 grants to develop permanent housing. The Robert Wood Johnson Foundation is providing funds to develop housing in Philadelphia that will help support the closure of the Philadelphia State Hospital. Efforts have been under way to develop counties' abilities to develop supportive housing, most notably in Allegheny County, where a holding company was developed to acquire and manage supportive housing.

Special needs populations identified in the 1989 state plan include forensic patients, the elderly, hearing impaired, people with AIDS, Women, Minorities, and people with dual diagnoses (substance abuse or mental retardation). Emphasis is laid upon the forensic population, broadly defined, to develop mental health care in the Department of Corrections and to provide technical assistance to counties to improve jail services. Efforts are also under way to begin coordinating services with the probation and parole system, where patients are often seen as too risky to treat in the community mental health system. The Department is developing linkages with the newly established MA case management system for people with AIDS, to focus on depression and the increase in psychoneurologic symptoms associated with increased life span for PWAs. A third area of emphasis is on the substance abuser with mental illness. There is currently little tracking of the problem between the county mental health and drug and alcohol programs. There are few structures available to deal with the substance abusing person who has a mental illness, and they tend to rely on general hospitals for outpatient care. There are three adult residential and four adolescent non-residential programs for dually diagnosed abusers, and the Department and the Office of Drug and Alcohol Programs cooperate in Children and Adolescent Service System Program (CASSP) funded student assistance programs in 28 counties.

Many of the 55,000 children and youth who come into contact with the system receive only a single assessment or contact. These represent about half of those who would be considered at risk of serious emotional disturbance. Estimates are that over 60% of the 62,500 children and youth in the child welfare system in Pennsylvania receive MH treatment, and that 47% of adjudicated delinquents had diagnosable disturbances. There is a general perception that children are entering the system "younger and sicker." There are insufficient numbers of children's mental health professionals, outreach is described as minimal, and services are described as poorly coordinated with other child service systems.

Program and Service Initiatives

The 1989 State Plan describes several program and service initiatives. These include: (1) establishing a comprehensive community support program for adults; (2) developing a complete array of mental health services for children and adolescents; (3) implementing early intervention and prevention programs for children at risk of developing SED; (4) creating county capacity to participate in and manage a coordinated system of care for children and adolescents with a SED; (5) providing intensive case management to both adults and children; (6) defining the role of the state hospitals; (7) increasing access to income supports and benefits, vocational/employment services, and housing; (8) developing adequate services for the homeless, and special needs populations; (9) achieving quality service through human resource development, quality assurance, and training and research; (10) developing policies to guide advocates and consumers in institutions as well as the community; and (11) providing support for the closing of the Philadelphia State Hospital.

Community supports for adults have developed in this state in a non-systematic way, so that their lack of integration led to a policy statement that asserts that treatment planning is a continuous and inclusive process without regard to the location of the consumer, and that continuity of care, rather than continuity of caregivers should be the standard for adults with serious mental illness. Three crisis demonstrations, three pilot supported living programs, six or more housing assistance projects, expansion of consumer self help organizations, improved access to income support and benefits, and development of county level Community Support Program (CSP) committees to build local coalitions and link to the network of Area CSP committees are planned. In addition, four counties have initiated county housing committees that include developers, housing authority, and mental health representatives. The Department operates an SSI outreach program through its eligibility and outreach arms, and has developed two demonstrations to assist applicants with mental illness; they have found that this has helped speed up the application process. However, there is a high rejection rate. A 5 year Medicaid capitation financing model covering 30,000 mentally ill people is being demonstrated in Philadelphia; this project incorporates a separate insuring authority that will use RWJ Foundation funds to oversee the entire range of mental health services. This organization will enter into performance contracts with CMHCs for persons who do not have heavy service use patterns, and include heavy use patients under a capitation approach. The project planned to use preferred providers for inpatient hospitalization, with the hope that these will expand their array of services to include step-down services.[4]

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[4]. This information was obtained from " Capitation Financing of Public Mental Health Services for the Chronically Mentally Ill," T.R. Hadley et al, Administration and Policy in Mental Health , Vol 16. No. 4, Summer 1989, pp 201-213.

Children's Services

The state relies heavily on Children and Adolescent Service System Program (CASSP) grant funds to develop its children/adolescent service system. There are three state level CASSP committees composed of representative from child welfare, juvenile justice, drug and alcohol, special education and mental health/retardation. These include the Interagency Children's Committee, the CASSP Advisory Committee and the state-level Interdepartmental Children's Policy Committee. Locally, the 28 CASSP counties have committees that include system representatives, family members and community agencies. This process has resulted in a description of the array of services, and a set of proposals for action spread out over 3 years and including developing all the services in the array. The plan also includes providing 1 family based project in each county, developing county plans for day services and intensive case management, developing an inpatient diversion program (Delaware County), providing family support services and respite in 20 counties, expanding the number of Children and Adolescent Service System Program coordinators to 45, expanding the student assistance program, integrating a behavioral assessment component into the EPSDT (Early Prevention, Screening, Diagnosis and Treatment) examination and into the child abuse system. Several additional outcome measures are being used to gauge system development. For example, by June 1992 no child under age 10 will be admitted to a state hospital, and by June 1990 every patient should have a vocational goal in the treatment plan on the juvenile forensic unit. Sexual abuse victims are able to receive programs funded by the office of children and youth; while this is not in the mental health agency, there is growing recognition that this population has mental health needs.

Crisis Services

Intensive, home based case management is seen as the primary method for preventing crises from becoming more acute for both children and adults. The intensive case management program is designed to qualify as COBRA targeted case management under Medicaid, and efforts are under way to develop the rehabilitation option under the state Medicaid plan for these services, as well as to cover IEP special education services under Medicaid. For children and youth, a family and home based respite program is used as well, and application has been made to incorporate this into the state's Medicaid plan. There are two funded pilot inpatient diversion projects targeting children and youth that use intensive case management strategies and coordinate funding from different sources. Seed funding from the Robert Wood Johnson Foundation will provide a pool of funds for the "wraparound " financing of case management, respite care, individual assessments, and specialized group homes. Other monies from this grant will go to a managed care demonstration for children and youth administered by Blue Cross and Blue Shield. The Children and Adolescent Service System Program (CASSP) grant received from NIMH is being used to develop programs that target children and youth served through five agencies in 28 counties. This initiative appears to have grown out of the legislature's directing the Joint State Government Commission to develop a strategy for reorganizing services provided through county offices to problem children. The state has also negotiated with the counties to decrease inpatient expenditures for General Assistance as part of a strategy to reduce

inpatient bed use, so that the county's definition of crisis precipitating state hospital placement is not influenced by cost-shifting considerations.

Counties

There are 45 county (or "joinder") programs that administer mandated services for all 67 counties in the state, with a 10% local match, except for short term inpatient and partial hospitalization services. Other mandated mental health services include emergency evaluation and treatment, outpatient treatment, specialized rehabilitation and training, aftercare, unified intake and consultation and education. These services reflect the legislation that patterned a core of services along the 1963 CMHC legislation, but that developed the mental health service,and planning mechanisms in each county. this is primarily done through purchase of services contracting.

The county-based community mental health program is predominantly oriented toward community inpatient, partial hospitalization and outpatient services. The case management is described as administrative in nature, and individual caseloads average 309 clients. County case management plans are calling for a $26 M expansion of funds, to reduce the caseloads from an average of 309 per worker. The state plan has suggested a policy of using consumers and family members as an important labor pool to meet work force needs caused by turnover and recruitment problems.

The state's mental health system is described as community centered, with 236,000 patients in the community and only 6,900 in state hospitals; however, the big issue identified in the Torrey study involves moving funds from institutional budgets to pay for community care. The Governor in 1988 directed the DPW to develop a plan for a unified system of mental health services. In this plan, the counties would budget for state hospital use as well as for community based care. The steady decline in state hospital censuses,has been attributed to community treatment teams, to community residential care beds and to an explosion in the supply of acute community inpatient care beds (there are 90 psychiatric units in general hospitals, and 20 private specialty hospitals). The state's perception is that counties oppose a unified mental health system as directed by the Governor in 1989, because they reportedly don't want the added Medicaid responsibility and are worried about their liability regarding commitment. Private providers reportedly oppose this policy as well. Efforts to develop demonstration capitation programs under Medicaid are just beginning; however, one planned for Philadelphia has experienced difficulty in getting started.

The state plan calls for restructuring appropriations and reimbursement mechanisms so that the counties have increased control over Medicaid expenditures on mental health (Medicaid accounts for 43% of community mental health expenditures). In addition to authorizing Medicaid payment for services, counties will be able to authorize general fund payments for state hospital care. The county will in effect become a gatekeeper to the mental health system.

State Hospitals

According to the 1989 state plan, " The state mental hospital system's mission has never been defined in statute or regulation, and it has evolved as an almost arbitrary response to public demands for service and/or lack of community-based alternatives." The state hospitals have experienced a 14% reduction in census driven by commitment laws with strict admission criteria and provision for early discharge, development of alternatives in the community, and a decrease in skilled and intermediate nursing care use. There has been little change in the general psychiatric, forensic or children/adolescent census. One of the sixteen state facilities is a nursing home. Nine of the Hospitals are certified as medical assistance long term care providers. Approximately 20% of the inpatients are elderly and physically infirm, of whom 1/4 could reside in the community, and another 25% of admissions are short term emergency commitments. There are four medium secure and one maximum secure forensic unit for males, and one unit each for females and adolescents. The State Plan for 1989 has developed a goal to strengthen the role of the state hospital in the overall service delivery system. There are several objective being pursued over the next three years: (1) discharge planning that identifies specific community resource needs in the context of interagency service agreements, (2) integrating hospital and community programming, including consumer organization involvement, (3) improving management processes, (4) maintaining an accessible, healthy and safe physical plant, and (5) ensuring that all patients aged 18-22 have access to special education services. The state plan provides several principles to guide the system as it defines the role of the state hospitals. These include providing active psychiatric treatment for patients who need extended care beyond what the community can provide, specialized services (e.g., for children/adolescents, offenders, violent patients), extended care and activities for those who can't leave due to illness severity, and nursing home care that cannot be provided in the community.

The closing of the Philadelphia State Hospital is seen as an opportunity to demonstrate the feasibility of using available state hospital staff to comprise eight 7 member multi-disciplinary community treatment teams. These teams were supported by specialists in vocational, housing, community resources, and benefits, and outside clinical consultation and training are regularly available. Individual client assessments provided the basis for service planning. A closing advisory committee consisting of county administrators, families, consumers, employee representatives, boarding home representative and a psychiatrist was formed to advise on services structure and an evaluation of the closing. A 24 bed diversion unit was opened, and another state hospital was developed as backup for long stay patients. Housing is being developed in Philadelphia for 627 adults with severe mental illness (SMI) using Robert Wood Johnson Foundation grant funds. Two federal suits have been brought, focusing on adequacy of community resources and continuing hospitalization need; these are being negotiated. Expansion of vocational support and intensive case management in the community are issues.

Private Providers

Over 60% of the $424 M spent on community mental health in FY 86-87 was derived from revenues generated by and directly paid to service providers. The private provider system, composed of 23 free standing hospitals, and inpatient psychiatric units in general hospitals, are able to receive payment for services to people regardless of whether they are registered in the county program. About 1/4 of the 82,000 annual admissions to these facilities are involuntary. There are problems with discharge planning for persons with serious mental illnesses, and there is concern that there is no directed management control over a major part of the community mental health system. The Department's recommendations to the Department of Health regarding Certificate of Need applications have been overruled, and there is a question about whether the two agencies are using consistent standards and criteria in their review. A task force was formed to determine the current and future need for psychiatric inpatient services in a unified system. The Health Department's Certificate of Need planning has changed; recently, the office of mental health and the counties became involved in this concurrent hospital review process. There is no mandated mental health benefit law in Pennsylvania, and private insurance dollars represent 11% of total received and spent on community mental health care; the state plan comments, "additional revenue generation from mental health insurance would reduce this major disparity between the public and private sector financing of the public mental health system." There are over 5200 private inpatient hospital beds in the state, and over 900 of these are for children and youth.

Families and Consumers

Families are involved along with consumers in the county-level planning process and on the regional community support program advisory committees. Children and Adolescent Service System Program (CASSP) funds provide for staffing family support groups for children and youth, through the Parent's Involvement Network. The state funds a statewide family office for families of adult consumers. The state plan call for respite care and family based service demonstrations for families with SED children; this would include foster families. In Philadelphia, a consumer run advocacy program is funded through federal McKinney Act funds for the homeless.

Regulation, Evaluation, Research

There are several quality issues facing Pennsylvania as it moves toward a unified county mental health service system. The plan describes inconsistent application of quality standards, direct care and case management staff turnover and recruitment problems, and a need for a comprehensive approach to staff development. The state mental health authority is just developing its evaluation capacity, and is now conducting medicaid utilization review of outpatient and partial hospitalization services. Data systems are seen as old; however, the department has made efforts to improve tracking clients through the system, helped in part with NIMH funding, which is now able to be spent. In 1989 the department has developed and released integrated data base software to the counties for the intensive case management reporting system. A second management information system including

a "minimum data set" to track all clients with the public mental health system is being designed (1989). Every two weeks, each county receives a state hospital patient days printout showing historical and service use data. A fourth initiative which attempts to provide feedback to counties on Medicaid inpatient claims and service use.

The decline of the pool of direct care applicants is fueling discussion of the importance of a consumer role in service provision. Training entry level workers, expansion of the Intensive Case Manager training program concurrent with expansion of staff, and development of county management skills in program development, fiscal management and personnel management are all seen as needs.

There are seven Medical schools that have departments of psychiatry in this state, and three colleges operate psychiatric hospitals as research and training institutes. In all there is an estimated $34 M in the current research portfolio in psychiatry in these schools. The state plan seeks to use this resource as a way to increase training and continuing education as well as provide assistance in their efforts to develop service research and demonstration projects as the unified services model emerges. The small size of the state mental health agency makes administrative solutions such as demonstrations to illustrate models of unified services, capitation, and comprehensive planning the only route open to reforming the system. Unified services legislation, planned for 1991, may provide the impetus for system change; the most recent director of the office was able to develop new intra-departmental Medicaid linkages, due to experience in Medicaid, and this promises to provide a way to expand community services in the future.

Impressions

Pennsylvania is a state where institutional interests are well developed and where reform involves building a local service delivery system. The reform is not yet based in statute as in Ohio. The dominance of the private inpatient system, particularly in regard to children and youth is seen as a financial problem as well as a control problem that may be partially addressed by creating a wider array of community services and by restructuring the financing system. The understanding of the human resource development issues in the state plan is particularly profound, and represents an apparently insoluble problem that will worsen. The plan for unifying the system at this time appears to be oriented toward establishing necessary administrative infrastructure to support the expansion of medicaid, to articulating a vision developed by opening up the process to families and consumers at the state and county levels, and by developing and maintaining a variety of policy, research, and program development relationships within the system.

WISCONSIN

Wisconsin was selected for study because it was highly rated in the 1988 Torrey Study, and because it exemplifies a mature community-based mental health system. Two interviews were conducted to obtain administrative and legislative perspectives. In addition, materials were reviewed that describe Mental Health Crisis Intervention, the Program of Assertive Community Treatment (PACT), the human services funding system, and the Mental Health Program. There was some difficulty encountered in engaging the state in interviews, partially because the mental health leadership was changing at the time. The interim director, when finally contacted, was able to provide much historical perspective as well as identify current system strengths and challenges. Wisconsin's mental health services delivery system is based around the county's Community Mental Health Board established under provision of the State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act, Chapter 51 of Wisconsin Statutes. The state agency is called the Office of Mental Health, and it is located in the Division of Community Services in the Department of Health and Social Services (DHSS).

Dependence on Institutional Care

Wisconsin has two State Hospitals (referred to as Mental Health Institutes), and operates a maximum security facility as well at the Mendota Mental Health Institute in Madison, the state capitol. The institutes have been downsized in accordance with a 10-year plan that started in 1971. Reportedly, there are no separately state-funded clients who come to the institutes, although they can serve as Designated Receiving Facilities and may well serve those counties where there are few services in the community. The role of these Institutes is defined as primarily acute care and stabilization with smaller long-term units for specialized services that are not likely to be available elsewhere (e.g., dually diagnosed, deaf, children and autism). Outpatient clinic services can be provided directly by the institution; however, the state can do this (with a charge back to the counties) only if county services are not available or for persons who are not state residents. Chapter 51 makes three important provisions that would forestall use of state hospitals: 1) limited guardianship is available to individuals who may require treatment in the community, 2) the counties are billed for use of institute services by county residents, 3) the courts are required to commit a person (except prisoners or out of state residents) for acute psychiatric treatment to the Community Mental Health Boards. In this commitment process courts are required to designate the "maximum type of inpatient facility which can be used for treatment." This effectively allows for a judicial limit on level of care required and for review if there is a need for a higher level of care.

In the institutes, the state continues to directly provide mental health treatment to involuntarily committed state prisoners and it can conduct court ordered evaluations of forensic cases. However, state prison inmates who do require inpatient treatment can be committed for outpatient treatment in the prison.

The downsizing of the mental health institutes has ended, and state funds for "State Hospital" care have been integrated into what is described as the Community Aids Funding System.[5] The downsizing occurred over a ten year period, with a four year phase-in of the Community Mental Health Boards structure. During this period, some county hospital beds were lost due to state regulatory efforts to close the "social care" system; the state then started two 20 to 30 bed inpatient units to provide inpatient care for the two institutes catchment areas. At this point, the NIMH provided support for research and development of the program for Assertive Community Treatment.[6] The program took professional staff from the Mendota Mental Health Institute and used the University of Wisconsin to train steams of social workers, doctors, and nurses to develop mobile treatment teams. Based on the premise that the hospital ward could be replaced by the community, the institute staffed two shifts of 17 staff to serve 130 clients. No group homes were used, and efforts centered around helping provide for basic living needs in the community. A foster family care program was developed to provide supported community living arrangements for this population. There were no group homes available when this transition was occurring.

Service Delivery

All state residents with mental illness[7] are eligible for publicly funded services regardless of income. A statewide uniform income based fee scale is applied, and county boards are required to charge fees for services, including community support services. The local human services delivery system, of which mental health is a part, is characterized as one that is county administered and state supervised; of the state's overall human services allocation to the counties, almost 3/4 originates as general purpose revenues and 1/4 as federal revenues.

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[5]. In this single allocation system, federal and state funds are drawn down by a 10% county match; Mental Health Block Grant funds are allocated through a separate formula and no local match requirement. Counties are able to "overmatch" spending in excess of their match requirement; about 1/7 of total expenditures originate as county overmatch.

[6]. For a review of the model see "A Historical Review of the Madison Model of Community Care", K.S. Thompson, E.H. Garrity, P.J. Leaf, Hospital And Community Psychiatry, June 1990, Vol 41, No. 6

[7]. Statute defines mental illness as "mental disease to such an extent that a person so afflicted requires care and treatment for his or her own welfare, or the welfare of others, or of the community." 51 Wis. Statute §51.01 (13)(a). The definition for purposes of involuntary commitment is more specific: "... a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life..." (§51.01 (13)(b). Chronic mental illness is defined separately as will in this statute.

The Mental Health Act (§51.42) requires counties to offer, within the limits of available funding, the following mental health services: (a) collaborative and cooperative services with public health and other groups for programs of prevention; (b) comprehensive diagnostic and evaluation services,; (c) inpatient and outpatient care and treatment, residential facilities, partial hospitalization, emergency care and supportive transitional services; (d) related research and staff training; and (e) continuous program planning and evaluation. A local plan is required, and it must include a component for persons in need of emergency services. The county is liable for emergency services for detention, for protective intervention or placement for not more than 72 hours.

The counties are afforded in statute a large amount of flexibility in how they organize themselves for planning, oversight, and mental health services delivery: (a) 27 have merged their Social Services and Mental Health, Alcoholism, Drug Abuse, and Developmental Disabilities Boards into a single policy making human service board and agency; (b) 45 counties have one board to jointly operate social services departments and usually a corresponding Mental Health or Mental Health/Developmental Disabilities (MH/DD) Board; (c) 28 counties have a single Mental Health, Alcohol/Drug Abuse and Development Disabilities Board; (d) 31 counties receive a single allocation and determine how it is allocated between social services, mental health and developmentally disabilities services; (e) there are also five multi-county MH/DD/Alcohol and Drug Abuse Boards. These governing and policy making boards are established by the county boards of supervisors or by the county executives and are responsible for planning and evaluation, appointing an administrator, and budgeting. This flexibility in design is supported by a flexible approach to funding local priorities, where each mental health board is able to spend its basic county allocation as it sees fit, subject to various maintenance-of-effort requirements. In mental health, these categorical programs include; Community Support Program, a categorical allocation for Services to Children (state in 1985), Child Sexual Abuse treatment, A Family Support Program; Relocation Services, Epilepsy Grants, Supported Employment, and Developmental Disabilities Grants. Special initiatives are funded through separate allocations.

Oversight and Funding

The degree of supervision of the system by the state is a controversial area. The mental health needs assessment process is county-based and the flexibility afforded in statute has made implementation of performance based state-local contracting difficult. There are problems in drawing inter-county comparisons because county mental health proposals vary considerably in format.

A 1988 legislative audit identified three concerns about the uniform human services reporting system: (1) in 1987 the system was collapsed from 42 program categories to nine, which fails to provide sufficient detail to determine how funds are spent; (2) there is a need to more closely link the reporting system to the funds payment system; and (3) data was inaccurate. The Legislative Audit Bureau's concerns to remedy insufficient monitoring and lack of systematic planning, evaluation, or quality improvement by the DHSS

resulted in two major recommendations: (1) require counties to submit budgets in a standard format; and (2) expanding DHSS's monitoring and technical assistance activities at the regional office level (including quarterly reports on each county). In addition to the need to improve oversight and reporting, there is a history of resistance to "unfunded mandates" by the counties. While the waiting lists of unserved persons with developmental disabilities are currently being addressed by categorical grants, there is emerging concern that the severely mentally ill are becoming "wait listed" (unserved). The conflict over expanding the involuntary commitment statute in 1986 to add "gravely disabled" as a criterion (beyond the fairly explicit behavioral criteria included in the four standards of dangerousness that could be applied to involuntary commitments), was resisted as an "unfunded mandate".

In the 1988 Torrey report, Wisconsin's relatively low per capita public mental health spending for the seriously mentally ill was seen as a problem that would be constrained from growing due to tight funding. The current effort to seek federal Medicaid reimbursement through adding the rehabilitation option for community-based case management and psychosocial rehabilitation in the state place is being phased in throughout the state. Counties are required to share the costs of Medicaid services under this option. There are also efforts to obtain enriched federal Medicaid reimbursement for clinical teams at the county level, as well as to maximize Medicaid for state institutional care.

Crisis Intervention

The dominant model for crisis intervention in Wisconsin has been to expand the Assertive Community Treatment program. By emphasizing use of mobile treatment teams to supervise people with recurrent problems, the state is hoping to keep caseloads near the standard of 20. Crisis intervention is required under the statute; it varies widely across the state. The usual model is to tie it into a generic crisis line for the county and to make services available in the clinic during the day and on location at off hours. There are few mobile teams, however.

A 1988 Senate bill calling for a DHSS study of local mental health crisis intervention systems yielded the following results:

1. In 1988, $6.6 million in funds were reported to be available for crisis intervention.

2. Services that are universal include professional coverage around the clock, and a hotline; 20 agencies provide 24 hour mobile outreach, while eight rely on law enforcement for this.

3. Forty-one percent of the respondents contract for non-medical crisis beds, often as an adjunct to emergency hospital services.

4. $2.7 million was estimated to meet current unmet need for crisis services, and priorities were placed on staff, training, and transportation.

5. From 1984 to 1987 the estimated number of contacts had grown from 90,000 to 136,000. One respondent suggested that the clients in the Community Support Program for the Seriously Mentally Ill, particularly those who refused treatment or on waiting lists due to lack of services, would need additional crisis intervention services.

Impression

Wisconsin's approach to mental health systems development has been to integrate service delivery with the generic human service delivery system under a system of local governing authorities. The approach also has been to ensure that counties have a high degree of flexibility in how they plan, organize, deliver, and finance mental health services. The trend toward maximizing federal Medicaid funds to guide service expansion to emulate models and to achieve greater uniformity will clearly require a degree of centralization, and uniformity in assurance efforts. The state's comprehensive approach is strongly oriented toward ensuring that civil rights are preserved as the state and counties act to intervene in ways which emphasize the least restrictive alternative for treatment. Overall, Wisconsin has made many legal and administrative tools available that should facilitate flexible intervention in people's affairs. However, this commitment to flexibility is likely to erode as funds become tighter. As a result of this probable erosion, it is unclear what will happen to the state's concept of universal entitlement.

RHODE ISLAND

Rhode Island was very highly rated in the 1988 Torrey Study, showing significant improvement in services for the severely mentally ill. It has also been described as an example of a state-administered unified mental health service system where it has been able to work with a network of Community Mental Health Centers to shift savings in state hospital use to community programs. An in-depth examination of Rhode Island was carried out, including interviews with state administrators, advocates, and community mental health administrators. The primary reference sources for this study are a document entitled Decade of Progress-1989-1998: A Mental Health Plan for Rhode Island, Rhode Island Department of Mental Health, Mental Retardation and Hospitals, June 1988 and The 1989 Annual Report of the Rhode Island Council of Community Mental Health Centers. The Office of Children's mental health services in the Department of Children and Families was not contacted for interview in this study due to time constraints; material describing the Office and its relationship with the adult service system was contained in the State Plan.

State Organization

The Department of Mental Health, Retardation and Hospitals is a cabinet level agency of state government that has primary responsibility for serving people with mental illness, substance abuse problems, developmental disabilities, and long term care for physical disabilities. In the State Plan, there were four Divisions in the Department that reported to the Director; Mental Health and Community Support Services, Retardation and Developmental Disabilities, Hospitals and Community Rehabilitative Services, and Management and Support Services. The Mental Health Division includes line operations including community services, a proposed Office of Operations, a Quality Assurance Office for technical assistance and consumer affairs, and an Institute of Mental Health. Mental Health field operations include human resource development, a Psychiatric Research and Training Center, Planning, and Management Information Services. The state operated mental hospital is operated by the Mental Health Division, and is referred to as the Institute of Mental Health (IMH). The Psychiatric Research and Training Center serves as a training resource for professionals and conducts basic mental health research in such areas as dyskinesia, recidivism of detox patients, and chronic psychosis.

The Division of Hospitals and Community Rehabilitative Services provides and develops clinical and support services to frail elders and persons with chronic disabilities, provides institutional and community programs for substance abusers,and operates two public hospitals. There is close collaboration between the substance abuse and mental health functions in this organization, and there are several local pilot projects demonstrating how Community Mental Health Centers can share responsibility for service provision with local substance abuse providers.

System Organization

At the State level, there are five advocacy organizations that represent the interests of primary consumers, families, and Community Mental Health Centers. The Office of the Mental Health Advocate serves as an independent advocate appointed for a five year term by the Governor and represents clients in the Institute for Mental Health, psychiatric hospitals (e.g., the private Butler Psychiatric Hospital and the public General Hospital), group homes, and in the community. This office was created in 1984 is currently concerned about prisoners and nursing home residents with mental illness, and is regularly involved in reviewing procedures as well as cases of mortality and alleged abuse. As the diffusion of Institute for Mental Health patients into the community occurs, and as the system moves toward more scattered site housing, the advocate's office may find it more difficult to ensure that rights are protected. At present, its primary activities include interviewing all new admissions to psychiatric hospitals and investigating treatment complaints. The Rhode Island Mental Health Association, the Alliance for the Mentally Ill (consisting of ten regional family support groups) and the Coalition of Consumer Self Advocates, are all involved in community education. The Council of Community Mental Health Centers represents the eight Community Mental Health Centers in the State, and focuses on case management training and certification, networking and public education on children's and aging issues, and on dually diagnosed service issues.

Planning

The Governor's Council on Mental Health provides review and analysis of mental health issues in the state. Membership includes the advocate's office, the Departments of Human Services, Corrections, Education, Health, Elder Affairs, and Children and Families, and Mental Health/ Retardation. In addition, representatives from the legislature's two houses and other interests are involved. The Council supports executive level coordination and has done so for several years; for example, in 1983, the Council directed the Department to develop a coordinated planning process with the Department of Children and Families to provide services to children and adolescents.

The Governor's Council has, since receiving NIMH grant funding in 1986, prepared the State's Comprehensive State Mental Health Plan. The plan, prepared at the Governor's direction, recommends a "phased approach to systems development" over 10 years. This planning process included extensive subcommittee work and involved over 130 people in an 18 month period. The plan document represents what the state feels is a community consensus on services to <u>adults</u> in five areas. These include the following principles:

(1) Provide housing for clients in settings that maximize community integration and opportunities for acceptance,
(2) Treat clients in the community with sufficient service intensity to maintain or improve the functional level of the group as a whole,
(3) Rehabilitate clients to help them get work,
(4) Provide case management and support services to clients to improve their level of independence, and

(5) Provide outreach services to special populations to develop systems linkages with those populations (elders, homeless persons and their children, prisoners), provide a means for assessing their needs more directly, and assure provision of services to them.

The plan underscores three desired results: (1) improved client participation in treatment and support programs; (2) improvements in overall functioning (using a RAFLS[8]-style system of functionality); and (3) improved accountability for client outcomes. The plan also acknowledges that the availability of community programming to meet security and protection needs would result in a smaller Institute for Mental Health census.

Service Delivery

The service delivery system is organized around eight catchment areas, with one Community Mental Health Center in each catchment area. This arose from a planning process with the state's Office of Community Services in the mid-1970's where the original Community Mental Health Centers and state regions were realigned. The Community Mental Health Centers provide prevention, consultation and education, around the clock emergency service, outpatient care, and community support services to severely mentally disabled adults. In 1987, Community Support Services performance contracts and represented from 57% to 82% of Community Mental Health Center budgets; these services include case management, medication management, inpatient crisis stabilization, and residential rehabilitation. The Community Mental Health Centers are the gatekeepers to the Institute for Mental Health, and have responsibility for all needed public mental health services in their catchment areas.. The system has provided over the past several years the authority to Community Mental Health Centers to oversee the commitment process and to access alternatives in a local system. The basic components are funded in each area. In addition, the Community Mental Health Centers have the responsibility for determining what services are needed, acting as the single point of access to the public system of community and hospital services. The state provides the resources, 93% of which go for services to people with severe mental illness; these resources consist of reallocated state hospital monies for care to long term and short term patients, and of new appropriations. The system is essentially capitated for the SMI population, with Community Support funds for long stay clients. Contracts in the community are also made by the Department for treatment other than inpatient care, and a matching grant program exists for services to non-SMI persons where the state provides $2.33 for every $1.00 from the Community Mental Health Centers, which raise funds from towns in their catchment areas. This

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[8]. Resource Associated Functional Level Scale, developed by the Human Services Research Institute. There are seven functional levels: (1) of potential harm to self and others, (2) unable to function, current psychiatric symptoms (acute), (3) lacks ADL/personal care skills, (4) lacks community living skills, (5) needs role support or training, (6) needs support/treatment to cope with extreme stress or seeks treatment to maintain or enhance personal development, and (7) systems independent (able to use natural helpers or generic services).

matching program is essentially level funded, as there has been no cost of living adjustment worked in.

In addition to the Community Mental Health Centers there are five other major mental health provider organizations. Three of these organizations provide residential and community based programming and mobile treatment services to severely mentally disabled persons. Two consumer run businesses (a bakery and a plant store) received capital financing and startup funds from the Department; the 1985 Bond Issue passage also guaranteed more capital funding for similar projects such as these.

System Strengths

The system has a clear structure, has proceeded from a basic plan developed in the late 1970's, and has developed consensus over the years through a participative planning process that has had strong executive support. The small size of the state and its cultural cohesiveness are seen as factors, as is the relative permanence of the Community Mental Health Center directors (some of who have been there since the beginning in the 1960's). The focus of the Department on serving adults, the evident commitment of public funds to the severely mentally disabled, and the successful integration of these priorities with the more "traditional" Community Mental Health Center priorities have laid the groundwork for further systems development. The "Transfer" policies of the late 1980's represent the beginning stages of unification of service delivery in the Community Mental Health Centers, and Community Mental Health Centers are now able to use some state funds previously allocated to Institute for Mental Health to purchase care in state hospitals. To some extent, continuity of executive and program leadership has contributed to the long range perspective the state feel free to take. The planning process has also been able to achieve credibility in the participants' eyes because it is external to the Department, and because it includes all relevant executive level human services agencies which touch those with mental illness in one way or another.

System Gaps and Weaknesses

The Governor's Council identified several shortcomings in the State Mental Health Plan that needed to be addressed. These included:

(1) the lack of a comprehensive plan that examines "the interaction of all those separate planning efforts in the context of a system emerging from a period of substantial growth,"
(2) lack of "an empirically based assessment of client need on which to base categories of levels of care,"
(3) lack of variety in the service system beyond the basic system components which can meet the different needs for intensity for adults as well as special populations,
(4) "lack of a range and quantity of housing options" in that the main emphasis has been on group homes,
(5) there is no detailed plan describing the role and future size of the state hospital,

(6) there is a lack of coordination with Children's services, particularly as severely disturbed adolescents age into the adult mental health system,

(7) there is a "prospect of insufficient resources to support the existing mental health system in a stable manner or to provide for needed growth," as level federal funding continues and the portion of state hospital costs that could be easily transferred to community programs declines, and
(8) the consensus achieved in the 1980's is threatened by a possible slowdown in development of community based services.

Target Populations and Unmet Needs

In addition to the above problems, there are some populations that are experiencing difficulties accessing the balanced system of care. This includes the elderly with mental health needs (particularly those who live at home), adults who need case management but do not meet the criteria for severe mental illness[9], persons who do not have a major mental illness, persons with mental health and substance abuse (although a few pilot projects exist), and children who are moving in institutionalized from out of state placements or who have problems external to the system but who are receiving some Community Mental Health service.

Prisoners with severe mental disabilities are reportedly not well served in the prison system. A survey showing 4.1% of prisoners at the Adult Correctional Institution with severe mental disabilities, and 8.2% of those received in the Correction system's intake service center were so identified. Compared to state hospital patients other than those in the forensic unit, the prisoners had generally higher functioning level and they tended to be younger with a higher proportion of minority prisoners. There are psychiatric, psychological and counseling services available, including a sex offender program and substance abuse counseling. There are no programs targeted to the special needs of the Severely Mentally Disabled in the prison, and there is no screening service at the Intake Service Center to evaluate mental health needs and make necessary referrals. Finally, there is no protocol regarding referral of released prisoners with Severe Mental Disabilities to the community.

The Plan identified a status target that would increase the proportion of Community Mental Health Center outpatients discharged as having completed

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[9]. The Plan proposes that the Department assume a policy-shaping role for the non-publicly funded portion of the mental health system. This would include educating the public about mental health benefits, encouraging insurers to broaden the range of reimbursable providers and achieve similar copay/deductible requirements as physical health, increase medicaid payments to enhance access. The Department and the CMHCs are undertaking a new process to identify populations at risk for mental health problems and others believed to be inadequately served.

treatment. This marks the beginning of a formal policy shaping role for the Department in this area, which is concurrent with state efforts to improve the level of funding in its matching grant program. The issues for the Community Mental Health Centers at present are to make sure that the services are integrated for all and to maximize federal revenues to support expansion of acute crisis intervention.

Elders are another focus of discussion. The state's survey of non-hospitalized elders suggest that one out of seven to one out of five persons receive psychotropic medication. Of those in a Brown University study of Nursing Homes, 44% to 64% were reported to receive psychotropic medication; in the General and Zambarano Hospitals sampled, 56% and 31% respectively received psychotropic medication. The difficulties with assessing severe mental disability in the older population led the Planning Project to conclude that "the kinds of action recommended are essentially those which would bring mental health services to elderly people in a variety of settings and establish them as a component in an integrated set of health welfare and social services." Recommendations include: Community Mental Health Centers assigning outreach personnel to senior centers, day care, sheltered care facilities and publicly subsidized senior housing; Community Mental Health Centers developing agreements with community and public hospitals for joint discharge planning; referral agreements and protocols between Community Mental Health Centers and Community Health Centers; and establish protocols for in-home mental health assessments in conjunction with existing providers and on referral by "informal gatekeepers" such as mailmen and meter readers.

There is a need to develop residential care in small group settings for children under the auspices of the Department of Children and Families, which has primary responsibility for children's and adolescent mental health. The transition of children with severe emotional disturbance to the adult system is sometimes difficult because the person may have an institutional history yet not require care in the adult Institute for Mental Health, because there are fewer services and because the definitions of disability are sometimes different enough to make community based care difficult to reimburse. A separate unit for children's mental health services in the Department of Children and Families is monitored by a technical committee consisting of Health, Mental Health/Retardation, Education, and Social and Rehabilitative Services. These departments all have interagency operating agreements regarding children's services. Efforts to maximize medicaid reimbursement for community based services to this population are being made. The Community Mental Health Centers are the designated regional mental health providers, and receive technical assistance and guidance in service delivery and coordination issues from four Community Service Coordinators assigned from the Department of Children and Families. On respondent observed that there are multiple Medicaid providers for community based mental health services to children, in contrast to the adult population where the bulk of Medicaid reimbursement is in the Community Mental Health Centers.

Homelessness poses several problems for service delivery, in both identifying and engaging people with mental health problems to accept care. Homelessness is a problem in the cities of Providence and Newport, and the plan calls for street-based outreach workers, on site treatment teams in the

shelters and soup kitchens, a drop in center for a whole array of human services including mental health, and transitional residential beds included under basic residential beds (see Housing).

Hospitals

The size of the public and private psychiatric hospitals have been linked to the future of community alternatives in the state. In 1981, The Governor's Commission on Mental Health recommended that the Institute for Mental Health be used for only persons needing continued hospitalization. Since then, Community Mental Health Centers have tended to use Butler Hospital, local community hospitals, crisis care beds and Institute for Mental Health for acute or short term admissions. The Department's stated policy regarding phasing out of services states that "Whatever the current setting, no currently utilized service will be phased out until an appropriate community service or set of services has been established...." In the State Plan, there is a beginning effort to define 29 different services as components of a system of care, among which are Institute for Mental Health and Butler as specialty hospitals, and 5 community hospitals with short term inpatient psychiatric services. The estimated costs of specialty hospital service are projected to decrease (in 1987 constant dollars) from an estimated $5.1 M in 1989 to $3.8 M in 1998 and total annual system costs are projected to decrease from $68.9 M to $48.2 M in the same period. The moving of clients to less costly functional levels is expected to explain the major savings in total systems costs. For example, in 1989-1993, 50 % of "level 1" and 1% each of levels 2 and 3 on the RAFLS scale would use specialty hospitals an account for 18,400 units of service. By 1998, if the community service system developed in accordance with the Plan, the number of units of service would drop to 13,600. It is interesting to note that the decline in annual cost of this service in 1987 dollars is $1.3 M, and that this is far smaller than the expected decline in residential care, where almost $5.6 M less would be spent in 1998 on basic care in supported apartments, sheltered care or board and care facilities.[10] Community hospitals are projected to pick up 10% of the level 1, 2% of the level 2, and 1% of the level 3 clients and move from 1800 units of service and $670,000 in 1989 to an estimated 1100 units and $420,000 in 1998. The service alternatives implemented in the 1989-1993 period are expected to shrink the census from 260 (1985) to 120 (1991) and to sustain the current effort to meet acute psychiatric needs with 55 beds. Currently the census hovers around 170.

The Transfer programs essentially constitute a capitation program. Under these two programs, the state pays the provider a fixed amount per SMI client, and the provider purchases the needed care. The first year targeted people who had up at least one full year's stay in the Institute for Mental Health; as of 1989, there were 208 persons in the program, and the Community Mental Health Centers receive $8000 annually, $4500 of which is advanced. The second transfer program provided per capita funding of $20,000 per year to Community Mental Health Centers that agreed to serve more disabled persons who

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[10]. see Appendix B for pages 90-98 of the Plan, with projected utilization and cost information.

had been Institute for Mental Health patients for 2 years or longer; these persons were also able to be placed in group homes, something that was not allowed for "Transfer 1" patients. Under this system, the provider has an incentive to control costs by regularly evaluating use of services. This is achieved when someone is in the Institute for Mental Health by a policy that allows the attending community physician to have admitting privileges.

At this point, all but one of the Community Mental Health Centers use the Institute for Mental Health for acute care. Butler Hospital (experiencing a low census) and two general hospitals that serve as designated receiving facilities are entering the system as providers to Community Mental Health Center clients under the program; the current plan is to phase these three hospitals into the system so that the Community Mental Health Centers would be able to purchase care in those for which the Department would pay. The evaluation of forensic patients is a problem at this time, where there is a need to evaluate persons who are determined to be not competent to stand trial so they may be moved to the civil side of the hospital as soon as possible; the state has just started allocating these patients to acute admission status but with an expectation that they will be long term patients, so that there is an incentive for Community Mental Health Centers to come into the Institute for Mental Health and evaluate the person in a timely fashion and reduce utilization. The targets for utilization have reportedly tightened so that 15 of the 40 acute Institute for Mental Health beds are for admissions of involuntary patients. Treatment at the Institute for Mental Health is seen as of different quality from other hospitals, primarily because the shrinking facility is approaching a core of senior staff who were hired in a more custodial era; accordingly the treatment options at the facility are primarily oriented around medication rather than programming.[11] Community services are used to provide vocational services to Institute for Mental Health residents off-site. It is important to note that the elderly and persons with AIDS who may have mental health needs are now placed in the state's General Hospital, a non-psychiatric facility that provides extended care.

Community Based Services

The array of mental health services for severely mentally ill adults was defined in the state Plan and appears in the tables in Appendix B of this report. The expansion of community based services planned for the years from 1989 to 1993 includes substance abuse treatment, medication maintenance, family treatment, emergency assessment, vocational assessment, general support (day care, homemaker, transport), protection and advocacy services, and job finding or development. Major expansions are planned for drop-in center hours (from 515 to 14,822 hours per month), supported work/transition employment (in integrated settings, to grow from 4700 to 78,100 hours per month), and case

[11]. One interviewee suggested that the ability of the client to refuse medication in the community may result in either court hearing or a hospital discharge; as a result emergencies tend to be broadly defined so that the medication can be administered. Standards are available which cover IMH and the CMHCs, but not the private hospitals.

management hours (from 7093 to 14,866 hours per month). Two new services will be added: mobile treatment teams, up to a level of 3900 hours per month; and day treatment of 16,400 hours per month.

Housing

A variety of residential programs will be expanded: intensive and specialty residential units, respite beds (current capacity is 6, it is planned to grow to 23 by 1993), adult foster care (a jump from 6 to 159 slots), and basic residential care (minimal supervision). New residential efforts are planned, including a family subsidy program for people who want to live with their families, and supported independent living in subsidized apartments or homes.

The Rhode Island Housing and Mortgage Finance Corporation plans to devote part of its funding for special needs populations. HUD projects have also been sponsored. The trend away from group homes may be related to a problem with exclusionary zoning, as well as to the difficulty these facilities have serving the "never institutionalized" younger population. The move toward scattered site apartments is portrayed as a more normalizing influence. The expansion of case management, mobile treatment teams, and medication maintenance assume new importance because they are able to prevent crises from occurring in the residential setting as well as achieve a measure of control over the individual. Increasing the mix of housing options in the community is seen as an important strategy for meeting consumer needs and maximizing consumer choice of where he or she can live in the community.

Consumer Issues

The effort to create a statewide consumer support network has been somewhat unsuccessful, in that while the current network has emphasized personal advocacy there has not been an emphasis on "empowerment" for systems advocacy in program and policy settings. Consumers are involved in local planning, although it remains difficult for the Community Mental Health Centers to involve them actively as required in planning; for example, one Community Mental Health Center reportedly experienced great difficulty in involving consumers or families at all because it was seen as counter-therapeutic. The need for improving consumer choice of housing and consumer based services have also been reported. The orientation of the system away from a medical model was seen as necessary, although there is concern that there is improper management of medical problems for some patients discharged to the community, and that community programs may need to pay close attention to monitoring people with prior suicide attempts or who have preventable medical risk (e.g. diabetes).

Robert Wood Johnson Foundation funds are used to contract with a statewide consumer-operated mutual support program. The state also has encouraged Community Mental Health Centers to develop consumer based services, ranging from small businesses (such as catering and frame shops) to supported employment, tapping into federal Title II vocational rehabilitation funds. Consumer based case management is being discussed, and one consumer has been involved in case manager certification so far. The state also has a clear

commitment to normalized housing and vocational services and to community integration through scattered site housing and programming models.

Impression

Rhode Island's Director of Mental Health identified three system strengths: (1) the system is built on a clear commitment to major mental illness by the public sector; (2) there is a strong partnership between the state and the Community Mental Health Centers, and the provider network is actively involved in developing financial and regulatory protocols; and (3) there has been consistent leadership. The external planning and collaboration with other departments regarding mental health issues helps the state establish the expectation that the department is part of a system. The creation of a basic core of services in the community and the evolving authority the Community Mental Health Centers have in deciding where people should receive services both will support the further downsizing of the state hospital. The concept of integrating the individual into the community is emphasized and the configuration of community services, vocational and residential services is expected to result in functional improvements in the population served and less cost over the long run. The long term commitment to systems evolution in Rhode Island and movement toward a balanced system of care is supported by a department that has had a clear focus on its own priorities, leadership that worked to draw on the experience of the Community Mental Health Centers to sustain a network, and a shared desire to create a single community resource that would meet the mental health needs of all the people. The system seems driven by a sense that if it can't be done in a state as small and as close knit as Rhode Island, then it can't be done at all.

MINNESOTA

Minnesota was selected for an in-depth examination to determine how the mental health system operates in a health care system that has a long history of using managed care approaches. It was also selected because it was demonstrating systems change, springing from a Governor's Mental Health Commission study in 1986 that described the mental health system as a non-system. Four respondents were interviewed, representing the legislative, advocacy, community and state agency perspectives. Materials reviewed include the Three Year Plan for Services to Persons with Mental Illness, 9/89, Department of Human Services Mental Health Division, and a compilation of the "Minnesota Comprehensive Mental Health Act-- With 1988 Revisions".

Systems Organization and Issues

There is a sense that the Regional Centers are down to a "core" population, consisting mainly of older institutionalized people, many who are nearing their 60's and 70's. The majority of the patients have less than a year's average stay, and there are efforts to increase case management in the community to facilitate community placement. Seventy percent of the state's mental health funds are spent in the state hospitals, and this is attributed to the division of the state functions for institutional care and for mental health services into two separate divisions headed by separate assistant commissioners in the Department of Human Services (DHS). It is also a potent economic development issue for the rural areas involved to keep the jobs the Regional Treatment Centers provide. Both factors contributed to the recapitalization of three Regional Treatment Centers, and one respondent opposed to recapitalization of 900 beds noted that the architectural firm that analyzed bed need tended to rely primarily on the data concerning the number of people committed awaiting hospitalization provided by the counties (the local mental health authorities), which have a financial incentive to use state hospital care and to control costs for community based care (and which might tend to overestimate the actual need). One example of this perverse incentive is that the county share for community case management is higher than the share counties must pay for care at the State Hospital.

The current plan under discussion is for the state to assume 100% of community care costs for children and youth with severe emotional disturbance (SED) and adults with Severe Mental Illness, so that this incentive is removed. The local social service directors appear to see the need for this, as they are familiar with the level of service demand; the 87 county commissioners, on the other hand, recalling the imposition of case management responsibility on the counties in 1987 and the backup into the community waiting for state hospitals resulting in part from the Jarvis Decision (that determined that involuntary admissions may still be competent to refuse treatment) may be reluctant to accept this. The use of case management to cut down length of State Hospital stay has occurred at the same time that the health care system has ratcheted down on access, and this has resulted in "gaming" where the hospitals have learned to seek state hospital placement when a patient refuses treatment. Counties have found that filing a petition with the court for review can shift part of the cost of the stay awaiting placement to the court's budget and away from theirs. One respondent noted

that about half of the patients in general hospitals for mental health care awaiting placement in state hospitals could be released from the general hospital. The state makes funds available for emergency services, and most hospitals are involved in providing inpatient care. CMHCs are actively involved in a multi-agency team effort providing crisis intervention services including hotline, drop in centers, crisis residences/apartments, and arranging for observation at the general hospital. Some CMHCs enter into risk sharing contracts with Health Maintenance Organizations, and the state has developed an incentive for outpatient services that are prior authorized by an HMO. There is expressed concern that HMO capitation models may not meet the needs of the severely disabled, however.

The state's plan to reduce institutionalization includes a broker model of county case management that is based around an individualized community support plan prepared within 30 days of state hospital admission. The counties function as fiduciary conduits, often contracting with autonomous DHS Rule 36 rehabilitation/ residential care providers and Community Mental Health Centers (CMHCs) as well as arranging for care in general hospitals. Rule 36, which governs services and housing for people with mental illness in this state, emphasizes that people should be able to live in stable, affordable housing and participate in their selection. It also emphasizes the client's being empowered to make choices in living arrangement. There is some concern that this rule creates an artificial marriage between services and housing which may conflict with the goal of housing choice and with a policy that provides services to support community placement for the severely mentally ill.

The state is under pressure to place 300 adults from nursing homes that had been declared Institutes for Mental Disease in 1989, and is facing an expansion of general assistance medical care to prevent mass discharges from nursing homes; the state has sought from the counties proposals for nursing home alternatives to downsize facilities to 16 or fewer residents. This is occurring at a time when the comprehensive mental health acts are in the startup phase and injects an additional element of complexity into as well as sidetracks funding from the system's efforts to achieve reform. It is worth noting that the assumption of mental health case management by the counties is fairly new, but that a county based long term care pre-admission screening function instituted in 1980 may have played an instrumental role in placing mentally ill persons in nursing homes. In effect the nursing home may have been used as a placement target for people who needed medical supervision due to mental illness and this may have contributed to the current problem. This idea is supported by the state's requiring long term care pre-admission screening teams to refer to the mental health case management service shortly after the implementation of the Federal Nursing Home Reform Act.

Children and Families

The state has a strong stated emphasis on the primacy of the family when a child has mental illness; however, only one family support service is funded on a statewide basis. (Home care and personal care are available to eligible families). One respondent noted that 70% of emotionally disturbed children leave school and end up in the corrections system, but there is no separate

crisis intervention service for children, and there is no uniform system for screening to control out of state placement into residential treatment centers, which separate families from their children. A subcommittee of the Mental Health Advisory Board and the DHS conducted statewide hearings and surveyed counties to provide a basis for planning that resulted in the 1989 Comprehensive Children's Mental Health Act, which borrowed much language from the Adult Mental Health Act. There is no advocacy group for children's mental health issues, although the local (i.e., county-level) advisory committees are beginning to involve parents in planning for services. In addition, the DHS funded 8 demonstration projects modeled after the NIMH Child and Adolescent Service System Program (CASSP) interagency coordination/service delivery model. The legislation established state and county level advisory bodies, established mechanisms for interagency coordination, and mandated a comprehensive set of services ranging from early intervention to therapeutic foster care. There is some concern that the $27 M in new funding for the services has been postponed until the next biennial budget cycle, although the state needs time to develop mechanisms for administering these funds to children who are not currently eligible for medical assistance. Given the newness of the program, case management services are not yet available to children as envisioned in the Act. There is some confusion about the role of schools in implementing the Act, and there was some DHS and local opposition observed to mandating the services on the counties.

Target Populations

The legislature has also defined two priority populations-- adults with severe or persistent mental illness and severely emotionally disturbed children as the primary responsibility of the state; this has occurred over a series of legislative initiatives stemming from the Governor's Commission report in 1986. The state resources are being targeted in the recent comprehensive plan at the more severely disabled and through special initiatives to the following groups: compulsive gamblers, refugees, Native Americans, the homeless, and older adults. The severely impaired adults who are over the Medicaid income levels, but who lack private insurance, are another group identified that has special needs but is unserved; this is not referenced in the recent state plan. One respondent observed that only one of the 80 state funded community residences takes people who have behavior problems; this suggested a need for non-congregate housing for this population. Minnesota is one of four states participating in an 18 month NIMH Rural Mental Health Demonstration Project (terminated 1989), and has identified lack of professional personnel, and lack of coordinated information to support outreach as major issues.

Planning and Needs Assessment

The needs of the population are defined through a variety of means, including Local Area Councils which are linking up to the State's Advisory Board and which advise the counties. Counties are required to submit a need analysis to the state each biennium; however, this is often based around historical use patterns and has been portrayed as a compliance document. The state contracts with a university in the state to estimate prevalence in each county. A new state level needs assessment process for children is beginning,

and this will include a local coordinating council that should involve a range of agencies to develop recommendations to improve coordination and funding for SED children and youth. These councils, created in statute in 1990, are to meet on at least a quarterly basis. The observation was made in the Three Year Plan that since staff shortages are more the rule than the exception at all system levels, that identified needs are generally addressed through new legislative and budgetary initiatives. This plan also suggests that there is a strong need to establish consensus and trust through both the planning process and the plan document itself. However, the legislature sought the state council's advice about providing secure housing for children or youth in state hospitals and failed to fund a $27 million package of community based services for children even though the council had opposed the use of institutions for secure housing and supported the community based care package. This also illustrates the impact of the DHS and the counties, which opposed a mandated service array for children, and which may have been interested in controlling their costs incurred in out of state residential treatment centers.

Quality and Performance Review

While the needs and issues are well articulated in the state's comprehensive three year plan, the ability to monitor what is occurring is just beginning: a set of proposals for improving the mental illness management information system called for in 1987 legislation is starting to be expanded to track community mental health service utilization and to monitor availability and accessibility of services. Quality assurance efforts can be monitored by the state's MH/MR ombudsman, which has been housed since the 1987 legislation in an office separate from the state agencies, where it makes an annual report to the governor; aside from this and the review by DHS and national accrediting and funding authorities, there is no special system of quality assurance noted. The state has described its central office program development, program evaluation, and applied research efforts as limited.

State Hospitals

The state's Regional Treatment Centers continue to win JCAHO approval, and there is a statute governing active treatment in the Regional Treatment Centers. There is also Rule 36 (residential care standards) licensure by DHS that governs all the Regional Treatment Centers, and sets staffing levels and program requirements. One problem is that it is difficult for the state Hospital to coordinate discharges with the county for follow-up. This is attributed to the separation of service functions from fiduciary functions, where rule 36 agencies, CMHCs, other providers, and county case managers need to be contacted. This suggests that continuity of care is also an issue, and there is discussion about whether there should be a caseload standard adopted for case managers; continuity of care is complicated by the relative newness of the statewide tracking system. Legislative attention has helped create physical fitness programs and a work activity program for all regional center patients. The state has also received a policy commitment and initial funding to plan for the development of small, state-operated community facilities as an alternative to long term residence in Regional Treatment Centers. This may provide a familiar and acceptable solution to the problem of what to do with

state hospital personnel when units close; a consent decree (Welsh Decree) in the Minnesota Mental Retardation system essentially stopped institutional use and shifted clients and staff to the community, prompting the development of small, state operated group living facilities. In one situation, the state has reached agreement with a community to use state hospital space for a prison; the respondent observed that this might be an acceptable transfer of skills for some state hospital staff.

There is also a requirement that the state plan include a human resource development plan that will coordinate the efforts of the Regional Centers Transition Team to develop Regional Centers workforce skills as it guides changes in the role and function of the Regional Treatment Centers. The state obtained a 3 year capacity building grant from NIMH to develop research and training linkages around effective treatments for mental illness, to develop a minimum HRD data set that meshes with organizational and client data sets, and to develop a HRD plan focusing on client based outcomes, changing and supporting changing staff roles, training administrators and linking client needs to staff skills. This would seem to dovetail with the requirement for clinical survey of all state hospital patients, which the 1989 legislation required as a basis for planning and redesigning services. The intent of this grant appears to develop the state hospitals as the applied research base for universities, and discussion is beginning about using the state hospitals as professional training centers. A second focus of the state is to develop a data base to help with recruitment.

Advocacy and Due Process

The Jarvis Decision in Minnesota (that determined that involuntary admissions may still be competent to refuse treatment, i.e. medication) increased due process protections for involuntarily committed people who refuse treatment. The strengthening of the ombudsman's office occurred in 1989 to include subpoena power, 24 hour notification by facilities of death, two weeks notice of team meetings for public wards, and mandated reporting of defined serious injuries. The advocacy community is moving toward a perspective where it maintains that vigorous enforcement is needed over a period of time, and where there has to be an organizational presence similar to the NAACP. There is currently no separate protocol for dealing with sexual abuse on a statewide basis; however, there are some CMHCs conducting group sessions for perpetrators and victims, and there is some outreach to schools. With regard to involuntary emergency treatment, the state institutions have adopted a separate process for reviewing psychotropic drug use.

Stigma

Minnesota has a history of efforts to address the stigma issue. It was originally funded through an NIMH Depression Awareness grant program. New efforts described in the state plan include a self-esteem and wellness program targeted at young children, jointly done with DHS and the Department of Health. The DMH plans to develop a public education campaign using special funds appropriated by the legislature. This will include developing agency policy regarding jargon and appropriate terminology, providing active outreach to ensure consumer input, promoting the employment of consumers, and involving

families and consumers in the treatment process. One respondent suggested that there need to be incentives for vocational rehabilitation case managers to take on people with mental illness, and that they should be graded on their efficiency. Another suggestion was that the state needs to actively disseminate best normalizing practices by taking a commercial marketing approach. The State has developed with the Health Department an "anti-stigma" kit and has made it available to the local advisory councils and the counties, although only $500 has been appropriated this year for its distribution.

Consumers and Families

The role of the family and consumer in the mental health system is reportedly strong, and the Alliance for the Mentally Ill and the Mental Health Association are leaders in the effort. There is a growing consumer organization that has been involved in revising the residential care regulations, peer helping networks were established in the Rural Mental Health Project (now unfunded), and in the human resource development planning process. At this stage, the natural support system is seen as having little involvement in the helping process, although local providers may provide training to police to develop a smooth crisis response. Efforts are under way to develop a consumer and caregiver presence on the statewide advisory and local advisory bodies, and there is a stated DMH goal to provide active outreach to ensure consumer input and to assure involvement of families and consumers in the treatment process. These will be incorporated into state level efforts to ensure access to the process as well as through a performance standard that ensures that counties involve consumers and families.

Impression

Overall, there was a sense of frustration that the state had recapitalized three of its six state hospitals ("Regional Treatment Centers") and a general feeling that the efforts toward mental health systems reforms sparked by the 1986 study were in danger of losing their momentum. There was a general tone of fatigue noted in the responses, and while the philosophy and statutes are in place, the lack of adequate resources is seen as a problem. One respondent suggested that structural elements prevent mental health from being perceived with a health care mind set, and instead contribute to its perception as a form of welfare. as one example reported by an interviewee, the state has recently attempted to remove expanded coverage of group mental health benefits from state insurance policies. The assistant commissioner who Fuller Torrey described as the "Margaret Thatcher of Mental Health" brought in to lead the change has since resigned; one respondent noted that the governor had originally sought to make this a commissioner level position, folding in the responsibility for the regional centers. The interviews convey the impression that the reform effort has reached a plateau and there is no clear vision of where to go next. This reflects uncertainty about the gubernatorial election as well as about the commissioner's successor and the continuation of the state hospitals. The legislative initiatives are essentially complete; however, the incentives for changing behavior are not all in place, and there is an expressed need to develop a coalition between the CMHCs and the Counties.

NEW HAMPSHIRE

New Hampshire was selected for study because this state has undertaken system wide reforms and was ranked third among the states in the 1988 Torrey Report. It has taken steps to involve consumers in service planning and delivery. Five of its ten community mental health centers were the first to obtain JCAHO accreditation and it has encouraged entrepreneurship by community mental health centers. It has also replaced its state facility with a 144 bed facility, arranged to have Dartmouth Medical Center operate it, and has established each of its ten regional community mental health centers as gatekeepers to the system of inpatient care, outpatient care, and vocational rehabilitation.

This report incorporates interview findings and review of planning and budgeting documents provided by the Division. Statute and current regulations and an article entitled "Unique Linkages As an Alternative to State Operated Facilities," by Robert Vidaver, M.D., were also reviewed. Interviews were conducted to obtain the perspective of advocates, legislators, and administrators in the system.

State Agency

The state agency responsible for mental health is called the New Hampshire Division of Mental Health and Developmental Services. This agency is one of six divisions in the Department of Health and Human Services, which itself is one of twelve executive branch agencies. The Division has four support units and three Bureaus: Mental Health, Developmental Services, and Institutional Services. The Institutional Services Bureau consists of the New Hampshire Hospital, a Developmental Center, and a Home for the Elderly. The Bureau of Mental Health administers all state-supported community mental health programs through annual performance contracts. The Division provides guardianship, contract review, standards development, and client rights hearings through its Client and Legal Services Office. An Evaluation and Quality Assurance Office conducts site reviews, monitors client eligibility, certifies all community residences of four or more beds, and performs special program reviews.

Values

The primary value driving the mental health system in New Hampshire appears to be to achieve efficiency in use of public funds and to promote quality private sector treatment services. The Division has defined its mission "to create a mental health service system to serve persons with serious mental illness, children, and elderly persons..." These services would be provided in such a way that they would foster integration into the community. The Division and the New Hampshire Alliance for the Mentally Ill at a statewide forum in 1988 developed a statement of principles and service system components. This statement provided a basis for follow up regional planning activities. These principles include a focus on the client as a self-directed person who should receive normalized supports in strong family

systems. Additional principles address flexibility in maintaining clients in the community and innovativeness in designing services that are appropriate and responsive to individuals's unique needs.

System Description

The New Hampshire Mental Health system is best characterized as tight. There is tight control over admission to the system and utilization of New Hampshire Hospital. This is facilitated by clear eligibility standards that facilitate provision of services to a target population with serious mental illnesses, and a dominant role of public funds. There is a variety of crisis response elements ranging from involuntary hospitalization in the community to drop in centers. In addition, a strong emphasis on vocational rehabilitation and relatively unspecialized housing options seem designed to help people achieve independence. The increasing emphasis on substance abuse behavior by people with mental illness, a voucher system of services, and the growing emphasis on consumer support are directed at the younger uninstitutionalized population who need support and help with often chaotic living situations. The interest in public psychiatry and the synergistic effect of having the medical school operate the state hospital promise a more rational approach to matching treatment to an increasing array of services.

Changing Roles

The system has essentially shifted from a role of the public hospital as asylum toward a role as a tertiary care facility. This has been achieved by a sustained commitment over six years and two governors, by a policy of targeting public funds to reduce heavy, inappropriate use of facilities, and by creating in the community mental health centers a community eligibility/gatekeeping function. In addition, commitments are now made to the mental health system rather than the New Hampshire Hospital; the inclusion of annual New Hampshire Hospital utilization goals in each community mental heath center performance contract and a penalty for overutilization also provide an incentive to shorten hospitalization. For recipients certified by the community mental health center system to receive long term mental health care there is a $7,000 annual cap on community mental health center services; for all others eligible for state funds, payment is limited to $1,000 per year at rates set by the Division. The incentive to reduce hospital costs is reinforced by state admission and discharge review and by ongoing case review of New Hampshire Hospital patients awaiting placement by community mental health centers, the hospital, and Division staff. These policies have resulted in stable admission rates but a decline bed days over the four years from the 64,000 in FY 85 to 43,000 in FY 88.

Eligibility

The General Court (Legislature) of the State spurred efforts to restructure the mental health system in 1985 by mandating that state funds be spent on four eligibility groups: (1) persons with severe disability, (2) those who were formerly severely disabled, (3) children up to age 17, and (4) persons over age 60. Intake, eligibility, and emergency services are provided to people who do not fall into these categories. This has clearly influenced

the community mental health centers, which now derive almost 80% of their revenues from the state. The targeting of public resources in the community at the population with potential heavy reliance on state hospital care has been accompanied by developing the New Hampshire Hospital's capacity to function as a tertiary care facility. Further reductions in census will require highly individualized plans for the remaining clients at New Hampshire Hospital.

Resource Allocation

It is worth noting that the community mental health centers were reportedly required to provide charity care to persons in need of service in their catchment area. At present, those not eligible for state funds are using local funds (2%). Half of the revenues for unfunded services are obtained through third party insurance, as mental health outpatient coverage is required for group insurance plans. The state has actively sought to expand its programs through leveraging federal Medicaid funds, through increased general fund appropriations, and by development of management information systems. Undertaking in 1987 the mental health portion of the Medicaid program, the Division now manages inpatient services for persons in state owned Intermediate Care Facilities and Institutes for Mental Disease. This Medicaid management has resulted in revised rules and increased rates for community mental health services. The Division has initiated a data based allocation process to rate providers an efficiency of resource utilization. Allocations were made to increase resource utilization and bring salaries to a statewide standard. Funds have also been reallocated from designated receiving facility subsidies to crisis bed programs, continuous treatment teams and supervised apartments. Plans are underway to extend utilization review to housing so that group homes can be phased down and funds shifted to supervised apartments which provide "high structure low expectation models" for clients.

A key performance indicators system has been in place since 1986 to include productivity measures in annual contracts. In addition to reallocating funds in the system, the Division has assisted community mental health centers with learning how to maximize third party revenues and encouraging entrepreneurial efforts such as employee assistance and stress management consulting. A pooled loan program to help providers make new capital purchases or refinance debt has been discussed, as well, to support service expansion.

SERVICES

Crisis care

All New Hampshire residents are entitled to emergency care, which is provided through mobile crisis response services available around the clock. There has been a significant expansion of these services since 1985. Plans are in effect to improve police, Emergency Medical Technicians, and peer response capability and to expand crisis housing. An ongoing program of education in crisis response for gatekeepers is expected to continue. Efforts are made to increase coordination between regions regarding high risk cases

and to review regional referral agreements with local organizations (e.g., police, shelters, general hospitals). The state plans to expand its continuous treatment teams of three to four clinicians and a part-time psychiatrist. These teams would become involved in active inpatient care, except at New Hampshire Hospital, for 200-280 persons next year.

The state subsidizes involuntary care in general hospital beds which are classified as "Designated Receiving Facility" beds. These are located in main population centers. These beds are for involuntary patients, and the average length of stay is under 21 days. These beds are intended for acutely ill patients as well as persons with exacerbation of chronic conditions. The New Hampshire Hospital Medical Director suggests that each of the Designated Receiving Facilities and general hospital psychiatric beds in the state, when combined with community-family support, substitutes for six to eight asylum beds. This system, crisis beds, case management and a new continuing treatment team program provide opportunities for flexibility in dealing with crises for eligible populations.

Residential Care

To deal with the problem of homelessness, the Division is the lead agency for the McKinney Block Grant funds, and it plans to use state hospital grounds for low income housing. A residential specialist training program in the Vocational College System has trained 60 residential staff in an effort to improve recruitment and retention and lower staffing vacancy rates. For substance abusers who have mental illness, foundation and state funds are being used to develop two residential facilities using a behavioral model. This special needs population is also served by a substance abuse coordinator in each community mental health center. An emergency shelter grants program requiring a 50% local match has resulted in increased service capacity throughout the state.

Residential services have shown dramatic growth since 1984, up to a current capacity of 700 community beds. Of these who remain at the state hospital, 40 will be housed in new transitional housing units. The community bed complement includes 130 apartments for independent living, and 40 crisis beds. Case management has expanded to reach people in apartments scattered throughout the community. Efforts are made to restrict the size of group homes to no more than eight clients.

Case Management

Case management has been funded throughout the state's ten regions since 1983, and currently consists of 120, each having an annual average caseload of 30 clients. Administrative standards require case management to be directly lined to executive management and as the state plan says, "not subordinate" to direct service programs. Case management is a required community mental health center service, and all eligible clients with long term disability receive it.

Case managers are based in the community mental health centers. In this setting at this time there is likely to be increasing caseload and role

changes that make face to face casework harder to achieve. A statewide training program, including certification, is planned as one way to develop standard practice. A career ladder is conceptualized and bringing compensation to parity with state institutional and agency clinical staff has yet to be resolved.

Vocational Rehabilitation

The state has developed vocational rehabilitation services over the past decade to serve 700 persons. Interagency agreements developed in each mental health region improved targeting, referral and collaboration. Of the clients served 42% are joint cases, and over half work 20 or more hours a week. A joint project with the Easter Seal Society has trained staff in how to help clients move toward substantial gainful employment; this project will be expanded. The state plan has identified continued staff shortages, the need to involve consumers in setting programs goals and serving as staff members, ongoing training for community mental health center staff in income and medical assistance programs as needs. The orientation of the agencies and personnel is toward vocational services to persons with developmental disabilities rather than psychiatric.

Consumer Involvement

There is what appears to be a serious effort to involve consumers in designing individual as well as community programs and policy. This appears to offset the apparent lack of choice the consumer has by virtue of being assigned to a treatment team at the community mental health center by virtue of where s/he lives. There are free-standing primary consumer groups that provide state-funded services, emotional support groups, and agency-related client governments. The state requires client participation in service planning and review. Regulations regarding individual treatment planning require the conference coordinator to take steps to maximize client participation. The state has a well-defined strategy for developing consumer groups, developed with a statewide group of consumers. This strategy includes increasing the availability of peer supports and participation. This includes developing peer crisis support services in three regions, technical support for a two existing consumer demonstration grant programs, expanding peer case management and outreach and continuing to fund a client service loan program. Statewide activities include annual training in organizational development, logistical support for a newsletter, and supporting development of after hours and weekend peer supports. Other planned projects include a resource directory or consumer guide, quarterly meetings between Division staff and consumers, help with obtaining funding for interactive teleconferencing for consumer meetings, and involving consumers in the local annual community mental health center site review process.

Family Support

Family involvement is a primary mission of the New Hampshire Alliance for the Mentally Ill, which is staffed by a former Division staff person. The state and AMI have undertaken a family education initiative using a team approach and basic education for "new" families by the New Hampshire Hospital

and the community mental health centers. A second element is to provide public education for businesses, landlords and church groups. A Community Support Project grant is also being used to develop AMI local leadership in chapter as well as support group activities.

This emphasis on basic education and support is in response to a lack of consistent ongoing, statewide programs where content is defined by what families need. An anti-stigma campaign is underway, where AMI members lead community meetings and forums. The AMI chapter is actively discouraging families from assuming that guardianship is the only option they have in providing for the client.

Research

An important element of systems reform has been developing an applied clinical research capacity. The Division's Office of Applied Clinical Research is staffed through a contract with Dartmouth Medical School. Community Mental Health, New Hampshire Hospital, and Division staff serve as an advisory board to this office. This office will evaluate the substance abuse continuous treatment team currently under way.

Unmet Needs

There are at least three unmet needs: children's services, elder services, and adults who do not meet state aid criteria.

Children

Children are targeted in the state plan, and local outpatient and crisis management functions are performed. Home-based respite care for children is in short supply, there is irregular collaboration between child-serving systems, and little community mental health center service is provided to families. The potential for overlapping services is great, and the lack of integrated financial management at the state level may result in wasted funds. There is concern that children may not receive community mental health center outpatient care that is coordinated with inpatient (residential treatment or hospital) care. Staff recruitment for children's services workers is made difficult by low community mental health center salaries, There is insufficient reimbursement for administrative and collaborative efforts, and services cannot be reimbursed to parents unless there is a finding of abuse or neglect or if the child is "court-related." The current plan is for the mental health service component for youth to be the responsibility of the Division. Current state initiatives include a law that would allow schools to become Medicaid providers, a grant funded program of therapeutic foster and day care, after school day care, programs for homeless children, and early intervention (with a "zero-reject" policy) for all persons up to age 3. Plans are underway to develop a home and community based services waiver, to expand case management and to seek JCAHO accreditation for inpatient care.

Elders and Adults

Elders over age 60 were identified in statute as a population eligible for public mental health funds, just as eligible children are. Almost 40% of clients in treatment are under age 40, while only 21% are over age 60. Growth in the older population with serious mental illness is not expected until the next century. The Division's 1986 initiative in rural delivery to elders with Alzheimer's-type disease provides a useful example of linking to the health system. The county nursing homes have shifted their geriatric patients with mental health needs to the two state-run Interim Care Facilities. This has created geographic access problems; however, alternate residential care placement appears to be politically difficult at this time.

Adults who do not meet eligibility criteria may simply be referred elsewhere. They may be able to receive community mental health services, and there is reportedly a requirement that community mental health centers provide charity care. Such care is subsidized by the towns, or the individual's insurance is billed. Assessment and crisis intervention are available, and centers are encouraged to try to recover their costs.

Impressions

New Hampshire is a state where there is a strong commitment to increasing the quality, efficiency and accountability of services to people with serious mental illnesses who are at risk of institutional placement. The transition of the New Hampshire Hospital from an asylum into a tertiary care facility has been supported by careful development of administrative, housing and vocational services, as well as a basic crisis response capacity throughout each of the community mental health center regions. The most remarkable aspects of the state presented in this survey is the consensus that New Hampshire has been able to achieve the control they have been able to sustain over community development. This is testimony to the importance of executive and legislative commitment and the ability of the Division to interact with Medicaid and other parts of the Human Service System. It is also testimony to the effect of developing programs in a context of where - subject to sunset legislation and increasing competition for public funds - they must remain lean and relevant.

VERMONT

Vermont was selected for review because it was rated fifth in the 1988 Torrey study, having made a dramatic rise in the ratings. It was also selected because it was developing a regional community mental health system as an alternative to the Vermont State Hospital. Since it is a New England state, mental health governance issues were likely to be similar to those in Maine. Vermont was selected for an in-depth review.

The study consisted of a series of interviews in June and July of this year with people who represented administrative, consumer, community mental health, and Mental Health Association viewpoints. A substantial amount of literature was received and reviewed, including the following:

A Feasibility Study to Examine the Development of a Regional Community Mental Health System as an Alternative to Vermont State Hospital P.J. Carling, L. Daniels, F.L. Randolph, Center for Psychiatric Rehabilitation, Boston University, December 1985

Agency of Human Services Department of Mental Health FY 1991 Budget Fulfilling the Vision: Completion of a Community Based System in Vermont, Vermont Department of Mental Health, February 1987

Final Report: Fulfilling the Vision: Completion of the Community Based System in Vermont, Vermont Department of Mental Health, April 2, 1990

Vermont Case Study: Creating the Next Generation of State Mental Health Systems, D. Goodrick, R.L.Schaff, National Technical Assistance Center for Mental; Health Planning, COSMOS Corporation, December 1988

Annual Report: The Counseling Service of Addison County, Addison County Mental Health and Mental Retardation Center, 1989

A Community Based System of Care: Its Design, Implementation and Impact, R. Copeland, Vermont Division of Mental Health, paper given in South Carolina, 1988

State Organization

The Vermont Department of Mental Health is a cabinet level agency that was created in 1964. It is headed by a Commissioner, and carries out its responsibilities through two Divisions: The Division of Mental Retardation, and the Division of Mental Health. The Department views its ability to reduce the population at the Vermont State Hospital, its ability to develop additional alternatives to institutional care, and its success in preventing institutionalization of new clients as measures of its success.

In the Division of Mental Health, the state is responsible for the Vermont State Hospital (VSH) , community based children's services, community based services for adults with mental illness, community based emergency and

screening services, and outpatient and consultation services for adults and children. The purpose of the Division is to enable Vermonters to receive services that are sufficient to meet the individual's needs, are community based, are oriented toward fostering independence, are effective, are available when needed, and are provided at a reasonable cost. The Division serves approximately 2,900 severely mentally ill adults, 3,300 emotionally disturbed children and an estimated 5,600 others with major emotional problems or disorders. The Division plans to continue piloting regional programs as alternatives to care at the Vermont State Hospital, maintain the range of community services needed to prevent institutional use, continue children's services development, and revise and standardize cost accounting practices across Community Mental Health Centers.

Regionalization

The Mental Health system in Vermont has historically used its ten Community Mental Health Centers as the focus for planning and service delivery. All the Community Mental Health Centers are private not for profit corporations. The Community Mental Health Centers are also responsible for mental retardation services as well as for substance abuse services. The importance of the Community Mental Health Centers in service delivery was first is established in a 1978 statute which indicated that the Commissioner must give first priority to establishing community services in the Community Mental Health Centers. In the early 1980's, the Community Mental Health Centers played a major role in serving severely mentally disabled persons, helping reduce the Vermont State Hospital census by a third. By the mid 1980's Vermont had the highest proportion of mental health funds in the community, but was concerned that the Vermont State Hospital utilization was beginning to increase. This increase was attributed primarily to the low rate of additions to general hospital inpatient services.

These centers all provide emergency and screening services and community rehabilitation and treatment services. Twenty four hour emergency services are provided for people in crisis.[12] The lack of medicaid eligible inpatient acute care and the increasing pressure of a decertified Vermont State Hospital on the state's general fund threatened in the mid 1980's to shift program development away from the community. A report by the Mental Health Association at the time was titled "A Hospital of Disgrace"; following this report the hospital's medical director. The Department commissioner was replaced by a professional public administrator following this period. (see footnote 13).

These problems helped set the stage for regionalizing the mental health service delivery system in Vermont. A Joint Legislative study committee, concerned that access was insufficient, suggested in 1985 that the Department evaluate the feasibility of regionalizing the Vermont State Hospital; the

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[12]. However, interview data suggest that the younger severely disabled and dually diagnosed (with substance abuse or developmental disabilities) populations continue to use VSH because few other crisis sources exist and because there are no alternatives for involuntary treatment.

committee concluded that the state should close the Vermont State Hospital and use the funds to expand the community system. The feasibility study carried out by Boston University throughout 1985 concluded that, since the current Vermont State Hospital population was similar to those served by the Community Mental Health Centers in the community rehabilitation and treatment program, since over 68% were seriously disabled, and since 24% needed long term care in a nursing home or intermediate care facility, the following:

" ...The needs of current and future Vermont State Hospital clients can be met in a regionalized community system which is oriented to a rehabilitation approach. However, specialized services must be developed to adequately meet the need of certain subgroups of patients including those with medical problems and patients for whom secure environments are necessary because of behavior of legal status.(Boston University, 1985)."

The report went on to suggest that regionalization be piloted before statewide implementation occurred. This was endorsed by the legislature, but not by the governor's office. At the same time, a five year state planning process was started; its conclusion that the Vermont State Hospital should close except for forensic cases. This would include closing a 36 bed intermediate care facility on grounds.

The regionalization concept would require both expansion of Medicaid and other third party financial involvement in community mental health services, placing clear financial and programmatic responsibility at the Community Mental Health Center level. It would also require efforts to create involuntary inpatient care services that would be shared on a multi-regional basis. The regionalization concept, now with strong advocacy and legislative support and reportedly "dubious" support from the governor and the Department (with reported resistance from parents to Vermont State Hospital closure) was greeted with relative skepticism by the Community Mental Health Centers. To achieve these things and obtain Community Mental Health Center and Departmental support, $600,000 in bridge financing was sought in 1987 and obtained from the Robert Wood Johnson Foundation that would increase access to inpatient and crisis programs in the community and expand long term support services for the severely mentally ill. Staff training for the new programs (including outreach and case management) would be obtained from the University of Vermont, and Division of Mental Health developed a computerized management information system to monitor involuntary care in the community. Contrary to the recommendation in the feasibility study and the grant proposal, the state adopted the regionalization approach on a statewide basis. As the Vermont State Hospital regained certification, $700,000 in general fund monies in 1988 were allowed to remain in the budget for use in developing community services. This was supported by the governor.

The final report to the Robert Wood Johnson Foundation in 1989 attributed much of the success in reducing Vermont State Hospital use to controlling admissions through development or expansion of community alternatives such as temporary housing subsidies, mobile crisis intervention teams and expanded case management services, which have access to crisis stabilization and intervention services as well as peer support services. Success was also credited to increased Vermont State Hospital discharges,

which were supported by a small community placement specialist unit (3 staff and one student intern). While the project resulted in ward closure occurring every six months as planned, the lack of consumer operated crisis services, the inability to fund training through the University, and the lack of funds for a formal evaluation were identified as ongoing problems. In addition, the census fell from 200 to 100 without creating new involuntary care settings in the community. The Final Report states that

> "The expressed desires of consumers, the complexity of the legal procedures involved, the lack of a conclusive assessment of need, and the lack of local interest or support for involuntary care in the community have led, instead to emphasis on flexible, accessible voluntary options.(p.10)."

Community Mental Health Center Issues

The Transfer of funds from Vermont State Hospital to the community has been seeded with the foundation grant and the freeing up of General funds due to Vermont State Hospital recertification. As Vermont State Hospital wards closed, the Division of Mental Health would seek a budget adjustment to transfer funds to a regional cost center. These funds would be reduced by Medicaid patient fees and the remainder would be allocated to the regional Community Mental Health Center. This incentive is tied to a Vermont State Hospital utilization target; recent efforts to penalize Community Mental Health Centers that exceeded the utilization target were defeated in the Legislature. There is reportedly little incentive under this arrangement to expand Community Mental Health Center services. The State's mental health budget cites the limitation in federal funds placing increased pressure on Community Mental Health Center outpatient and family service programs, with the result that waiting lists are longer than desirable.

The Community Mental Health Centers also express some concern that regionalization has increased the dominance of public funding for the severely mentally ill and fear that this may detract from their traditional mission of serving the whole population . While the strength of in the Vermont system is its policy aim to create one rather than two systems of care through the Community Mental Health Centers, the dominance of state funding and priorities for care may reportedly result in erosion of the traditional base of support for the Community Mental Health Centers. It is interesting to speculate that the Community Mental Health Centers also -- as one interviewee reported -- have witnessed the erosion of their power base with the regionalization process[13], as the state negotiated with them separately rather than as a bloc. While the state has offered incentives to Community Mental Health Centers to recruit direct care state staff, other Community Mental Health Center staff salaries are not at parity with prevailing salaries, and this affects recruitment in the Centers. While the Community Mental Health Centers support regionalization, they remain concerned that budgetary pressures will

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[13]. One respondent suggested that the CMHCs helped get rid of the former Commissioner because they opposed the performance contract method in use at the time.

result in insufficient funding to deal with the increased administrative responsibilities.[14]

Planning

The regionalization concept has provided a framework for what appears to be a continuing strategic planning process that involves consumers, legislators, advocates, and providers. This process has been described as informal, participatory, and focused on service principles and outcomes as opposed to method, and has been characterized as a process that is primarily motivational and facilitative. (COSMOS Corporation, 1989). The thirteen principles in the 5 year plan have provided a broad vision that has translated into flexibility in program design and development across the ten regions. This broad statement of values appears to have sustained the coalitions needed to achieve reform. The regionalization concept is seen as the centerpiece of state mental health policy, and its simplicity has allowed the state agency to focus its energies. The informality of the planning process and the state's willingness to empower consumers in the process is evident from the interview material.

On a more formal basis the Division has required Community Mental Health Centers to ask their case managers on a monthly basis what it is that the clients need; in addition, there is a significant effort in the Department to review each case as it enters the Vermont State Hospital to stimulate discharge planning and identify what is needed to prevent the admission from recurring. The state also requires the regional advisory boards to include families, consumers, and providers. There is also a statewide regionalization advisory committee that includes consumers, legislators, and providers and which meets every month to monitor progress. In addition, the Mental Health Association has been actively involved in holding forums to educate and inform consumers, families, and the general public about the regionalization process.

Crisis Response

As an example of Vermont's formal planning, the Division convened a Crisis Task Force to examine how the crisis response system could be improved. Their findings included consumer input that it was important to be able to talk with a friend, then to a professional who did not have involuntary commitment power. They also concluded that manageable caseloads could facilitate routine contact, that a 24 hour a day support (not screening) was a needed adjunct to case management, and that crisis support workers (volunteers, friends) should be allowed to enter emergency rooms to be with the patient. Medication follow up at a local hospital was seen as an important way to ensure continuity of care. The state is attempting to emphasize crisis stabilization through mobile treatment teams; one Community Mental Health Center project has demonstrated its ability to screen out dangerous situations using a mobile treatment team so that only 5 out of 60 referrals have required Vermont State Hospital admission.

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[14]. Case management was funded as program administration; however, there is no provision for administrative overhead.

The mental health crisis response system in Chittenden County is described as a model stimulated by regionalization that is driving a restructuring of the generic crisis response service system in the Burlington area. In 1988, the Howard Mental Health Services Community Mental Health Center expanded its home based intensive case management and crisis support to around the clock coverage; it also contracted with University of Vermont Medical Center Hospital for two beds for clients at risk of VSH placement. By 1990, the Center was establishing a community based outreach crisis service, coordinated with other Center services. The Burlington area- a major population center- has an active consumer support network that is interested in providing peer support and residential support for people who are experiencing mental health crises.

Services

Unmet service needs are greatest in the following areas: (1) substance abusers with acute suicidal behavior; (2) out of state transients seeking hospitalization through the emergency rooms of general hospitals; (3) Persons with mental retardation who are in crisis; (4) people with brain injuries, (5) housing; and (6) gaps in the continuum of services for children and families, which result in unnecessary out of home placement. Substance abuse programs, while delivered through the Community Mental Health Centers are administered through a separate state agency; the services are not clearly integrated at this time.

The Department plans to pursue a vision of comprehensive mental health care in the community in several ways:

(1) establishing a greater array of crisis alternatives in all catchment areas, including consumer controlled options
(2) expanding subsidized housing and integrated housing in the community for the low income mentally ill[15], including retaining housing during hospitalization
(3) increase vocational opportunities and accommodations
(4) reorganizing crisis services in the Burlington area
(5) a commission will examine the role of Vermont State Hospital in the 1990's
(6) negotiate with the University of Vermont Medical School for a faculty position in public mental health and revise the psychiatry curriculum and residency programs to include community service
(7) use NIMH training funds to develop pre and in-service training for social work, psychology, and special education students at the University of Vermont
(8) develop a statewide campaign to publicize services and address stigma
(9) evaluate regionalization

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[15]. The CMHCs are able to define their regions' needs with some flexibility; for example, at least one CMHC is debating whether new housing should follow a group home or an apartment format. This was cited as an example of how the CMHCs need technical assistance to develop responsive (i.e. scattered site integrated housing) approaches.

The Report to the Robert Wood Johnson Foundation also describes community services as part of the regionalization project.[16] The State agency senses a need for a statewide family advisory group, and has use funds to hire an executive director for the Alliance for the Mentally Ill.

Housing

The Division has formulated a housing policy that aims to increase the availability of affordable housing that is integrated in the community and supported by outreach support services. The emphasis in this policy is on scattered site affordable units that are not exclusively for persons with mental illnesses. The Division funds 9 Community Mental Health Center group residences, yet views these as treatment services of a short term nature rather than as housing. It also discourages Community Mental Health Centers from applying for HUD 202 Congregate housing which is portrayed as segregated and stigmatizing. The Division sees its primary role as advocating for consumer preferences for housing, at the State, local and Federal levels. Respite housing and outreach support services are desired to facilitate continued stay in existing housing, and the primary consumer network is exploring developing a consumer governed residential alternative to supplement its peer support activities and provide respite in a non-medicalized environment. The emphasis on advocacy rather than housing development appears to be frustrating to consumers, and respondents agree that more state funds are necessary to develop low income housing.

Hospitals

General Hospital psychiatric units are generally considered to not be a strong part of the system, although the state agency feels that VSH clients could be treated in community hospitals rather than VSH. In 1985, four of the ten Community Mental Health Centers have agreements with local general hospitals to provide inpatient psychiatric treatment. At that time, there were five inpatient units ranging from 8 to 32 beds; a sixth unit in the Northeastern part of the state was under development and the University of Vermont Medical Center was proposing adding 12 beds. Of these, three had arrangements with Community Mental Health Centers where the Center provides treatment or consultation, and one where the Community Mental Health Center screens admissions. One facility provides acute psychiatric in a scattered beds model on a 15 bed rehabilitation unit. The primary concern is that the community hospitals are unwilling to accept dangerous, non-disruptive clients and involuntary admissions. The admissions to VSH dropped from almost 500 a year in 1988 to just under 400 in FY 1990 without a community involuntary treatment program.

The Vermont State Hospital's role is unclear at this time, although declining census has improved the staff client ratio and the facility has regained certification. A study commission has been formed to define the role of the VSH in the system. The current census hovers around 115, having dropped from an average census of 165 in 1983. The population is characterized as

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[16]. The list is attached in Appendix C of this report.

diverse, with short term care, forensic patients under evaluation or commitment orders, multiply handicapped elders needing nursing home care, and a "hard core" chronic special needs group that is too disturbed for community care. The hospital is currently oriented toward acute crisis stabilization and the state makes efforts to ensure that the job and home are maintained during hospitalization and with identifying both post hospital supports that will be needed as well as identifying ways in which similar admissions can be prevented in the future. The Division staff are closely involved in admission review activities, and use "jawboning" tactics (COSMOS Corp.) with the Community Mental Health Centers to ensure that admission rates are acceptable; this is used to assure that Community Mental Health Centers are in line with regionalization objectives.

Human Resources

The VSH labor force at the beginning of the regionalization process was already what remained after a reduction in force of 200 positions that began in the early 1980's, and had seniority. The Department of Personnel became committed to helping outplace these staff as the facility reduced in size, and a special incentive program was established to facilitate Community Mental Health Center recruitment of VSH direct care staff. In the regionalization feasibility study it was unclear whether the closure of the facility was an example of management action to contract out state services in violation of a collective bargaining agreement. The feasibility study reported that

> "The extent to which the Vermont State Employee Association Contract represents a barrier to regionalization is dependent on whether regionalization is considered to be 'contracting out' of VSH services. However, stipulation in the agreement allows exemptions when it can be demonstrated that the work can be accomplished more economically, or that special technology is available. It appears that these exemptions can be met."

Children's Services

Vermont is considered to be a national leader in developing financing mechanisms to support provision of services to severely emotionally disabled children and adolescents. In 1985, however, the Department was not a major player in services to this population, and there was reportedly widespread discontent that these children were being served mainly through the child protective service system. The NIMH Child and Adolescent Service System Program grant program stimulated state level interdepartmental planning that has now been emulated at the local level, and which has stimulated local program planning for this population. There is now a regulatory basis for such collaboration, where social services, education and mental health funded providers must perform joint case review and engage in systems planning. The state, using Child and Adolescent Service System Program funds, also funds a .33 FTE organizer/problem solver at each Community Mental Health Center to facilitate collaboration. Funding projects in the local plans was made possible by joint funding and by use of Robert Wood Johnson Foundation grant funds; these services included social, educational and mental health services. Funds for program expansion were also made available through increased

federal Title IV-E Child Welfare funds, expansion of Medicaid, and reallocation of monies earmarked for out-of-state-residential treatment services. Medicaid expanded under the home and community based services waiver program, which facilitates targeting persons at risk of institutional placement, and which often allows for an expanded array of services that would receive Medicaid reimbursement, including therapeutic foster care, crisis intervention and respite. The provision of case management as a service proceeded slowly under Medicaid, until the state developed contracts with Community Mental Health Centers to provide case management to children and youth who met the state's Child and Adolescent Service System Program definition[17]. This may have been facilitated by the increased degree of accountability in the MH system. The state was able to designate non medical care professionals as case managers, and services are not restricted to any specific site. These case managers are also required to work with local interagency teams to plan and implement services.[18]

In 1991, the Division plans to expand its waiver program under medicaid to serve 115 SED children which would prevent hospitalization, by providing the following services: (1) group, family and medication therapy; (2) case management support to ensure access to basic assistance for community living; (3) day programs of two or more hours for training in community living and self care skills; (4) professional staffed and supervised residential care as well as house based support services; and (5) family support groups and mutual support groups (the latter NIMH funded since 1985). These represent the range of mental health services that are available to adults as well as children.

Consumer Issues

The state funds 6 to 8 projects that are consumer operated as drop- in centers or offer telephone support. The Community Support System program also provides funds for social support programming for people with serious mental illness. Problems center around the degree of autonomy the consumer has in choosing care options. The ability of the system to monitor medical problems associated with medication usage is characterized as limited, largely due to low availability of psychiatrists in the public system. There is currently no medication monitoring system other than peer review in effect, and the state has recently profiled medication use in the community. A task force on medication use in the system was proposed but has not yet been established.

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[17]. (1) exhibits behavioral, emotional or social impairment that consequently disrupts the ...academic or developmental progress, family and/or interpersonal relationship (2) has had impaired functioning for at least one year or is experiencing an impairment of short duration but high intensity, and (3) is 18 or younger. the definition also observes that these clients are often involved with multiple service systems and are either out of the home or in danger of out of home placement.

[18]. For more information on this subject in Vermont and other states, see "The Use of Medicaid to Support Community Based Services to Children and Families," The Center for the Study of Social Policy, Working Paper FIN-1, November 1988

The ability to choose treatment or services is reportedly negotiated between the person and the system; however, the lack of options, and the fear of retaliation for self advocacy make it difficult for this to occur. The consumer organization in the state is planning to provide local training to consumers interested in peer support, and is advocating for a residential support service in the Burlington area. There is also interest in incorporating consumers more directly in crisis support activities, and some consumers have even participated in case management training. At the program planning and policy levels, the consumer network is actively involved, and there is clearly strong informal contact with the Division at these levels.

Impression

Vermont's system represents a model for planning that is simple, focused on developing community services that are responsive to consumer needs, and represents a partnership between the state and Community Mental Health Centers. The regionalization concept stemmed from a crisis in state hospital service delivery in a state where the Community Mental Health Centers and the state have a history of close cooperation. The Vermont experience suggests that the provision of consumer based support and crisis response services to persons with serious mental illnesses can reduce the need for involuntary treatment and state hospital use. The transition from a state operated system to a unitary system of mental health care involved defining community based support and intervention as a technology that was better than what the state could offer in its state hospital. Much of the energy for change is due to legislative support ; however, the system's ability to gauge its success and communicate that to reinforce an ongoing process of strategic planning is an important way to sustain and broaden support. The continued need for expansion of vocational opportunities , affordable housing, and a wider range of community crisis supports represent new challenges for Vermont. There is a strong impression that the willingness to criticize and debate systems issues stems from a sense of basic trust that has been established and nurtured by state agency staff in a wide range of stakeholders. Ultimately the success of Vermont may lie in the adoption and agreement about guiding values, the first of which is an expectation that change will occur only when consumers, providers and communities agree to change their behavior.

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APPENDIX A

Oregon Residential Care

The M-ED Residential Task Force was created by the program office of the Department of Human Resources Mental Health Division in 1986 to describe characteristics of persons needing residential services, to identify an ideal array of residential services, and to describe gaps and barriers to developing a comprehensive residential care system in Oregon. Four characteristics of those in the larger population of persons with a psychiatric disability needing residential services were identified: (1) behavior problems, (2) skill limitations, (3) psychotic symptomatology, and (4) physical health or mobility limitations.

The Task Force developed a continuum of residential care settings as a basis for the report's recommendations. These included adopting and implementing regional development strategies where **supportive** resources and at least one form of crisis respite would be locally available; where all large counties or regional clusters of smaller counties would have **structured** resources available; and where **special skilled** resources would be available on a regional (or statewide basis in the case of highly specialized facilities). The State has determined that "with the exception of acute crisis care for children and adults, programs offered by the state hospitals are focused on appropriate patient populations whose needs cannot be met elsewhere." (Governor's Commission on Psychiatric Inpatient Services, 1988)

The Task Force's philosophy included:

"Most Empowering Setting. Wherever possible, a client should be integrated into a community by living in existing, independent housing. Non-facility based support services should be used to compensate for skill deficiency areas and to encourage participation in the social support network. The housing coupled with the support services should equal the '**most empowering setting**'(emphasis added) for the resident. Structured options (including the hospital) should be reserved for those individuals unable to live in existing, independent housing with (or without) available support services."

The Task Force identified four target groups and the needed community residential care alternatives. The point was made in their report that while these groups shared common characteristics, they were heterogeneous rather than homogeneous, and members may vary in terms of the four characteristics (behavior, skill, psychosis, physical health/ mobility). The four groups are:

(1) the **multiple/extreme needs group**, age range from 18 to 60 who tend to be long term or repeat users of state hospitals, whose symptoms aren't easily controlled by medications, who may be difficult to engage in treatment, and who may have a variety of problem behaviors. About two-thirds required special/skilled community residential programs, and the remainder may need a structured community residence in either a hospital setting or in treatment oriented family, (2) the **functionally limited/non-accepting group**, age range 18 to 40 who tend to deny their mental illness, may resist affiliation with

the formal system, are often hospitalized involuntarily, and who may have a concurrent substance abuse problem. Half of these are estimated to require care ranging from in home care to boarding homes and apartments; about 1/4 need transition housing or treatment oriented family care, and the remainder need special skilled programs. (3) the **functionally limited/service accepting** group ages 30 to 60 who have skill deficits and problems that are barriers to independent living, but who are relatively cooperative, insightful, and are motivated to learn independence skills. They require less special skilled programs than the previous group. (4) the **ongoing support** group who have adequate survival skills but who may decompensate due to problems with judgment or poor coping skills unless there is a minimal level of support. About 40% need maintenance in a structured apartment or family care setting, and about 60% would need supported programming including supportive apartments, Fairweather Lodges or boarding homes.

APPENDIX B

The material in this appendix describes the mix of services to be implemented in Rhode Island in the 1989-1993 period for clients at six different levels of dependent functioning. The levels of functioning are located under item six on the enclosed "Rhode Island Client Data Form service Programs Baseline." The plan operates under the assumption that using the community mental health centers as payors for state institutional as well as community services will result in expansion of proactive community services that will prevent deterioration of functioning over the long term. A Table marked "Units and Costs of Service for the Period 1989 to 1998 in Constant 1987 Dollars" suggests that if the service mix called for in the state plan is implemented, $20.7 million less would be required at the end of the ten year period than at the beginning. The Source for this information was Decade of Progress 1989-1998: A Mental Health Plan for Rhode Island, The Rhode Island Department of Mental Health, Retardation and Hospitals, pp. 90-99.

SERVICE PROGRAM OPTIONS TO BE IMPLEMENTED IN THE
PERIOD 1989-1993 FOR FUNCTIONAL LEVEL I CLIENTS

SERVICE COMPONENT	TYPE UNIT	COST PER UNIT	% OF CLIENTS	FREQ PER MO	AVG NO UNITS PER CLIENT	AVG MO COST PER CLIENT
SUPPORT						
Case Management	hours	$35.00	100.0%	16.0	16.22	$567.78
Drop-in Center	hours	$6.00	15.0%	10.0	1.52	$9.13
General Support	hours	$35.00	15.0%	4.0	0.61	$21.29
Protection and Advocacy	hours	$56.34	8.0%	2.0	0.16	$9.14
ADD NEW SERVICES ABOVE LAST ROW ONLY						$607.33
REHABILITATION						
Psychiatric Rehab 3-hour	days	$25.00	0.0%		0.00	$0.00
Voc/Ed Assessment 4-hour	days	$42.00	0.0%		0.00	$0.00
Sheltered Workshop 4-hour	days	$31.00	50.0%	12.0	6.08	$188.58
Supported Work/TEP 4-hour	days	$24.00	0.0%		0.00	$0.00
Job Finding/Development	hours	$39.00	0.0%		0.00	$0.00
Educational Services	hours	$42.00	0.0%		0.00	$0.00
ADD NEW SERVICES ABOVE LAST ROW ONLY						$188.58
RESIDENTIAL						
Intensive Residential	days	$143.00	68.0%	30.0	20.68	$2,957.72
Specialty Residential	days	$78.00	0.0%		0.00	$0.00
Basic Residential	days	$52.00	0.0%		0.00	$0.00
Respite	days	$52.00	0.0%		0.00	$0.00
Foster Care	days	$30.00	0.0%		0.00	$0.00
Family Subsidy	days	$30.00	0.0%		0.00	$0.00
Sup. Indep. Living/S	days	$5.75	0.0%		0.00	$0.00
Sup. Indep. Living	days	$0.00	25.0%	30.0	7.60	$0.00
ADD NEW SERVICES ABOVE LAST ROW ONLY						$2,957.72
TREATMENT						
Specialty Hospital	days	$278.25	50.0%	20.0	10.14	$2,821.15
Community Hospital	days	$374.85	10.0%	5.0	0.51	$190.03
Crisis Beds	days	$111.00	33.0%	5.0	1.67	$185.69
Emergency Assessment	hours	$81.00	25.0%	5.9	1.50	$121.13
Mobile Treatment Team	hours	$39.00	25.0%	30.0	7.60	$296.56
Counseling	hours	$40.00	5.0%	3.0	0.15	$6.06
Family Treatment	hours	$40.00	2.5%	3.0	0.08	$3.04
Subtance Abuse Tx-Outpt.	hours	$40.00	5.0%	6.0	0.30	$12.17
Med Maintenance	hours	$71.00	95.0%	2.0	1.93	$136.77
Intensive Day Treatment 3-hour	days	$32.00	25.0%	10.0	2.53	$81.11
subtot					26.41	$3,853.74
TOTAL MONTHLY COST PER CLIENT						$7,607.38

SERVICE PROGRAM OPTIONS TO BE IMPLEMENTED IN THE
PERIOD 1989-1993 FOR FUNCTIONAL LEVEL II CLIENTS

SERVICE COMPONENT	TYPE UNIT	COST PER UNIT	% OF CLIENTS	FREQ PER MO	AVG NO UNITS PER CLIENT	AVG MO COST PER CLIENT
SUPPORT						
Case Management	hours	$35.00	100.0%	16.8	17.03	$596.17
Drop-in Center	hours	$6.00	5.0%	10.0	0.51	$3.04
General Support	hours	$35.00	30.0%	8.0	2.43	$85.17
Protection and Advocacy	hours	$56.34	8.0%	2.0	0.16	$9.14
ADD NEW SERVICES ABOVE LAST ROW ONLY						$693.51
REHABILITATION						
Psychiatric Rehab	3-hour days	$25.00	40.0%	20.0	8.11	$202.78
Voc/Ed Assessment	4-hour days	$42.00	0.0%		0.00	$0.00
Sheltered Workshop	4-hour days	$31.00	15.0%	12.0	1.82	$56.57
Supported Work/TEP	4-hour days	$24.00	16.0%	18.0	2.92	$70.08
Job Finding/Development	hours	$39.00	0.0%		0.00	$0.00
Educational Services	hours	$42.00	0.0%		0.00	$0.00
ADD NEW SERVICES ABOVE LAST ROW ONLY						$329.43
RESIDENTIAL						
Intensive Residential	days	$143.00	35.0%	30.0	10.65	$1,522.35
Specialty Residential	days	$78.00	32.0%	30.0	9.73	$759.20
Basic Residential	days	$52.00	5.0%	30.0	1.52	$79.08
Respite	days	$52.00	10.0%	7.0	0.71	$36.91
Foster Care	days	$30.00	10.0%	30.0	3.04	$91.25
Family Subsidy	days	$30.00	5.0%	30.0	1.52	$45.63
Sup. Indep. Living/S	days	$5.75	0.0%		0.00	$0.00
Sup. Indep. Living	days	$0.00	21.0%	30.0	6.39	$0.00
ADD NEW SERVICES ABOVE LAST ROW ONLY						$2,534.42
TREATMENT						
Specialty Hospital	days	$278.25	1.0%	10.0	0.10	$28.21
Community Hospital	days	$374.85	2.0%	10.0	0.20	$76.01
Crisis Beds	days	$111.00	16.5%	10.0	1.67	$185.69
Emergency Assessment	hours	$81.00	13.0%	7.8	1.03	$83.27
Mobile Treatment Team	hours	$39.00	21.0%	30.0	6.39	$249.11
Counseling	hours	$40.00	5.0%	3.0	0.15	$6.08
Family Treatment	hours	$40.00	2.5%	3.0	0.08	$3.04
Subtance Abuse Tx-Outpt.	hours	$40.00	5.0%	4.0	0.20	$8.11
Med Maintenance	hours	$71.00	81.0%	0.9	0.74	$52.48
Intensive Day Treatment 3-hour	days	$32.00	10.0%	20.0	2.03	$64.89
subtot					12.59	$756.91
TOTAL MONTHLY COST PER CLIENT						$4,314.27

SERVICE PROGRAM OPTIONS TO BE IMPLEMENTED IN THE
PERIOD 1989-1993 FOR FUNCTIONAL LEVEL III CLIENTS

SERVICE COMPONENT	TYPE UNIT	COST PER UNIT	% OF CLIENTS	FREQ PER MO	AVG NO UNITS PER CLIENT	AVG MO COST PER CLIENT
SUPPORT						
Case Management	hours	$35.00	100.0%	9.6	9.73	$340.67
Drop-in Center	hours	$6.00	35.0%	10.0	3.55	$21.29
General Support	hours	$35.00	30.0%	8.0	2.43	$85.17
Protection and Advocacy	hours	$56.34	8.0%	2.0	0.16	$9.14
ADD NEW SERVICES ABOVE LAST ROW ONLY						$456.26
REHABILITATION						
Psychiatric Rehab 3-hour	days	$25.00	15.0%	16.0	2.43	$60.83
Voc/Ed Assessment 4-hour	days	$42.00	2.0%	20.0	0.41	$17.03
Sheltered Workshop 4-hour	days	$31.00	15.0%	20.0	3.04	$94.29
Supported Work/TEP 4-hour	days	$24.00	35.0%	18.0	6.39	$153.30
Job Finding/Development	hours	$39.00	4.0%	7.0	0.28	$11.07
Educational Services	hours	$42.00	2.0%	5.0	0.10	$4.26
ADD NEW SERVICES ABOVE LAST ROW ONLY						$340.79
RESIDENTIAL						
Intensive Residential	days	$143.00	0.0%		0.00	$0.00
Specialty Residential	days	$78.00	32.0%	30.0	9.73	$759.20
Basic Residential	days	$52.00	37.0%	30.0	11.25	$585.22
Respite	days	$52.00	10.0%	7.0	0.71	$36.91
Foster Care	days	$30.00	10.0%	30.0	3.04	$91.25
Family Subsidy	days	$30.00	10.0%	30.0	3.04	$91.25
Sup. Indep. Living/S	days	$5.75	0.0%		0.00	$0.00
Sup. Indep. Living	days	$0.00	31.0%	30.0	9.43	$0.00
ADD NEW SERVICES ABOVE LAST ROW ONLY						$1,563.82
TREATMENT						
Specialty Hospital	days	$278.25	1.0%	10.0	0.10	$28.21
Community Hospital	days	$374.85	1.0%	10.0	0.10	$38.01
Crisis Beds	days	$111.00	16.5%	7.0	1.17	$129.99
Emergency Assessment	hours	$81.00	11.0%	5.4	0.60	$48.78
Mobile Treatment Team	hours	$39.00	10.0%	30.0	3.04	$118.63
Counseling	hours	$40.00	15.0%	3.0	0.46	$18.25
Family Treatment	hours	$40.00	2.5%	3.0	0.08	$3.04
Subtance Abuse Tx-Outpt.	hours	$40.00	5.0%	6.0	0.30	$12.17
Med Maintenance	hours	$71.00	81.0%	0.9	0.74	$52.48
Intensive Day Treatment 3-hour	days	$32.00	10.0%	16.0	1.62	$51.91
subtot					8.22	$501.46
TOTAL MONTHLY COST PER CLIENT						$2,862.33

SERVICE PROGRAM OPTIONS TO BE IMPLEMENTED IN THE
PERIOD 1989-1993 FOR FUNCTIONAL LEVEL IV CLIENTS

SERVICE COMPONENT	TYPE UNIT	COST PER UNIT	% OF CLIENTS	FREQ PER MO	AVG NO UNITS PER CLIENT	AVG MO COST PER CLIENT
SUPPORT						
Case Management	hours	$35.00	100.0%	2.5	2.53	$88.72
Drop-in Center	hours	$6.00	50.0%	10.0	5.07	$30.42
General Support	hours	$35.00	25.0%	5.0	1.27	$44.36
Protection and Advocacy	hours	$56.34	8.0%	2.0	0.16	$9.14
ADD NEW SERVICES ABOVE LAST ROW ONLY						$172.63
REHABILITATION						
Psychiatric Rehab 3-hour	days	$25.00	25.0%	8.0	2.03	$50.69
Voc/Ed Assessment 4-hour	days	$42.00	2.0%	20.0	0.41	$17.03
Sheltered Workshop 4-hour	days	$31.00	5.0%	20.0	1.01	$31.43
Supported Work/TEP 4-hour	days	$24.00	40.0%	18.0	7.30	$175.20
Job Finding/Development	hours	$39.00	4.0%	7.0	0.28	$11.07
Educational Services	hours	$42.00	5.0%	6.0	0.30	$12.78
ADD NEW SERVICES ABOVE LAST ROW ONLY						$298.21
RESIDENTIAL						
Intensive Residential	days	$143.00	0.0%		0.00	$0.00
Specialty Residential	days	$78.00	0.0%		0.00	$0.00
Basic Residential	days	$52.00	58.0%	30.0	17.64	$917.37
Respite	days	$52.00	3.0%	3.0	0.09	$4.75
Foster Care	days	$30.00	5.0%	30.0	1.52	$45.63
Family Subsidy	days	$30.00	10.0%	30.0	3.04	$91.25
Sup. Indep. Living/S	days	$5.75	12.0%	30.0	3.65	$20.99
Sup. Indep. Living	days	$0.00	25.0%	30.0	7.60	$0.00
ADD NEW SERVICES ABOVE LAST ROW ONLY						$1,079.97
TREATMENT						
Specialty Hospital	days	$278.25	0.0%		0.00	$0.00
Community Hospital	days	$374.85	0.0%		0.00	$0.00
Crisis Beds	days	$111.00	0.0%		0.00	$0.00
Emergency Assessment	hours	$81.00	9.0%	5.4	0.49	$39.91
Mobile Treatment Team	hours	$39.00	0.0%		0.00	$0.00
Counseling	hours	$40.00	10.0%	3.0	0.30	$12.17
Family Treatment	hours	$40.00	2.5%	3.0	0.08	$3.04
Subtance Abuse Tx-Outpt.	hours	$40.00	20.0%	3.0	0.61	$24.33
Med Maintenance	hours	$71.00	81.0%	0.7	0.57	$40.82
Intensive Day Treatment 3-hour	days	$32.00	15.0%	5.0	0.76	$24.33
subtot					2.82	$144.60
TOTAL MONTHLY COST PER CLIENT						$1,695.41

SERVICE PROGRAM OPTIONS TO BE IMPLEMENTED IN THE
PERIOD 1989-1993 FOR FUNCTIONAL LEVEL V CLIENTS

SERVICE COMPONENT	TYPE UNIT	COST PER UNIT	% OF CLIENTS	FREQ PER MO	AVG NO UNITS PER CLIENT	AVG MO COST PER CLIENT
SUPPORT						
Case Management	hours	$35.00	100.0%	2.0	2.03	$70.97
Drop-in Center	hours	$6.00	35.0%	20.0	3.55	$21.29
General Support	hours	$35.00	25.0%	2.0	0.51	$17.74
Protection and Advocacy	hours	$56.34	8.0%	2.0	0.16	$9.14
ADD NEW SERVICES ABOVE LAST ROW ONLY						$119.15
REHABILITATION						
Psychiatric Rehab 3-hour	days	$25.00	0.0%		0.00	$0.00
Voc/Ed Assessment 4-hour	days	$42.00	2.0%	20.0	0.41	$17.03
Sheltered Workshop 4-hour	days	$31.00	0.0%		0.00	$0.00
Supported Work/TEP 4-hour	days	$24.00	40.0%	18.0	7.30	$175.20
Job Finding/Development	hours	$39.00	10.0%	3.0	0.30	$11.86
Educational Services	hours	$42.00	0.0%		0.00	$0.00
ADD NEW SERVICES ABOVE LAST ROW ONLY						$204.10
RESIDENTIAL						
Intensive Residential	days	$143.00	0.0%		0.00	$0.00
Specialty Residential	days	$78.00	0.0%		0.00	$0.00
Basic Residential	days	$52.00	0.0%		0.00	$0.00
Respite	days	$52.00	3.0%	3.0	0.09	$4.75
Foster Care	days	$30.00	5.0%	30.0	1.52	$45.63
Family Subsidy	days	$30.00	15.0%	30.0	4.56	$136.88
Sup. Indep. Living/S	days	$5.75	23.0%	30.0	7.00	$40.23
Sup. Indep. Living	days	$0.00	72.0%	30.0	21.90	$0.00
ADD NEW SERVICES ABOVE LAST ROW ONLY						$227.47
TREATMENT						
Specialty Hospital	days	$278.25	0.0%		0.00	$0.00
Community Hospital	days	$374.85	0.0%		0.00	$0.00
Crisis Beds	days	$111.00	0.0%		0.00	$0.00
Emergency Assessment	hours	$81.00	3.0%	2.7	0.00	$6.65
Mobile Treatment Team	hours	$39.00	0.0%		0.00	$0.00
Counseling	hours	$40.00	10.0%	2.0	0.20	$8.11
Family Treatment	hours	$40.00	5.0%	2.0	0.10	$4.06
Subtance Abuse Tx-Outpt.	hours	$40.00	20.0%	2.0	0.41	$16.22
Med Maintenance	hours	$71.00	77.0%	0.7	0.55	$38.80
Intensive Day Treatment 3-hour	days	$32.00	30.0%	8.0	2.43	$77.87
subtot					3.77	$151.71
TOTAL MONTHLY COST PER CLIENT						$702.42

SERVICE PROGRAM OPTIONS TO BE IMPLEMENTED IN THE
PERIOD 1989-1993 FOR FUNCTIONAL LEVEL VI CLIENTS

SERVICE COMPONENT	TYPE UNIT	COST PER UNIT	% OF CLIENTS	FREQ PER MO	AVG NO UNITS PER CLIENT	AVG MO COST PER CLIENT
SUPPORT						0
						0
Case Management	hours	$35.00	100.0%	0.5	0.51	$17.74
Drop-in Center	hours	$6.00	25.0%	10.0	2.53	$15.21
General Support	hours	$35.00	5.0%	3.0	0.15	$5.32
Protection and Advocacy	hours	$56.34	8.0%	2.0	0.15	$8.57
ADD NEW SERVICES ABOVE LAST ROW ONLY						$46.84
REHABILITATION						
Psychiatric Rehab 3-hour	days	$25.00	0.0%		0.00	$0.00
Voc/Ed Assessment 4-hour	days	$42.00	1.3%	20.0	0.26	$11.07
Sheltered Workshop 4-hour	days	$31.00	0.0%		0.00	$0.00
Supported Work/TEP 4-hour	days	$24.00	0.0%		0.00	$0.00
Job Finding/Development	hours	$39.00	17.0%	2.0	0.34	$13.44
Educational Services	hours	$42.00	0.0%		0.00	$0.00
ADD NEW SERVICES ABOVE LAST ROW ONLY						$24.52
RESIDENTIAL						
Intensive Residential	days	$143.00	0.0%		0.00	$0.00
Specialty Residential	days	$78.00	0.0%		0.00	$0.00
Basic Residential	days	$52.00	0.0%		0.00	$0.00
Respite	days	$52.00	1.0%	7.0	0.07	$3.69
Foster Care	days	$30.00	0.0%		0.00	$0.00
Family Subsidy	days	$30.00	0.0%		0.00	$0.00
Sup. Indep. Living/S	days	$5.75	30.0%	30.0	9.13	$52.47
Sup. Indep. Living	days	$0.00	68.0%	30.0	20.68	$0.00
ADD NEW SERVICES ABOVE LAST ROW ONLY						$56.16
TREATMENT						
Specialty Hospital	days	$278.25	0.0%		0.00	$0.00
Community Hospital	days	$374.85	0.0%		0.00	$0.00
Crisis Beds	days	$111.00	0.0%		0.00	$0.00
Emergency Assessment	hours	$81.00	5.0%	3.2	0.16	$13.14
Mobile Treatment Team	hours	$39.00	0.0%		0.00	$0.00
Counseling	hours	$40.00	25.0%	3.0	0.76	$30.42
Family Treatment	hours	$40.00	12.5%	3.0	0.38	$15.21
Subtance Abuse Tx-Outpt.	hours	$40.00	20.0%	3.0	0.61	$24.33
Med Maintenance	hours	$71.00	64.0%	0.6	0.39	$27.64
Intensive Day Treatment 3-hour	days	$32.00			0.00	$0.00
subtot					2.30	$110.74
TOTAL MONTHLY COST PER CLIENT						$238.26

UNITS AND COSTS OF SERVICE
FOR THE PERIOD
1989 to 1998
IN 1987 DOLLARS

SERVICE COMPONENT	TYPE UNIT	COST PER UNIT	PLAN IMPLEMENTATION PERIOD 1989 to 1993 TOTAL UNITS	PROGRAMS	COSTS	PERIOD OF MAJOR PLAN IMPACT 1994 - 1996 TOTAL UNITS	PROGRAMS	COSTS	1997 - 1998 TOTAL UNITS	PROGRAMS	COSTS
SUPPORT											
Case Management	hours	35	178,397		6,243,898	129,623		4,536,819	121,910		4,266,849
Drop-in Center	hours	6	177,865		1,067,190	165,772		994,638	162,327		973,962
General Support	hours	35	41,624		1,456,847	30,181		1,056,324	27,935		977,712
Protection & Advocacy	hours	56	8,537		480,985	8,294		467,305	8,291		467,110
Subtotal					9,248,920			7,055,086			6,685,634
REHABILITATION											
Psychiatric Rehab	days	25	48,443	186 sl	1,211,069	29,626	114 sl	740,645	26,221	101 sl	655,532
Voc/Ed Assessment	days	42	17,689	68 sl	742,933	16,839	65 sl	707,228	16,582	64 sl	696,435
Sheltered Workshop	days	31	38,810	149 sl	1,203,095	24,283	93 sl	752,785	22,096	85 sl	684,964
Supported Work/TEP	days	24	234,314	901 sl	5,623,539	190,320	732 sl	4,567,682	173,398	667 sl	4,161,549
Job Finding/Development	hours	39	15,628		609,477	15,997		623,873	16,210		632,189
Educational Services	hours	42	3,526		148,063	2,265		95,141	1,910		80,206
Subtotal					9,538,196			7,487,354			6,910,875
RESIDENTIAL											
Intensive Residential	days	143	50,115	159 bd	8,310,416	42,103	115 bd	6,020,714	40,246	110 bd	5,755,170
Specialty Residential	days	78	65,613	180 bd	5,117,834	34,502	95 bd	2,691,183	31,672	87 bd	2,470,410
Basic Residential	days	52	232,781	638 bd	12,104,621	145,404	398 bd	7,560,985	123,533	338 bd	6,423,724
Respite	days	52	8,548	23 bd	444,500	6,382	17 bd	331,946	6,167	17 bd	320,661
Foster Care	days	30	61,837	169 bd	1,855,122	46,658	128 bd	1,399,738	42,575	117 bd	1,227,265
Family Subsidy	days	30	126,114	346	3,783,434	106,233	291	3,187,001	97,553	267	2,926,575
Sup. Ind Liv/subsidy	days	6	321,629	881 bd	1,849,365	362,890	994 bd	2,085,618	375,410	1,029 bd	2,158,607
Sup. Ind Living	days	0	896,524	2,456 bd	0	959,944	2,630 bd		980,144	2,685 bd	0
Subtotal					33,465,292			23,278,085			21,332,412
TREATMENT											
Specialty Hospital	days	278	18,419	50 bd	5,125,137	14,185	39 bd	3,947,115	13,675	37 bd	3,805,108
Community Hospital	days	375	1,779	5 bd	666,915	1,183	3 bd	443,471	1,121	3 bd	420,279
Crisis Beds	days	111	11,955	32 bd	1,315,851	7,088	19 bd	786,718	6,626	18 bd	735,527
Emergency Assessment	hours	81	16,839		1,363,934	13,335		1,080,142	12,848		1,040,726
Mobile Treatment Team	hours	39	40,699		1,587,279	25,519		995,256	23,999		935,958
Counseling	hours	40	22,998		919,922	25,247		1,009,889	26,557		1,062,284
Family Treatment	hours	40	10,024		400,974	11,773		470,940	12,544		501,751
Substance Abuse Tx-Outpt.	hours	40	26,434		1,057,354	26,972		1,078,870	27,372		1,094,852
Med Maintenance	hours	71	30,532		2,167,772	27,727		1,968,638	27,246		1,934,432
Intensive Day Treatment	days	32	65,557	252 sl	2,097,813	55,928	215 sl	1,789,666	52,025	200 sl	1,664,806
Subtotal					16,702,951			13,570,724			13,195,733
Total					68,955,359			51,391,249			48,174,454

1. Residential Service Units are divided by 365 to obtain beds.

2. Non-Residential Day Services are divided by 260 to derive # of slots.

3. Psych Rehab & Int. Day Tm - "days" = 3 hours. Voc/Ed Assess, Shelt Wrkshp, & Sup Wrk/TEP - "days" = 4 hours.

RHODE ISLAND CLIENT DATA FORM
SERVICE PROGRAMS BASELINE

1. Facility/Program code (see attached list) 1. _____

2. Client code 2. _____

3. Date of Birth 3. __/__/__

4. Sex 4. _____

Male (1)
Female (2)

5. Race 5. _____

American Indian/Alaskan Native (1)
Asian/Pacific Islander (2)
Black (Non-Hispanic) (3)
White (Non-Hispanic) (4)
Hispanic Origin (5)
Other (6)
If other, specify: _____
Unknown (7)

6. Functional level 6. _____

Of Potential Harm (1)
Dysfunctional/Acute (2)
Lacks ADL/Personal Care Skills (3)
Lacks Community Living Skills (4)
Needs Role Support/Treatment for Routine Stress (5)
Needs Role Support/Treatment for Extreme Stress or Seeks Treatment Voluntarily (6)
System Independent (7)

7. Primary Diagnosis 7. _____

Schizophrenia (1)
Major Affective Disorder (2)
Organic Brain Syndrome (3)
Mental Retardation (4)
Substance Abuse (5)
Personality Disorder (6)
Don't know (7)
None (8)
Other (9)
If other, specify: _____

8. Secondary Diagnosis 8. _____

Schizophrenia (1)
Major Affective Disorder (2)
Organic Brain Syndrome (3)
Mental Retardation (4)
Substance Abuse (5)
Personality Disorder (6)
Don't know (7)
None (8)
Other (9)
If other, specify: _____

9. Most frequent housing situation in last 6 months (Choose 1) 9. ____

Street (1)
Shelter-temporary (2)
Hospital (3)
Prison (4)
Nursing Home (5)
Parents/Family (6)
Alone/Friends (7)
Sheltered Care (Non-DMH) (8)
DMH Supervised housing (9)
Other (10)

10. What payment/income source(s) does this client have for MH treatment and/or housing? (Code all that apply-1)
(Code all 'no'-2)
(Code all 'Don't Know'-3)

Medicaid 10a. ____
Medicare 10b. ____
SSI 10c. ____
SSDI 10d. ____
Private insurance 10e. ____
GPA 10f. ____
AFDC 10g. ____
VA 10h. ____
Gainful employment 10i. ____
Parental/Spouse Support 10j. ____
Other 10k. ____

11a. Does this client have a written service plan? 11a. ____

Yes (1)
No (2)

11b. Date of most recent service plan 11b. __/____

12. Type of Case Manager

ILA 12a. ____
General 12b. ____
Other 12c. ____
If other, specify: _____
None 12d. ____

CODER'S NAME _____

WORK TEL.# _____

DATE: _____

SERVICE COMPONENT	Type Unit	(1) Check If Service In Client Service Plan	(2) # Units Actually Provided To Client Past Month	(3) Services (Fewer Or More) Client Should Ideally Receive With Estimate Of Number Of Units Per Month	(4) Reasons Why Services In Column 3 Not Provided Or Fewer/More Units Than Column 2 (Indicate All That Apply)
RESIDENTIAL					
13a. Specialty Hospital	day	a.1 _____	a.2 _____	a.3 _____	a.4 _____
b. Community Hospital	day	b.1 _____	b.2 _____	b.3 _____	b.4 _____
c. Crisis Beds	day	c.1 _____	c.2 _____	c.3 _____	c.4 _____
d. Respite Beds	day	d.1 _____	d.2 _____	d.3 _____	d.4 _____
e. Basic Residential	day	e.1 _____	e.2 _____	e.3 _____	e.4 _____
f. Specialty Residential	day	f.1 _____	f.2 _____	f.3 _____	f.4 _____
g. Intensive Residential	day	g.1 _____	g.2 _____	g.3 _____	g.4 _____
h. Foster Care	day	h.1 _____	h.2 _____	h.3 _____	h.4 _____
i. Family Subsidy	day	i.1 _____	i.2 _____	i.3 _____	i.4 _____
j. Independent Living	day	j.1 _____	j.2 _____	j.3 _____	j.4 _____
TREATMENT			CODE IN MONTHS		
k. Emergency Assessment	hours	k.1 _____	k.2 _____	k.3 _____	k.4 _____
l. Mobile Treatment Team	days	l.1 _____	l.2 _____	l.3 _____	l.4 _____
m. Counseling	hours	m.1 _____	m.2 _____	m.3 _____	m.4 _____
n. Family Treatment	hours	n.1 _____	n.2 _____	n.3 _____	n.4 _____
o. Substance Abuse Tx-Outpt	hours	o.1 _____	o.2 _____	o.3 _____	o.4 _____
p. Med Maintenance	hours	p.1 _____	p.2 _____	p.3 _____	p.4 _____
q. Day Treatment	hours	q.1 _____	q.2 _____	q.3 _____	q.4 _____
r. Day Activities	hours	r.1 _____	r.2 _____	r.3 _____	r.4 _____
REHABILITATION			CODE IN MONTHS		
s. Voc/Ed Assessment	hours	s.1 _____	s.2 _____	s.3 _____	s.4 _____
t. Sheltered Workshop	hours	t.1 _____	t.2 _____	t.3 _____	t.4 _____
u. Supported Work & TEP	hours	u.1 _____	u.2 _____	u.3 _____	u.4 _____
v. Job Finding/Development	hours	v.1 _____	v.2 _____	v.3 _____	v.4 _____
w. Educational Services	hours	w.1 _____	w.2 _____	w.3 _____	w.4 _____
SUPPORT			CODE IN MONTHS		
x. Case Management	hours	x.1 _____	x.2 _____	x.3 _____	x.4 _____
y. Drop-in Center	hours	y.1 _____	y.2 _____	y.3 _____	y.4 _____
z. General Support	hours	z.1 _____	z.2 _____	z.3 _____	z.4 _____
aa. Protection/Advocacy	hours	aa.1 _____	aa.2 _____	aa.3 _____	aa.4 _____

****

* LIST OF REASONS FOR COLUMN 4

01 Service was not available
02 Ideal service was not available
03 Service has insufficient capacity
04 Client was refused for behavioral reasons
05 Inability to pay
06 Client refused service
07 Clinician/case manager discretion
08 Accessibility (transportation, handicapped access, etc.)
09 Language or cultural barrier
10 Patient/family/other request
11 Any other reason not listed above

specify: _____

Net Need Per Month

Phase I: 1989 - 1993

Service	Unit of Utilization	Total Need Per Month	Current Volume Per Month	Net Need Per Month
Support				
Case Management	Hours	14,866	7093	7773
Drop-In Center	Hours	14,822	515	14,307
General Support	Hours	3469	1256	2213
Protection & Advocacy	Hours	711	213	498
Rehabilitation				
Psychiatric Rehab.	Hours[1]	12,111	31,139	-19,028
Voc/Ed Assessment	Hours[2]	5896	1494	4402
Sheltered Workshop	Hours[2]	12,937	5793	7145
Supported Work/TEP	Hours[2]	78,105	4699	73,406
Job Finding/Development	Hours	1302	350	952
Educational Services	Hours	294	489	-195
Residential				
Intensive Residential	Days	159bd[3]	5bd[3]	154bd[3]
Specialty Residential	Days	180bd[3]	42bd[3]	138bd[3]
Basic Residential	Days	638bd[3]	388bd[3]	250bd[3]
Respite	Days	23bd[3]	6bd[3]	17bd[3]
Foster Care	Days	169bd[3]	6bd[3]	163bd[3]
Family Subsidy	Days	346	0	346
Sup. Ind. Liv. w/Sub.	Days	881bd[3]	0bd[3]	881bd[3]
Sup. Ind. Liv. w/o Sub.	Days	2456bd[3]	3655bd[3]	-1199bd[3]
Treatment				
Specialty Hospital	Days	50	241bd[3]	-191bd[3]
Community Hospital	Days	5	7bd[3]	-2bd[3]
Crisis Beds	Days	32	14bd[3]	18bd[3]
Emergency Assessment	Hours	1403	1014	389
Mobile Treatment Team	Hours	3392	0	3392
Counseling	Hours	1917	1606	311
Family Treatment	Hours	835	117	718
Substance Abuse Treatment	Hours	2203	786	1417
Med Maintenance	Hours[1]	2544	1588	956
Intensive Day Treatment	Hours[1]	16,389	0	16,389
TOTAL				

1. Three-hour slots converted to hours.
2. Four-hour slots converted to hours.
3. Days converted to beds.

APPENDIX C

The material in this appendix describes the array of services developed during Vermont's implementation of the "regionalization" concept. These services were developed with a combination of grant and general fund monies and were primarioy intended to provide a more effective approach to mental health treatment for the severely disabled in the community. The source document for this list is Final Report-- Fulfilling the Vision : Completion of the Community Based System in Vermont , State of Vermont Agency of Human Services, Department of Mental Health, Appendix I, RWJF Grant No. 12502, August 1, 1987-July 31, 1989, Updated April 2, 1990.

RWJF Grant No. 12502 (Appendix I)
April 2, 1990

SERVICE ENHANCEMENTS TO COMMUNITY MENTAL HEALTH CENTERS
AS A RESULT OF REGIONALIZATION FUNDS
FISCAL YEARS 1988-1990

Counseling Service of Addison County. 1988: Establishment of a paraprofessional team to work with psychiatrically disabled clients who need routine support services and/or crisis support services in the clients' home environment. 1989: Establishment of an Alternative Hospital program to work with Community Rehabilitation and Treatment clients in crisis, consisting of an additional 4.5 FTE. 1990: Establishemnt of a housing contingency fund for persons with severe and persistent mental illness waiting for Section Eight housing subsidies. Total FTE positions created: 11.

Franklin/Grand Isle Mental Health Services. 1988: Establishment of one case management position and the funding of the operational costs of a community care home which serves psychiatrically disabled clients. 1990: Establishment of a housing contingency fund for persons with severe and persistent mental illness waiting for Section Eight housing subsidies. Total FTE positions created: 1.

Howard Mental Health Services. 1988: Modification and expansion of capacity to provide home-based intensive case management services and home-based crisis support to all psychiatrically disabled clients twenty-four hours a day, seven days a week. HMHS contracted with the Medical Center Hospital of Vermont for two endowed beds for HMHS clients in danger of VSH hospitalization. 1989: Expansion of Assist Program by 1 FTE to increase capability to provide double coverage during peak hours. 1990: Establishment of a community-based, outreach-oriented crisis service, located at HMHS and coordinated with other HMHS services. This involves relocating and restructuring the current Crisis Services of Chittenden County. Total FTE positions created: 13.

Lamoille County Mental Health Services. 1988: Establishment of three additional case management positions and one emergency service position to work with psychiatrically disabled clients. Two temporary community care home staff positions will be funded for six months. 1989: Establishment of two aditional case management positions so that the center can provide seven-day-per-week, sixteen-hour-per-day outreach case management services to CRT population with their crisis services center as backup. 1990: Establishment of three new crisis support positions so that a mobile crisis support team can provide twenty-four-hour, seven-day-a-week coverage to persons with severe and persistent mental illness. Establishment of a crisis bed program in a community apartment and the development of hospital bed capacity at Copley Hospital. Establishment of a housing contingency fund for persons with severe

and persistent mental illness who are waiting for Section Eight housing subsidies. Total FTE positions created: 9.

Mental Health Services of Southeastern Vermont. 1988: Establishment of two case management positions to work with psychiatrically disabled clients. Establishment of staff positions to work with psychiatrically disabled clients in Rockingham Hospital. 1989: Establishment of a mobile crisis support team consisting of one coordinator and four FTE positions to provide outreach support services to CRT persons in crisis. This team is available twenty-four hours a day, seven days a week. 1990: Establishment of a housing contingency fund for persons with severe and persistent mental illness who are waiting for Section Eight housing subsidies. Total FTE positions created: 12.

Northeast Kingdom Mental Health Services. 1988: Establishment of six positions to work with psychiatrically disabled clients to include four case managers and two day treatment staff. 1989: Establishment of 2 day emergency positions to work out of the St. Johnsbury and Newport offices to provide crisis intervention services. Expansion of the case management services by 6 FTE to add capacity to provide support services to CRT clients. 1990: Establishment of a housing contingency fund for persons with severe and persistent mental illness who are waiting for Section Eight housing subsidies. Total FTE positions created: 14.

Orange County Mental Health Services. 1989: Establishment of one FTE crisis outreach support position to work with CRT clients. This position would be blended into an already existing team. 1990: Establishment of a housing contingency fund for persons with severe and persistent mental illness waiting for Section Eight housing subsidies. Total FTE positions created: 1.

Rutland Mental Health Services. 1988: Establishment of three case management positions and one-half crisis worker to work with psychiatrically disabled clients. 1989: Establishment of three additional case management positions and a half-time crisis position to increase capacity to provide seven-day, twenty-four-hour intensive outreach case management services to between forty and forty-five CRT clients needing this level of support. 1990: Subsidy to develop a community care home in Fair Haven. Establishment of a housing contingency fund for persons with severe and persistent mental illness waiting for Section Eight housing subsidies. Total FTE positions created: 7.

United Counseling Service of Bennington County. 1988: Establishment of a paraprofessional team to work with psychiatrically disabled clients who need routine support services and/or crisis support services in the clients' home environment. 1989: Establishemnt of after-hours, weekend, and holiday on-call system at local psychiatric inpatient unit. 1990: Establishment of a housing contingency fund for persons with severe and persistent mental illness waiting for Section Eight housing subsidies. Total FTE

positions created: 3.

Washington County Mental Health Services. 1988: Establishment of 4.5 case management positions to serve psychiatrically disabled clients; 2.5 of these positions will serve "difficult-to-serve" clients, and the other two positions will focus on providing housing support services. Additional staff support to Central Vermont hospital for on-call and medical services. 1989: (1) Establishment of a crisis intervention team to work with CRT clients in crisis who refuse other forms of voluntary care (hospital, day hospital, emergency bed, etc.); (2) establishment of an apartment support program in Waterbury; (3) increase MD coverage so as to provide inpatient coverage at local hospital; (4) increase funding for crisis support program; (5) incrase capacity at day hospital by one staff position. 1990: Establishment of eight new positions. Four positions to be added to the Apartment Program and the other four positions to form a second Hospital Intervention Team. These eight positions will work as an interim team to transition ten long-term VSH patients into a appropriate community setting. Establishment of a housing contigency fund for persons with severe and persistent mental illness who are waiting for Section Eight housing subsidies. Total FTE positions created: 2.

Alliance for the Mentally Ill. 1988: Seed funding to hire an executive director. Total FTE positions created: 1.

Green Mountain Support Group. 1990: Establishment of increased operating budget to meet increased consumer demand for this service.

Grand total, statewide FTE positions created: 94.